

**‘FAMILIES AT RISK’ –
A CRITICAL ANALYSIS OF IMPLICATIONS FOR
POLICY AND SERVICES**

A Thesis submitted in fulfilment of the requirements for the Degree of
Doctor of Philosophy in the:
Department of Politics and International Studies
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LIST OF ABBREVIATIONS

AHMAC	Australian Health Ministers Advisory Council
ARC	Australian Research Council
SACOSS	South Australian Council of Social Service
UK	United Kingdom
UNICEF	United Nations Children's Fund
USA	United States of America
WHO	World Health Organization

THESIS SUMMARY

This thesis examines policy and service delivery issues in the development of health and support for ‘families at risk’. The research focuses on families with children less than 7 years of age living in some of the most disadvantaged neighbourhoods of metropolitan Adelaide. The thesis draws on evidence of (a) barriers to service support perceived by these families and (b) their strengths and resources in order to identify and develop arguments related to key issues of policy and service delivery.

The thesis was developed using data from two sources: survey interviews with a research population of 500 families and in-depth qualitative research conversations with a subset of fourteen mothers and their front-line service providers. The largely quantitative survey data enabled a detailed local picture of associations between social disadvantage, support and service use, and family health and well-being to be drawn. In addition, the ‘lay knowledge’ of mothers and their service providers gathered in the qualitative research, extended and in some instances challenged, the large-scale survey data by providing:

- ‘thick’ descriptions related to the strengths and resources of mothers of young children and of their experiences of service support;
- insight into the dynamics of ‘helpful help’ and the potential of service relationships and practices to challenge social health inequalities.

The doctoral research was one part of the Australian Research Council (ARC) funded *Linkages* project - *Families at Risk: their strengths, resources, access to services and*

barriers. The author was a member of the collaborative research team responsible for this project and has been centrally involved in the conduct of the quantitative field research interviews and in the drafting of key reports produced by the project team. At the same time, the author worked independently in conducting the qualitative research conversations and in developing and writing this thesis.

The thesis research framework is drawn from critical population health and feminist perspectives. People's strengths and resources are understood to be (re)produced by fundamental societal processes which shape the relationships between them as individual 'agents' and the socioeconomic, cultural, living environments and political landscapes they inhabit. The first three chapters of the thesis are devoted to the research literature and the policy and service contexts within which research questions about how best to support 'families at risk' are being asked.

Both quantitative and qualitative research evidence have been employed in the second part of the thesis to examine the ways in which the unequal distribution of health-determining conditions and unequal social relations fundamentally determine parents' and children's health and well-being. From this, the need for a paradigm shift from one focused primarily on parents' (mothers') individual strengths or deficits to a focus on redressing social health inequalities, framed the thesis argument regarding implications for services. In these chapters, theory and practice issues which constitute these different problem understandings and more equal social power relations are examined.

In summary, the thesis contributes to the body of knowledge about the mechanisms which link structure and agency to reproduce or challenge social health inequalities and, in particular, the potential of family support services to contribute to achieving health equity.

Statement of Sources

I certify that this thesis does not incorporate without acknowledgment any material previously submitted for a degree or diploma in any university; and that to the best of my knowledge and belief it does not contain any material previously published or written by another person except where due reference is made in the text and as noted below.

.....

Data, mainly in the form of figures and tables, which were developed by other members of the *Families at Risk* research team, have been reproduced in this thesis and are specifically acknowledged:

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¹ The project's website can be viewed at:
<http://ehlt.flinders.edu.au/education/FamilyNeeds/index.htm>.

CHAPTER 1: EVIDENCE, POLICY AND IMPLEMENTATION: THE RESEARCH IN CONTEXT

This research project is located within large and complex fields of fertile and well tilled literature. The thesis aims to contribute in some areas where there are significant gaps, particularly those in the health inequalities literature which are related to the effects of gender and the role of unequal social power relations in generating health inequalities (Macintyre 1997; Williams 2003; Ostlin, Sen et al. 2004). The origins of this thesis were in the broad research questions framed by an Australian Research Council (ARC) funded *Linkages* project - *Families at Risk: their strengths, resources, access to services and barriers* – of which it was one part. These broad research questions were - What are the strengths, resources, access to services, and barriers to support, experienced by parents of young children living in areas of concentrated disadvantage? In addition, what are the policy and service implications which follow from these?

In the original ARC project proposal this last question was the designated focus for the doctoral research. The data sources for this thesis included the primarily quantitative survey interview data collected by field researchers employed by the *Families at Risk* project, as well as qualitative data transcribed from in-depth interviews facilitated by the author. The intention was not to deliberately compare the two sets of data, but rather to use the quantitative data to map out general patterns and associations and the qualitative to reveal the social processes and meanings which underpin the determinants of health and their unequal distribution. However, there are numerous examples (see Chapters Five and Six in particular) of the qualitative data

providing complex and challenging descriptions of constructs which had been used unproblematically in the survey interviews.

The aim of this first chapter is to outline the various contexts for this research and outline the aims, theoretical underpinnings and research approaches of the *Families at Risk* study and of this thesis.

1.2 The Families at Risk project description

Families at Risk: their strengths, resources, access to services and barriers was an Australian Research Council *Linkages*² project funded for the period 2000-2003 as a collaboration between the Flinders University (FUSA), The University of South Australia (UniSA), the South Australian Department of Human Services (DHS)³, and the Women's and Children's Hospital, Adelaide (WCH). The project team comprised academic staff from Education (FUSA), Social Work and Social Policy (UniSA), policy and research workers (DHS) and a public health research epidemiologist (WCH), as well as a doctoral research student funded by an Australian Postgraduate Award (Industry) and supported by all the project partners⁴. In addition, three field researchers worked part-time during the intensive periods of data collection and a part-time data analyst was employed for the project's duration.

² At the time of this project's funding the *Linkages* grant program was named Strategic Partnerships with Industry, Research and Training - *SPIRT*.

³ On July 1st 2004, the South Australian Department of Human Services was split to form the Department of Health and Department for Families and Communities.

⁴ The principal supervisor for the PhD was from outside the project and had no involvement in it at any stage. The original intention was that co-supervision would be provided by a member of the research team but this relationship, for various reasons, never developed.

Key questions which informed the development of the *Families at Risk* research project included⁵:

- What barriers (personal, family or service related) are perceived by families (both accessing and non-accessing) as impeding or preventing them from accessing services?
- In their similar contexts of multiple disadvantage, why are some families apparently ‘high’ service users and others ‘low’ (or no) users of services?
- What level and types of resources (services, informal social support and coping strategies) are available to parents living in situations of multiple disadvantage?
- What is the role of social capital?
- Which service type(s) and service delivery strategies best support / build parents’ capacity or resilience?

The documented aims of the *Families at Risk* project were⁶:

1. To employ an innovative sampling procedure to establish contact with a sample group of families who are at risk.
2. To document the demographic indicators, as well as person (parent and child), family, and community characteristics of risk and resilience, including the extent of service use among the families.

⁵ Not all these questions appear in these forms in the original research proposal but were recorded in notes taken by the author during early stage research team meetings about what survey questions/instruments should be piloted for the field research.

⁶ Flinders University, University of SA, Department of Human Services (SA), Women’s and Children’s Hospital, Adelaide. *Families at Risk: their strengths, resources, access to services and barriers*. Unpublished report of the ARC (SPIRT) funded project (December 2003).

3. To examine differences between families who are high and low service users on various factors including child adjustment, social capital, personal and family strengths, available resources, and barriers to service use.
4. To utilise the research findings at a community level to promote some common understanding between service providers and families of the ways in which barriers to service use can be overcome.

The *Families at Risk* project was a study of 500 families⁷ with young children aged 0 to 7 years resident in the lowest socio-economic status Census collection districts of metropolitan Adelaide. Parents⁸ or primary care-givers in these areas were invited to undertake one or two survey interviews about their experiences of parenting, their neighbourhoods and sources of formal and informal help. Ethics clearance for the project was obtained from the relevant ethics committees of the two universities, the WCH Research Ethics committee and, in addition, ethics advice was sought from Yunggorrendi⁹.

The *Families at Risk* target population were families with young children (0-7 years) living in highly disadvantaged circumstances. Hence, twenty-seven metropolitan Adelaide census collection districts (CDs) were selected on the basis of very low

⁷ The term ‘families’ is used in the broadest sense to encompass the range of different family and household formations encountered. The primary care-giver of the young children in each family was the interview participant.

⁸ Use of the term ‘parents’ is somewhat misleading in that 92% of participants were mothers (half of the interview population were sole mothers). Following this, the doctoral research component of the project explicitly applied a gender lens to the issues of parenting in situations of multiple disadvantage.

⁹ Yunggorrendi, the First Nations Centre for Higher Education and Research at Flinders University, is a learning centre which supports the access of Aboriginal and Torres Strait Islander people into tertiary study and establishes an environment where the history and culture of Indigenous Australians is respected and valued.

Australian Bureau of Statistics (ABS) SEIFA¹⁰ scores (using ABS Census 1996) and with a 'high' percentage (20-35%) of families with young children (see Appendices A and B). Participants in the in-depth interviews which were facilitated by the author lived or worked in one geographic section of these CDs. To ensure that the target of around 500 families was enlisted for the project, field interviewers knocked on the doors of more than 5 000 houses to make contact with as many eligible¹¹ families as possible within each selected CD. The survey interviews were then conducted in two stages. The first with 500 caregiver respondents and the second with a random sample of 206 families drawn from these five hundred from stage one. Interview One recorded a range of demographic variables and focussed on questions about children's health and well-being, parental sources of help and advice, financial resources and participants' attitudes and experiences of parenting. Interview Two sought information about stressful events in the participant's life, aspects of housing and neighbourhood, service use, and more about children and parents' health and well-being (see interview schedules in Appendices C.1 and C.2).

In this thesis, Chapters Five and Six in particular feature data collected in these two schedules of interviews. The author participated in the development of these schedules as well as in a small number of these survey interviews in both stages of the project

¹⁰ The Socio-Economic Indexes for Areas (SEIFA) are four summary measures derived from the ABS Census of Population and Housing to measure different aspects of socio-economic conditions by geographic areas (see <http://www.abs.gov.au>). These indexes allow ranking of regions/areas, provide a method to determine the level of social and economic well-being in that region and include:

- *Index of Advantage\Disadvantage* - a continuum of advantage to disadvantage. Low values indicate areas of disadvantage; and high values indicate areas of advantage.
- *Index of Disadvantage* - focuses on low-income earners, relatively lower educational attainment and high unemployment.
- *Index of Economic Resources* - includes variables that are associated with economic resources - rent paid, income by family type, mortgage payments, and rental properties.
- *Index of Education and Occupation* - includes all education and occupation variables only.

¹¹ 'Eligible' families were those with children 0-7, regardless of their actual socio-economic circumstances.

and in the analysis of data for inclusion in the project reports, various seminar presentations and this thesis.

1.2 Implications for services – the thesis project

The intention of the *Families at Risk* project to be of practical use was expressed in its fourth aim, to use the research findings to “promote some common understanding between service providers and families of the ways in which barriers to service use can be overcome”. This aim framed the task of the doctoral research - that is, to engage with service providers and families to explore and interpret the 'evidence' and to develop proposals for policy and practice. Having the ability to tap into service provider networks, in part through the project's partnership with the Department of Human Services, made 'micro-level' research focused on service practices possible. In addition, the author brought her own academic, service and policy networks to the project. Consistent with the *Families at Risk* project's emphasis on 'strengths' she decided to examine practice examples of 'helpful help' – that is, service relationships which women with young children¹² reported experiencing as enabling more positive outcomes for themselves and their children by supporting their values and ability to act in chosen ways¹³. By investigating these helpful service relationships the research aimed to:

¹² The intention was not to discount or deny the experiences and needs of fathers of young children or the necessity for research to improve policy and service responses in this area. Many fathers who are primary care-givers experience being on the 'bottom rung' of the ladder in a world outside of public institutions, especially when they are not in paid work. In also excluding the experiences of Aboriginal women who are mothers of young children, mothers with a physical illness or disability, mothers newly arrived in Australia after fleeing war and insecurity, this thesis project has also excluded the experiences of many women who occupy even lower rungs.

¹³ This is the concept of 'agency' defined as “actions, activities, decisions and behaviours, that represent some level of meaningful choice” (Deacon and Mann 1999). In their definition of agency as “the conscious and ongoing reproduction of the terms of one's existence while taking responsibility for this process”, Alexander and Mohanty (1997) emphasise notions of autonomy and the determination of one's own identity (cited in Lister 1998).

1. illuminate the ways in which mothers and their service providers talk about ‘family needs’; what helps families and why it is helpful; and their experiences of the role of ‘client’ and ‘service provider’;
2. through a close examination of service relations, explore the role and potential of services to redress social health inequalities;
3. develop policy and practice proposals for more effective service support for families with young children living in situations of multiple disadvantage;
4. contribute to mothers’ and service providers’ learning in their efforts to achieve more helpful and empowering relationships.

Women’s experiences of these enabling service relationships were in direct contrast to their more common experiences of feeling not listened to, discounted, judged and ‘done to’ rather than worked with. As these ‘unhelpful’ service relationships replicate the unequal power relations which are known to adversely effect health and well-being it was hypothesised that these instances of ‘helpful help’ could inform better ways of interpreting and responding to family needs. Starting questions which helped focus the research were:

- What constitutes appropriate and effective service support in response to the needs of families with young children living in situations of multiple disadvantage?
- What is or should be the role of the state in providing this support?

The initial research hypothesis was –

That the experiences of service providers and service seekers who are engaged in more equal, respectful and empowering service relationships suggest alternative

(different from the current) roles for ‘client’, service provider, and state-provided family services.

To contribute to an exploration of this hypothesis, in-depth research interviews were conducted with fourteen eligible mothers and their service providers engaged in helpful service relationships (see interview question guide in Appendix D). The accounts they gave in these interviews illuminated many problematic practices encountered by these mothers of young children living in situations of multiple disadvantage. At the same time, many aspects of their descriptions of ‘helpful help’ affirmed current health reform and early childhood policy agendas. Exploring these successful practice examples, or instances of ‘resistance’, was a way of understanding the paradox that the consensus of ideas regarding what families and young children need does not match continuing unhelpful practices.

In addition to the in-depth research conversations, the author worked with *Families at Risk* project team members and at times alone to consult with human services policy makers and service providers. This engagement took a range of different forms.

- Periodic discussions with an industry reference group, which was established in the project’s pilot stage to achieve a two-way flow of information and advice between the research team and human services managers and policy decision makers.
- In 2003, two service provider forums (one in the northern metropolitan area and one in the southern) facilitated by the author, in which *Families at Risk* project team members presented early ‘findings’ and participants gave feedback (both critical and confirming). This feedback guided additional

Families at Risk project data analysis by highlighting issues and questions most relevant to ‘the field’.

- In 2004 and 2005, two conference presentations and discussions¹⁴.
- In 2004-5, a report of the *Families at Risk* project to the South Australian Department of Health (DH) which summarised the research findings and proposed policy and service implications¹⁵. The author produced the draft of this report using contributions from other project team members and report production support from the DH.
- In February 2005, presentation of the survey interview and doctoral research ‘findings’ at a *Children in Disadvantaged Families* seminar organised by the South Australian Department of Health¹⁶. This seminar program included other presentations by leading Australian researchers in this field.
- In response to requests from individual community based health and welfare services throughout the project period, the author contributed to service manager and provider planning activities related to improving outcomes for disadvantaged children and families.

1.3 Ethics approval

In addition to ethics approval for the *Families at Risk* project as a whole from the Flinders University of South Australia, separate approval was gained for the thesis

¹⁴ Roe, M & Morris, A. *The capabilities of women: towards an alternative model of ‘responsibility’ in supporting families and children*. Australian Political Studies Association Conference. Adelaide, October 2004.

Morris, A. & Roe, M. “*Not just a piece of the furniture*” in children’s lives: *The capabilities of women and services for women mothering in disabling environments*. Fifth Australian Women’s Health Conference. Melbourne, April 2005.

¹⁵ P. Slee, Flinders University of SA (to be published in 2006). *Families at Risk: the effects of chronic and multiple disadvantage*. Shannon Research Press, Adelaide.

¹⁶ *Children in Disadvantaged Families – Research and Policy Directions* Seminar. Strategic Planning and Research Branch, Department of Health, South Australia. Held at the Radisson Playford Hotel, Adelaide on February 18, 2005.

research from that University. Separate approvals were then required from the research and ethics committees of each service agency represented in the thesis research sample. These processes of approval took up to six months in some agencies, whilst others were satisfied with viewing the approval notification given by larger service institutions and agencies. These larger agencies also required annual reporting and renewal of ethics approval.

1.4 *Situating the research*

The first three chapters of this thesis provide a necessary exploration of the context in which the research project is situated. There are three key components of this context. One is the evidence-base for policy and practice related to families at risk. The second is health and social policy as it relates to the major issues of the thesis. The third is policy implementation as evidenced by its translation in service provision. Most significant is the relationship between these three components, and the alignment of evidence and policy on the one hand and between policy and services delivered on the other. An important aim of this thesis is to contribute to the narrowing of these evidence-policy-implementation gaps.

In this Chapter One, the issues which have shaped the research questions and approach are broadly surveyed, including issues of evidence, policy and implementation (or lack of it) from a variety of perspectives. Chapter Two will be mainly focused on the evidence-base and the relevant research literature. Chapter Three will provide a more detailed and in-depth exploration of some relevant policies and policy debates.

1.4.1 The politics of evidence and ‘needs’

There is a great deal of local, national and international policy and research interest related to early childhood disadvantage and its effects. Over the past two decades there has been a concerted research effort, in Australia and elsewhere, to investigate the associations between socio-economic status and health and well-being outcomes. There is a broad international early childhood and health inequalities research consensus (see Chapter Two for a review of this literature) based on evidence that:

- (1) the health and well-being of families with young children can be accurately indexed by their position in a society’s socio-economic hierarchies;
- (2) their health and well-being are greatly influenced by the quality of their social relationships and environments; and
- (3) differences in health and well-being outcomes can be attributed largely to the effects of early developmental experiences.

The Australian evidence is clear that health and well-being outcomes are unevenly distributed between population groups and geographic areas and that these inequalities mirror the uneven distribution of socio-economic status¹⁷. This evidence base has provided the impetus for the establishment by the Commonwealth Government of the Health Inequalities Research Collaboration (HIRC) to “enhance Australia’s knowledge on the cause of and effective responses to health inequalities, and to promote vigorously the application of this evidence to reduce health inequalities in Australia (Dixon 2002)”.

¹⁷ Examples include: (National Health Strategy 1992; Glover, Shand et al. 1996; Turrell, Oldenburg et al. 1999; Judge and Paterson 2002; Australian Council of Children and Parenting 2004; Blakely, Hales et al. 2004; Community Affairs Reference Committee 2004; Flood 2004; Hetzel, Page et al. 2004; Stanley, Richardson et al. 2005).

However, despite the growing evidence-base related to promoting the health and well-being of families and children, there are significant barriers to its transformation in social policy, service planning and practice. Labonte (2005) observes:

The ‘divide’ between financial and social policies, embodied within economics itself as the ‘divide’ between equity and efficiency outcomes, may prove the hardest for population health researchers to bridge (p15).

These ‘divides’ are of particular relevance to this thesis and will be introduced briefly in this chapter and explored in more depth in Chapter Three. From a review of policy implementation related to redressing child health inequalities, Hetzel (2003) concluded that “it is difficult to find many current Australian examples of policy related practice that have been based on the best available evidence in the area of health inequalities (Hetzel and Glover 2003)”. The links between evidence, policy and practice are the focus of intensifying interest and the territory of this thesis.

In this thesis project, it is argued that research, needs interpretation and policy development are primarily political rather than rational processes which require going beyond reliance on ‘scientific’ approaches and traditional forms of evidence. Recognition of the political nature of research highlights the ways in which assessments of strengths and needs are intertwined with proposals and assumptions about what strengths are desirable and which needs are legitimate (Tesh 1988; Skeggs 1994; Seedhouse 1997; Bryant 2002). The priority of these needs in the allocation of social resources and the role of the state in relation to families and communities are the subject of much political debate.

How the relationships between individual women/mothers, families and society are conceived is of particular relevance to this thesis. As policies and services can be seen to reflect, implicitly or explicitly, a ‘need interpretation’ (Fraser 1989) or ‘problem representation’, understanding the needs of mothers and how they can best be addressed requires an analysis of “...competing constructions of issues ...and the ways in which these constructions leave other issues untouched (Bacchi 1999)”. From this viewpoint, the engagement of the subjects of policy and those who are experiencing help in the determination of what is helpful is of critical interest (Lobovits and Seidel 1997; Rossiter 2000; Bryant 2002). These theoretical underpinnings and the different research approaches of the *Families at Risk* study and this thesis are discussed later in this chapter.

Recognition of the political nature of research, and the understanding that strengths and needs are problem representations rather than objective facts, open up the question of why there is policy interest in ‘at risk’ parents of young children and their access to services at this time and who or what is driving this interest. In the following sections of this chapter, key aspects of the current political, policy and service contexts for this research are broadly introduced to be explored in more depth in other chapters. These include:

1. social theory linking disadvantage and poorer health and well-being; and concern about increasing poverty and inequalities in health and well-being outcomes, especially for children;
- conservative welfare politics including the priority to distance governments from social provision for what are considered individual and family needs;

- the failure of many services to meet the needs of families and young children living in the most disabling contexts with the worst health and well-being outcomes.

1.4.2 Different conceptions of the links between disadvantage and health

While it is generally acknowledged that the fundamental determinants of health and well-being are social and economic factors and their distribution, there are different conceptions of how they are linked. A question that drove the *Families at Risk* project was – are the ‘answers’ to supporting the ‘strengths’ and addressing the ‘needs’ of families with young children to be found within their disadvantaged social and economic contexts or within their own behaviour, knowledge, beliefs? Since the Black Report, published in the UK in 1980 (Department of Health and Social Security 1980), drew attention to the extent of social health inequalities, research and policy development have tended to reflect either materialist/structuralist or cultural/behavioural explanations (Macintyre 1997; Thomas 1999).

Materialist/structuralist explanations understand people to do well or badly depending on the social circumstances in which they live and work. In focusing on the disadvantages inherent in low social position and poor social circumstances, people are conceived as reacting to circumstances beyond their control rather than as active or potential agents of individual and social change (Oakley and Williams 1994). This materialist/structuralist explanation however, can be seen to provide inadequate explanation for differences in social health outcomes: for example, why do some families with young children fare better than others do when faced with similar stressful life situations and material circumstances (a key question for the *Families at*

Risk project)? Cultural/behavioural concepts such as ‘capacity’ and ‘resilience’, which focus on individual characteristics and behaviours, may provide more adequate explanation.

To some extent, this ‘binary opposition’ between social and individual has been overcome or ‘transcended’ by the idea that people’s experiences are individual *and* social. This is reflected in broad policy acceptance that intervention is required at all ‘levels’ - individual, community and society. This thesis is based on the understanding that the relationships between disadvantage and health are mediated by fundamental social processes. These processes shape complex and fluid relationships between individuals as ‘creative human agents’ and the social, economic, cultural, environmental and political landscapes they inhabit (Frazer and Lacey 1993; Williams and Popay 1999). These landscapes and processes have enabling as well as constraining effects on individual agency so that, in different contexts and at different times, individuals are differently vulnerable and have differing capacities to respond to ‘risk’ or the health ‘insults’ and opportunities they face (Giddens 1979; Connell 1987; Deacon and Mann 1999; Williams, Popay et al. 1999). Following this, the thesis aimed to shed light on the social relations of parenting and service support to help to explain “how survival, damage, and oppressive social/economic relations meld together (Fine, Weis et al. 2000).”

1.4.3 Increasing inequality and the politics of public provision

Despite sustained economic growth in the past 20 or more years and strong anti-poverty rhetoric in Australia and other affluent nations, poverty has persisted or continued to rise. In the ten years 1991-2001, the proportion of low-income families in

Australia increased from 17.1% to 20.7% while in South Australia it increased steadily from 19.0% of all families in 1991 to 23.8% in 2001 (Hetzel, Page et al. 2004)¹⁸. While there is considerable debate about how poverty should be measured, three commonly used measures show an increase in child poverty in Australia since the late 1990s (Harding, Lloyd et al. 2001). Although Australian government payments to families have mediated the effects of rising social and economic inequalities, Australia still has many more children living in poverty (around 17% of children) than do most European countries (Community Affairs Reference Committee 2004; UNICEF 2005).

Policy decisions about whether intervention to improve unequal health and well-being outcomes should be focused on individuals, community or society are underpinned by different ideological positions concerning the priority and place of public provision. In market liberalism, the currently dominant political force, the health of society is understood to depend most importantly on individual enterprise and self-reliance. So, although it may 'go without saying' that intervention is necessary at all three levels, intervention most frequently focuses on problematic individuals or communities.

While income and other socioeconomic inequalities are increasing, social policy concern with disadvantage is focused mainly on those at the margins, not on reducing social gradients (the distance between the most advantaged and least advantaged).

Whilst the goal of redressing social health inequalities fits some interests (for example: anti-poverty, public health, women's health and other social movements) the

¹⁸ There has been a greater increase in poverty in South Australia over this period than in any other State/Territory, attributable to the State's declining manufacturing base and lower economic growth. (Schrapel 2003).

current main drivers of service policy and system decisions are the imperatives to contain or reduce costs and manage ‘demand’ pressures (Stilwell 1999; Self 2000; Davies 2003).

These dominant trends in economic and social policy contradict what is known about the impact of social determinants and their distribution on individual and population health and well-being. In Australia, over the past three decades the relationship between individuals/families and government has substantially changed. Economic growth policies and associated values of wealth accumulation, increasing consumption, individual responsibility and participation in paid work have placed governments increasingly at ‘arm’s length’ from individuals and communities. The dominant paradigms framing service delivery are primarily individual, as expressed for example in targeting 'at risk' children and parents and promoting their capacity and resilience. A more detailed review of debates about welfare policy will be undertaken in Chapter Three.

However, against this political tide, there is considerable public, policy and academic debate about the ‘public interest’ to be served by government. What is (or should be) the meaning (and practices) of the traditional Australian value of ‘a fair go for all’ in a time of unprecedented economic prosperity (Harris 1999; Self 2000; Gleeson 2005)? There is growing concern about increasing social and economic inequalities and, in particular, the evidence of worsening health and well-being for some population groups (including and especially ‘families at risk’) (Flood 2004; Stanley, Richardson et al. 2005).

1.4.4 The need for more effective service responses

There is broad agreement in the poverty, health inequalities and early childhood research and policy literature that there is room for improvement in support/service provision for families with young children, particularly those with the worst outcomes and/or the least access to services (see Chapter Two). Questions about the role of family support, and social provision more generally, in reducing or reproducing social health inequalities have particular urgency in the light of the growing evidence that some people, particularly those with multiple risk factors in their lives, are not helped by existing services and/or fall through the ‘cracks’ in social support systems (Melaville and Blank 1991; Halpern 2000; Fonagy 2001; Victorian Department of Human Services 2001; Mathews 2003; Moore 2005). There is a great deal that is known about the difficulties services have in effectively meeting the needs of all young children and their families. This evidence is of direct relevance to this thesis and it is worth attempting a broad summary of these service issues in this introductory review of the thesis context. A number of points can be made:

- There is inadequate public provision for children and families so that existing services (prevention, support and treatment) are insufficiently funded. It is clear that investments in social infrastructure are needed. Beyond the rhetoric, the allocation of resources to help build social networks, communities and supportive environments remains in a low or marginal position on governments’ agendas for policy action.
- Families report having difficulty finding out about and accessing services they need and that when they do, some services and service providers are not helpful, and in some instances harmful, to parents’ health and well-being.

Many interventions can serve to increase rather than decrease inequalities because the most socially excluded and those with the highest number of risk factors are the least likely to access or benefit from the intervention (the ‘inverse care law’ – those with the greatest need tend to have the poorest access).

- Public management reform agendas have increased the pressure on service agencies to implement ‘demand management’ strategies to cope with high levels of demand/ need for help. Many services have waiting lists and are unable to provide help opportunistically or at an early stage when the need first arises. In many cases, people are not eligible for a service until their situation is at breaking point or has already broken down.
- Many services are treatment and crisis-oriented. Service providers and their managers can feel frustrated and dispirited in the face of not being able to help all those who need it and the apparently slow progress of service/system reform. Despite health reform recommendations, the shift of resources towards comprehensive prevention strategies has been slow to materialise.
- It is difficult for agencies to tailor services to meet the different needs of different families - especially with regards to 'high risk', ‘hard to reach’ and culturally and linguistically diverse families. Many services have difficulty meeting the different needs of mothers and fathers within families – for example, engaging fathers in sharing the responsibility for protection and care of young children.
- No single service can meet the complex needs of many families. Most commonly, the problems of parents, children and families are divided into

rigid and distinct categories which do not reflect their interrelated causes and solutions. Services tend to be provided within, rather than across, service categories. For families with complex needs, interventions which address only one risk factor (for example, teaching parenting skills; treating postnatal depression; providing therapy for a child with a disability) may make a short-term difference but are unlikely to produce sustained change.

- Specialised providers and agencies can find it difficult to design and implement comprehensive solutions to complex problems and are often hampered by the lack of critical support services and resources (for example, childcare, emergency housing, allied health services).
- Services are not well integrated. Each service/agency has its own funding source, professional orientation and institutional mandate. Within the current context of competitive tendering, agencies/services may be competing for scarce resources. Each service concentrates on a specific problem in line with its service/agency objectives rather than working with others to address the range of factors contributing to a family's situation. In other words, service systems may be more effectively meeting the needs of providers and service organisations than those of families with young children.

As previously argued, service responses follow from 'needs' definitions. Research plays an important role in shaping these definitions and service policy and practice. In the following section, the risk factor approach which is typical of research related to the strengths and difficulties experienced by 'poor' parents is briefly reviewed.

1.5 A risk factor approach

Typically research related to ‘families at risk’ employs fixed classifications, whether of individual characteristics and behaviours and/or social categories, as indicators of risk. Various categories and scales are used to measure attributes of individual agency such as self-efficacy, stressful life events and network size. Commonly, income and other socio-economic factors are simply seen as one of many individual-level risk factors for poorer health and well-being outcomes (Shaw 2002; Raphael, Macdonald et al. 2005). In this approach, the social context is understood as a ‘descriptive backcloth’ or source of contributing factors and parenthood is conceived as an individual identity within which people carry certain risk factors (Sevenhuijsen 1998; Mayall 1999). Simply put, parenting in poverty is framed as a problem of what poor people lack rather than a problem of unequal or unfair distribution of resources and opportunities.

Families research focused on individual characteristics typically uses a range of ‘diagnostic’ tools to assess the skills, knowledge, beliefs and coping strategies of individual parents in comparison with others in order to shed light on the ‘real’ needs of families, draw conclusions about a parent’s capacity to effectively care for their children and evaluate the degree to which services satisfy particular needs defined by ‘experts’. When parenthood is “reduced to atomised and measurable dimensions” of people’s living conditions and beliefs, knowledge and behaviour, ‘deviance’ and ‘risk’ can be defined against universal norms, definitions or standards (Young 1997; Thomas 1999). From this, problems and needs are equated with lacking something and are primarily attributed to individuals.

Vulnerability and need for care and support are located in the ‘needy’ and not in ‘normal’ functioning people who demonstrate ‘independence’ and ‘responsibility’ (Goodey 1999 : 310).

Research and intervention focused on individuals tend to neglect the ways in which social inequalities and disabling environments work to amplify the difficulties experienced by individuals and families and exclude and isolate them from others. Similarly, the societal processes which reproduce persistent patterns of social health inequalities are hidden from view. Policy and service implications which arise from individual-level risk factor conceptions of the relationships between socioeconomic factors and health are rarely concerned with the distribution of resources and opportunities for health, but rather emphasise individual behaviour or lifestyle changes (Labonte 1992; McKinlay 1998; Coburn, Denny et al. 2003; Raphael 2003; Ostlin, Sen et al. 2004).

The *Families at Risk* research proposal can be characterised as a population (demographic and geographic) study of ‘disease burden’ and risk and, with closer examination, a number of both explicit and implicit assumptions and interpretations contained within its conception can be revealed. Although not clearly stated, the implicit broad aim of the research was to reveal the factors which support ‘at risk’ families to become effectively functioning and contributing parents and children. From this, dominant definitions of what constitute ‘properly’ functioning adults and ‘good’ development, form the parameters of understanding both about what is interesting about parents and children, and about what issues ‘need’ attention.

That the ‘poorest of the poor’ were the particular focus of the *Families at Risk* research is an acknowledgement of the evidence that social and economic disadvantage and poor outcomes for children and families are linked. That is, poverty is an important part of ‘the problem’. At the same time, the focus on poor families and the most disadvantaged communities (and not on well-off families or all families) could imply that the causes of and solutions to poor and unequal outcomes for children are to be found within poor parents and poor communities rather than in the unjust and unequal distribution of resources and opportunities for health and well-being.

1.5.1 The politics of ‘service use’

The *Families at Risk* project was underpinned by an hypothesis that there is an association between the health and well-being of families with young children living in situations of multiple disadvantage and their use of services. The project’s fourth aim proposed a link between overcoming barriers to service use and improved outcomes for these families. In this aim, it appears to be assumed that service use is helpful and that the ‘problem’ is services not being sufficiently or appropriately accessed. From a ‘what’s the problem?’ perspective (Bacchi 1999), the project’s third aim - to explore differences between families who are ‘high’ service users and others who, in apparently similar disadvantaged circumstances, are ‘low’ service users - raises some challenging questions. What meaning is being given here to being a ‘high’ service user? Is it a desirable or undesirable thing? Is ‘low’ service use more or less desirable? What about ‘no’ service use?

The answers to these questions are bound up in a variety of normative ideas including ‘coping’ and ‘resilience’ as well as current market-driven ideologies such as ‘efficiency’ and the imperative to ‘manage demand’. When questions like these are examined, different and conflicting ideologies and interests are revealed. For example, ideals of universal entitlement to appropriate and affordable services arise from a paradigm different from that of improving individual ‘resilience’ in order to reduce ‘need’/demand for services. In relation to the project’s fourth aim, there is likely tension between involving service providers and families in developing proposals to ‘overcome barriers to service use’ and the pressure on the human services departments (a principal audience for the research) to reduce costs and manage demand. This tension is apparent in particular examples of policy and practice such as the policy rhetoric of improving ‘access’ and the practice of restricting eligibility to manage demand and contain or reduce costs for particular services.

The current emphasis on ‘evidence-based’ policy, funding and practice decisions has produced some challenging questions for services (Lin 2003). Previous reference has been made in this chapter to the argument that assessments of parents’ service use and their strengths and needs are intertwined with proposals and assumptions about what strengths are desirable and which needs are legitimate or have priority, as well as what to do about building strengths and meeting (or reducing) needs. Added to these are at least implicit assumptions about how we can best know about strengths and needs and from whom or what that knowledge should come. A variety of critical questions are raised. What constitutes ‘valid’ evidence? How can factors or experiences which are non-quantifiable be ‘measured’? What about when evidence is conflicting? Whose

knowledge about strengths and needs has most influence on what is valued or given priority and whose has least? What about the gap between the evidence and a service's capacity to respond?

Proposing individual and binary measures of service use such as 'high' and 'low' renders invisible the reality that most people's service use (and experiences of parenting) is inseparable from their social context and social relations and is likely to change over time. From this understanding, the task of interpreting patterns of service use requires more complex, non-linear research methodologies quite different from traditional forms and fixed categories of evidence.

In this chapter so far, a range of issues related to evidence, policy and service contexts for this research have been outlined. In the remainder of the chapter, the thesis research approach will be explained in some depth. A detailed account of the thesis research methodology will be provided in Chapter Four.

1.6 Thesis research approach

As previously argued, any research or policy project is structured by theoretical understandings of the social world which shape problem and needs definitions, as well as by ideas of what there is to know and of what constitutes valid knowledge. As described earlier, these theoretical commitments, which in the *Families at Risk* project were largely implicit, determined the questions asked and of whom they were asked and provided the frame for interpretation. Generally, these theoretical frames also determine what is interesting in people's responses and what constitutes 'valid' evidence. In developing theory, decisions about whose experience to trust and what knowledge to value, are also political decisions.

In line with much epidemiological research and research on families, social support and coping, the *Families at Risk* study is underpinned by a ‘scientific’ perspective - that the ‘reality’ of family life and child development are knowable and their elements can be accurately and reliably described. As the researcher is assumed to stand ‘outside’ what is being observed, the identification of ‘needs’ and solutions is a rational and logical process (Madsen 1999). This ‘positivist’ approach is implied in the broad research question for this thesis – *what are the implications for services of the strengths, resources and barriers to support experienced by parents of young children living in areas of concentrated disadvantage?* This question implies linearity in research - that is, through the application of valid research tools the strengths and needs of parents can be defined in a way which can provide a basis for objective and rational choices between policy options. It is assumed that family life (and society as a whole) can be improved by the application of abstract, ‘universal’ knowledge. ‘Useful’ knowledge or successful theory helps to predict and hence to control social outcomes (Ife 1997). In this ‘positivist’ model of ‘knowledge generation’ expert knowledge is gained by academic researchers and transmitted through policy and professional education to service providers who pass it on to families (Doherty 2000). The collaborative research team approach required by the *Families at Risk* research grant was, at least in part, recognition of the limitations of ‘positivist’ research models. More equal and engaged relationships between academic and human services agency researchers are seen by many as fundamental to achieving more effective links between research and practice (Gibson 2003). The project’s aim to actively engage

with service providers and families to interpret the data and develop recommendations reflected this viewpoint.

The idea that the data produced by researchers can directly reflect reality is underpinned by the tenets of ‘structuralism’ – that there is a deep structure to everything and everyone and the complexity of any phenomenon can be reduced to the elements which are its building blocks. These elements represent the ‘truth’ of the phenomenon and can be classified and categorized in ways which facilitate analyses and interpretation. In this framework, the difficulties parents experience are characterised as essentially caused by individual or socioeconomic factors. If the experiences of parents which bring them in contact with services are understood to be surface manifestations of deeper ‘truths’, then these experiences require interpretation through the application of expert knowledge and professional intervention to explain, recommend, fix or control what is lacking or going wrong (White 2000). The effectiveness of policy and program options is evaluated in terms of predictable and measurable levels of ‘risk’ reduction (Jackson, Krouskos et al. 1988).

‘Structuralism’ is one of two main strands within the sociological tradition. In the second strand, social phenomena are understood as constructed by individuals (‘social constructionism’). These two viewpoints are aligned with ‘positivist versus interpretivist’ and ‘quantitative versus qualitative’ debates in research methodology (Williams 2003). Structuralist understandings position both the researcher and the service provider as expert, and social constructionist (‘interpretivist’) understandings

position them 'alongside', connecting with people's own knowledge, skills and understandings.

In the assumption that 'objective' measures are the most reliable form of knowledge, insights into the complex dynamics of life, health and systems from the viewpoints of the lived ('subjective') experiences of individuals (who are also policy and program recipients) and of front-line practitioners (who implement policies and programs) are missed. These 'lay knowledges' provided the main source of data for this thesis. There is a growing literature which similarly draws on the 'voices' of people who are the recipients of policies and services (Beresford, Green et al. 1999; Peel 2003; Saunders and Sutherland 2006). The author found support in this 'service user' literature for the task of collecting and interpreting mothers' and service providers' accounts of their experiences. In particular, it supported the use of an interpretivist research approach which was different from but could 'add value' to the approach and findings of the larger *Families at Risk* project.

In a 'social constructionist' view, an individual's thoughts, feelings and actions are shaped by their interdependent relationships with others and with social structures. From social categories and from their personal histories and experiences people forge a sense of who they are and how they belong. Their lived experiences and the meanings they make of them are continually influencing each other. Social reality is not 'given' nor the result of 'essences' which make up the individual, but is being continually created through language, learning, social institutions, 'normative guidelines', and the different effects of power. Importantly, neither social reality nor identity is unitary or fixed as people act in a variety of ways to creatively manage or

survive their situations, including the use they make of services. People are not just service seekers or service providers; they are mothers, daughters, teenagers, church goers, sole parents, and more. These “multiple social categories and positionings” are more or less important to them at different times and in different contexts (Williams and Popay 1999).

From this viewpoint, ‘problems’ are not internal to people but are constructed and experienced in ways related to social structures and practices. The problems people experience are related to the whole context of their lives in ways which challenge and blur the traditional demarcation, made in liberal theory between the individual and society. Rather than individual freedom being ‘taken’ via individual acts of autonomy, individual freedom is ‘granted’ through communal practices and the provision of public goods which help members of society to develop their common, and hence their personal lives (Culpitt 1999).

1.6.1 Critical and feminist perspectives

Particular formulations of critical theory underpinned the framework for this thesis project (Ife 1997; Leonard 1997; Forbes and Wainwright 2001; Williams 2003; Grbich 2004). These formulations are based on the understanding that social structures, practices and discourses shape and are shaped by people in the contexts of their everyday lives. They incorporate a vision for social justice and health equity and reveal the social relations and practices which reproduce inequalities and give them social meaning. The challenge was to integrate structural and experiential understandings in order to reveal the ways in which ‘the personal is political’ and vice versa.

Social structures are “*constructs* (constructed by *us* furthermore) and can and must be deconstructed (Frazer and Lacey 1993)”. Through deconstruction or critique the historical forces, assumptions, values, institutions, relationships and practices which sustain structure and identity and shape people’s lived experiences can be made apparent.

The constitutive effects of language are central to this task. The ways things are talked about (categories of discourse or discursive practices) give meaning to people’s experiences of the world and of each other.

This perspective shifts the focus from "who we are" (as a pre-existing quality) to "how we are" (our ways of being that are continually being reinvented). However, the person we are becoming is profoundly shaped by and inseparable from our social context (Madsen 1999).

From this viewpoint, an important role of research is to deconstruct the dominant and unhelpful discourses which influence the ways people live and the stories they tell about themselves and their lives. The purpose of research as a ‘critical project’ is to engage with prevailing social structures and challenge these dominant discourse practices and power relations to achieve a more just distribution of ‘health-determining conditions’ (May 1997; Labonte 2005). However, people are not simply the effects of the “multiple discursive, institutional and cultural practices” which are present in their everyday lives (Frazer and Lacey 1993). Within the context of social relations, people act to work with or resist those structures or practices.

Critical theory is informed by feminist theory and they share many common elements and aims including, in the example of this thesis, the intention to do research that is

for women rather than merely about them (Fine, Weis et al. 2000; Olesen 2000; Kitzinger 2004). The critical researcher “has a partisan, though not uncritical, identification” with the people or groups who are oppressed or disadvantaged by current social institutions and relations (Fraser 1989; Kincheloe and McLaren 2000). Dorothy Smith has argued that feminist social research is a form of ‘consciousness-raising’ in that it is concerned (like other critical projects) to identify how private experiences of oppression may be understood as part of a general system of oppression which shapes women’s experiences (Smith 1990). Gender/power is conceived as inhering in the structures and processes which construct us as social beings (Flax 1990). However, ‘gender’ as a social structure and a form of social relations is not fixed but shaped by interaction with other structures and relations such as class, race and other elements of people’s social and political contexts (Elliot 1997).

An important goal of feminist research and practice is to help women (individually and collectively) to move away from ‘en-gendered’ prescriptions “towards a preferred sense of self that is of their own choosing and reinforced by a strong network of others who have similar views (ibid: 66)”. The desired result is that women would not see problems as inherent within themselves but as a problem in society which can potentially be changed; change which they can contribute to achieving (White 2000). The term ‘empowerment’, which describes the development of individual autonomy and increased control in a person’s own life as well the development of collective influence over the social conditions which affect people’s lives, fits this feminist goal (Young 1997). The concept of collective empowerment refers to the processes

through which relatively powerless people come to understand the social sources of their powerlessness by engaging in dialogue with each other.

Research methods which devalue or ignore women's everyday lived experiences and their socio-political contexts, prevent women's 'private troubles' from being recognised as public and political issues and in this way can contribute to reproducing ideas which regard the experiences of particular women as faulty or deviant (Smith 1987; Reinharz 1992).

Research as 'social practice'

Using the concept of 'social practice' - defined as human action which is socially based and organised, underpinned by a combination of formal or informal institutions (Frazer and Lacey 1993) – it is possible to generate understandings which incorporate the contesting agendas and political processes (the 'strife of interests') involved in transforming research evidence into policy and practice in ways not amenable to traditional positivist or constructivist approaches. 'Social practice' focuses attention on the social relations which shape the interaction between individuals and their social context. Women's relationships and processes of power are seen as key to understanding the 'social condition' of motherhood (and 'clienthood' and 'providerhood'). Within the context of unequal resources, institutional rules, expert knowledges and social expectations, individual women act and give meaning to their social world.

From the perspective of social practice, the predominance of certain common sense understandings reflects the power which certain groups have to define what is right or wrong, true or false. In the social relations of research (and service provision), the power differences between the roles of researcher and researched (and client and

provider) are reflected in who controls the definition of the problem/need, available options and resources, whose knowledge and authority is most valued and whose 'language' is spoken (Skeggs 1994; Goodey 1999). Whilst the researcher's (service provider's) values and experiences do not wholly determine the ways they view things, they do position them in certain (and variable) ways in relation to the research participants (clients) (Kitzinger 2004).

1.6.2 A critical understanding of 'health and well-being'

The most widely cited definition of 'health' is that developed by the World Health Organization (WHO) in 1946 – "*Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity* (World Health Organization)." More recently the European Region of WHO has expanded this definition:

[Health] is the extent to which an individual or group is able, on the one hand, to realize aspirations and satisfy need, and on the other hand, to change and cope with the environment. Health is therefore seen as a resource for everyday life...emphasizing social and personal resources as well as physical capacity cited in (National Public Health Partnership 2003).

This broad definition of health and well-being draws attention to individual and collective aspirations and agency as well as health-determining conditions and resources. Key to both these are social practices which link the 'individual' and 'social'.

1.6.3 Critical population health research

Labonte's (2005) definition of 'critical population health research' matches the research approach of this thesis project. He identified three elements as characterising this small but growing field (Labonte 2005):

- Health is seen as embedded in social relations of power and historically inscribed contexts. The main focus of research is the unequal distribution of health-determining conditions, rather than the differences in health outcomes between social groups.
- Policy and service research should be shaped by the interests of those with the worst health outcomes (the greatest 'burden of disease').
- Research methods should aim to be empowering and health enhancing in their own right.

1.6.4 Valuing lay knowledge

Along with the expanding service user literature referred to earlier, the small but growing field of lay knowledge research provided theory and research practice guidelines for this thesis project (Blaxter 1983; Blaxter 1990; Popay and Williams 1996; Popay, Williams et al. 1998; Lawton 2003; Peel 2003; Popay, Bennett et al. 2003; Williams and Popay 2006). The concept of lay health knowledge – defined as the ideas and perspectives employed by social actors to interpret their experiences of health and illness in everyday life - is a critical extension of more common research interest in 'lay health beliefs' especially in relation to chronic illnesses or conditions. Lay health beliefs, or the ideas and perspectives which shape what people know and think about their health and illness, have been of research interest primarily in relation to medical and health system priorities, including reducing the pressure on hospital

beds by improving patient education and self-management of illness conditions. The shift to the term 'lay health knowledge' reflects increasing recognition of the potential value of lay perspectives in improving health policy and practice. However, a focus on and a valuing of people's lived experiences do not fit comfortably with either medical dominance and other 'expert' positions or positivist traditions (Raphael and Bryant 2002).

Valuing lay knowledge represents a challenge to the 'objectivity' of academic and professional knowledge and dominant or taken-for-granted problem definitions and understandings. Oakley argues that from an 'alongside' position in which 'lay knowledge' is sought and valued, it is possible to do research "without reducing the people whose experiences are drawn on to the limiting status of objects of others' interpretations (Oakley and Rajan 1991)". However, this 'alongside' relationship is not unproblematic: for example, differences in age, class, education and ethnicity may have limiting effects on interaction between the researcher and researched and these differences may in turn effect the conclusions drawn. According to Popay (2005), despite current policy emphasis on achieving health systems/services partnerships, the unequal power relations between lay people and professional and institutional service systems and cultures are the source of considerable "resistance to giving lay people influence" (Popay 2005).

As people's individual stories or narratives are the vehicle for lay knowledge, research methods appropriate for collecting this 'data' and understanding the narrative structure of this 'subjective' knowledge are necessary. However, in critical population

health research, it is not sufficient to describe the determinants of people's health and use of health services without addressing the issue of how those determinants might be changed. Ideally, to release the potential of lay knowledge to contribute to improvements in policy and practice, lay people's participation needs to go beyond the discussion of the results of research as proposed in the *Families at Risk* project aims, to include a role in defining the research questions and participating as 'co-researchers' in the design and conduct of the research (Labonte, Polanyi et al. 2005; Williams and Popay 2006).

Liz Kelly and colleagues describe the development of 'challenging methods' in their feminist research practice. That is, ways of doing research to encourage different ways of thinking and to question dominant or oppressive discourses in order to raise/offer different ways of understanding experience (Kelly, Burton et al. 1994). Listening to women's "knowledges about life and skills of living (White 2003)" and developing shared understandings which make it possible for them to interpret their experiences, connect to others and to the wider community, are central to the processes of empowerment (Labonte 1992; Williams and Popay 1999; Williams, Labonte et al. 2003). Opportunities and processes to speak, hear and value lay knowledge can lead people to embrace their "devalued and subjugated" knowledge and skills and the opening up of options for action (White, *ibid.*).

These 'challenging methods' are underpinned by feminist and critical theory which add structural perspectives to interpretive understandings. In this thesis, locating mothers' and service providers' experiences within contexts of disadvantaging social

policy, increasing socioeconomic inequalities, and unequal and inadequate access to resources and relationships for health, provided the frame for interpreting their in-depth interview accounts. In this way, “the research process engages with societal processes through insiders’ understandings of their own lives (Mayall 1999)”.

Listening to the experiences of mothers and their service providers to better understand the ‘societal processes’ of mothering and mothering support gives a central place to the debate about what is ‘real’. Is there an essential reality in people’s lives which can be known to a researcher, or are there multiple realities, revealed in the accounts of different informants, all of which may be versions of ‘truth’ (Holland and Ramazanoglu 1994)? Different assessments of validity reflect different stances on ‘reality’ and how best to know about what is real. The ‘positivist’ version is that the data produced by researchers can directly reflect reality through application of correct and unbiased techniques. At the other extreme, the post-modern or ‘relativist’ view is that there is no reality which is knowable through interviews because 'what is there' depends on who's speaking or looking. As there are many fragmented and contradictory truths, it is not possible to come to conclusions. People’s accounts of their experiences can only ‘speak for themselves’.

A third version has been adopted in this thesis. It recognises that experience is shaped by social structures and social relationships and that while experience itself is not a reliable ground for knowledge claims, it provides a window into understanding the relationships between the ‘personal and political’ or the social processes through which social structures are (re)produced (Holland and Ramazanoglu 1994; Skeggs

1994; Ife 1997; Williams 2003). For the researcher, this ‘middle way’ involves the telling of a ‘plausible story’, clarifying how conclusions have been arrived at and acknowledging the difficulties in doing so (Holland and Ramazanoglu 1994; Melia 1997; White 1998).

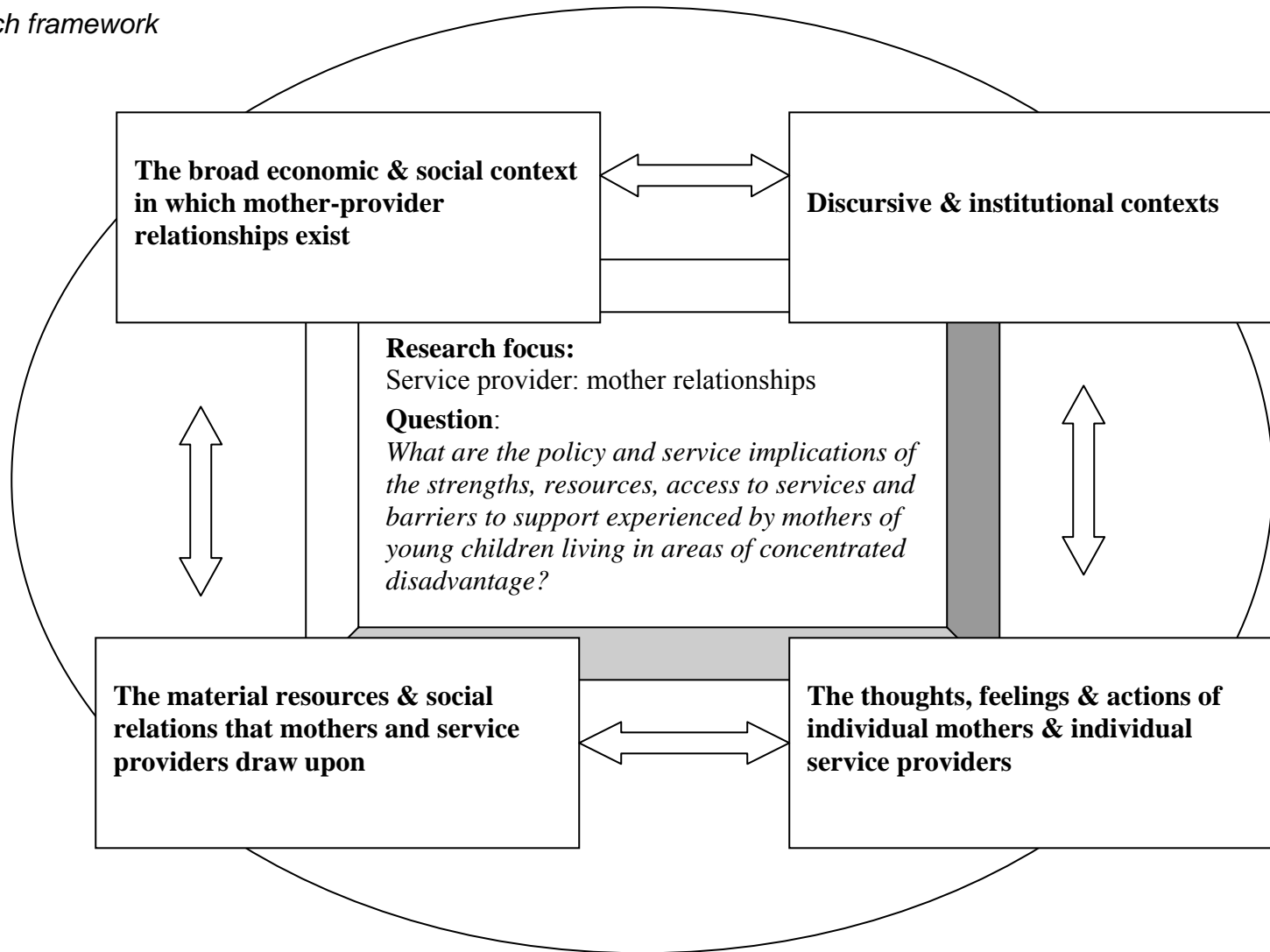
The account of the thesis research method provided in Chapter Four will describe in detail the processes used to come to conclusions.

1.7 Research framework

The critical population health research framework introduced in this chapter can be represented visually as comprising four domains (Figure 1). One domain is the broad social and economic policy context (including changes in household form, gendered parenting roles, women’s participation in paid work, increasing income inequality and the contraction of the welfare state). Another domain is the discourses and practices which flow from these contexts (including the ways ‘needs’ and the ‘problems’ and ‘responsibilities’ of parents/mothers are formulated as well as professional and service frameworks). A third domain is the resources (including income, education, housing, kinship, social networks, community groups) and social relations which women draw on in their everyday lives and the meanings they give to these. Particular attention is given to the landscapes and the effects of unequal access to resources and power which mothers (and their service providers inhabit) including social isolation, local environments of concentrated disadvantage, discrimination, violence and abuse. In the fourth domain are individuals, including their narratives, their actions or strategies for managing their situations, their sense of who they are and how they belong as well as their social position (low-income, sole parent, ‘at risk’ tenant). All of these domains

are overlapping and interrelated and all are shaped by, and at the same time shape, the social relations of power.

Figure 1: Research framework



CHAPTER 2: FAMILIES AT RISK: THE RESEARCH LITERATURE

Relevant literature has already been drawn upon in Chapter One in the detailed exploration and delineation of the context for this research. The aims of this chapter are to review the research literature related to patterns of social health inequalities, their cause(s) and effective service and service system responses and to explore their relevance to the questions posed by the *Families at Risk* project and, in particular, by this thesis.

In relation to the issues covered in this review a huge amount of research from a wide range of fields is, in a basic sense, relevant to this thesis. In particular, in the fields of health inequalities and social capital there has been an exponential increase in research activity and policy debate in the past two decades, much of which has been published since this thesis research project began in 2001.

2.1 *The ‘strengths and resources’ of families at risk*

As described in Chapter One, the *Families at Risk* study was, in part, a mapping project, recording the distribution of risk and protective factors known to be associated with better/poorer health and well-being outcomes. There are numerous other examples of this type of evidence being used to map the unequal distribution of risk and protective factors between places and populations. However, there is less convincing evidence and more debate in the literature about the ‘causal mechanisms’ which link these health and well-being determinants to poorer/better outcomes and about how best to intervene. These debates are considered in the third section of this chapter.

Risk and protective factors are most commonly classified according to ‘levels’. That is, better/poorer health and well-being outcomes are seen as created and maintained by the effects of individual, family, community and broader social and environmental factors on health and well-being. The following table of risk factors in early childhood associated with adverse outcomes includes examples drawn from three Australian sources (Centre for Community Child Health 2000; Commonwealth Task Force on Child Development 2003; Australian Bureau of Statistics 2005).

Table 1: Risk factors in early childhood

Child characteristics	low birth weight, disability, difficult temperament, poor attachment, disruptive behaviour
Parent characteristics and parenting style	single parent, young maternal age, postnatal depression, harsh or inconsistent discipline
Family factors	large family size, family conflict, divorce
Peer factors	quality of relationships, cultural norms, structured and unstructured play activities
Life events	unemployment, social isolation, poverty, frequent relocation
Community and social factors	few recreation spaces, unhealthy neighbourhoods and cities, socio-economic disadvantage, lack of resources and services, social inequalities, discrimination

There is a great deal of research which details the associations between individual risk and protective factors and children’s and families’ health, all of which in a broad sense is relevant to this thesis¹⁹. However, its relevance is not sufficiently direct to justify a detailed review in this chapter.

The idea that there are levels or layers of influence on people’s health and well-being has been influential at least since the late 1970s (Bronfenbrenner and Morris 1998)

¹⁹ Examples include: (Loeber and Stouthamer-Loeber 1986; Browne 1995; McCubbin, McCubbin et al. 1997; Murray-Harvey and Slee 1998; Olds, Pettitt et al. 1998; Zubrick, Williams et al. 1999; Fraser, Armstrong et al. 2000; Howard and Johnson 2000; Osofsky and Thompson 2000; Lochman and van den Steenhoven 2002).

and is widely accepted in the fields of health promotion and health inequalities (Dahlgren and Whitehead 1992; Turrell, Oldenburg et al. 1999; National Public Health Partnership 2003; Labonte, Polanyi et al. 2005). While it is generally acknowledged in the early childhood literature that risk factors at each level and between levels are interrelated and interwoven in their effects (Ellis 1998; Olds, Henderson et al. 1999; Kirk 2003), the ‘causal pathways’ which link these layers of health determinants to unequal health and well-being outcomes continue to be debated (Whitehead 2005).

These levels, which are usually classified as downstream (or micro), midstream (intermediate) and upstream (macro), also reflect different policy levels which could impact on factors associated with health and well-being outcomes. For example, strengthening individuals, strengthening social networks and communities, improving living and working conditions and access to services, and making structural changes to environmental, economic and cultural conditions.

The increasing availability of longitudinal data sets and evidence from neurological research has enabled the development of ‘life-course’ models, which add the dimension of time to understanding the effects of determinants of health and well-being. These models draw on strong evidence which shows (1) the damaging effects of disadvantage in the early years and (2) that these effects are cumulative and compounding over time and particularly at crucial (‘transition’) points in the life of an individual (Keating 1999; Lynch, Davey-Smith et al. 2000; Meisels and Shonkoff 2000; Halfon and Hochstein 2002; Judge and Paterson 2002; Shaw, Dorling et al. 2002; Davey Smith 2003; Hertzman 2004; Bartley 2005). The health status of

individuals at every level of the social hierarchy is an outcome of the accumulating (from conception onwards) and compounding effects of health ‘insults’ and opportunities afforded by their social position (Bartley 2003).

From this perspective, which is increasingly dominant in numerous fields including mental health/illness prevention, crime prevention as well as early childhood intervention, it is clear that social policies, including health, education, housing and welfare, do not always provide enough protection and support for people at crucial points in developmental pathways (Fonagy 2001; Commission on Social Determinants of Health 2005). A life-course perspective raises an important distinction, which is often ignored in research. That is, the difference between a focus on risk and protective factors as determinants of health and well-being and a focus on how social health inequalities are (re)produced (Graham and Kelly 2005).

2.2 *The social determinants of health and well-being*

The Australian evidence which: (1) points to serious inequalities in the health of Australians and the effects of low income on health and other social outcomes of families and children, and (2) demonstrates the link between these social health inequalities and similar patterns of variation in social, environmental and economic factors, was introduced in Chapter One. This evidence is consistent with a great deal of evidence from other countries linking material disadvantage to poorer health, well-being and development outcomes for parents and children (Keating 1999; Mustard and McCain 1999; Kirk 2003). Researchers in the United Kingdom, in particular, have drawn attention to the extent of health inequalities, the associations between social position and health and disease and what action the British government should take (Department of Health and Social Security 1980; Townsend, Davidson et al. 1992;

Acheson, Barker et al. 1998; Gordon, Shaw et al. 1999; Graham and Kelly 2005). In qualitative studies, people have reported that living on low incomes in disadvantaged neighbourhoods wears them down emotionally and physically, undermining self-confidence, making it more difficult to be healthy and to provide a positive environment for children (Kohen, Brooks-Gunn et al. 2002; Savarese 2003; Freiler, Rothman et al. 2004; Popay 2005).

As well as the problem of health inequalities between population groups, the distance between the top and the bottom of social hierarchies in a population has been shown to affect the overall level of population health and well-being (Wilkinson 1998; Kawachi and Kennedy 2002; Wilkinson and Marmot 2003). There is strong evidence that actual and relative deprivation as well as social isolation and exclusion can “recruit people into depression and despair (Oulton and al 2003)”.

A substantial evidence-base²⁰ has grown to support the notion that socio-economic and societal factors are the *most* (more than individual characteristics, lifestyles, family and social networks)²¹ fundamental determinants of population health and well-being. The extent to which individuals are able to access the opportunities and

²⁰ A valuable source of a great deal of this evidence is provided via the listserv: SDOH@YORKU.CA.

²¹ The difference between these understandings of health determinants is illustrated by the contrast between the 10 tips for better health given to the public by the Chief British Medical Officer in 1999 and the alternative ‘tips’ proposed by Townsend Centre for International Poverty Research, University of Bristol (Shaw 2001).

First, the message from the Government:

1. don’t smoke. If you can, stop. If you can’t, cut down.
2. follow a balanced diet with plenty of fresh fruit and vegetables.
3. keep physically active.
4. manage stress.
5. if you drink alcohol, do so in moderation.
6. cover up in the sun.
7. practice safer sex.
8. take up cancer screening opportunities.
9. be safe on the roads.
10. learn the first aid ABCs – airways, breathing, circulation.

Second, the alternative list:

1. don’t be poor or don’t be poor for too long.
2. don’t live in a deprived area. If you do, move.
3. don’t be disabled or have a disabled child.
4. don’t work in a stressful, low paid, manual job.
5. don’t live in damp, low quality housing or be homeless.
6. be able to afford to pay for recreation and annual holidays.
7. don’t be a lone parent.
8. claim all the benefits to which you are entitled if you are unemployed, retired, sick or disabled.
9. be able to afford to own a car.
10. use education as an opportunity to improve your socio-economic status.

resources necessary to realise their aspirations, satisfy need, and to cope with or change their environments is crucial.

Social determinants of health have been defined as the conditions in which people live and work. “They are the ‘causes of the causes’²² of ill-health” (World Health Organization 2005). A social determinants of health approach draws attention to health and well-being outcomes both within and between populations and to the unequal distribution of health-determining resources and opportunities. It is explicitly political, demanding a focus beyond individual lifestyles and behaviours to economic and social policies and other societal factors which systematically (re)produce patterns of inequalities in population health and well-being (Kawachi and Kennedy 1997; Wilkinson 1998)). The goal of achieving ‘health equity’ means changing socially unjust or unfair inequalities in health and well-being (or in their social determinants) between different social (or population) groups (Whitehead 1992; Braveman and Gruskin 2003; Commission on the Social Determinants of Health 2005).

A focus on the social determinants of health is not new. Its origins can be traced back to nineteenth century public health measures – for example, cleaner air, improved housing and sanitation. In the 1980s, the World Health Organization’s Ottawa Charter for Health Promotion identified ‘prerequisites for health’ as peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity (WHO 1986).

²² Geoffrey Rose first used this phrase in his book *The Strategy of Preventive Medicine*. Oxford. Oxford University Press, 1992.

More recent definitions of the social determinants of health identify two major groups of social determinants – macro level (or structural) and intermediate level determinants (Raphael, Macdonald et al. 2005). Structural determinants include political, economic and social forces and social power relations. Specific examples include: income and its distribution, labour market policies, social safety net, social exclusion, discrimination (by class, gender, race, ethnicity or sexuality) and violence and abuse. Structural determinants generate social hierarchies and influence the quality of intermediate level determinants.

Intermediate determinants flow from social position and determine differences in exposure and vulnerability to health and well-being risk factors. These intermediate determinants include unemployment, housing and area of residence, working conditions, early life experiences, education, food security, transport, recreation, social support, stress and access to health services.

The *Families at Risk* project fits within a growing literature focused on the associations between disadvantaged living places / conditions, and poorer health and well-being outcomes (Lang and Hornburg 1998; Macintyre and Ellaway 1999; Macintyre and Ellaway 2000; Campbell and Gillies 2001; Cattell 2001; Baum and Palmer 2002; Curtis 2005). A closer examination of this literature will be the focus of the next section.

2.2.1 The effects of ‘place’

A focus on spatial disadvantage represents a shift of focus ‘upstream’ from individual and family characteristics in the search for causal explanations for poorer health and well-being outcomes and what to do about them. Along with low income, the environmental and social stressors associated with ‘locational disadvantage’ increase

the difficulty and demands related to caring for children and undermine the attempts of many committed parents to raise healthy children (Human Resources Development Canada 1999).

The term ‘locational disadvantage’ refers to residential areas in which there are inadequate ‘opportunity structures’ for individual and population health and well-being (Baum and Palmer 2002). These opportunity structures are known to have independent as well as aggregated and interwoven effects and include the area’s reputation as well as resources (including employment, education, transport and services) and social relationships. The World Health Organization’s ‘Healthy Cities’ movement provides a framework and examples of research and practice focused on the contextual factors which support and generate health as a resource for daily living (Baum 2002). There is however, considerable debate in the literature about the relative contributions of living in a poor environment and being poor to people’s health and well-being outcomes (Forster 2000; Levanthal and Brooks-Gunn 2000; McLoughlin and Nagorcka 2000; Veenstra 2005).

It seems likely that these ‘context’ and ‘compositional’ explanations are inter-related as there is evidence to support the view that ‘place’ provides the setting or context in which people’s advantage/disadvantage is (re)produced. As health and access to opportunities for health are essential to overcoming the effects of social disadvantage, inequities in the distribution of health determinants systematically further disadvantage already disadvantaged groups with respect to their health. A number of studies have found that the properties of contexts, social interactions / relationships,

and the characteristics of the individuals within them, all matter in intervening to improve health and well-being (Fullilove 1996; Lang and Hornburg 1998; Macintyre and Ellaway 1999; Macintyre and Ellaway 2000; Campbell and Gillies 2001; Cattell 2001; Baum and Palmer 2002; Macintyre, Ellaway et al. 2002).

In relation to services for families with young children Moore (2005) argues:

...what is important is how many of the services they need are within what the *Sure Start* planners in the UK call 'pram pushing distance', how pleasant and safe the walk is, and how many other families with young children they are likely to meet on the way or when they get there (Moore 2005).

2.3 *The (re)production of social health inequalities*

It has already been highlighted that there is a great deal of evidence regarding the social determinants of health and well-being and their unequal distribution but much less clarity about the systematic processes or mechanisms through which these social health inequalities are (re)produced. The comparative contributions of structural and material factors and social processes are the subject of intensive debate in the literature (Lynch, Due et al. 2000; Kawachi, Kim et al. 2004; Muntaner, Lynch et al. 2004; Navarro 2004; Wilkinson 2004). From this debate there are broadly three different causal explanations for the link between socioeconomic inequality and better/poorer health and well-being outcomes - social support (or the lack of it), the effects on individuals and populations of inequality, and access to material resources and power. These explanations, briefly outlined in the following pages, are not mutually exclusive as each incorporates or interacts with aspects of the others.

2.3.1 Social support

It is generally accepted that caring and protective relationships, at the levels of society and community as well as between individuals and within families, can be potent protective factors against adverse health and well-being outcomes. At the same time, there is increasing attention being given in the literature to the evidence that not all support has positive outcomes and that access to support is dependent on location, cultural, social and economic factors. According to the novelist Penelope Lively:

Most of us require a support base – family, community. Everyone does, perhaps the extension of oneself that allows ‘me’ to dissolve into ‘us’, that supplies common cause and provides opportunities for altruism and reciprocal favours and also for prejudice, insularity, racialism, xenophobia and a great deal else (Lively 1999).

In the research literature, there are various dimensions of social support, including the number of people with whom support is exchanged (network type and size), people’s experiences of the quality of that support, and resources gained through different types of social connections (‘social capital’).

Epidemiological evidence strongly connects size of social networks with health and well-being outcomes (Stansfield 1999; Berkman, Glass et al. 2000; Weber 2004) and, in particular, various aspects of parenting, including mothers’ mental and physical health and children’s development outcomes (Cohen and Syme 1985; Cooper, Arber et al. 1999; Layzer, Goodson et al. 2001). Access to friendship and supportive relationships can have both stress prevention and stress buffering effects through the provision of material and emotional support and by reducing the toll of stressful

contexts and events by supporting people to manage their situations (Thompson 1995);(Baum, Palmer et al. 2000). However, social ties and support can constrain individual actions and choices as well as generate positive outcomes. Studies have shown how strong networks of peers, family and friends which help members of one group can enable the exclusion of ‘outsiders’ (Portes and Landolt 1996). Further social ties can be sources of relational strain, with ambiguous health consequences (Due, Holstein et al. 1999). Some researchers have found that negative interactions (for example, violence and abuse) are more harmful than positive interactions are helpful (Weber 2004).

Of particular relevance to this thesis, the meaning of support to the individual receiving it is important – needing and receiving help can imply personal failure or dependence, invoke expectations of reciprocity or indebtedness and evoke fear of judgement (Thompson 1995). Following this, studies of social support suggest that the *quality* of social support relationships is more important to well-being than *quantity* (Thompson 1995; Thompson and Ontai 2000; Baum 2002; Mathews 2003).

Most commonly, research into social support and coping focuses on individual variation in access to support and responses to stress. There is very little research on people (and especially mothers) who are relied on for support/care and a relative lack of participation of disadvantaged women in research on social support (Weber 2004). This focus on the ways in which individuals cope is mirrored in lay people’s explanations of the links between material advantage/disadvantage and health and well-being. In recent research from the United Kingdom, individual resilience and

‘strength of character’ were perceived by many as a means to avoid the toll taken by their disadvantaging living conditions (Popay, Bennett et al. 2003).

While individual social support and personal coping strengths can act as buffers to some of the effects of disadvantage, they do not completely explain its effects on health and well-being. Rather than coping or resilience being a fixed attribute or a set of skills which an individual brings to a stressful event, they are context dependent and likely to change depending on the situation (Reinhardt Pedersen and Madsen 2002; Ungar 2004; Ungar 2005). The access of families with young children to social support and social capital resources is known to vary substantially, depending on place factors including the level of ‘opportunity structures’ in a local area as well as parents’ level of education, income, occupation and the number of parents in the household (Macintyre and Ellaway 1999; Cattell 2001; Baum 2002; Peel 2003; Social Support Research Program 2004; Moore 2005).

It is clear from some studies that the benefits of provision of formal (by services) social support can not entirely compensate for the effects of complex socioeconomic disadvantage (Oakley and Rajan 1991; Thompson 1995). In relation to programs that provide support to families and children and aim to prevent child abuse and neglect, Thompson (1995) argued: "If one single intervention were to be recommended to curb child maltreatment, adequate employment for lower-income families would be the answer (ibid.)". Unless social support is understood to exist within the context of macro-level social and economic policies and social health inequalities, it is in danger of being one more thing that poor people / poor communities don’t have enough of (a

form of victim-blaming) (Navarro 2004; Szreter and Woolcock 2004; Ziersch, Baum et al. 2005).

2.3.2 The effects of social and economic inequality

Attributes of social advantage/disadvantage such as wealth, status and power define how people are grouped at different levels in social hierarchies (Braveman and Gruskin 2003). As described in Chapter One, people occupy positions in multiple hierarchies. Within these social hierarchies, social position is the “pivotal link in the causal chain”, the point at which societal factors such as economic and social policy, “enter and shape people’s lives”, influencing their exposure to factors which directly affect their health (Graham and Kelly 2005). There is a great deal of evidence (especially from health inequalities studies in the UK) of marked differences in a range of outcomes (including physical and mental health, literacy, level of completed education, employment opportunities, housing tenure, birth weight, and children’s behavioural problems) from top to bottom of social hierarchies – “regardless of how wealthy, the little bit wealthier are a little bit healthier (Nossar 2005)”. This is known as the ‘health gradient’. This gradient effect, in which there is no clear cut-off point between the ‘poor’ and ‘not-poor’, has important implications for the policy and service question of where to intervene (Graham and Kelly 2005). This issue is taken up in Chapter Three.

The effects of stress arising from people’s perceptions and experiences of their position within social hierarchies has been theorised as *the* primary driver of health outcomes in affluent societies (Marmot and Wilkinson 2000; Kawachi and Kennedy 2002; Szreter and Woolcock 2004). In comparing their personal status, material

conditions and other aspects of their lives to others of higher social status, individuals experience feeling shame, worthlessness and envy which have long-term physiological and psychological effects upon their health (Wilkinson 1998; Wilkinson 2004). From the *Whitehall* studies, Marmot and colleagues identified the physiological effects of stress arising from inequalities in occupational status and experiences of lack of autonomy and control, as the primary cause of inequalities in health outcomes (Marmot and Wilkinson 2000). The 'fight or flight' reaction to threats or perceived threats, including social relations and material conditions, works through the sympathetic nervous system and the hypothalamic pituitary-adrenal axis to produce adverse physiological changes (Stansfield & Marmot 2002 cited in: Raphael 2003). Stress can act to suppress immune and other physiological systems and so make people more vulnerable to disease.

Qualitative studies which listen to people's experiences of living/working in situations of complex social and material disadvantage reveal the ways in which "poverty means not just a disadvantaged and insecure economic condition but also a shameful and corrosive social relation (Lister 2004)". As described earlier, individuals have different responses to needing and receiving support. Mathews points to the negative effects of the judgement and blame which are spoken or implied when people fail to arouse respect and to meet social, legal and professional expectations (the standards of 'experts') and to seek or need help (Mathews 2003). These responses may relate to self-respect and feelings of social worth including deservingness of support (Weber 2004). Affirming Marmot's conclusions about the importance to health and well-being

of perceptions and experiences of the social relations of autonomy and control, Sennett observes:

There is nothing inherently shameful about the statement “I need help”, so long as it can be *managed* by the person who makes it. What adults, like children, need is to control the conditions under which they see and are seen (Sennett 2003).

Just as social and economic inequalities determine the health of individuals, the unequal distribution of economic and social resources within a nation affects overall population health (Lynch, Due et al. 2000). That is, the more unequal the distribution of income and other social determinants within a country or region, the poorer the population health. This is well illustrated by USA, which is the wealthiest nation but consistently has the highest rate of child poverty (UNICEF 2005). In addition, widening hierarchies and social distance weaken social cohesion as social relationships in general become less egalitarian and mutually respectful and instead become increasingly distrustful and suspicious (Wilkinson 1997).

In Japan and Scandinavian countries where the distribution of resources is more equal, population health indicators are amongst the best in the world (Lynch, Davey-Smith et al. 2000; Lynch, Davey Smith et al. 2004). More egalitarian societies are more cohesive, less violent, more trusting, and foster more involvement in community life (Wilkinson 1998; Wilkinson 1999). This evidence confirms that achieving equity in health and well-being means providing equal opportunity to be healthy, for all population groups. In particular, social investment in public infrastructure (including education, affordable housing, income support, urban renewal, employment options

and security) is required (Freiler, Rothman et al. 2004; Raphael 2004; Commission on Social Determinants of Health 2005; Graham and Kelly 2005).

2.3.3 'Political economy' - access to material resources and power

From this 'political economy' viewpoint²³, inequalities in health and well-being outcomes are fundamentally and directly caused by differences in access to material resources and unequal power relations which, in turn, arise from ideological contexts and the public policy decisions made by governments (Esping-Andersen 1990; Baum 1998; Goodin, Heady et al. 1999; Macintyre and Ellaway 1999; Macintyre and Ellaway 2000; Krieger 2001; Wallerstein 2002; Lynch, Davey Smith et al. 2004; Navarro and Muntaner 2004; Raphael 2004; Nossar 2005). Numerous studies involving people on low incomes record the impact of inadequate income on (1) social participation, (2) the experience of exclusion, and (3) experiences of negative contact with some government and non-government agencies (Freiler 2002). Especially with regard to income distribution and public social infrastructure, it can be argued that economic and social policy is in effect health policy (Raphael 2003; Bambra, Fox et al. 2005). Increasing inequities are a 'side-effect' of the dominant policies of governments described in Chapter One, which favour market-led economic growth, 'small government', and competitive individualism (Self 2000; Hofrichter 2003; Raphael 2004).

Evidence that the distribution of material advantage or disadvantage over the life-course is a reliable predictor of people's physical, developmental, educational and social outcomes, led Bartley to propose the notion of a 'life-course political economy'

²³ This notion of 'political economy' is being used here in a simplified way in the context of public health. It is acknowledged that political economy is an extensive discipline in its own right.

to draw attention to the ways in which political and socioeconomic environments influence individual development, capability and resilience over time (Bartley 2005). From this political economy viewpoint, the most fundamental determinants of health are government policies, laws and regulations and the ‘originating injustices’ including class²⁴, racism, sexism, heterosexism, and other social relations maintained by power relationships (for example, Navarro and Muntaner 2004; Hofrichter 2005). For example, the recently established World Health Organization (WHO) Commission on Social Determinants, identified gender and social exclusion as key “deeper structural sources” of health inequalities (Commission on Social Determinants of Health 2005).

Redressing social health inequities requires changes in the unequal distribution of resources and opportunities as well as a theory of power and analysis of the processes and practices of social inclusion, exclusion and dis/empowerment (Labonte 1999; Diderichsen, Evans et al. 2001; Wallerstein 2002). This means changes to the institutions and social practices which “both systematically disadvantage particular population groups increasing their vulnerability to poorer health and well-being outcomes, and also generally compound the social and economic consequences of poor health and well-being (Braveman and Gruskin 2003)”.

The ways in which methods and practices of service provision contribute to building and transforming social relationships are central to this challenge (Mathews 2003). Services can replicate, or alternatively challenge, unequal and unfair distributions of

²⁴ ‘Class’ most commonly refers to measures of occupational status or income but can also be defined in terms of economic, political and social power. This definition extends the ways social position (and importantly for this thesis, gender) can be understood to affect people’s access to resources and opportunities for health and well-being (Navarro and Muntaner 2004).

resources and power which are known to be detrimental to individual and population health and well-being. In one example, an ethnographic study which explored gender relations in child protection services in the UK highlighted the absence or invisibility of men's/father's responsibility in service responses to child abuse and neglect. In contrast, responsibility was expected of all mothers but not all mothers had access to the resources (including, and especially, power) to achieve what was expected of them (Scourfield 2003). The unequal social power relations of parenting and service practices are of central interest to this thesis.

Within a human rights framework, the right to health is inseparable from other rights such as the right to education, decent living and working conditions, personal safety, freedom from discrimination, and the right to participate in society (World Health Organization 1946; Braveman and Gruskin 2003; Commission on Social Determinants of Health 2005; Graham and Kelly 2005). These inter-related human rights comprise a vision for 'full citizenship' and the realisation of personal aspirations and 'human capabilities' (Nussbaum 2001). There is an important role for the state as a 'just arbiter'- ensuring these rights as well as a fair distribution of collective resources and equal chances to participate to the full in the community's life (Braveman and Gruskin 2003; Ananad 2004).

The social isolation / social exclusion which many disadvantaged people experience can be understood to limit their claims to full citizenship. For example, women living in disadvantaged situations have limited access to community associations, clubs, recreation and culture groups, and other associations which bring women together to work on issues (Melville Whyte 2002). Such opportunities for 'social learning and

development' and individual and community 'capacity building' are fundamental to these conceptions of 'health-full' citizenship and 'well-fare' (Leonard 1997).

2.4 Intervening early to improve outcomes for families and children

As outlined in the previous chapter, the evidence for intervening in early childhood to support health and development is well established. However, despite this evidence, the health of children in Australia is poorly resourced relative to other stages of the life-course (National Public Health Partnership 2003; Flood 2004; Stanley, Richardson et al. 2005). Despite the evidence regarding the social determinants of health and explanations for how their unequal distribution 'gets under the skin' to influence health and well-being, interventions to improve outcomes for families and children have tended to concentrate on legal/statutory programs (for example, child protection, family court), early detection of health problems through screening or health surveillance and improving individual/family 'resilience' (defined as more successful functioning in contexts of high risk).

Internationally, there is considerable debate about the most desirable forms of early childhood intervention, particularly between those who recommend programs focused on those at risk and others who seek to build wellness across the population from the earliest years (Human Resources Development Canada 1999; Fonagy 2001). As already described, the keystone of early childhood intervention in Australia and other countries is 'developmental prevention'. The focus is on building the internal and external 'assets' at critical transition points in children's lives in order to reduce or strengthen risk and protective factors (National Crime Prevention 1999; Fonagy 2001;

Victorian Department of Human Services 2001; Webster-Stratton and Taylor 2001; Halfon and Hochstein 2002; Commonwealth Task Force on Child Development 2003; Ruffolo, Evans et al. 2003; Search Institute 2003; Silburn 2003; National Public Health Partnership 2004).

Generally, the stated aims of early childhood and family support programs are to promote "sensitive, responsive, and engaged caregiving" and supportive home environments through strategies to enhance mothers' confidence and competence, improve their preventive health behaviours, build supportive social relationships, and link families to other needed resources and services (Armstrong, Fraser et al. 1999; Olds, Henderson et al. 1999). Most commonly these 'relation-based' early childhood and family interventions involve home visiting (Karoely, Greenwood et al. 1998; Kumpfer and Alvarado 1998; Gomby, Culross et al. 1999; St Pierre and I 1999; Brooks-Gunn, Berlin et al. 2000; Fraser, Armstrong et al. 2000; Webster-Stratton and Taylor 2001; Reynolds 2002).

A key understanding of many of these programs is that poor birth and early child development outcomes, as well as the likelihood of child abuse, neglect and accidental injury, are the result of inadequate knowledge, actions, capabilities and motivation of parents, and in particular mothers. 'Dysfunctional caregiving' is seen to be the result of mothers' poor prenatal health and use of health care services, psychological immaturity and mental health problems as well as mothers growing up in "households with punitive, rejecting, abusive or neglectful parenting" themselves (Olds, Henderson et al. 1999; St Pierre and Layzer 1999; Henricson, Coleman et al. 2000).

However, of particular interest to this thesis, the research does not consistently demonstrate positive findings for the impact of these early childhood intervention programs (Gomby, Culross et al. 1999; Human Resources Development Canada 1999; Meisels and Shonkhoff 2000; Ruffolo, Evans et al. 2003). Evaluations of intensive early years programs (mainly programs in the USA) suggest that programs are not always effective and, in particular, not necessarily effective with everyone. Evaluation findings suggest that programs:

- Have little or no effect on maternal mental health, subsequent pregnancy or maternal literacy (Halpern 2000);
- Can reduce child abuse and neglect but may not be effective in households where there is moderate to severe domestic violence (Eckenrode, Ganzel et al. 2000);
- Can have unfavourable outcomes for families with a high, rather than low or moderate, number of risk factors (Brooks-Gunn, Berlin et al. 2000; Webster-Stratton and Taylor 2001; Mathematica Policy Research Inc 2002);
- Can have less successful, unsuccessful or negative outcomes for mothers who live in households where no-one is employed, mothers who are single, teenage, have low level of completed education; have limited parenting skills and unrealistic expectations of their children; mothers living with significant personal stress, depression, low self-esteem; those who have experienced much grief, trauma, abuse and family violence; mothers who have few friends and little support; and those living with alcohol or drug dependency (Browne 1995; Brooks-Gunn, Berlin et al. 2000; Farran 2000; Knitzer 2000; Webster-Stratton and Taylor 2001; Mathematica Policy Research Inc 2002).

These findings are particularly significant as the participants in the *Families at Risk* research mainly fit these risk factor profiles. It will be necessary to look beyond typical forms of developmental prevention to gain insights into how intervention strategies might be improved.

Models of health outlined earlier in this chapter point to the need for action at four inter-related levels - strengthening individuals, strengthening communities, improving social infrastructure and access to services, and making structural changes to environmental, economic and cultural conditions (Dahlgren and Whitehead 1992). Generally prevention frameworks (also known as ‘health promotion’ or ‘health development’) distinguish between primary, secondary and tertiary prevention (Baum 1998; Victorian Department of Human Services 2001). Tertiary prevention focuses on already existing problems and aims to reduce their effects through remediation and rehabilitation. Secondary prevention (including developmental prevention) focuses on reducing the prevalence of problems amongst individuals in mainly specific ‘risk populations’ and tends to emphasise teaching and learning skills and behaviours through which exposure to risk factors and vulnerability may be decreased.

Primary prevention focuses on environments, infrastructure, resources and social relationships, aiming to change the conditions which create ill-health and ‘ill-being’ (WHO 1986). Recent recommendations for health/human services system reform have focused on the need to reorient resources and intervention effort ‘upstream’ (Commission on Social Determinants of Health 2005). This ‘public health’ or ‘population health’ approach is focused on populations (rather than on individuals

who comprise the population) and the social patterns, structures and processes which shape people's opportunities for health and quality of life (Baum 2002). Population health and other social policies are examined in more detail in Chapter Three.

The remaining sections of this chapter will be devoted to a review of the relevance of 'social capital' and the roles of health/human services in contributing to improved health and well-being for families with young children. Both of these were key questions for the *Families at Risk* and the thesis projects.

2.5 The role of social capital

In line with the 'social support' argument outlined earlier, the broad thesis of 'social capital' is that social relationships and networks which generate trust and reciprocity are fundamental to health and well-being. Social capital is generally depicted as positively instrumental for the health and well-being of individuals, groups or communities. Through its focus on networks and social cohesion, the concept of social capital appears to offer the possibility of explaining the strengths and resources of parents in ways which go beyond the characteristics, attitudes and behaviours of individuals. An understanding of the social processes which lead to social capital creation could be helpful to an analysis of, and recommendations related to, mothers' coping strengths and resources.

Putnam, who along with Coleman and Bourdieu is generally credited as a key social capital theorist, argued that there is strong evidence to connect social capital to health via some variation of a direct social support mechanism (Putnam 2000). Some examples of empirical evidence for the connection between social capital and health

and well-being outcomes include: improved health/reduced health inequalities (Kawachi and Kennedy 1997; Wilkinson 1998; Baum 1999); improved quality of life in low-income areas (Lang and Hornburg 1998); child development (Keating 2000); self-rated health (Ellaway and Macintyre 2000) (Subramanian, Kawachi et al. 2001); and mental health (Kawachi and Berkman 2001).

There are many aspects to social capital²⁵ and a great deal of literature concerning the difficulties in defining, measuring and interpreting it as a single explanatory variable, as well as capturing the effects of social context and the ways in which social capital changes over time and place (Portes and Landolt 1996; Kawachi, Kennedy et al. 1999; Leeder and Dominello 1999; Schuller, Baron et al. 2000; Stone and Hughes 2002). There is also considerable debate about the validity of some individual measures and the practice of aggregating individual measures to indicate group, community or national social capital (Astone, Nathanson et al. 1999; Macintyre and Ellaway 2000; Macinko and Starfield 2001; Stone and Hughes 2001).

In the main, measures of social capital are quantitative and generally assess compositional aspects of social capital (attitudes and practices of individuals) and aggregate these as measures of collective social capital (Hawe and Shiell 2000). There are far fewer qualitative studies interested in social capital not as ‘a thing’ but as a process affected by and affecting social structures, norms and historical, cultural and environmental contexts (Labonte 1999). The dynamics of social relationships – the “subjective, experiential dimension of social capital” - critical to the development of

²⁵ Reflected in the wide range of possible social capital measures including: social network characteristics; social trust; reciprocity; social activity; civic participation; neighbourhood safety; neighbourhood pollution; family structure; parenting actions; and institutional infrastructure.

trust and reciprocity, are difficult to measure and are mostly ignored (Popay, Williams et al. 1998; Popay 2000).

In exploring the relevance of the social capital literature to the *Families at Risk* research it is worth noting that there are different versions of social capital with significant differences between them. Coleman emphasised the role of families, close social networks and formal institutions (particularly education) in guiding and supporting children (Coleman 1988; Coleman 1990; Coleman 1993). He defined social capital as:

A set of resources which inhere in family relations and in community social organization and that are useful for the cognitive or social development of a child or young person (1990:300).

This understanding of social capital has been widely used in social research related to children's health and development and parenting (Parcel and Menaghan 1993; Morrow 1999; Sampson, Morenoff et al. 1999). Whilst he acknowledged that the resources available to a person from social capital are shaped by cultural and contextual factors such as income, sources of support and isolation, for Coleman social capital within the family depended largely on the physical presence and attention given by adults to children. Working mothers and sole parents represented a "structural deficiency in family social capital" contributing to overall declining social capital and loss of community cohesion (Coleman, 1988). Etzioni's notion of the 'parenting deficit' echoed these ideas (Etzioni 1993).

In contrast to the idea of social capital as a resource for individuals and families, Putnam used the concept as a property of groups, towns, regions and nations (Putnam 1993; Putnam 1995; Putnam 2000; Putnam 2001). The benefits of social capital are to the population as a whole in the form of achieving shared objectives, for example, reduced crime rates, better health, improved educational outcomes and better governance. He defined social capital as:

...features of social organization, such as networks, norms, and trust, that facilitate action and co-operation for mutual benefit (1995).

The relationship between social networks and the observance of norms or rules were important in both Coleman's and Putnam's concepts of the function of social capital. Civic values, norms, obligations, expectations and sanctions help parents, teachers, police and other authorities to maintain discipline and positive social environments (Coleman 1988:S98 and S103-4) (Putnam 2001). These versions of social capital fit comfortably with communitarian ideals of a 'good society' based on a 'moral consensus', including expectations of "regular, honest, and co-operative behaviour (Fukuyama 1995)"²⁶. These ideals of the 'common good' have been taken up in current Australian government policy rhetoric in which 'social capital building' is a key strategy (along with 'workforce flexibility') to overcome the "known problem of welfare dependency"²⁷.

The assumptions that such a moral consensus exists and that being able to meet its standards is uncomplicated and a matter for individual choice, have been widely

²⁶ See also: (Etzioni 1993; Etzioni 1996; Giddens 1998; Etzioni 2000; Giddens 2000).

²⁷ Comments made by the Australian Treasurer, Peter Costello on the *Lateline* program (ABC Television) - 21/07/05.

criticised (Wall, Ferrazzi et al. 1998; Erben, Franzkowiak et al. 1999; Foley and Edwards 1999; Schuller, Baron et al. 2000). The fact that access to the benefits of social capital is not equally shared (so in that sense, not a ‘common good’) and the realities of conflict and inequality in the lives of disadvantaged families and communities contradict these “highly essentialist notions” (Astone, Nathanson et al. 1999; Campbell and Gillies 2001). Norm observance is a passport to inclusion and therefore problematic for the excluded. The sanctioning capacity of social relationships and practices to ensure compliance by individuals with social expectations can contribute additional stress and further isolation and exclusion. Of particular relevance to this thesis, the expectation to care for children and others is internalised by women as an ‘ethic of responsibility’ and ‘failure’ to meet these expectations results in ‘self-policing’ and feelings of shame, guilt and self-blame, which impact on women’s health and self-care (O’Grady 2005).

Shared notions of the ‘common good’ are not central to Bourdieu’s version of social capital. Rather, like Marx, he focused on the struggle for social position which goes on within an historical and social context of unequal power and resources (Wall, Ferrazzi et al. 1998; Schuller, Baron et al. 2000). In this view, the creation of social capital and its use are seen as inhering in the practices and processes of everyday life which reproduce privilege (Bordieu 1986). While Coleman’s and Putnam’s versions of social capital affirm the value of social relations they offer little explanation for the experiences of resource-poor families except in terms of their having ‘low social capital’ – that is, something else they haven’t got enough of (Morrow 1999; Muntaner

and Lynch 1999; Campbell 2000). Bourdieu's version avoids this problem in that "it is essentially a theory of privilege rather than a theory of inadequacy (Morrow *ibid.*)".

Hawe and Shiell (2000) usefully distinguish three components of social capital – *relational, material and political*. 'Relational' refers to the dynamics of relationships and groups and in particular to the dynamics of trust and reciprocity, norms and expectations. 'Material' relates to the resources accessed through the transformation of social capital, and 'political' to the role of social capital in challenging or reproducing relationships of power and advantage (Hawe and Shiell 2000). These three components can be seen as interwoven and, in particular, power relations (including class, gender, race/ethnicity, sexuality) and the dynamics of social inclusion/exclusion are central to all three.

2.5.1 Bonding, bridging and linking social capital

The close social ties characteristic of disadvantaged populations are known as 'embedded' (Woolcock 1998) or 'bonding' social capital (Putnam 2000). This form of social capital has both psychosocial (for example: feelings of belonging; identity formation; development of values and aspirations; emotional strength) and material (for example: child minding; information; shared transport) value. The downside of bonding social capital arises when trust extends only to close ties, creating walls of exclusion and discouraging members from mobility and from connections with 'outsiders' (Fukuyama 1995; Portes 1998; Fukuyama 1999). In the lives of people who primarily rely on family for support the adverse effects of family conflict, violence and abuse on parenting and health are compounded (Due, Holstein et al. 1999). Szreter argues that, although personal friendships and close ties may be useful

to people lower down the social hierarchy, the overall pattern of social relationships available to them in societies characterised by steep or growing inequalities may be responsible for an extra ‘burden of disease’ (Szreter and Woolcock 2004).

‘Bridging’ social capital is between heterogenous groups and is characterised by looser ties. It can be ‘vertical’ or ‘horizontal’ (Woolcock 1998). Vertical refers to ‘linkages’ between people and networks or organisations of higher power or status and ‘horizontal’ links are those within communities with people who are not close but are more or less equal in terms of their status and power. The potential of services to facilitate both forms of bridging social capital is considered in the next section of this chapter.

The concepts of bonding, bridging and linking relate to their relative value in terms of access to resources, services and institutions and building civic society. In these terms, there is general agreement that bridging is best. Social inclusion is more likely to be fostered through transformations of bridging social capital than through bonding capital.

Bonding social capital constitutes a kind of sociological superglue, whereas bridging social capital provides a sociological WD-40 (Putnam 2000).

However, opportunities to build bridges or even walk across them are not equally shared and change over time and place. Stocks and the distribution of social capital are not only generated through social relations and networks. They reflect unequal social, physical, cultural, economic and geographic opportunities and outcomes (Skocpol 1996; Cattell 2001; Szreter 2002). Social capital experienced at the micro-

level (individuals and groups) affects and is affected by social capital at the macro-level. That is, higher levels of social and civic participation are associated with having strong social/local area network connections (Ziersch, Baum et al. 2005). Following this evidence, the ideals of ‘strong families’ and ‘strong communities’ providing a safety-net of social connectedness for parents and children living in contexts of social disadvantage are likely to be seriously constrained²⁸.

Critics of Coleman and of Putnam argue that their formulations of social capital represent an attempt to reduce the social to the individual by allocating responsibility for the production and the decline of social capital to individuals rather than to social, economic and political structures and strategies led by corporations and governments (Skocpol 1996; Labonte 1999)²⁹.

There is evidence that creating, sustaining and accessing informal social networks are strongly gendered (Lowndes 2000; Campbell and Gillies 2001). Research related to the role of local ‘opportunity structures’ as determinants of health and well-being was cited earlier in this chapter. More deprived areas have lower levels of social exchange, lower perceived social cohesion and lower social capital, all of which mediate the effects of poverty and social exclusion (Stone and Hughes 2001). Higher participation rates in social and civic activity are associated with income and educational levels

²⁸ The ‘Stronger Families and Community Strategy 2004-2008’ is an Australian Government initiative “giving families, their children and communities the opportunity to build a better future”.

<http://www.facs.gov.au/internet/facsinternet.nsf/aboutfacs/programs/sfsc-sfsc.htm>

²⁹ In his later work, Putnam concurs with the importance of historical, location and structural effects in the development of social capital.

...the best single predictor of the level of social capital in American states is distance to the Canadian border. Being closer to the Canadian border means more social capital... low social capital is very clearly associated with the depth of slavery in the 19th century, because slavery as a system and the post slavery reconstruction period were institutionally designed to destroy social capital. ...social capital, among Blacks at least, and later in post-slavery, social connection between Blacks and poor Whites would have threatened the structure of power (Putnam 2001:8).

(Baum, Bush et al. 2000; Hogan and Owen 2000; Freiler 2002) and lower levels of neighbourhood co-operation and trust are linked with lower home ownership, higher residential mobility and lower socio-economic status (Stone 2000; Winter 2000; Cattell 2001). It may be that social capital is just one of a number of ‘intermediate-level’ social determinants of health and well-being and the fundamental causes of unequal outcomes are power relations and differences in access to material resources (Muntaner, Lynch et al. 2004; Navarro 2004; Ziersch, Baum et al. 2005).

Bridging social capital can have political value in the sense of its role in reproducing power and privilege or in challenging the unequal distribution of power and access to resources. When social capital is understood in this way, questions about where and with whom that resource is located and who benefits or what interests are furthered through its creation and use, are of significant concern (Bourdieu 1986; Schuller, Baron et al. 2000; Szreter 2002; Wallerstein 2002). Narrative research, such as the in-depth interviews with mothers and their service providers which were a data source for this thesis, can illuminate social capital as a process by listening to the perceptions of lay people about their everyday experiences related to norms, networks (including services) and aspects of place (Campbell and Gillies 2001; Baum and Palmer 2002; Ziersch, Baum et al. 2005). This qualitative data has the potential to contribute to understanding social capital as a social dynamic operating “at the interface” between individuals and their social context of unequal power and resources (Popay 2000).

2.6 Implications for services and the health system

Answers to the question of how services and service systems can best respond to the strengths and resources of ‘at risk’ families with young children are political as much

as they are guided by research or theory related to the determinants of social health inequalities. Because the determinants of health and well-being are complex and intertwined, a single explanation for any particular social inequality in health and well-being seems unlikely (Siegrist and Marmot 2004). Rather than the different causal explanations reviewed in this chapter being in competition with each other it is possible that all are valid and have relevance to service planning and delivery issues (Kawachi, Kim et al. 2004).

The notion that the problem of how best to respond to the strengths and needs of families at risk is a 'wicked problem' is worth exploring. Wicked problems are difficult to define because they are embedded in a set of interweaving structural and social relations which change or evolve in their effects over time (Rittel and Webber 1973; Madron and Jopling 2003; Conklin 2005). The notion of wicked problems is a completely different paradigm from the problem solving approach which characterises bio-medically and business administration driven service systems. This standard approach is to divide 'objectively' defined problems into manageable sub-problems and deal with them in logical and linear ways.

In contrast, fundamental to the processes of problem solving and acting on wicked problems is the notion that there is no 'objective' version of the problem (or the solution) and participation in learning and action by all those who care about or have a stake in the problem are needed. Problem solving processes are continuous and understood to be dependent on participation and resources like 'opportunity structures', which are in turn dependent on social and political contexts. This emphasis on working and learning together has the potential to seriously challenge

dominant problem understandings and the unequal power relations which reproduce social hierarchies, and therefore social health inequalities (Mathews 2003; Labonte, Polanyi et al. 2005).

The program for action to address health inequalities in the United Kingdom provides an example of the application of a wicked problem understanding (Department of Health UK 2003). The framework for local action is based on the idea of a 'web' of causation, a web which contains possibly hundreds of factors illustrating that a variety of problem life situations have common and interwoven antecedents (Krieger 1994). The framework is designed to enable those who have a stake in improving health and well-being outcomes to review the interacting factors, set local priorities, develop and implement action.

Moving the focus now from policy and service systems to the level of service delivery, there is broad agreement in the literature that services can mediate the differential consequences of illness and problems in people's lives (Commission on Social Determinants of Health 2005; Graham and Kelly 2005). The regular contact which many families have with generalist or universal services such as childcare, preschools, schools, general practitioners, child and maternal health services and so on, make these agencies uniquely positioned to effectively support families with young children (Government of South Australia 2005). There is evidence from early childhood program evaluations that these programs can improve participants' receipt of child and family development services, as well as education related services, employment related services and transportation (Karoely, Greenwood et al. 1998;

Armstrong, Fraser et al. 1999; Gomby, Culross et al. 1999; Olds, Henderson et al. 1999; Marsh, D'Aunno et al. 2000; Mathematica Policy Research Inc 2002; Ryan 2002; Sanders, Turner et al. 2002).

The ways in which social health inequalities affect the capacity of people occupying lower positions in social hierarchies to access and benefit from opportunities (including services) for health and well-being have been referred to earlier in this chapter. Parents deemed most at risk for child abuse and neglect, as well as those most in need of health care, are amongst the least likely to access relevant services (Armstrong, Fraser et al. 1999; Fraser, Armstrong et al. 2000). Similarly, where neighbourhoods or population groups are low in social capital, individuals report higher levels of stress and isolation and a reduced capacity to receive effective public health service interventions (Campbell 2000; Winter 2000; Szreter and Woolcock 2004).

In contexts of serious inequalities, social distance, disrespect and little shared sense of the 'common good' (characteristic of the contexts of the lives of *Families at Risk* study participants) people's access to opportunities and resources for health and well-being needs to be carefully nurtured.

The onus is on those with the power and resources to think very carefully about how to create the shared sense of fairness, including mutual respect between all those concerned...the necessary precondition for shared understandings and group norms or joint goals to emerge. ...the poor remain active agents, albeit

heavily disadvantaged; ...but a skilled response from those in power and authority will be critical...(Szreter and Woolcock 2004).

Szreter's argument is that the development of social capital is as much about the structures and practices of health, welfare and social institutions and provision as it is about access to material resources and "the seemingly abstract properties of 'social cohesion'... (ibid: 657)". Support for the potential of services to resource and facilitate bridging social capital is drawn from studies, especially in socially disadvantaged communities, which show that the nature and extent of respectful and trusting relationships with service providers (for example, classroom teachers, health, housing and welfare practitioners and police) have a major impact on health/welfare outcomes (Lipsky 1980; Narayan 2000; Peel 2003; Social Support Research Program 2004). Of particular relevance to this thesis is the proposal that the role of services and service relationships in building social capital could represent an intermediary or bridging strategy between dominant micro level individual behaviour change approaches and macro-level structural and economic interventions (Lang and Hornburg 1998; Morrow 1999; Campbell 2000).

From the viewpoint that social health inequalities are fundamentally caused by unequal power relations and differences in access to material resources which, in turn arise from cultural, historical, political and place contexts, the nature of 'state-society' relations is of central importance. This can be illustrated by the ways in which 'social capital' has been used to justify contradictory public policy measures (Foley and Edwards 1999). Some theorists, concerned with the decline in social trust, reciprocity and civic participation, argue that the state should intervene to increase 'stocks' of

social capital (Coleman 1993; Etzioni 2000; Putnam 2000). Social democrats and ‘positive liberals’ argue that state intervention is necessary to support a flourishing civil society (Skocpol 1996; Cox 1997; Latham 1997; Norton 1997; Woolcock 1998; Latham 2000). In contrast, conservatives argue that ‘strong’ individuals and communities and state intervention are contradictory opposites, so that social capital is enhanced by reducing state intervention and, in particular, by dismantling the ‘welfare state’ (Fukuyama 1995; Fukuyama 1999).

From a human rights and ‘full’ citizenship perspective, Benzeval, Judge and Whitehead argue that the health system has an obligation to redress inequity by responding appropriately to the health care needs of different social groups; by improving equitable access to services; and by fulfilling the multi-sector, multi-level leadership and advocacy roles which are outlined at the end of this section (Commission on Social Determinants of Health 2005). A detailed review of current policy and service contexts follows in Chapter Three.

Alongside this evidence and argument that services can play a key role, the weight of evidence suggests that the contribution of health care services to improving the health of populations is relatively minor in comparison to social and economic factors. That is, as previously described, the major determinants of health are outside the health system (Turrell, Oldenburg et al. 1999). Health and welfare systems are ‘intermediate’ social determinants in so far as they are influenced by macro-level economic and social policies which determine the financing, provision, quality and utilisation of services, and these in turn are influenced by the social value placed on health and

health care (Braveman and Gruskin 2003; Commission on Social Determinants of Health 2005).

While addressing the unequal distribution of the social determinants of health involves many areas of social and economic policy which fall outside the jurisdiction of health and welfare departments, the health and welfare sectors can still play a key role. More specifically, the health system can³⁰:

- monitor the incidence of ‘dis-ease’, measure the associations between different contributing factors and assess the impacts of disease on population groups in ways which enable policy priorities and targets for intervention to be identified;
- co-ordinate planning activities to address the social determinants of health;
- raise awareness of the social determinants of health, assess the health impacts of policies, and advocate for health promoting policies and programs in other sectors (such as schools, workplaces, early childhood centres);
- engage with communities and other partners in ways which integrate and strengthen action and build capacity for future action;
- develop health organisation capacity, including workforce development and research.

2.7 Summary of key issues from the research literature

This review of the literature relevant to the strengths and resources (including access to services) of families living in seriously disadvantaged places and their implications for services has revealed several broad areas of agreement.

³⁰ Adapted in part from (Queensland Health 2004).

- A conception of the determinants of children's and families' health (and inequalities in their distribution) as multi-layered and that intervention to achieve improved health is required at each of these levels (individual, family, social networks, living and working conditions and structural and societal factors).
- Links between social position, material disadvantage and poorer health, well-being and development outcomes for parents and children produce persistent patterns of social health inequalities.
- The adverse effects of locational disadvantage on health and well-being. There is however, debate about whether people are disadvantaged by where they live or whether individual characteristics contribute more to disadvantage.
- The need to focus interventions 'early' to redress the negative affects of risk factors and social inequalities on people's health and life chances, particularly on infants and young children. The effects of these inequalities can be cumulative, multiplying over time, and without intervention their health and other life outcomes are likely to be poor.
- Current early childhood intervention programs are not always effective with the most disadvantaged families (the *Families at Risk* study population).
- As well as the provision of adequate material resources and opportunities for health, social practices and social relations are fundamental to developing and delivering effective interventions. A focus on adequate resources points to the need for redistributive social policy and social investment. An emphasis on social relations brings issues of power, responsibility, social support and social inclusion to the fore.

Along with these broad areas of agreement there are two areas of disagreement which are of particular relevance to this thesis. First, there is considerable debate in the early childhood literature about whether intervention programs should target those with the worst health outcomes or most ‘at risk’, or the whole population. This debate relates to theoretical disagreements in the health inequalities literature regarding the mechanisms through which social health inequalities are (re)produced: in particular, the comparative contributions of structural and material factors and social processes. Second, the conclusion drawn from the review of evidence in this chapter is that the ‘problem’ of families at risk is not just a problem of life-stage nor of risk factor profiles nor lack of resilience but a problem of inequitable distribution of resources and opportunities for health to which unequal social relations are key. However, despite the evidence, individually focused service responses remain dominant. Rather than the focus being on social and economic inequalities, the focus is on their effects (for example: adverse health behaviours, parent competencies, unhealthy lifestyles, child abuse and neglect) (Raphael 2003). There is a range of possible explanations for the persistence of this ‘individual care’ approach, which are explored in the next chapter.

CHAPTER 3: THE POLICY AND SERVICE CONTEXTS IN DETAIL

Our children are our present and our future. Wanting the best for our children is a thread that binds us as families, communities and governments. ...This means acting now to provide the levels of safety, opportunity and choice that will enable children, families and communities to flourish. There is much to be done to help close the gap for those who are falling behind and excluded by circumstance from the same opportunities and choices as other South Australians. Building a more socially inclusive society is up to all of us (Government of South Australia 2004).

In Chapters One and Two, arguments were presented to support the proposals that: (1) social, economic and cultural conditions, beyond the control of any individual, fundamentally shape opportunities and barriers for the health and well-being of children and families; and (2) there is a need for redistributive social policy and reorientation of programs and services towards creating living and working environments which support all people's health and well-being.

In the first section of this chapter, barriers to the development and implementation of evidence-based equity in health policies are described. In the next three sections, the potential of population health, social inclusion/exclusion and early childhood policy frameworks to address the social determinants of health are explored. Debates about welfare policy and the ways in which trends in Australian social policy contradict the arguments covered in the previous chapters, will be examined in fifth section of this

chapter. The sixth section will focus on relevant South Australian social policies. A more detailed snapshot of the planning and service contexts of the local area from which the *Families at Risk* study population was drawn can be found in Appendix E.

3.1 Evidence-based policy and implementation

The quotation at the beginning of this chapter is illustrative of current South Australian government social policy in which equity and social inclusion are strong themes. In Australia since the late 1980s, public health advocates have argued for public policies to reduce social health inequalities and create social and economic conditions supportive of the health of all Australians (AHMAC 1988; National Health Strategy 1992; Turrell, Oldenburg et al. 1999; Baum 2002; Leeder 2002; AHMAC 2003; Baum 2003; Productivity Commission 2003; Stanley, Richardson et al. 2005). A similar momentum has gathered in a number of other developed and developing nations (Acheson, Barker et al. 1998; Department of Health UK 2003; Ontario Public Health Association 2004; Wanless 2004; WHO Task Force on Health Systems Research Priorities for Equity in Health 2004). According to the WHO's Equity Team, "improving the social and environmental conditions that create differential opportunities to be healthy is today's most far-reaching health policy challenge (Vega and Irwin 2004)".

'Equity in health' policies combine broad redistributive social policies and integrated action coordinated at a national level and locally managed area-based initiatives to achieve:

- improved living standards and ‘healthful’ (health promoting) social, economic and physical environments which are explicitly recognised as the causes of poorer outcomes at the level of individual and family;
- improved accessibility to appropriate universally provided services and programs;
- improvements in the lives of those with the greatest needs and the least resources to address them.

The most frequently cited international example is the recent adoption by the Swedish national government of an overall social policy goal “to create social conditions that will ensure good health for the entire population (Hogstedt, Lundgren et al. 2004)”. Importantly, the adoption of this Public Health Objective Bill (2002) disconnected improving population health from health and medical care policy and connected it to general social policy at national and local levels. The policy contains eleven objectives, five of which relate to structural factors; one to the health system (orientation towards health promotion); and five that relate to ‘lifestyle choices’ which are understood to be influenced by individuals as well as their social environments (ibid.).

Alongside these initiatives there is a growing literature concerned with the considerable gaps between evidence and health policy, and between policy (where it has been developed) and implementation (Short 1997; Spoth and Redmond 2000; Hetzel and Glover 2003; Lin 2003; Marmot 2004; Normand 2005; Sheldon 2005).

Regarding the gaps between evidence of the social determinants of health, policy and implementation there are at least two main explanations. The first relates to

knowledge (for example, the availability and quality of evidence and whether it has been effectively communicated) and the second to politics and power (Dixon 2002; Navarro and Muntaner 2004; Commission on the Social Determinants of Health 2005).

It is generally agreed that whilst there is a great deal of evidence describing the problem of health inequalities, there is little research which helps to identify practical responses and further, that the evidence which does exist does not match the ‘gold standard’ (usually randomised controlled trials) of Evidence Based Medicine (Macintyre, Chalmers et al. 2001; Nutbeam 2003; WHO Task Force on Health Systems Research Priorities for Equity in Health 2004; Gerberding 2005). Where there is evidence, it is mainly focused on individual risk factor modification rather than on the more fundamental macro-level determinants of health and the ways in which existing social and economic policies sustain or increase inequities (Diderichsen, Evans et al. 2001; Dixon and Sibthorpe 2003; Ostlin, Sen et al. 2004). Against the compelling visibility of health threats (such as tobacco and drug use, obesity, child abuse and neglect) and the ‘must dos’ related to the acute sector, social health inequalities and health system reorientation tend to ‘drop down the agenda’ (Dixon 2002; Hunter and Killoran 2004).

As argued in Chapter One, political factors have powerful effects in research and on the translation of evidence into policy and policy into action (Walt 1994; Nutbeam 2003; Bryson and Mowbray 2005). Sax (1984) described these processes of policy development and implementation as “a strife of interests”. In relation to the

implementation of the Swedish public health policy for example, Hogstedt refers to the same policy ‘divide’ raised in Chapter One:

The future of Swedish public health policy appears in the main to be dependent on whether public health can be established as the main objective of central social policy, where issues concerning economic growth and labour market/business sector development have hitherto been the center of attention (ibid: 64).

Participants in policy and implementation processes are informed by different values and ways of thinking as well as by economic constraints, political ‘realities’, organisational imperatives and system problems and concerns (in particular, demand management and financing) (Short 1997; Willis 2003; O’Neil 2004). In Australia as in other countries, there are a number of constituencies likely to benefit from the status quo in which the social determinants of health are not addressed (including: the advantaged, acute medical care professionals and institutions, pharmaceutical companies) (Navarro and Muntaner 2004). As there are multiple causes of health inequalities there are multiple policy options, some of which represent “nightmarish” political choices to neo-liberal governments (Dixon 2002). In addition, as there are multiple causes, no one portfolio can be allocated responsibility for action, and in collaborations individual departments may lose authority and control, including funding they have hitherto seen as ‘theirs’.

In the following sections three current policy frameworks and the politics of their implementation will be reviewed. These policy frameworks are relevant to families

with young children and the reduction of social health inequalities: population health, social inclusion and early childhood intervention.

3.2 *Improving population health*

Fundamental to prevention theory is the evidence that positive changes in individual health status are best achieved through promoting the health of whole populations (Rose 1992).

Population health aims to improve the health of the entire population and to reduce health inequalities among population groups by addressing and acting upon a broad range of factors and conditions that influence health (Department of Health 2005).

Typically, health reform agendas such as that being implemented by the South Australian Government identify *population health* as a fundamental theme and approach to health service delivery (Health Canada 2001; Government of South Australia 2003). A key feature of a population health approach is the acknowledgement that actions to improve health will be achieved largely through partnerships and actions outside the health system. There is considerable overlap between ‘population health’ and the concepts of ‘new’ public health, health promotion and primary health care. These were developed in the late 1970s, influenced by community-based approaches to social programs and development which had emerged in the 1960s. These community-based approaches challenged the curative technologies and power relationships of models which were clearly not meeting the needs of poor and marginalised populations (Friedmann 1992).

The World Health Assembly in 1976 and the International Conference on Primary Health Care at Alma-Ata in 1978, powerfully championed the cause of 'Health for All by the year 2000' with 'primary health care' as the principal means for its achievement. The 'Alma-Ata' declaration explicitly stated the need for a comprehensive health strategy, which, as well as providing services and programs, would address the underlying social, economic and political causes of poor health (WHO/UNICEF 1978).

Primary health care is generally conceived as a level of health care, people's first point of contact with the health system, as well as an approach comprising: a commitment to meet people's basic needs (not only accessible, affordable, appropriate health care but also food, clean water, housing etc.); a continuum of strategies moving from assessment and management of a person's health/illness through to population based approaches focused on health-determining conditions; the building of individual and community participation in social/health development; and the fostering of intersectoral action to address the social determinants of health (Government of South Australia 2003).

In 1986, the Ottawa Charter on Health Promotion defined eight key determinants of health (see Chapter Two) and a range of strategies to reduce poverty and other social health inequalities. These strategies were focused on building individual and collective capabilities and fostering coordinated action involving health and a wide range of other sectors, organisations and community groups (WHO 1986). In the past decade, alongside the rise of 'social determinants of health' there have been attempts to revitalise the concept and practice of health promotion (WHO 1998; Nutbeam

2005). The WHO's Ottawa Charter for Health Promotion was subtitled *Towards a new public health* and it was this document which brought the term into use. According to Baum (2002), the discipline of the "new public health strives for a fairer, just, healthier, more compassionate world and recognises the role of human action in creating it (Baum 2002)".

The principles which underpin a population health approach reflect those of new public health, health promotion and primary health care outlined above, with an emphasis on strategies which contribute to outcomes for populations as a whole (Baum 2002; Department of Health 2005; Harvey 2005). Whilst the concept of population health is potentially radical and redistributive it runs counter to prevailing ideologies, in health (illness) care and in conservative social policies more broadly, which focus on individual behaviour and responsibility. Not surprisingly, the term population health can have a variety of meanings and applications which reflect different ideological positions (Raphael and Bryant 2002). Lewis aptly described population health as a 'we' (collective) concept in a 'me' society (cultural and policy contexts which focus on individuals) and so, not surprisingly, its implementation is full of social and political contradictions (Lewis 1999).

Accordingly, the WHO Commission on the Social Determinants of Health has classified population health policies in terms of the "stage of the social production of disease/well-being at which they seek to intervene (2005:24)". This classification also reflects the primary, secondary and tertiary levels of prevention characteristic of primary health care approaches.

1. Redistributive measures to alter fundamental social inequalities (including income, access to resources/power, status).
2. Measures which reduce vulnerability and the negative health consequences of occupying lower social positions – for example, improving living and working conditions, early childhood intervention programs, reducing tobacco use amongst low-income pregnant women.
3. Targeted programs and services providing treatment, care and urgent support to prevent the effects of ill-health from further lowering people's socio-economic status.

3.3 Social inclusion and exclusion

To advance children's well-being, the Canadian Laidlaw Foundation recommended radical policy action to address five 'cornerstones of social inclusion' (Freiler 2002):

- Valued recognition – recognition of diversity and difference, recognition of common worth by providing universal social/health programs.
- Human development – ensuring learning, development, recreational opportunities and to make a valued contribution.
- Participation – involvement in decisions and in community life.
- Proximity – opportunities to interact with others and reduce social distances between people.
- Material well-being – including adequate income and housing, to enable people to participate in community life.

In theory at least, social inclusion provides a compelling framework for public policy concerning children and families because it gets at the heart of people's 'universal needs' such as belonging, acceptance, recognition and the development of competence

and recognises their fundamental social determinants (Nussbaum 1995; Nussbaum 2001; Stanley, Richardson et al. 2005). From this perspective, rather than poverty being primarily understood as a condition of economic insufficiency, it is also social and political exclusion (Commission of Inquiry into Poverty 1975; SACOSS 2005). The concept of ‘social exclusion’ is seen by many commentators as an advance on ‘poverty’ narrowly defined in terms of low income or occupational status, because of its potential to frame dialogue around the creation of a just, healthy and inclusive society (deHaan and Maxwell 1998; Freiler 2002)³¹.

An early policy initiative of New Labour when it came to power in the United Kingdom in 1997 was to address ‘social exclusion’ defined as:

...a shorthand term for what can happen when people or poor areas suffer from a combination of linked problems such as unemployment, poor skills, low incomes, poor housing, high crime environments, bad health and family breakdowns (Social Exclusion and Cabinet Office 2001)

The concept of social exclusion focuses attention on the active nature of the relational processes which shape disadvantage: firstly, the ‘joined up’ nature of social problems, including the dynamics which affect people’s participation in everyday activities and institutions; and secondly, the interrelationship between individual motivation and capability (agency) and broader social and economic factors (structure). To ensure

³¹ Whether ‘social exclusion’ is an advance on ‘poverty’ is the subject of much debate as not all definitions of poverty are narrow. For example, the definition of social exclusion quoted above is remarkably similar to the definition of ‘poverty’ developed by Peter Townsend in 1979, which emphasised the processes underlying inequality – “being excluded from ordinary living patterns, customs and activities” (Townsend, Davidson et al. 1992). However, there is not the space in this thesis to consider this debate in depth.

that all children's early years are as advantageous as possible, holistic or 'joined up' policy solutions and action are required.

Like 'population health', however, there is a clear distinction between the concept of social exclusion and its ideology-based implementation (Silver 1994; Jones and Smyth 1999; Arthurson and Jacobs 2003). Jordan (1996) described 'weak' and 'strong' versions of social exclusion. 'Weak' ideas focus on individual explanations and solutions such as overcoming individual and family 'deficits' in skills, lifestyles, coping strengths, morals and motivation. 'Strong' ideas see social exclusion as a dynamic relationship between wealthy and poor, between inclusion and exclusion and focus on collective and redistributive action to change inequalities in resources, power and relationships (Jordan 1996).

In a similar vein, Levitas (1998) identified three discourses of social exclusion which are deployed in social policy: a redistributive discourse (RED) where the primary concern is poverty; a moral underclass discourse (MUD) which focuses on the moral and behavioural delinquency of the excluded themselves; and a social integrationist discourse (SID) which primarily centres on paid work (Levitas 1998). Levitas is critical of the concept of social exclusion in its suggestion that the most significant division in society is between an included majority and an excluded minority, thus drawing attention away from the inequalities amongst the included.

Exclusion appears as an essentially peripheral problem, existing at the boundaries of society which characteristically delivers massive inequalities across the board.... The solution implied by a discourse of social exclusion is a

minimalist one: a transition across the boundary to become an insider rather than an outsider in a society whose structural inequalities remain largely uninterrogated (1998:7).

As the rhetoric of social inclusion is fundamental to Australian and South Australian policy proposals regarding the health and well-being of families and children, these discourses are worth further exploration here. The following table, based on Levitas' three discourses, interprets their implications for child and family policy.

Table 2: Social exclusion/inclusion discourses applied to child and family policy Source: Adapted from: (Levitas 1998; FaCS 2000; FaCS 2002; Arthurson and Jacobs 2003).

<i>Discourse/ Ideology</i>	Cause of social exclusion	Link to child and family policy	Type of policy/program
Redistributive	Poverty and inequality	<ul style="list-style-type: none"> - Central importance of access to resources and opportunities for health development across the life course. - Focus on inequalities (the social/health gradient) as linking poverty to poorer health and well-being outcomes. 	<ul style="list-style-type: none"> - Government investment in social provision. - Universal access to publicly provided services and programs. - Public ownership, administration and provision of social programs. - Community participation in governance, planning and provision of programs and services.
Underclass	Individual motivation, skills behaviour	<ul style="list-style-type: none"> - Problem families exist only at the margins. - Social provision is a cause rather than a solution of problems. 	<ul style="list-style-type: none"> -Tight criteria to access and maintain welfare benefits. - Privatisation of social programs (eg. housing, legal aid, education). - Targeted programs to promote self-sufficiency and independence eg. lone mothers, teenage parents
Social integrationist	Non-participation in paid work	<ul style="list-style-type: none"> - Focus on achieving social inclusion through paid work. - Emphasis on the role of social provision in connecting people to paid work. - Concerns about the welfare of children in jobless families. 	<ul style="list-style-type: none"> - Intensive one-to-one employment entry support. - Training and volunteer activity a prerequisite for receipt of welfare benefits. - Mothers receiving welfare payments required to re-enter the paid workforce once their youngest child is 8 years old. - Social capital building

While the child and family policy consensus described in the following section of this chapter reflects aspects of a ‘redistributive’ discourse, more generally, current social policies of the Australian Government are a mix of all three but reflect primarily a ‘social integrationist’ discourse with a strong dose of ‘moral underclass’. These social policies are examined in more depth later in this chapter.

3.4 *Early childhood intervention*

In Australia in recent years, there has been a proliferation of work done to develop frameworks to guide the concerted and co-ordinated commitment necessary to nurture and support the health and well-being of young children and their families³². In line with international frameworks, these Australian examples acknowledge the social determinants and identify as a priority the development of comprehensive and integrated early education, childcare, family support and health services. ‘Early years’ policies and programs are in various stages of implementation nationally and in each state in Australia (Child and Youth Health Intergovernmental Partnership 2004). However, commentators suggest that in Australia there is not yet the “necessary commitment” to ensure the recommended universal coverage and an integrated and sustained effort (Calvert and Smith 2004; Stanley, Richardson et al. 2005).

Early childhood initiatives in Australia and internationally share similar goals including: enhancing parenting capacity, fostering child health and development, reducing rates of child abuse and neglect, increasing family access to supportive

³² Examples include: (National Crime Prevention 1999; Turrell, Oldenburg et al. 1999; Department of Family and Community Services (FaCS) 2000; Department of Human Services 2003; Child and Youth Health Intergovernmental Partnership 2004; Department of Family and Community Services (FaCS) 2004; Government of South Australia 2004; National Public Health Partnership 2004; Government of South Australia 2005)

resources, and developing supportive social and community environments and networks. There is also a broad consensus concerning key areas of policy action to best achieve these goals. According to the South Australian Health Department's (a partner in the *Families at Risk* research) early childhood policy framework:

Research studies indicate prevention and early intervention programs for children and families have the greatest impact when they are capable of addressing a broad range of issues and are provided as part of a coordinated network. The best preventative interventions are those that involve an integration of different services (Department of Human Services 2003).

In addition to these emphases on prevention and early intervention (at a young age and at the earliest stage of problem development) and improved 'joined up action' across sectors and between services, key aspects of this consensus include:

- Building family 'capacity' to provide stable and continuous care for children by efforts to increase parents' confidence and competence in parenting and build supportive social networks.
- Improving access to services – in particular, antenatal and postnatal support services through strategies such as nurse home visiting, local child and family centres and employment of family 'links' or liaison workers.
- Recognising the impact on health and access to services of low income and the social contexts and environments in which people live – including education, employment, health and 'place' inequalities, violence and abuse, social isolation.
- Building safe and supportive community environments for families and children

- Focus on the most vulnerable children and families and on those with the poorest outcomes (Aboriginal and Torres Strait islanders, children living in poverty, in foster care, exposed to violence and abuse, from isolated areas, with disabilities, and from non-English speaking backgrounds).
- ‘Family-focused’ interventions, tailored to the needs of individual children and families (rather than agency or auspice systems).
- Increasing participation of individuals and communities in decision-making and action about their concerns.
- Building evidence-based practice and monitoring progress towards goals and targets.

With closer examination, some important differences in emphasis in early childhood policy frameworks which have particular relevance for this thesis can be revealed. These differences relate to commitment to redress economic and social inequalities and to universal entitlement to public provision of the support needed to nurture child and family health and well-being. By way of example, the most recent South Australian policy proposal made an explicit commitment to a future in which early childhood services will be universally available for children from birth to the age of eight years as an entitlement in the same way that compulsory school education is an entitlement (Government of South Australia 2005). In contrast, as its title suggests, the focus in the Commonwealth Government’s *Stronger Families and Communities Strategy* (2000), which was recently renewed for another four years, was on parents’ access to antenatal and postnatal services and the role of parents and communities in

providing supportive environments for child development (Department of Family and Community Services (FaCS) 2000).

These differences are important in the light of evidence from the USA and Canada, where, despite their excellent (according to program evaluations) early years programs which (in their policy and program rhetoric) acknowledge the detrimental effects of poverty and inequality, the incidence of child poverty has increased (Raphael 2004). When universal programs are judged too expensive, targeted strategies are preferred but these address the consequences of disadvantage and leave the processes that cause it largely unchanged. The important differences between programs which focus on those in the poorest circumstances and poorest health and those that attempt to alter the social health gradient or the distribution of resources and opportunities for health across the whole population are central to redressing social health inequalities (O'Neil 2004; Graham and Kelly 2005) .

Despite the policy commitment, having insufficient resources for universal coverage has constrained the implementation of early years policy and programs in Australia. According to close observers, programs have generally been managed within a series of small, short-term funded projects, with shortages of appropriately skilled staff, and with conflict arising from competition for priority/resources between child protection and health promotion (Spencer and Alperstein 2005).

Another issue of relevance to this thesis is that the role and support needs of women (mothers) are not generally a specific focus of Australian child and family health

policies. Generic use of the terms ‘families’ and ‘parents’ obscures the reality that, in the main, women are the primary carers, especially of young children. The primary focus of these policies is outcomes for children and although policies advocate ‘family-centred’ approaches, services often focus on the child with little reference to their social and family context or, in particular, on supporting mothers’ health and mother-child relationships (Scott 2005). This issue is explored in more depth in Chapters Seven and Eight.

3.5 Australian welfare policy, health and families

The current prevention and early intervention focus of child and family policy stresses the links between different social policies (for example, housing; income protection) and between Commonwealth and State policies (for example: health; housing; education; tax policies). Policy values described in the previous section, including universal entitlement and adequate public provision to redress inequalities in opportunities for health and well-being and in outcomes, are not the values which underpin the current Australian Government’s approach to social policy more generally. The propriety and efficiency of state intervention to promote social health equity are being strongly contested. As at least three-quarters of the *Families at Risk* study population were reliant on government benefits and public provision, competing ideologies and values in the welfare debate are of direct relevance.

As argued in Chapter One, different discourses construct the problems and needs of families at risk (and families more generally) differently and differ in their policy ideas about what constitutes an appropriate response. For each, ‘welfare’ has different goals and meanings (Young 1997; Seymour 1999; Williams, Popay et al. 1999). The

dominant ideas which have influenced Australia's approach to social policy for almost three decades are a mixture of 'market rationalities' and 'libertarianism' - the virtues of the 'free market' and the rights of the individual to choose their own lives and livelihoods and be responsible for the outcomes (Bryson 1994; Harris 1999; Stilwell 1999; Self 2000; Burke 2001; Marston and Watts 2004). These market rationalities are central to the economic, social and political ideas of 'neo-liberalism'³³.

The goals of economic growth and national competitiveness in the global economy have shaped politics and policies and have been given priority over social goals. Politically, market theory requires the state to provide an efficient legal framework to enable market operations but otherwise confine itself to limited functions – governments should “steer not row (Osborne and Gaebler 1993)”. As the ‘trickle-down effects’ of economic growth are assumed to result in prosperity for all, social equity and social cohesion are not primary concerns for government. To the extent that government intervention is necessary, it should be modelled according to market principles and methods. The impact of market rationalities on public and community services will be considered at the end of this section. Socially, the market system is underpinned by the notion of rational self-interest which defines and promotes individual rights, responsibilities and opportunities. A central aim of social policy is to maximize individual autonomy and ‘choice’.

³³ It is worth noting that values and political commitments amongst proponents of what is broadly characterised as 'neo-liberalism' vary. For example, the proposals of neo-conservative analysts such as Saunders from the Australian Centre for Independent Studies and Fukuyama are substantially different from those of more 'positive' liberals such as Galston and Nussbaum (Galston 1991; Nussbaum 1995; Fukuyama 1999; Saunders 2000).

In broad terms, the dominant policy approach to social disadvantage is based on assumptions that poverty is short-term, affects only those people at the margins and that their problems are caused by lifestyle choices, addictions and other personal skill, motivational and behavioural deficits. Categories like ‘poverty’ and ‘the poor’ have been replaced by the ‘problem of welfare dependency’ – that is, people who are experiencing problems are primarily seen as “victims of their own mismanagement” (Burke 2001; Marston and Watts 2004). The primary focus is on individual self-reliance, ‘responsibility’ and ‘mutual obligation’ in return for income support and the provision of a ‘safety net’ for those judged most in need.

Since the late 1970s, market imperatives and the assumptions and values of self-interested individualism have been the source of a sustained critique of the ‘welfare state’³⁴ and have driven welfare reform in Australia. Increasing numbers (and proportion) of people of working age receiving income support payments, the declining birth rate and the prospect of a smaller proportion of people of working age (a smaller tax-base) to support the future care needs of the ‘baby boomer’ generation, underpin the assertion that the costs of welfare are unsustainable. In addition, it is argued that the costs of welfare require a level of personal tax which impinges on individual freedom³⁵, and that this causes high levels of debt for government making the nation uncompetitive in a global market (Butterworth 2003).

³⁴ Generally defined as the commitment to full employment, mass educational opportunities and state-provided, professionally delivered ‘universal’ protection from poverty, unemployment, ill-health and homelessness, which were features of most developed Western countries for 20 or more years following the second World War (Titterton 1992; Oakley and Williams 1994; Williams 1999).

³⁵ Actually, in terms of government social spending Australia is a ‘small’ welfare state (Goodin, Heady et al. 1999) Whilst Australia’s social spending has grown in the past two decades, at around 8% of GDP it is about 5% below the OECD average and more than 10% below the Scandinavian countries which invest most (Calvert and Smith 2004; Marston and Watts 2004).

As the ‘core business’ of government is to facilitate maximum economic growth and global competitiveness, the notion of ‘public interest’ to be served by government has substantially altered. With the aim of redressing the perceived current imbalance in the relationships between government, market and individuals/community and of reducing public expectations of what the government should provide, the priorities of welfare reform are to reduce government expenditure and transfer costs and responsibility for social outcomes to individuals, families and communities. Some examples of how this has been achieved include: reducing access to benefits and services, tax rebates for private health insurance, ‘work-for-the-dole’ and ‘user pays’ strategies. While social or public provision for the ‘collective good’ is declining, at the same time in some areas state surveillance and intervention in the lives of individuals is increasing (for example, child protection, compulsory immunisation, programs that exhort individuals to change their adverse health behaviours).

In neo-liberal and neo-conservative political discourse the welfare state is cast “not as a source of protection from risk, but as itself a major *generator of risks* – of disincentives to initiative, of welfare dependency, of an underclass, of inefficiency and expense in the public sector...(Williams 1999:670)”. The receipt of welfare is ‘immoral’ in that it denies self-reliance, deprives individuals of a sense of responsibility, creates dependency, and undermines communities and even nations by weakening the moral obligations that people once felt (Murray 1984; Culpitt 1999; Newman 1999; Saunders 2000). The idea of ‘no rights without responsibilities’ or ‘mutual obligation’ underpins a ‘new social contract’ in which individuals (especially those receiving welfare payments) are obliged to make an active contribution in return

for the support they get from society (Yeatman 2000). In the new social contract justice and fairness are about individuals getting what they ‘deserve’ and paid work (the labour ‘contract’) is central to self-reliance and independence (Macdonald 1999; Butterworth 2003).

[Paid work] is the first duty of citizenship, rather than one of its central rights... Parents (both mothers and fathers) in paid work provide a good role model for their children and a social network for themselves. Paid work then, is what we owe our government, our country, our families, our communities and ourselves (Williams 1999).

Just as workforce participation is perceived as a moral duty, ‘family’ has become political shorthand for moral values and typecasting of good and bad families (Young 1997; Schultz 2005). The assumption that families will provide models of “good relationships and civic virtues” and thereby (re)build a dutiful and cohesive society places a strong focus and responsibility on parents (Cox 1995)³⁶.

Never has so much public attention been spent on family relationships and their rights and wrongs; never so much spectating on relating; never so much anxiety about ‘the family’. ... There is, allegedly, a crisis of parenting – well, if there isn’t one, we’ve certainly invented one (McLeod 2001).

The ideal intact two–parent family is seen as best able to promote the welfare of children and produce good citizens – that is, independent and contributing members of the community. In the words of the Australian Prime Minister:

Strong family and community networks nurture children, care for those in need, and help people take up opportunities to find work. It’s about neighbourhoods

³⁶ One example of the rhetorical appeal of ‘family’ is the slogan - ‘Home: A Place to Save Our Society’ – which was used to promote the annual South Australian ‘Families Week’ in 2002.

and families helping each other in times of crisis. It is strong family relationships that are the vital building blocks of strong communities. In turn, it is only strong communities that have the capacity to truly engage families in economic and community life (Howard and Newman 2000).

These ideals of family and 'community' provide no alternative narratives for parents and children (including sole mothers, households in which no person is employed, victims of violence and abuse) and disadvantaged communities who do not fit these ideals. Lister (2002) points to the ways in which the stigma and shame associated with not being an 'ideal' family, citizen or community can contribute to further social isolation and exclusion and to increasing social health inequalities (Lister 2002). Other critics argue that focusing on paid work as the solution for stressed and under supported families undervalues essential unpaid family and community work (Gordon 1990; Giddens 1998; Burggraf 2000; Driver and Martell 2000; Skolnick 2000; Hakim 2003). Whilst it was once accepted that it was in children's best interests for a sole parent to be a full-time parent, lone mothers are now being forced into low paid, insecure and often unrewarding work.

However, rather than a simplistic story that a once progressive Australian welfare state is being dismantled, the picture is more complex as welfare expenditure, and social spending more broadly, have continued to increase (Whiteford 2001). The 'real' argument in welfare reform therefore may not be so much about welfare spending but about the notion of the 'public interest' to be served by government. The perceived tension in neo-liberalism between individual freedom and the state, expressed in the demarcation of a 'public' sphere of politics and state intervention and a 'private'

sphere in which state (political) intervention is viewed as inappropriate and constraining of individual autonomy, generally constructs the needs or struggles of families with young children as a 'private responsibility' outside the sphere of politics (Bittman and Pixley 1997).

In everyday experience, however, there is no clear demarcation between 'public' and 'private'. In the 'private' sphere of the family, parents are expected to responsibly raise their children and at the same time are subject to wide-ranging regulation and intervention by the state (for example: compulsory schooling, mandatory reporting of suspected child abuse or neglect, compulsory immunisation and health surveillance, and welfare-to-work programs). The attribution of privacy to some but not other aspects of family life is political. The decision not to intervene is just as political as intervention (Culpitt 1999; Beresford 2000).

The assertion that solutions to social problems can be found in the resources generated by families and community support ignores or denies the structural sources and processes which shape individual 'choice' and 'responsibility' and generate social health inequalities including the gendered nature of family and community support. In this way, the emphasis is taken away from other possible policy responses. In particular, the connection between the reduction of the role of government in social provision and increased poverty and disadvantage is obscured (Burke 2001; Fincher and Saunders 2001; Whiteford 2001; O'Neil 2004; Parker 2004).

There is strong evidence that health and quality of life outcomes are better in nations with higher rates of social investment compared with nations with market approaches to policy development (Goodin, Heady et al. 1999; Raphael and Bryant 2004; UNICEF 2005). The proposal that the state should resource and facilitate adequate provision for basic human needs is underpinned by a ‘positive liberal’ conception of society as a joint co-operative project in which all members have a claim to the necessary requirements to make a worthwhile use of their liberty. That is, each person is entitled to positive ‘empowerment’, support to enhance their ‘capabilities’ or opportunities for functioning as well as negative respect for their privacy and personal liberty (Nussbaum 2001). From this, a framework for welfare would recognise vulnerability and need, redress unequal social relations and build relationships of care and trust underpinned by the notion that all humans need a great deal of care when we are young, old and sick as well as relationships of care and support throughout our lives. This proposal contests the assumptions which underpin the current neo or conservative liberal conceptions of individual rights and responsibilities.

3.5.1 Public sector and community services reform

With the goal of achieving smaller, more efficient government, market rationalities have driven a thorough, systematic reform of public and community services. The organisation and delivery of services are mainly driven by the imperative to demonstrate efficiency and accountability in managing demand for what are perceived to be scarce public resources. In the application of market rationalities, the relationship between the public sector and the public is altered from one of entitlement, assistance or support to one in which the users of services are ‘customers’ or consumers of health, education, housing and so on, goods or products (Culpitt

1999)³⁷. Despite differences in national and regional contexts, a number of ‘new public management’ reform strategies have been commonly implemented (Pusey 1991; Culpitt 1999; Moore-Wilton 1999; Self 2000; Commission on the Social Determinants of Health 2005). These include:

- Reduction in the number of full-time public servants through privatisation, direct cuts and the use of short-term employment contracts.
- Focus on efficiency by, for example, concentration on ‘core business’, defining performance/outcome indicators and achieving a ‘stronger budgetary position through expenditure restraint’.
- Separating funding, purchasing and service provision functions.
- Increasing private sector presence – for example by contracting out of services, encouraging private health insurance.
- Development of increasingly sophisticated tools to enable the administration of need. These tools standardise and define services as products and underpin assessments of ‘eligible’ and ‘ineligible’ service recipients. They include the use of benchmarks and standardised procedures, defined categories and tiers, accreditation, triaging and other assessment systems.
- Centralising planning and decentralising implementation. Strategic plans are made by central agencies and management is devolved to line departments through performance agreements with tight financial controls and an emphasis

³⁷ From the perspective of service seekers, some aspects of this ‘customer-focus’ may be positive – for example in the emphasis on ‘quality service’, listening to the ‘customer’ and adapting services to meet ‘customer’ needs, empowering employees to get results and holding managers to account for promised outcomes.

on ‘can-do’, quick implementation rather than on achieving a more complex balance between conflicting goals and priorities.

From his critical observation of the effects of market rationalities and narrowing social policy definitions on the organisation and delivery of public housing in Australia, Burke (2001) argued:

Housing issues which are grounded in structural imperfections of the market or which were created by growing income inequality were off the bureaucratic agenda. Less senior public servants, particularly at the Commonwealth level, have largely become process workers who spend most of their time monitoring and administering existing programs, and rarely have time to reflect on the broader outcomes or even relevance of such programs (Burke 2001).

These contexts of little political support, bureaucratic lack of interest and/or capacity, and restricted eligibility, have detrimental effects on service infrastructure, access, and quality of service provision. Research on health sector reforms suggests that they have produced increased barriers to access to health services for the less well off, including women and children and low-income households (WHO Task Force on Health Systems Research Priorities for Equity in Health 2004). A more impartial and limited role for the state in support of the market system also means stronger competition for public funds. The poor and socially excluded whose interests in large part depend on the support and advocacy of welfare organizations are likely to be the worst affected (SACOSS 2001).

3.6 South Australian policy context

In general, the policy discourses revealed in South Australian government social policies relevant to the health and well-being of disadvantaged families with young

children echo those of New Labour policies in the United Kingdom. The ‘social inclusion initiative’ of the South Australian government was established in March 2002, with the aim of ensuring “everyone who lives in South Australia has access to all our society offers; helping people to live fulfilling lives and to feel part of a community (Social Inclusion Board 2005)”.

The priorities for this social inclusion initiative largely reflect a ‘weak’ or ‘social integrationist’ version of social inclusion in that they focus on improving outcomes (which are able to be measured) for individuals at the margins³⁸. One priority relates directly to the *Families at Risk* study population – that is, *improving the circumstances of families with multiple, complex needs in identified geographical locations*. The development of early childhood and child protection policy frameworks (Department of Human Services 2003; Government of South Australia 2004; Government of South Australia 2005) and the universal nurse home visiting program referred to in the second section of this chapter have been major initiatives in this priority area.

The Government’s policy commitment to social inclusion is reflected in the State Strategic Plan which aims to improve opportunities and outcomes for **all** South Australians (Government of South Australia 2004):

Improving quality of life and the well-being of South Australians requires improvements in all areas of endeavour – environmental amenity, social justice

³⁸ The first seven priorities were high profile social issues of public (and political) concern: reducing the incidence of homelessness; increasing school retention rates; increasing Aboriginal well-being through sports, recreation and the Arts; reducing repeat offending; reducing self-harm and suicide amongst rural youth; tackling problems related to drug use; and increasing youth employment opportunities.

and inclusion, public services, provision of world-class infrastructure, and provision of quality education and training and health systems (p20).

The influence of ‘third way’ thinking is apparent in the Plan in its emphasis on ‘joined up’ solutions, social inclusion and the linking of economic (‘prosperity’, ‘sustainability’ and ‘expansion’) with social objectives (‘well-being’, ‘creativity’ ‘communities’). However, it is not a redistributionist plan. There is for example, only one performance indicator related to improving low income (SACOSS 2005).

As with the social inclusion priorities, the specified targets related to ‘improving well-being’ focus on population groups with the poorest outcomes. These targets mostly focus on individual behaviour or lifestyles³⁹, which is somewhat inevitable given the imperative to specify ‘measurable outcomes’. The ‘performance indicators’ are of individual illness/dysfunction, death and service utilisation rather than measures or descriptors of ‘healthful’ (health promoting) environments, health outcomes and/or quality life. Despite the inclusion rhetoric, the concern is not with equity across the whole population or the processes which create opportunity and disadvantage; these are much more difficult to measure.

Rather than focusing attention ‘upstream’ on the broader societal determinants of health, the ‘health’ priorities of the Plan focus ‘downstream’ primarily on individuals. This is consistent with ideological understandings of health and health improvement as individual more than as societal issues.

³⁹ Smoking, obesity and overweight, psychological distress, infant mortality, and healthy life expectancy.

Within these understandings, the South Australian Department of Health (a partner in the *Families at Risk* research) has responsibility for achieving the ‘improving well-being’ targets. The broad policy principles which shaped the development of the Health Department’s *Strategic Directions 2004-2007* mirror those of the social inclusion and early childhood services policies (South Australian Department of Health 2004). These ‘inclusive’ principles emphasise prevention, early intervention and primary health care approaches; partnerships and consultative relationships; and ‘joined-up’ planning and implementation of programs and services across departments, sectors and communities. In 2003, the report of the of the South Australian government’s health reform enquiry supported a social determinants of health approach to child and family health and well-being:

...early childhood should be a priority for a whole-of-government approach to ensure coordination and focus across government, and provide clear accountability for specific outcomes. There should be a strong early intervention and prevention focus, particularly on the social and economic factors impacting on health and well-being of children and families (Government of South Australia 2003).

A reorientation of health system priorities towards prevention was argued to be fundamental to achieving a ‘sustainable’ health care system in the light of growing ‘budget pressures’ and demand for illness care from an ageing population. A conservative application of ‘population health’ focused on governance, funding and information sharing and the most vulnerable populations (Aboriginal people, children and young people, people with a mental illness and the frail aged) shaped the Health

Department's health reform implementation plan (Government of South Australia 2003).

In contrast to the conservative versions of population health in the policies described above, the recently released South Australian Women's Health policy asserted that "improving the health of **all women** will improve the health of the whole community (bold in original)" and that "a [health] reform agenda that is silent on the issues and needs of women is a reform agenda that will not succeed (Government of South Australia 2005)". This policy used the language of women's 'right' to health and entitlement to services and opportunities to support their specific health needs. Reflecting the national women's health policy, the policy priorities are primarily social rather than individual (CDCSH 1989; Willis 2003). Unlike the early childhood policies reviewed in the fourth section of this chapter, the women's health policy is explicit about the fundamental role of women as primary care givers.

3.7 Competing discourses

Expectations for the use of evidence in the development of health policy have grown in parallel to the growing influence since the 1990s of evidence-based medicine (EBM) on clinical practice. However, as indicated in this review of the extent to which social determinants of health evidence is incorporated in policies and services relevant to improving child and family health and well-being, evidence-based policy and implementation may be more 'aspirational' than realistic goals (Macintyre, Chalmers et al. 2001; Lin 2003; Nutbeam 2003).

Just as ideology and politics powerfully influence research and policy development, the organisation and delivery of programs and services are influenced by competing

discourses. In developing a model for critical social work practice, Ife identified four competing discourses in the organisation and delivery of welfare services in Australia - 'community' (welfare as participation for the citizen), 'professional' (welfare as a service for the client), 'managerial' (welfare as a product for the consumer) and 'market' (welfare as a commodity for the customer) (Ife 1997). In a similar vein, Fraser (1989) referred to the "politics of the interpretation of needs" and the ways in which different and often competing 'needs discourses' interact to construct service responses. She identified three competing discourses. *Reprivatization* discourses oppose public provision for 'runaway' needs - needs which should be restrained, or returned to the 'private'(individual, family) or 'market' spheres. The *expert* discourses of professionals, academics, welfare administrators, social planners and policy makers effect the translation of needs into problem categories and 'problem-solving services'. *Oppositional* needs discourses, most often arising from social movements (such as women's health), advocate needs which often remain hidden or are attributed to the 'private' sphere in other discourses (Fraser 1989).

In the main, the service relationships which were the focus of the in-depth interviews for this thesis project were located within services influenced by social movements which challenge dominant beliefs and social norms and are committed to generating new knowledge and achieving social change. Most had been shaped, at least in part, by the women's health movement which has had considerable success in influencing and achieving changes in the health system in Australia; including the establishment of women-centred services responsive to women's own definitions of their health needs and with alternative systems of management to those of mainstream services;

and a reorientation of services from a biomedical towards a public health/health promotion paradigm (Palmer and Short 2000).

Underpinning these service models and practices is an understanding of the ‘politics of health’ (Bambra, Fox et al. 2005) and the tenets of emancipatory or empowerment service models. The feminist notion that the ‘personal is political’ focuses attention on the ways in which unequal access to resources and power and dominant ‘discourse practices’ (Epston and White 1990) are sustained and ‘get under the skin’ to influence people’s identity, ‘resilience’ and health and well-being outcomes.

According to Burke (2001), the uncomfortable and competing mix of discourses described above has produced social policies and social practices which are “neither fish nor fowl” and which enable politicians and “policy influentials” to take the parts which best fit their ideological and system agendas and ignore others (Burke 2001). Despite the early childhood policy consensus and apparently supportive local policy contexts described in this chapter, when reform agendas or policy responses are driven by the imperatives to ‘manage demand’, demonstrate efficiency and financial restraint more than by a clear vision of better outcomes for parents and children, systems and services which further marginalise already marginalised groups are likely to be reproduced.

3.8 ‘Families at risk’ – developing policy and service implications

This third chapter concludes the first section of this thesis in which the need for a critical approach to the task of developing policy and service recommendations from

evidence about serious social health inequalities has been argued. These three chapters have been concerned with situating the thesis project within a variety of contexts:

- current academic and policy research interest in early childhood and in the associations between socio-economic status and health and well-being outcomes;
- different perspectives on ‘health’ and competing models for health improvement;
- dominant political and social values as they relate to social health inequalities and the needs of families with young children;
- competing public policy priorities and the mainly conservative (rather than transformative) implementation of social and health policies;
- service improvement issues and challenges in responding to worsening inequalities and the needs of people with the worst outcomes.

In these three chapters it has been shown that there is strong evidence and a broad consensus of ideas about the fundamental importance of the social determinants of health, especially in early childhood. At the same time, dominant ideologies, public policy priorities and approaches to improving health contribute to maintaining, and in many instances, worsening social health inequalities. It has been argued that evidence or definitions about ‘problems’ and ‘needs’ have little meaning without consideration of whose perspectives and which purposes and values are represented, as well as the contexts within which the evidence is to be applied. By adopting a critical approach, this thesis aims to enrich and extend understanding of what is required to improve health and well-being outcomes for ‘families at risk’ by listening

to the perspectives of mothers and front-line service providers about the needs which arise from their experiences of social health inequalities and service support.

CHAPTER 4: THESIS RESEARCH METHOD

Introduction

In Chapter One it was argued that decisions about research methodology follow from assumptions about what there is to know and how best to know about it. In the *Families at Risk* research proposal, as is common in much research, these positions were assumed and remained unspecified and largely unexplored. Ontological and epistemological assumptions underpin responses to key questions in any research, including: (1) what questions/problem(s) the research seeks to answer; (2) where these answers are best able to be found; and (3) what forms/types of knowledge/data and from which sources, are likely to have most explanatory value. The previous chapter highlighted the fundamental influence of these assumptions on the use of evidence in policy development and its translation into practice. Because of the political nature of research and the requirements of a policy project the assumptions underpinning this thesis need to be made fully explicit.

The aim of this chapter is to account for the research methodology employed by the author and to establish the criteria by which the quality of the research and the authority of its conclusions may be judged. As explained in Chapter 1, the large scale interview survey methodology employed by the main part of the *Families at Risk* study provided one source of empirical data for this thesis. A detailed account of this methodology can be found in Appendix F. There are various aspects to the thesis research methodology and these are examined in chronological order – beginning with general issues related to the decision about what methodology to adopt, and to questions of validity; then going on to research techniques, including triangulation,

sampling and interview design; then the interview process and issues related to researcher accountability; and finally, to the methods used to analyse and interpret the data. The chapter will conclude with a reflection on the collaborative team approach to this research project.

4.1 Quantitative and qualitative methods

While it seems obvious that the choice of research methods should relate to their appropriateness to the questions, purpose and context of the research, there has been considerable antagonism between proponents of quantitative and qualitative methods. This antagonism has arisen from a ‘paradigm clash’ – the differences between positivist and interpretivist frameworks described in Chapter One. The *Families at Risk* study, and in particular this thesis project, represent an attempt to constructively employ both methods.

The quantitative data collected from a relatively large sample population during the survey interviews was useful in identifying patterns and, through statistical correlation, pinpointing ‘risk’ and issues for further study. Importantly, in relation to the aims of this policy project, this method has the potential to produce enough ‘statistical power’ to influence policy decisions. The survey instrument(s) also included some open-ended questions in a mainly ‘tick box’ (categories pre-determined by researchers) questionnaire (see Appendices C.1 and C.2). Text transcribed from notes on the survey instrument recorded by the field researchers from participants’ responses to these open-ended questions provided one source of qualitative data.

In addition, the thesis component of the project employed a dyadic, in-depth interviewing method with a small subset of mothers from the target population and their service providers. The author facilitated, tape-recorded and transcribed these interviews which, along with field notes made by the author after the interviews and consultations with policy makers, service managers and providers, provided the main source of qualitative data. The in-depth interviewing method allowed active exploration of mothers' and front-line service providers' perceptions and meanings related to 'strengths and resources' and the effectiveness of various forms of support, as a basis for framing recommendations for policy and practice.

The use of quantitative and qualitative methods in this thesis was informed by a substantial literature in which the 'paradigm clash' between them has been deconstructed (Bryman and Burgess 1994; Holland and Ramazanoglu 1994; Maynard 1994; Baum 1995; Bonell 1999; Oakley 1999; Patton 2002; Pyett 2003; Adily, Peacock et al. 2005; Liamputtong and Ezzy 2005). Positivism is not intrinsic to quantitative methods. In some respects, the *Families at Risk* project attempted to counter the limitations of positivist assumptions by: (1) the description of associations, (2) acknowledgement of the approximate and partial nature of the measures used and the contextual nature of the analyses generated and (3) acceptance that the standardised techniques and statistical methods used to investigate the results of survey research are suited to different purposes from text analyses of qualitative data.

In this thesis qualitative data was used to explain and extend findings from the quantitative research with four purposes. Firstly, to gain some understanding of how

individual mothers and front-line service providers interpret health, well-being and the challenges of parenting young children. Second, to contribute to insights into the ways in which the social determinants influence health and well-being outcomes for parents and young children. Third, to explore the social relations of support and service provision related to raising children in contexts of serious social/health inequalities. Fourth, from the ‘findings’ of these three above, to draw out implications for policy and practice.

4.2 *Research rigour and validity*

The question of what sort of ‘truth’ can be claimed for any conclusions drawn from this qualitative research was raised towards the end of Chapter One. Qualitative research, which is less governed by scientific procedures and rules, is often criticised as ‘soft’ or lacking in reliability and validity. When critics use these terms they refer to the consistency or dependability of the instrument or data collection strategy and to the question of whether the research method yields data which accurately represent ‘reality’. Both terms are derived from experimental and quantitative research methodologies (Patton 2002).

To be relevant to the aims of qualitative research, which are to understand, represent or explain complex social phenomena more than to simply measure, the idea of rigour needs a different interpretation, one that acknowledges the problematic nature of the notions of reliability and validity (Oakley 1981; Holland and Ramazanoglu 1994; Kelly, Burton et al. 1994; Skeggs 1994; Williams 2003). As described in Chapter One, different assessments of validity reflect different stances on ‘reality’ and how best to know about what is real. According to the critical feminist framework adopted for this

research, rigorous research (1) provides information related to events which happen in the world and (2) considers the political and socially constructed nature of the research findings. In the lived experience of being a parent, difficulties, possibilities and strategies to meet them are constantly changing and inseparable from their political and social contexts, which are also constantly changing in their effects.

From the perspective of research as a social practice (see Chapter One), notions of independent and objective knowledge seem impossible and implausible. Because individuals possess ‘agency’ and act in particular ways at particular times (and sometimes these actions are contradictory), it may not be possible to produce cause-and-effect statements about the social world or statements which are generalisable from one context to another. Yet, in both quantitative and qualitative research the creation of categories and the resulting emphasis on different aspects of a phenomenon and certain ways of speaking about and understanding it cannot be avoided (Oakley 1999).

Critical and feminist theorists have drawn attention to the problems of incorporating women’s accounts into existing knowledge frameworks which represent the ‘standpoint’ of those in positions of relative power. Women’s accounts of their experiences and their ‘common sense’ interpretations are understood to reflect the effects of unequal social relations; in particular, the power that certain groups have to define what is interesting, right or wrong, true or false. These definitions, which are often represented as ‘detached’ and ‘objective’, can contradict or render invisible women’s lived experiences (Fraser 1989; Devault 1990; Smith 1990; Harding 1991; Rothfield 1994; Skeggs 1994; Lupton and Barclay 1997).

A research moment (whether it is a survey or in-depth interview) captures the answers of a research participant at that time, in that place and in that context. It follows that the challenge of producing knowledge about meanings and social relationships exists for all researchers. This understanding refocuses the debate from the type of data (quantitative or qualitative) to its purposes and the meaning it is possible to derive from it. Despite the difficulties, there is broad agreement in the qualitative research literature that transparency and reflexivity form the bases for claims about validity and techniques for ensuring rigour (Holland and Ramazanoglu 1994; Maynard 1994; Dingwall 1997; Oakley 1999; Kincheloe and McLaren 2000; Grbich 2004; Liamputtong and Ezzy 2005).

The suggested criteria for evaluating the validity of this thesis research include:

1. Clarity about the theoretical assumptions upon which the research is based;
2. Sound argument including demonstrating connections with existing bodies of knowledge and theory;
1. Choice of methods appropriate to the research problem/goals and clear documentation of methodological and analytical decisions;
2. Clarity about how themes, categories, concepts were derived from the data;
3. Demonstrating 'interpretive rigour' by attempts to accurately represent participants' understandings of events and actions; looking for contradictory or disconfirming evidence; and demonstrating researcher reflexivity.

4.2.1 Role of the researcher

In quantitative methods, the notion of the 'detached' researcher implies a relationship in which the subject of research is a passive giver of information to the researcher

who, through the use of correct techniques of analysis, can produce an unbiased account of 'reality'. In qualitative approaches, the research context and the researcher's theoretical position, interests, political perspective and personal history are recognised as being intertwined with the method, the processes of interpretation and drawing conclusions in such a way that there can never be an account not mediated by the researcher's 'subjectivity' (Gergen and Gergen 1991; Holland and Ramazanoglu 1994; Gubrium and Holstein 2002; Pyett 2003; Warr 2004). That is, decisions about which sources of data to trust and what conclusions are valid are political rather than technical or neutral decisions.

The interaction between the researcher and those whose experiences were being researched engaged the author in the personal and sometimes distressing details of other people's lives. These sometimes challenging and uncomfortable experiences inspired the author's sense of responsibility to portray the women's accounts with empathy and a deep level of understanding and ensure that the research would provide them with some benefit. Reflexively understanding the role of the researcher's political commitments in shaping the research process and subjecting it to the same critical scrutiny as the rest of data are important aspects of demonstrating rigour and claiming validity (Maynard 1994; Grbich 2004).

It was proposed in Chapter One that the role of critical population health research is to create the space to explore the experiences of less influential people and 'alternative' or 'resistance' stories which challenge dominant understandings (Rossiter 2000; Labonte, Polanyi et al. 2005). In its focus on 'lay knowledge' and the practices of 'helpful help', this thesis has been developed and indeed nurtured in this space.

Different ideas of research as objective or political underpin different ways of writing research. In qualitative research writing, it is generally agreed that because the researcher is an instrument of the research, the language used is less distant and formal than that of quantitative research. Indeed, according to Wolcott (2001), the more critical the researcher's role and assessment, the more important it is to have that role and presence acknowledged in the reporting (Wolcott 2001). In this thesis, which has drawn on both quantitative and qualitative data, the author has attempted to write in a way which demonstrated an acceptable academic distance from the material and, at the same time, acknowledged and accounted for her integral role and passionate involvement in the research.

4.3 Research triangulation

The use of a combination of methods, researchers, data sources, and theories enabled the *Families at Risk* project to develop a more complex picture than if only one method had been used. This triangulation addressed the 'problems' which arise with the recognition that research methods are not neutral tools producing the same results regardless of the methods used (Mason 1989; Denzin and Lincoln 2000). Importantly, the use of triangulation in this project was not an attempt to discover what is 'actually' going on by comparing one method against another and deciding which one represents the 'truth', but to address the research aims from a number of different angles. Four types of triangulation were used in the project:

data source – parents, service seekers, service providers, published data, research literature;

data collection methods – large scale survey interviews, small-scale in-depth interviews, and different forms of analysis appropriate to these;

researcher – collaborative research team of policy makers, academics and research workers , use of study participants as co-researchers, involvement of ‘outsiders’ in coding qualitative data;

theory – drawing on multiple theoretical perspectives to gain new insights (including: psychology, sociology, child development, feminism).

This thesis has drawn on analyses of aspects of the quantitative survey data from the large scale survey interviews (Chapters Five and Six), on text analyses of responses to the open-ended questions in the survey interview and on the transcripts and field notes from the in-depth interviews facilitated by the author (Chapters Five to Eight).

4.4 Sampling

The sampling strategy for the large scale survey interview was framed by the aim to employ an “innovative sampling technique” and concern to ensure statistical representativeness so that the findings could be generalised to the population group ‘families at risk’. In contrast, the aim of the in-depth interview methodology was to select ‘information-rich cases’ for study in depth, and in particular to understand the interpretive processes by which they come to feel supported and ‘on top of things’.

Thus the sample for the qualitative project was purposive rather than random, participants being selected with the aim of producing ‘thick descriptions’ (Geertz 1973) of the strengths and resources of mothers with young children and their experiences of ‘helpful help’.

The starting point of the sampling strategy was opportunistic, involving the author in following up leads gained first-hand from hearing ‘clients’ (mothers of young children) speak publicly about their positive service experiences. As it happened, these two instances of ‘helpful help’ involved support services located in the northern metropolitan area of Adelaide and women who lived in suburbs from which the large scale survey population sample was drawn. Following this, and to reduce the sampling frame for the qualitative research to a manageable size, the author decided to concentrate on services funded or delivered in this northern metropolitan area by the South Australian Department of Human Services and to exclude other areas included in the larger project sample. The existence of active front-line service provider networks and a cross-agency ‘agenda’ for the health of children and families in the northern metropolitan area, developed through consultative processes with service providers, managers and policy decision makers (see Appendix E), provided a context of support for this sampling decision.

While the first step was opportunistic, the overall sampling strategy is best described as ‘triangulated’ – that is, a combination of at least three different sampling strategies to meet the needs of the project. These strategies included:

Criterion sampling – the criteria which provided the sampling frame were - (1) mothers of children 0-7 years of age, (2) residing in northern metropolitan areas matching those from which the large survey sample was drawn, and (3) currently involved in a ‘helpful’ service relationship. In the early stages of the project, the author made use of the extensive informal networks she had developed over twenty-five years as a community health service provider and manager to talk broadly with

service providers in the northern metropolitan area about the *Families at Risk* project. These informal conversations opened up contacts with other service providers whose clients had spoken publicly (at public meetings, workshops and conferences) about their experiences of ‘helpful help’. These service providers readily agreed to request their clients’ participation in an in-depth research conversation about their experiences. In addition to the first two opportunistically sampled interviews referred to above, two more interviews were organised through this informal networking process.

Volunteer sampling –in the early months of the *Families at Risk* project the author made presentations to various forums of child and family service providers in the study area to publicise the study’s aims and methodologies. At these forums she publicised her search for ‘helpful’ service relationships involving mothers with young children. This resulted in considerable interest from forum participants, some immediate volunteers and other contacts for follow-up. In addition, several service providers at these forums offered to publicise the project in their workplaces and seek volunteers on the author’s behalf. Through this strategy four more service provider-mother dyads were recruited.

Snowball sampling – the remaining six dyads were recruited by following leads provided by already recruited service provider participants to other providers or mothers who fitted the criteria and may have been willing to participate in the research. This strategy was effective because the service providers were well networked and had strong local knowledge.

Finally, to some extent the sampling strategy fitted Patton's description of '*extreme or deviant case*' sampling – that is, the selection of cases which have unusual or distinctive characteristics in order to illuminate the processes being examined and provide new perspectives on more typical cases (Patton 2002). The study's focus on 'helpful help' was in direct and deliberate contrast to the more common experience of unhelpful service support which many mothers living in contexts of serious social/health inequalities report (Roe and Morris 2004).

The triangulation of sampling strategies enabled the author to make contact with mothers who may have otherwise been difficult to find and/or approach directly. Being introduced to these mothers by someone they trusted (their 'helpful' service provider) meant that the important process of gaining their trust had begun prior to the interview. As is common in qualitative projects, sampling continued until little new information was being gained and the researcher was satisfied that the data was rich enough and covered enough of the dimensions of interest to support the desired analysis (Baum 1998; Liamputtong and Ezzy 2005).

There was no attempt to achieve a 'representative' coverage of mothers or service providers since the aim was not to prove or disprove any theory. In addition, their accounts cannot be assumed to be representative of the views or experiences of all mothers or service providers. As these accounts were intertwined with the 'social event' which was the interview, they inevitably remain both partial and contextual (Holland and Ramazanoglu 1994).

A data base of interview participants was established and continually updated, including details such as: the date a letter of introduction was sent, times and dates of phone calls, emails and letters related to scheduling the interview, confirming the time and place of interview, and follow-up thankyou's. Post-interview, the dates transcripts were sent out for participants to read, amend and approve and returned, were recorded.

Profiles of the sample of fourteen service provider-mother dyads are provided in Appendix G. These dyads were drawn from a range of community-based services and settings including:

Community midwifery – based within a women's community health service;

Universal child health service – nurse home visiting and intensive, sustained support program;

Counselling – individual counselling; group program for parents whose children have experienced abuse;

Parent support - on-going 'hands-on' support before and after birth for 'at risk' parents; individual and group counselling and peer support for 'at risk' mothers of babies and toddlers;

Childcare – childcare and parenting support for 'at risk' mothers and their young children;

Parent education – individual and group education and support;

Community drop-in centre - neighbourhood kids' club and adults' meeting place;

Housing tenancy support – intensive support for public housing tenants 'at risk' of eviction.

4.5 *In-depth interview design*

In the early stages of the research design, the intention was to conduct individual and separate interviews with each mother/service user and each service provider. This intention was driven by a concern that if they were interviewed together each woman's view would be 'distorted' in the presence of the other. However, the author's developing understanding of research and service delivery as 'social practices' led to the decision to focus on the service relationship – that is, the social relations of parenting (mothering) support. Support for this decision was derived from critiques of taken-for-granted assumptions in welfare research, in particular the notion that meanings and interpretations “reside in, and must be obtained from, the atomized individual subject (Critcher, Waddington et al. 1999)”. Interviews are not merely an opportunity to discover information which already exists.

The connection between methodological choice and interpretive possibilities is highlighted when interviews are understood as social or “speech events” (Oakley 1981) in which the interviewer participates in co-creating and reformulating the sense people make of their experiences.

The conception of choice of research method as a 'standpoint' - that is, a position taken by the researcher to explore a particular social phenomenon or setting – reveals how the descriptions of 'reality' and the meanings assigned to those descriptions will vary depending on the method employed. In this sense, the interpretive possibilities of qualitative research are established prior to data collection (Miller and Dingwall 1997; Liamputtong and Ezzy 2005).

The 'tick box' and open-ended components of the large scale survey interview and the accounts given in the in-depth interviews provided access to different data as would other methods, such as direct observation or recording of provider-client interactions. However, as previously proposed, regardless of method, the data provides no more than a glimpse at that time, in that context, with that researcher. Meanings and interpretations not only predate interviews but continue on after them. Transparency about the assumptions and methods which underpin any conclusions drawn from interpretation of the data long after the participants have gone becomes the central concern.

The point was made earlier that categories available from academic disciplines to construct 'topics' for research do not necessarily correspond with the lived experience of parents' or women's lives. This means more than avoiding structuring the interview in terms of the researcher's categories by using open-ended questions. Because people interpret and talk about their experiences in terms of dominant language and meanings, women (including researchers) may find it difficult to understand and talk about their experiences in other ways. There is often no language or no appropriate language to discuss or describe the ambiguities, contradictions and uncertainties which people face: for example, the ways in which a mother can, at the same time, both reject and take on various aspects of the pressure to be a 'good mother'. When the words which are available do not fit, parts of women's experiences may 'disappear' because they are not included in the language of the construct. The challenge was to ask questions and listen in ways which allowed the exploration of incompletely articulated aspects of people's experiences (Devault 1990; Ungar 2004; Warr 2004).

The author's own experience as a woman, mother, service user and provider was a resource for this kind of listening and can be analysed as an element of method. However, drawing on personal experience was only a beginning step in understanding what may have been incompletely said. Grounding the interview in accounts of everyday experiences and the use of critical questioning enabled the author to listen for clues to social relations in what was more like "everyday woman talk" or a "female style of knowing" (Belenky, Clinchy et al. 1997) than the language used in the large scale survey interview. Based on these ideas, the in-depth interview questions were designed and asked with sincere curiosity and in everyday language to seek 'thickly described' accounts of mothers' and service providers' lives and practices in ways relevant to them (Madsen 1999; White 2000; Ungar 2005).

An interview schedule comprising questions intended to aid exploration of the four domains of the research framework (Figure 1) was developed as a general guide (see Appendix D). Whilst the same set of issues was covered in each interview, the categories or range of responses were not pre-determined, and the order of the questions varied according to the natural flow of interaction between interviewer and interviewees. The phrasing of the questions was altered to fit each individual and often questions were reformulated as understandings emerged during the interview (NH&MRC 1995; Denzin and Lincoln 2000).

To test the interview design two pilot interviews were organised. For the first of these, a colleague who was a highly skilled interviewer was invited to observe the interview

and join with the participants and the researcher in critical reflection when the interview was over. The experience of the pilot interviews generally affirmed the appropriateness of the interview design. The major change made was to reduce the focus during the interview on the organisational barriers and supports experienced by the service provider. During the sustained and detailed focus on this aspect during the pilot interviews the mothers/clients disengaged from the conversation. This disengagement was communicated non-verbally, through body language, and was confirmed by participants in the reflection at the end of each pilot interview.

Rather than completely abandon the exploration of organisational barriers and supports, it was possible to address this topic opportunistically in each interview – for example, during a break whilst the mother was occupied feeding or changing her baby; in the car returning to the provider’s workplace from the interview venue; adding on an additional ten minutes to the interview expressly for this purpose and inviting the mother to choose to stay or leave.

The same demographic data collected in the *Families at Risk* survey interview was collected from participants at the conclusion of the in-depth interviews (Appendix G).

4.6 Interview process

The in-depth interviews of 1.5 to 2 hours duration took place between March and September 2002. Through their service provider, mothers were given first choice of location for the interview. Six of the interviews took place in the mother’s home and the remaining eight at the relevant service agency. The agency setting was familiar and comfortable for both provider and mother participants. In some instances, the mother rather than the provider offered the author coffee and went off to make it in

the agency kitchen. For the author, the experience of the interviews conducted in people's living spaces was different from those located in agency interview or meeting rooms. The emotions and sensations arising from first-hand observation and experience in people's homes (for example: overcrowded and chaotic living spaces; run down streetscapes and neighbourhoods; tidy, attractive living spaces achieved by people on very low incomes; interactions with children and other adults in the house during the interview) gave the author powerful impressions of how the world might feel from the perspective of the mothers being interviewed. Field notes taken immediately following each interview, later supplemented the transcripts of their spoken words.

At the start of each interview the author outlined the study, covering the material in the Information Sheet and Consent Form (Appendix H) before seeking verbal consent to proceed with the tape-recorded interview. This verbal approach was chosen rather than assuming literacy. In this introduction it was emphasised that the author viewed the participants as 'experts' and was interested in hearing whatever they thought was important or relevant. Participants were told they could stop the tape or stop the interview at any time. At the end of the interview, participants were given a copy of the Information Sheet to take away with them, asked to sign the Consent Form and to complete the demographic survey sheet before leaving. Participants were informed that the transcript of their interview would be sent to them for checking and approval before any use would be made of it.

Following these preliminaries, to achieve transparency about pre-existing theory or the starting points for the research, the researcher initiated each research conversation by outlining the study's theoretical understanding of health and well-being as socially determined and socially 'practised' and drawing on a sheet of 'butcher's' paper, the four domains framework (Figure 1). To aid clarity and understanding simple language, concrete 'everyday' examples and 'stick figure' drawings were employed in these explanations. To start the interview, the mother was invited to tell the story of how she came to seek support from this service and her understandings of the 'problem' at that time.

There is broad acceptance in the methodology literature that as the researcher is an instrument of the research, it depends at every stage on her/his skills, insights and capabilities. In-depth interviewing, in particular, requires interviewer skills of restraint and listening as well as interviewees who are verbal and reflective (Reinharz 1992; Patton 2002; Pyett 2003). The active participation of the interviewer in co-creating and reformulating the sense people make of their experiences meant that the interviews were a 'learning process' for both researcher and participants.

The interpersonal interaction between the author as interviewer and the participants involved a kind of participation which was more than the practical research tasks of conducting interviews, transcribing, analysing the data, and follow-up. The author's competence, particularly in enabling participants to talk about sensitive topics and disclose more about themselves, grew with each interview. Talking, careful listening and responding were made more challenging in the interviews which took place in

women's homes where, despite their efforts to create a quiet space, there were frequent interruptions by small children, partners, phone calls and visitors. In one interview, with the pain of a recent caesarean section, the demands of a week-old baby, the presence of an adult daughter, her toddler and a home-help in her very small home, a woman, her midwife and the author worked hard to participate in the interview conversation.

The stories of violence, abuse, judgement, blame and isolation in the lives of many of the women interviewed were sometimes shocking and distressing to hear and emotionally demanding to respond to appropriately within the interview setting. Although the interviews were rarely more than two hours in length, the tasks of transcribing, analysing and writing up required immersion in these stories – listening, reading and thinking about them, many times over. The issue of appropriate interviewer responses, the role of the researcher in counselling or offering comfort in these situations and the need for researcher support and debriefing following these encounters, are raised in the feminist research literature (Oakley 1981; Holland and Ramazanoglu 1994; Oakley 1999; Warr 2004).

During the short reflection time at the end of each interview, participants generally reported learning more about themselves and their relationship through both the dyadic process and the focus of the interview questions. Many of the mothers and service provider participants had had few opportunities to talk about their experiences in the terms in which they were raised by the interview. The challenges of gaining understanding about unarticulated or incompletely described experiences and of listening carefully to women's attempts to answer questions which do not quite fit

were raised earlier. In the interviews dialogue was enabled through a ‘not knowing’ questioning strategy which reflected the author’s genuine curiosity. This involved the use of open-ended questions which aimed to elicit the participants’ experience in their own words – for example: ‘can you tell me more about that?’, ‘what was that like for you?’, ‘what is important to you?’, ‘can you tell me a story of a time when...?’

One of the clear advantages of in-depth interviewing was that it enabled aspects of the social processes and negotiated interactions which characterise mothering and mothering support to be explored in ways unattainable by other methods. Compared with focus groups for example, the dyadic process incorporating an existing trust relationship between mother and service provider meant that participants were more willing to discuss sensitive matters such as their strong emotional responses, domestic violence, self-doubt and self-blame.

4.6.1 Reciprocity and accountability

In qualitative research, reciprocity and communicating respect for research participants are important issues. Feminist and many other qualitative research methodologies place emphasis on power relations and recommend that relations between researcher and researched should be non-hierarchical. Oakley, for example, suggested that researchers should productively use their power by freely giving any information or knowledge they have which may be useful to the researched (Oakley 1981). During one interview, the author felt outraged listening to one mother’s account of the terrible injustices in her encounters with services as the non-offending parent of an abused child. At the end of the interview, she raised with the woman the possibility of telling her story to the child protection review which was underway at

that time. With the woman's assent and to support her action the author made contact with the child protection review team to find out details of the submission process and rang her the following day to pass on that information.

The author generally experienced the in-depth interviews as a privilege, feeling humbled and often surprised at participants' willingness to share their stories with someone all of the mothers and most of the service providers had never met before. When, at the end of each interview, participants reported the experience as rewarding the author interpreted this as some (albeit limited) form of reciprocity. However, even with good intentions, more equal research relationships are difficult to achieve. The relatively unequal power relationship between service provider and client meant that it would have been difficult for a mother to refuse being 'chosen' by her service provider. The service providers had the power to access women's lives. This was demonstrated on two occasions when the woman a service provider had arranged to participate in the interview didn't turn up. The provider in each instance was able to ring another client who agreed to participate without delay.

That for many women the experience of being taken seriously and offered listening space is rare was raised earlier. Participants' sense of self-worth (both mothers and service providers) may have been enhanced through the opportunity to be listened to and valued and to contribute to improving service support. Following one interview, the woman told her service provider that she felt so good about what she had to say in the interview and how much she had "got her act together" since first making contact with the service, that she was considering going on to study midwifery to help other

women. Several service providers commented during and following the interview on the value of having the time and opportunity to reflect on their practice together with their client.

The participants in the survey interviews which comprised the larger part of the *Families at Risk* study were paid \$20 as one strategy to communicate their value to the study and in small part to equalise the relationship (our money for their time). To enable the women to participate in the in-depth interviews the author offered to cover the costs of childcare but this proved unnecessary. Either the women had their non-school age children with them or childcare was provided by the service agency as part of its everyday operations.

There were also other forms of reciprocity. Following common practice, especially in feminist research, the participants in the in-depth interviews were provided with an opportunity to read their interview transcripts prior to analysis and publication of their accounts (Reinharz 1992). Most made minor edits and some, to the author's disappointment, deleted some of their more controversial statements, usually negative references to particular agencies, providers or other social institutions. Although this meant that these statements were not able to be used as direct quotes, the author was still able to refer to them in the thesis in general terms.

As already described, not being a detached observer meant interacting with the women on a personal level, including some self-disclosure. There is some debate in feminist research regarding the comparative value of being a 'stranger' or 'friend' to the research participants. Self-disclosure can work to tell the participants the

researcher's relevant knowledge and experience and identification with their concerns and put participants at ease. Reinharz (ibid.) concludes that there is value in being both – that is, being a “knowledgeable stranger (pp26-7)”.

As outlined in Chapter One, the decision to give space and validity to the voices of mothers and front-line service providers and do research that is ‘for’ them rather than merely about them is an important aspect of critical population health research. However, this decision raises an ethical dilemma: how is it possible to be accountable to the participants for the ways the research speaks for them and about them? The question of whom the research is for is particularly significant given the goal of creating useful knowledge, knowledge that could be used to ‘make a difference’ by influencing early childhood and family policy and lending support to ‘helpful’ services.

Inevitably, research which is intended to inform change is written with people in established positions of power and status (‘policy influentials’) in mind, using language and concepts which enable them “to speak to each other (Skeggs 1994)”. Regarding research evidence intended to influence social policy development in Australia, Burke (2001) observed the increasing use of the terminology of ‘new managerialism’, a language that is neither accessible nor readily communicable to the subjects of the research (Burke 2001). In this thesis, lengthy quotes from the mothers’ and service providers’ accounts have been used as one response to this dilemma.

4.7 Analysis and interpretation

As previously stated, the intention of this thesis project was to employ both quantitative and qualitative data to draw conclusions in the form of policy and service implications. This raises (again) the issue of what authority and validity can be claimed for these conclusions. In addition to what has already been said on this issue it is necessary to consider the quantitative and qualitative data separately.

The quantitative component fits fairly comfortably within dominant models of research in which research questions are derived from theory and tested against research data (deductive) and/or theory is created from generalisations made from data (inductive). Established procedures for data collection and statistical analysis ensure ‘objective’ knowledge. Analyses of aspects of the survey data presented in Chapters Five and Six generally confirm existing theory and evidence concerning the associations between social disadvantage and poorer health and well-being outcomes. It would have been possible in this thesis to subject the survey interview methodology and statistical methods to a careful critique. However, rather than risk getting bogged down in a version of the ‘paradigm clash’ between quantitative and qualitative methods the decision was made to concentrate on the potential of both to usefully contribute to the thesis aims.

The basis for claims about the validity of the conclusions drawn from the qualitative data is the careful explication of the concepts, values, methods and processes of decision-making by which interpretations have been made. A number of factors (and the interaction between them) influenced the conclusions drawn:

- critical and feminist theory and political values;
- the researcher's subjectivity and standpoint;
- the ways in which participants formulated their accounts at that time and in that setting; and
- the participants' subjectivities, standpoints and values.

Within the framework of critical population health research, the contexts and purposes of the research as well as political values and power are understood to provide the bases for the evaluation of policy options (Pawson and Tilley 1997; Williams 2003; Labonte, Polanyi et al. 2005). According to their theoretical frameworks, values and understandings of possible policy options, different researchers will interpret the same data differently and so develop different policy implications. In addition, it is worth noting that readers will also bring to the reading and assessment of these policy recommendations their own theoretical frameworks, standpoints, values and subjectivities.

A typical approach to analysing in-depth interview data is to note the frequency with which particular 'stories' are told. Frequently told stories are highlighted as emergent themes and the discussion is organised around generalisations about the themes, interspersed with illustrative extracts. In this way, frequently told stories can be held to be literally descriptive of the 'truth'. Rather than this inductive (from the ground up) approach characteristic of early versions of 'grounded theory' (Glaser and Strauss 1967), the conclusions drawn in this thesis were built from an ongoing dialogue

between pre-existing theory and new insights generated from analyses and interpretation of the empirical data.

This approach followed from the recognition that the interview texts (and the survey data) were inevitably both partial and contextual and therefore could not be judged as 'true' or 'false'. The focus of analysis was the variety of ways in which participants described their worlds and the social (health-determining) conditions and processes associated with their different accounts. This approach can be described as 'descriptive and interpretive' as well as 'theory-building' (Bryman and Burgess 1994; Mayall 1999).

Descriptions of experience are not in themselves reliable grounds for conclusions. They produce images which are 'provisional' but which reflect some level of reality in that they exemplify structural relations as they are experienced in people's everyday lives. At the same time, these images can challenge taken-for-granted categories (for example, 'at risk', 'dysfunctional') and open up the space and possibility for "reconstruction in more socially just forms (Rothfield 1994)". Different theoretical readings at different times during all stages of the research sensitised the author to look for particular issues. In line with the idea that analytical concepts are context-dependent, she continually modified theories constructed from reading in the light of the transcripts, discussions with colleagues and reflections on her own experiences. The question "does this theory say anything to me about my experiences or the experiences of the women I interviewed?" was very useful in this process (Skeggs 1994).

In the following sections there are accounts of the processes adopted for transcribing and coding the interview texts.

4.7.1 Transcription

The power of an embodied voice, which can deliver a sense of struggle, despair, or resilience, is greatly watered down when it is transcribed into mere words on a page (Warr 2004).

Recognition that layers of context and meaning are lost in the process of transcribing and ‘tidying up’ interview text before it is analysed led the author to attempt to preserve what the participants said and the ways they said it using an exhaustive (and exhausting!) transcription method. Achieving something close to a ‘complete’ transcription involved a process of ‘saturation’ in the data and in the distinctive characteristics of participants’ speech, supplemented by field notes made immediately after each interview.

As the text of the transcript does not reveal the non-verbal behaviour and all the communication which occurred in the interview, the field notes and careful listening and re-listening to the tapes were used to note on the transcripts obvious emotions, such as laughter, tears, sarcasm or anger. More subtle non-verbal aspects (such as attenuated in-breaths or out-breaths) or hand or other body gestures and expressions were not recorded and, in this omission, important clues to experience and meaning may have been missed.

The decision was made to include in the transcription almost everything that was said including repetition, hesitations, qualifications and silences. Most but not all “ums”, “sort ofs” and “you knows” were transcribed. Halting, tentative and inarticulate

speech may signal "not-quite articulated experience, where standard vocabulary is inadequate, and where a respondent tries to speak from experience and finds language wanting (Devault 1990)." The frequent use of "...you know?" may signal something like 'I can't say this quite right' or 'I hope you will understand me / approve of what I'm saying'. In the interviews this request for understanding was most often acknowledged with "yes, yes" or "please tell me more" or by asking a follow-up question. Careful (re)listening to the tapes and (re)reading the transcripts aimed to uncover contradictory responses and what may have been left unsaid – what was "absent but implied (White 2003)".

The requirements of the NUD*IST software program influenced the transcription scheme and, in addition, the following transcription conventions were adopted (Potter and Wetherell 1994):

... three dots indicated pauses and silences (longer pauses were indicated with more dots)

[...] denoted inaudible material

definitely Underlining denoted emphasis

you can say that again! Exclamation mark denoted a whole phrase said with emphasis

maybe I - A dash marked a sudden cut-off in speech.

4.7.2 Coding

Coding and analysis of the transcripts were influenced by:

- detailed reading and re-reading of the interview transcripts as texts;
- specific terms and meanings used by the participants;

- the field notes made after each interview;
- careful reading of related literature/theory;
- discussions with research colleagues and service provider networks; and
- the author's own parenting, support, service seeking and provision experiences.

Codes were developed by reading through the transcripts and field notes for 'first impressions' and on subsequent readings developing concepts and codes on a higher level of abstraction. As a first step, codes which were broadly based on the 'topics' addressed by the interview questions as well as recurring themes were noted manually on the transcripts. For example: 'coping strategies', 'the highs and lows of being a parent', 'ideas about motherhood', 'barriers to service use', 'feeling shamed and blamed'.

The author worked with other members of the research team to develop codes within the broad topic areas which were the subject of open-ended questions in the survey interview. In addition, the colleague who had observed the first pilot interview listened independently to three of the interview tapes and noted recurring themes. Later the codes developed by the author and through these processes of triangulation were entered on the computer using the NUD*IST program. Whilst these processes were time consuming, the process of manual coding enabled an immersion in the data which may have been less if the 'distancing' process of coding directly on the computer had been used (Lee and Fielding 1995).

The subsequent tasks of further developing and refining codes and retrieving and comparing coded chunks were greatly assisted by the use of NUD*IST. Honouring the stories of the participants as they told them was a particular challenge in developing codes into higher levels of abstraction. In the process of cutting chunks of text and pasting them with others reflecting a similar theme, there was a danger of losing sight of the context in which they were spoken and of their relationship to other parts of the text.

4.8 Collaborative research

From a critical perspective, research and the development of social theory should be democratic or participatory to counteract the tendency to assign a lesser legitimacy to lay knowledge and reproduce ideas which regard the experiences of particular people as sub-standard or deviant. This viewpoint challenges the dominant model of knowledge generation in which knowledge is created by researchers, translated by service providers and ‘consumed’ by clients (Doherty 2000). The *Families at Risk* project team comprised academics and human services research and policy workers and proposed to challenge this dominant model through processes of university – human service industry collaboration and, in addition, by involving service providers and families in interpreting the data and developing proposals to “overcome barriers to service use”.

In addition to the industry reference group meetings and service provider forums organised in the early stages of the *Families at Risk* project (see Chapter One), a pamphlet which provided a summary of ‘findings’ from the large scale survey interview was mailed to respondents in the project’s final stage. While the service

provider forums resulted in the addition of specific questions about multiple service use and use of child care resources to the survey interview schedule, this was far short of collaborative ideals. This limited collaboration also mirrored that within the research team itself.

Holland (1994) described a collaborative research process which was far from the experience of the *Families at Risk* research team but summarises reasonably well what has been attempted in this and other chapters:

...we [the project team] have tried to make it as clear as possible to ourselves what we are doing when we do research: what we are taking for granted and why; what ‘findings’ we disagree over, and generally what we do to ... our primary data. To do this we must locate ourselves as researchers as fallible, subjective people within the research process. More than this, we have to make explicit what the [participants] who agreed to be interviewed contributed to the research and what we have made of these contributions (Holland and Ramazanoglu 1994).

In contrast to the author’s commitments, other members of the *Families at Risk* research team were influenced to varying extents by the positivist assumption that if a researcher is passionately engaged in policy debate their scholarship is less trustworthy, tainted by advocacy, commitments, or allegiances (Fine, Weis et al. 2000; Burke 2001). These differences led to some lively debate during project team meetings, particularly at the stage of making sense of the data and in formulating and writing policy implications. As already described, the various standpoints and

‘interactional rules’ (including power relations) which affected the interaction between team members remained largely unexplored throughout the four years of the project.

The project was only one of many interests and demands in the research, teaching and departmental roles most team members occupied. In contrast, the project was a primary focus for the author, principal field researcher and data analyst. While the team met monthly or as required to make research process decisions, time and workload pressures meant team members mainly worked alone (or in pairs) to analyse and interpret 'bits' of the data most relevant to their academic or workplace roles and interests.

Collaborative research practices closer to the ideal may have improved the quality of the interpretation and recommendations. Frequent and continuing discussion about values and meanings and improved reflexivity in the research; revealing or discovering alternative knowledge or perspectives; opportunities to make the research more useful by developing shared understandings and ongoing relationships with key people and networks; are only three examples of what might have been possible.

CHAPTER 5: DISADVANTAGE AND ITS CONSEQUENCES FOR FAMILIES WITH YOUNG CHILDREN

The thesis now moves to the reporting of ‘findings’ from the research. In this and the following chapter, quantitative data from the survey interviews of five hundred families provides a context for the lay knowledge gained from the in-depth interviews. The survey data enabled examination of the associations between disadvantage, service use and outcomes for families with children under 7 years old⁴⁰. Aggregations of data collected from individual caregivers during the survey interviews reveal serious socioeconomic and health inequalities. In the first section of this chapter attention will be concentrated on a range of intermediate-level social and economic determinants of disadvantage and of the health and well-being of caregivers and children. Survey respondents were predominantly young Australian-born female sole parents, not in the workforce, reliant on Government assistance, living in rented housing, residentially mobile and with low levels of formal education. Comparisons with state and national level data will help to make clear the extent of this research population’s disadvantage.

In the second section, three macro-level determinants – gender, cultural background and Aboriginality will be briefly considered. In the third section, aggregated data from the survey interviews will be supplemented with text analyses derived from the in-depth interviews and used to illustrate a range of

⁴⁰ Despite the inclusive language of ‘families and children’, the large scale survey interviews concentrated on primary parent characteristics and parent reports of their children’s health and well-being. Even use of the word ‘parents’ is somewhat misleading as the data came primarily from mothers’ reports.

health and well-being outcomes for children and caregivers. In the fourth section, there will be an examination of the different contributions of survey and in-depth interview data to understanding the role of parent efficacy in determining health and well-being.

5.1 Socioeconomic inequalities – a profile of the research population

5.1.1 Family/household form

47% <i>Families at Risk</i> Sole parent households	Metropolitan Adelaide (2001) - Sole parent families with children ⁴¹ - 27% (Australian Bureau of Statistics 2001)
	Australia (2003) - Sole parent families with children - 22.3% (DeVaus 2004) ⁴²

Thirty eight per cent of respondents lived in households where they were the only adult. Sole fathers were more likely to live alone with their children than sole mothers. Seventy-one per cent of households had 2 or more children, 57% had 3 or more children (up to 10 children).

2.35 <i>Families at Risk</i> Average number of children/household (2.65 - Aboriginal households)	Australia (2001) – average number of children per household – 1.75 (Australian Bureau of Statistics 2002)
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5.1.2 Age at becoming a parent for the first time

46.6% <i>Families at Risk</i> Mothers who birthed first child aged < 20 years (72% of Aboriginal mothers)	Metropolitan Adelaide (2001) – mothers who had their first child before the age of 20 – 9.8% (Pregnancy Outcomes Unit 2001)
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⁴¹ It was not possible to make direct comparisons between *Families at Risk* data, which relates to families with children under 7 years of age and ABS data which most often refers to ‘all families with children’ or families with children under 15 years of age.

⁴² “Nevertheless the image of the single mother as an irresponsible young woman who becomes pregnant while still at school is far from the reality. Sixty percent of lone mothers were married before becoming a lone parent, and of those who had never married, the majority were in a de facto relationship when their child was born. ... 70 per cent of lone mothers with dependent children are aged 30-49 (Anglicare Australia 2005:10)”.

Becoming a parent while still school age is known to be a barrier to women remaining engaged in education and is a strong predictor of poverty and social exclusion (Department of Health (UK) 1999) Children of teenage mothers are more likely to live in poverty, grow up without a father, experience neglect or abuse, have lower levels of completed education, become involved in crime, excessive use of drugs and alcohol, and become teenage parents themselves (ibid.).

5.1.3 Income and Employment

<p>74% <i>Families at Risk</i> Households reliant on government income support</p>	<p>Metropolitan Adelaide (2001) – households whose principal source of income was Government pensions and allowances – 33.8% (Australian Bureau of Statistics 2001)</p>
<p>57%⁴³ <i>Families at Risk</i> Households with income less than \$21 000</p>	<p>South Australia (2001) – low income households (less than \$26 000) – 23.8% (Hetzl, Page et al. 2004)</p>
<p>90% <i>Families at Risk</i> Respondents with no participation in paid work⁴⁴</p>	<p>Australia (2000) - Lone mothers with children under 5 years old not in paid employment – 70% (Australian Bureau of Statistics 2000)</p>
	<p>Study population areas some of the highest unemployment rates in metropolitan Adelaide - Playford - Elizabeth (21.1%), Playford - West Central (17.3%), Port Adelaide Enfield - Port (14.3%). (Hetzl, Page et al. 2004)</p>
<p>64% <i>Families at Risk</i> Children living in households with no wage earner</p>	<p>South Australia (2001) - children under the age of 15 years living in households where no parent was employed – 18.7%⁴⁵ (Australian Bureau of Statistics 2002)</p>

In addition to level of income, perceived income adequacy is another indicator of resources for parenting. The majority of *Families at Risk* respondents (50.2%) regarded their household income as *just enough*, while 24.4% stated they usually

⁴³ Does not include the 30% of respondents who answered ‘don’t know’ to the question about household income.

⁴⁴ Less than 10% of respondents were engaged in part-time paid work for up to 30 hours per week and 2.6% for more than 30 hours (up to 45 hours). More than three-quarters (78%) nominated ‘home duties’ as their major occupation.

⁴⁵ There is evidence that having no parent employed has an independent effect on children’s health and well-being outcomes, even when confounding variables of social class, family type, gender of the respondent and the parent’s immigrant status were taken into account (Reinhardt Pedersen and Madsen 2002) Children growing up in jobless households were more likely to leave school early, experience unemployment and long-term unemployment, have children by the age of 19, receive income support, and be classified ‘homeless’ for income support purposes (Pech and McCoull 2000; VIVA(SA) 2005).

had *some left over*, and 20.6% had *not enough*. 4.8% regarded their household income as *plenty of money*.

5.1.4 Education

<p>73% <i>Families at Risk</i> Respondents with fewer than 12 years of completed education</p>	<p>Metropolitan Adelaide (2001) – population with fewer than 12 years of completed education – 52% (Hetzel, Page et al. 2004)</p>
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Educational attainment is known to be steeply graded according to socio-economic position, with health and well-being improving with increasing levels of educational attainment (Hetzel, Page et al. 2004). The link between education and having the capacity to adapt to, respond to and control many aspects of life is particularly significant to parenting. Only two per cent of respondents were currently ‘students’, which is a significantly low rate in the context of current policy emphasis on education and training as a route to employment and out of poverty and ‘welfare dependence’.

5.1.5 Housing and housing mobility

<p>17% <i>Families at Risk</i> Owned or were purchasing own home</p> <p>56% Renting from the SA Housing Trust</p> <p>25% Renting in the private sector⁴⁶</p>	<p>South Australia (2001) –</p> <ul style="list-style-type: none"> • dwellings owned or being purchased – 68% • public rental - 8% • rented in the private sector – 17% • other types of tenure – 7% <p>(Australian Bureau of Statistics 2001)</p>
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Housing tenure and access to a car, adjusted for age, sex, income and self-esteem have been found to have an independent effect on various measures of health (Macintyre, Ellaway et al. 2000). A South Australian (Adelaide’s western suburbs) study found that homeowners had stronger neighbourhood connections

⁴⁶ The remaining less than 3% of respondents were boarders.

than those in public housing, and people in private rental accommodation had the least. Neighbourhood connections were stronger for those who had lived at the same address longer (Ziersch, Baum et al. 2005). Moving house and, in particular, frequent moving, creates financial and emotional stress, disrupts social networks, children's schooling and family ties.

Table 3: Mobility of Families at Risk Respondents

Time (yrs) living in the area (N = 499)	
≤ 1 year	170 (34%)
>1 year and ≤ 5 years	176 (35%)
> 5 and ≤ 10 years	81 (16%)
Over 10 (up to 38) years	72 (14%)
Times the parent (the family) moved during the last five years (N = 489)	
0 times	95 (19%)
1-2 times	137 (28%)
3-10 times	236 (48%) ^a
11-20 times	15 (3%)
21+ times	6 (1%)

^a Almost 70% of Aboriginal respondents had moved house more than three times in the past five years.

The current context of contraction in the availability of affordable housing is critical to understanding the vulnerability of the *Families at Risk* population to housing stress. Over the past ten years:

- public housing stock in South Australia has declined by more than 15%⁴⁷ due to significant reductions in grant funding under the Commonwealth/State Housing Agreement (Hetzl, Page et al. 2004)⁴⁸
- in addition to a serious decline in low-rent (public and private) stock there has been spatial contraction in affordable housing opportunities to the most

⁴⁷ At the same time in South Australia, the numbers of community housing association and Aboriginal housing association dwellings have increased, although not by as much as 15% (Anglicare Australia 2003)

⁴⁸ In 2003/4, further reductions in government funding and the withdrawal of GST compensation money (which compensated States for the higher costs borne by housing authorities as a result of the GST) may have worsened the situation (Anglicare Australia *ibid.*).

disadvantaged areas of the outer northern suburbs (coinciding with some in *Families at Risk* study areas) ⁴⁹

- The net loss of public housing assets has forced more low income people into the private rental market where they face very low vacancy rates, expensive rental charges and possible discrimination on the part of landlords. The stress associated with low income is exacerbated if families have to pay a high percentage of their income on housing⁵⁰.

5.1.6 Access to a car

37% <i>Families at Risk</i> Respondents with no access to a car when needed	Metropolitan Adelaide (2001) – Households without a car -11% (ABS 2001)
	Study population areas some of the highest proportions of dwellings without vehicles in metropolitan Adelaide - Port Adelaide Enfield -Inner (18.5%), Playford-Elizabeth (19.8%) and Playford-West Central (16.3%). (Hetzel, Page et al. 2004)

Not having the use of a car seriously constrains people’s access to resources and opportunities to support their health and well-being - access which is already constrained by the effects of inequalities already listed.

5.2 The dynamics of inequality

Static measures of structural and material inequality like those presented so far, miss the complex interrelationships among these factors and the ways in which change is constant in the lives of most families. In everyday living these factors are interwoven and interdependent in their effects on health and well-being. These effects and the ability to cope with life’s challenges change from day to day as well as over time (life stages and transitions) and change in different contexts.

⁴⁹ Unpublished data, 2005 - provided by Department of Families and Communities, South Australian Government. The accepted definition of ‘affordable housing’ is that for which a person pays less than 30% of their weekly income. People paying more than 30% of their income on housing costs are deemed to be in ‘housing stress’. Low-rent housing is defined as private rental stock in the bottom 15% of property valuations.

⁵⁰ This is not uncommon. Almost 90,000 low-income Australians received the maximum rent assistance from the federal government through Centrelink and still spent more than half their income on rent (ACOSS 2002 cited in Anglicare Australia, 2003).

It was clear, for example, from participants' accounts that the demands of managing children's behaviour were constantly changing. When asked to name the things she found most difficult about parenting Margie, a mother of six, first placed the constantly changing needs of her children:

You know one day one of your kids might be testing you and you're trying to work out what to do and the next day it could be something else...all different things.

For some, particular times of each day are more stressful than others – for example, difficulties at bed-time. For others, there were different emotional and behavioural challenges at different ages and stages and in situations of family disruption and trauma.

Parenting alone, having a new baby and times of trauma/crisis were contexts in which access to supportive resources and environments really mattered. In one in-depth interview, a parent support worker talked about her own experiences as a new mother to illustrate the extra demands on mothers when a baby is sick (as is common in the first six months) and their need for practical support.

If my baby was sick in the morning, someone else would take my partner to work, or I would. Then I could get in the car, go to the doctor, I could go then to the chemist. I could even go to my mum's and lie down for half an hour, get her to get me a cup of tea 'cos I'd been awake all night and I usually couldn't sleep 'cos I was wound up but I still had that. ... transport is a huge thing. Makes a big difference to how you can get around. ... Just those practical things can make a huge difference to how people can cope and how

they feel they are parenting. You know, that 'good / bad parent' sort of crap that people feel? (Julie)

This text also reveals the link between access to support and individual mothers' sense of competence and their physical, mental and emotional health and well-being. The notion of parent effectiveness will be more closely examined later in this chapter.

The effects of disadvantage are not only constantly changing but can also be cumulative and compounding to produce a 'cycle' of poverty and poorer health and well-being. One example of this from analysis of *Families at Risk* survey data was the relationship between the age at which the parent respondent left school and their children's current attitudes to school. The greater the number of years educated, the more likely the respondent reported their child as 'loving school'. Twenty-five per cent of respondents who left school aged 12-14 reported their children as 'loving school', compared with around 40% of those who left at 15-17 years, and 90% of those whose school leaving age was 18-19 years.

In the data presented so far, the *Families at Risk* population has been shown to be seriously disadvantaged even in relation to others in the poor areas in which they live. In addition to caring for young children (a stage of life associated with increased poverty and vulnerability), a much higher proportion of the study population had no car and no access to paid work than reported averages for the most disadvantaged areas of metropolitan Adelaide. The extent of disadvantage evident in this population is fundamentally entwined with broader contexts of increasing wealth/health inequalities at state, national and international levels and

unequal social relations including exclusionary practices related to gender and Aboriginality.

In this chapter so far, the focus has been on indicators of intermediate social determinants – age, household structure, income, occupation, education, housing, transport. Gender, ethnicity, and Aboriginality, which are fundamental determinants of social position and therefore of people’s experiences and their access to supportive resources and environments for health, will now be briefly considered.

5.2.1 Gender

Ninety-two percent of caregivers interviewed (459 of 500) were women, eight percent (41) were men. This gender imbalance almost certainly reflects the number of sole mothers in the research population and the unequal care load taken by women especially when children are young⁵¹. The links between disadvantage and health and well-being have a special importance for women. Evidence shows that poverty strikes women and children more frequently and more severely than men.⁵² In the antenatal and postnatal periods and when children are young, material and social inequalities have most impact (Morris 2002). In addition to high levels of financial stress, mothers in the in-depth interviews reported experiencing barriers to accessing information, opportunities and choices for health and well-being. Social isolation, the inequitable distribution of parenting and family support responsibilities, violence and abuse, and the societal

⁵¹ The gender division of domestic care for children is prominent especially when children are pre-school age. Once children are school age, this inequality is less (Australian Bureau of Statistics 1998).

⁵² There is a substantial body of research literature about women and poverty which is relevant to this thesis but within the limits on scope and length could not be included.

expectation that women's needs come last (after children, men and family) shaped their (and their children's) experiences and possibilities for health.

Gender not only works at the level of social structure in influencing women's access to resources (including power) and social networks. It also shapes how individuals think and act by mediating social meanings and how individuals see themselves in relation to others. The social value given to motherhood is fundamental to their health and well-being through its effects on the level of recognition and social rewards available to women. Gendered expectations shape women's and men's narratives about themselves; their actions; parenting practices; their experiences (or lack of them) of support and recognition. 'Engendered motherhood' (McMahon 1995) and the influence of discourses about 'good' and 'bad' mothering are examined in this and later chapters.

The accounts provided by mothers and their service providers in the in-depth interviews illustrated the effects of unequal power. In particular, they demonstrated the striking imbalance between expectations (self and cultural) of mother's responsibility compared with their lack of access to resources/power. Women were primarily responsible for the care of family and children, yet had limited access to the resources (including material resources, safe and supportive environments, parental authority and other forms of power) to support that responsibility.

Gender effects are observable not only for women. In contexts of poverty and child protection, social constructions of men/fathers as abusive, absent, irresponsible or victims have been shown to form (and reform) service responses

(Morris 1999; Scourfield 2003). Data from male respondents in the *Families at Risk* survey interviews suggested that male primary caregivers may feel more isolated than female. When asked about their perceptions of the quantity of support available to them as a parent, 54% of fathers responded that they had ‘no-one’ or ‘one or two’ people to call upon for support as a parent compared with 31% of mothers⁵³. As the number of males participating in the study was small (41), any observations could only be considered to be indicative.

5.2.2 Ethnicity

Eighty-nine per cent of respondents were born in Australia, compared to the 72% of the Metropolitan Adelaide population who were Australian-born. English was the major language spoken in over 95% of homes. This paints the picture of a particularly non-diverse population in terms of cultural background. Whilst the proportion of respondents born in non-English speaking countries was small, some data indicated the impact of cultural values on the expression of known social determinants of health.

- Fewer than 30% of respondents born in non-English speaking countries became parents for the first time when a teenager, compared with the study average of 46.6%.
- Their average number of children per household (2.1) was slightly fewer than the study average (2.35) and much fewer than families with Aboriginal children (2.7).
- Respondents from non-English speaking backgrounds were much more likely to be currently married (40.5%) than any other population group.

⁵³ Two other possible responses were ‘three or four’ or ‘many’ people available to support me as a parent.

- They were much more likely to have completed Year 12 and/or another post school qualification (42%) compared with the study average (17%).

At the same time, respondents from non-English speaking backgrounds reported having low annual incomes similar to those of non-Aboriginal respondents with English ancestry.

5.2.3 Aboriginality

Families with Aboriginal parents and Aboriginal children represented 10.9% of respondents. This figure rose to 13.1% when a significant group of Aboriginal children in families with non-Aboriginal parents was added. Overall in the study sample, Aboriginal children were likely to live in more disadvantaged families than non-Aboriginal children living in households in the same neighbourhoods.

- Three-quarters of Aboriginal respondents and 71% of non-Aboriginal parents with Aboriginal children reported having a household income of less than \$21 000 per year.
- There was a higher prevalence of teenage parenthood amongst Aboriginal parents in the study, with 72% reporting having their first child before the age of 20.
- Over half of Aboriginal parents (54.5%) were sole parents.
- Parents with Aboriginal children had lower school attainment and education levels, with 68% of Aboriginal parents completing Year 10 or less, and only one parent completing year 12 or higher.
- Aboriginal respondents shifted more frequently than non-Aboriginal – on average 4.8 house-moves in the past five years.

While the *Families at Risk* project had a very limited focus on Aboriginal families and children as a population group, this data reflects the vast quantity of existing evidence that Australia's indigenous people have the highest level of risk, the

worst access to resources and opportunities for health, and the poorest health and well-being outcomes (National Public Health Partnership 2003).

5.3 Unequal outcomes for parents and children

In this section, quantitative and qualitative evidence will be used to describe a range of health and well-being experiences and outcomes for parents and children including: stressful life events; concerns about children's physical, developmental and emotional/behavioural health; caregivers' physical and mental health.

5.3.1 Stressful life events

Major external sources of stress in the lives of families with young children are interrelated and include the societal factors and living and working conditions outlined above, major life events as well as 'daily hassles'. Parents living on low incomes are much more likely than parents in high income households to feel constantly stressed. Evidence related to the associations between stress and health and well-being was outlined in Chapter Two. There is also evidence of the links between chronic stress and parent effectiveness (Ross and Roberts 1999).

From analyses of relevant open-ended *Families at Risk* survey questions, most respondents (perhaps like all parents, not just poor ones) described the everyday demands of housework and parenting work as their main challenge and source of stress. Cleaning, cooking, washing, shopping, worrying about and paying the bills, home maintenance, getting kids organised, establishing and maintaining routines and meeting children's multiple needs (physical, material, emotional, developmental and entertainment) were the tasks most commonly listed by respondents as demanding. They reported that having a low or inadequate income and parenting alone made this work much harder. Many parents also described positive times - their joy when children expressed love and happiness, did as they were told, helped out at home and got on well with their siblings.

The 22-item Life Events Survey (Murray-Harvey and Slee 1998) was used in the survey interview to measure study participants' perceptions of stressful life events⁵⁴. As can be seen in Table 4 on the next page, the most frequently occurring stressful events in the lives of the study population were: another child being born into the family; using social welfare; unemployment; greater financial worries; and discipline problems with children. The events respondents experienced as most stressful were; serious illness in the family, family member robbed, discipline problems, parent accident and increased family conflict.

It is possible to compare these findings with a 2004 South Australian study (Avery, E Dal Grande et al. 2004) which reported on 4572 responses to a range of life events, eleven of which overlapped with the 22 events assessed in the *Families at Risk* study. Allowing for the fact that the 2004 study was drawn from a random sample of South Australians and there was some variation in the wording of some items, some comparisons can be made which show the lives of the *Families at Risk* population are subject to much higher levels of psychosocial stress.

⁵⁴ Respondents indicated through a 'yes' or 'no' format whether their family had experienced one or more of the 22 life events during the last few years. For 'yes' responses, a score on a 3-point scale was given to indicate how stressful the event was for adults in the household (3=stressful, 2=somewhat stressful' and 1=not stressful).

Table 4: Stressful life events

Stressful Life Event	Families at Risk – No. of responses	Families at Risk % of responses	SA Study % of responses
Another child born into family	134	65	3
Family moved several times	71	35	8
Increased intra-familial conflict	74	36	
Child hospitalised	84	41	
Death in family	92	45	20
Greater financial worries	107	52	5
Parent had an accident	26	13	
Parents separated	71	35	
Parent unemployed	120	58	5
Parents divorced	12	6	3
Home broken into	40	19	4
Family counselling	31	15	5
Others moved into home	58	28	
Parent away frequently	35	17	
Less marital harmony	44	21	
Family member robbed	21	10	
Child psychological counselling	34	17	
Parents changed jobs	58	28	12
Used social welfare	125	61	
Serious illness in family	60	29	8
Discipline problems	106	52	
Ethnic discrimination	19	9	4
Total number interviewed	206		

Note. Multiple responses per respondent were possible.

The primacy of issues related to managing children’s behaviour indicated in Table 4 above, also stood out from analyses of data from open-ended survey questions and the in-depth interviews. Issues commonly raised included:

- How to discipline without smacking and without yelling? How to remain calm and patient?
- The intense frustration of telling a child over and over again to do something and not being listened to.
- The challenge to control children rather than be controlled by them (stories about children’s shopping centre tantrums and other people’s poorly disciplined children were often told).

- The desire to build a relationship with open and honest communication so that your children will tell you “anything” was frequently mentioned by mothers (used with reference to children’s safety and experiences of abuse).
- What is it realistic to expect and how best to support a ‘challenged’ child (for example, children who have a disability, developmental delay or who have been subjected to abuse)?
- The challenge and anxiety related to keeping school-age children “on the straight and narrow” (away from truancy, window smashing, theft).

That parental authority and control are the key to behaviour management was a widely held notion. Emma, a mother of 5 children who nominated managing her children’s behaviour as her major challenge, echoed this view and hinted at the influence of social expectations of parents and children:

Just being firm with them I suppose and not letting them boss you around. Because a lot of kids think that parents are made for them not the other way around!

In the lives of mothers who participated in the in-depth interviews, stressful life events most often did not occur singly nor were they time limited as the word ‘event’ might suggest.

5.3.2 Concerns about children’s health and well-being

Assessment of children’s health and well-being outcomes was limited in the *Families at Risk* survey interviews to parents’ reported concerns. In the first survey interview, primary caregivers responded to questions about whether in the past 12 months, their child had been diagnosed, or whether they had an ongoing concern about their child, related to one of three health and well-being domains: (1) physical (2) developmental or (3) emotional/behavioural development.

From Table 5 it can be seen that 41% of respondents reported a diagnosed problem or concern regarding the physical health of their child (ren), 20% reported a developmental concern and 22% a problem/concern regarding the emotional/behavioural health of their child(ren).

Table 5 - Have any of your children (0-7 yrs) been diagnosed with an ongoing physical, developmental or emotional/behavioural problem or have a problem you are concerned about?

	Physical	Developmental	Emotional/Behavioural
‘No’	59% (294)	80% (402)	78% (388)
‘Yes’	41% (206)	20% (98)	22% (112)
TOTAL	500	500	500

This data was used to analyse the associations between reported child health problems/concerns and the socioeconomic factors reported above. Low level of completed education, financial hardship and sole parent status were found to be significantly linked with child health problems/concerns. More specifically:

- The higher the percentage of parents with fewer than nine years of completed education, the higher the percentage of families reporting problems/concerns for their children in the physical domain, and the higher the percentage of families with problems/concerns in at least one domain.
- The higher the percentage of families who considered their household income as ‘not enough’ to make ends meet, the higher the percentage of families with children reported as having developmental problems/concerns.
- For families who considered their household income as ‘not enough’ to make ends meet, the odds of having problems or concerns in physical, developmental, or at least one domain, were almost double those of families who considered their household income adequate.

- Sole parent families reported concerns in the emotional/behavioural domain at almost twice the rate of families with two parents.

These findings appear to support existing evidence which has demonstrated associations between childhood health and well-being problems and neighbourhood and family disadvantage⁵⁵.

5.3.3 Self-reported health status

Self-reported health status refers to a person's perception of her/his general health and well-being. There is evidence that people's self-reports of their health (physical and mental/emotional) are associated with household income, level of education, perceptions of trust and safety, feeling appreciated and supported, and feeling able to control economic and social aspects of their household⁵⁶. In

Table 6 below, data from the second survey interview are shown alongside comparable measures of self-reported health status of the South Australian and Australian populations.

Table 6: Self Reported Health Status: Families at Risk Study & South Australia, Australia

Self-Assessed Health Status	No. of responses in Families at Risk study	Families at Risk Study %	SA %	Aust. %
Excellent	18	8.8	16.1	18.9
Very Good	63	30.7	34.2	32.8
Good	74	36.1	29.8	30.2
Fair	44	21.5	15.5	13.3
Poor	6	2.9	4.5	4.8
Total Responses	205			

Source of SA and Australian figures: (Australian Bureau of Statistics 2001)

⁵⁵ For example: (Bor, Najman et al. 1997); (Boyle and Lipman 2002); (McLoyd 1998); (Levanthal and Brooks-Gunn 2000); (Rutter 2003); (Schneiders, Drukker et al. 2003).

⁵⁶ For example: (Macintyre and Ellaway 1999; Dunn and Hayes 2000; Marmot and Wilkinson 2000; Subramanian, Kawachi et al. 2001; Marmot 2002; Hetzel, Page et al. 2004; Ziersch, Baum et al. 2005).

The proportion of study participants rating their health as ‘excellent’ or ‘very good’ (39.5%) was less than for the South Australian population of adults over 15 years (50.3%) and the Australian population (51.7%). The proportion of the study population rating their health as ‘fair’ or ‘poor’ was at 24.4% compared with the SA (20%) and national (18%) populations.

In response to open-ended survey questions and in the in-depth interviews caregivers described the ‘wear and tear’ on their health and well-being that arose from insufficient sleep / rest, lack of time for self, continuing worry and stress, caring for other family members as well as children, family conflict, violence and abuse, as well feeling isolated and unsupported. A ‘shadow-side’ of mothers’ commitment to caring for children and other family members was that their own needs generally came last. According to Karen, a solo mother of two boys:

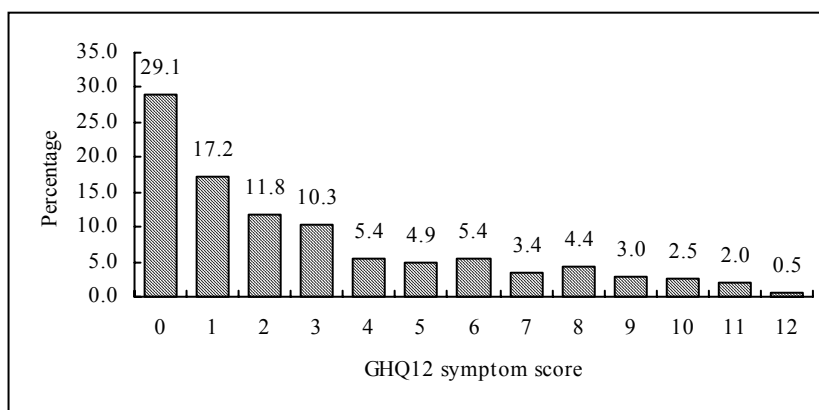
The thing I struggle with the most is meeting my own needs? Like you know I mean I'm struggling enough with their needs, not always doing that well. I neglect myself all the time.

The value to their health and well-being of having time for self-care and participation outside the home stood out from caregivers’ accounts in both the survey and the in-depth interviews. Time for self when the children were at school or asleep in bed, time out from the routine tasks of caring for children, time out for parents and children to calm down and to manage anger and frustration, time to get things done and time to get involved in community or school activities. For participants who had no family support or who parented in particularly difficult circumstances (insecure housing, domestic violence, and having children with disabilities) it could be “...day in, day out, every minute with the kids” compounding their experiences of stress and social isolation.

5.3.4 Self-reports of mental health

Data concerning parents' perceptions of their mental health was gathered, using the 12-item General Health Questionnaire - GHQ (Goldberg and Williams 1988)⁵⁷. Using the 1/2 cut-off point⁵⁸, the results in Figure 2 show that 109 (53.7%) of respondents were likely to have one or more mental disorders. This compared to the prevalence rate of 14.2% of adults in South Australia who had a mental health condition, using the same cut-off score (Dal Grande, Woollacott et al. 1999)⁵⁹. When the threshold was raised to 2/3, the prevalence rate dropped to 41.9% (compared to 12.1% in the Dal Grande et al. study).

Figure 2: Distribution of GHQ12 Symptom Scores in the Families at Risk study



According to evidence already cited this marked inequality in mental health can be attributed to social, economic and place disadvantage and to young age and life stage which were characteristic of *Families at Risk* study participants. Of particular relevance is growing evidence about the effects of social isolation,

⁵⁷ This self-report questionnaire is in common use to measure non-psychotic mental illness in the community and in general medical practice. The participants were asked if they had experienced a particular symptom or behaviour recently. Each item was rated on a three-point scale (*less than usual, no more than usual, rather more than usual*).

⁵⁸ The raw GHQ scores (i.e., individual item scores ranging from 0 to 3) were first recoded (0 1 = 0, 2 3 = 1). The GHQ12 symptom scores are the sum of the 12 recoded scores; they can thus range from 0 to 12. Using the cut-off point of 1/2 means that anyone with a symptom score between 2 and 12 is likely to have some mental disorder(s). If the 2/3 threshold is employed, the 'clinical' scores lie between 3 and 12.

⁵⁹ Caution needs to be taken when comparing the figures from these two studies, as the population groups are not directly comparable. The *Families at Risk* study selected parents with children under 7 years old, while the latter was a sample of the total South Australian population over 15 years.

family conflict, violence and abuse on women's mental and emotional health (Taft 2003; Taft, Watson et al. 2004).

In the in-depth interviews, a common theme in mothers' (and service providers') accounts was the fundamental importance of practical and emotional support from their own parents/mothers. Some reported receiving no family support due to situations of mental illness, physical illness, violence, abuse, geographical distance and/or family breakdown. When grandmothers did provide regular childcare for their grandchildren and advice to their daughters regarding parenting, the usefulness of this support was often compromised by conflict. An illustration was provided by Dianne, a young mother of 2 girls:

...anything I do is wrong, everything I do is wrong. Actually, nobody in my family thinks that [current partner] being here is good, don't think that I should work, don't think that I should... really do anything ... apart from being home with the kids.

Although not measured in the *Families at Risk* survey, violence against women, particularly by partners, is known to be associated with a range of factors which were characteristic of the research population⁶⁰. There is increasing recognition internationally and in Australia that violence and abuse are caused by fundamental social, cultural and economic factors including, and especially, the unequal distribution of resources and power between men and women (Bagshaw, Chung et al. 2000; Laing 2001; World Health Organization 2002). Partner violence is

⁶⁰ Twenty-three percent of Australian women who have been married or in a de facto relationship have experienced violence from a partner, and ninety-five per cent of cases of domestic violence are cases of male violence (Australian Bureau of Statistics 1996); (Mulrone 1999).

strongly associated with pregnancy, separation and divorce (Australian Bureau of Statistics 1996)⁶¹.

Lesley, a mother of six children, talked about the effects of her ex-partner's violence and abuse on her self-esteem and idea of herself as a capable parent –

I got a lot of negative thoughts. I guess that's where I lost a lot of my self-confidence. He used to run me down a lot and never give me much praise.

Sue's attempted suicide and hospitalisation for depression followed separation from her abusive, alcoholic partner and father of their three children.

I had hit rock bottom you know ... I couldn't cope with it. ... I thought the kids would be better off without me. ... I didn't know that people like me could get depression but you know you can, when you try to bring up three kids, you're by yourself and you've got a husband ... who's ringing up drunk 2 or 3 o'clock in the morning abusing you over the phone ... I just got physically sick and I tried to commit suicide a number of times ... it took a while to really get back to where I am... I mean it's like a nightmare but I suppose it just shows you know, that if you don't stand up for yourself, you know you can get walked on and yeah I can understand why people do get it [depression] now.

Heather, a mother of two children, explained her experience of postnatal depression and then serious illness as “situational”, caused by family conflict and social isolation:

⁶¹ Women previously or currently abused by partners are four or five times as likely to report depression as women free from violence; and partner violence is responsible for a greater ‘disease burden’ (that is, more ill-health and premature death) in women under the age of 45 than any other of the well-known risk factors (Taft, Watson et al. 2004; VicHealth and Department of Human Services 2004).

My PND was a situational thing rather than - . My parents were terribly upset I was pregnant to someone I didn't know, someone they didn't approve of. ...made our lives really difficult. ...so we actually moved from there [another state] to here. I came here 7 months pregnant and didn't know a soul. So I think that was probably a pretty big precursor. I was probably pretty down when we got here and after the birth of my son it just escalated...

When Heather referred to her depression as “a situational thing rather than -” what she probably left unspoken was individual psychopathology – that is, the widely held belief that depression is caused by individual dysfunction. In recent years, dominant professional (rather than public) understandings and responses to women’s mental ill health and violence and abuse have shifted from ideas of individual and family dysfunction to a ‘social ecology’ framework. Societal (eg. gender roles and norms); socio-economic (poverty, social isolation); relationship (conflict, power and control) and individual factors (being abused as a child, drug and alcohol use) are theorised as contributing to violence and abuse and exacerbating the effects of violence on women’s mental health (World Health Organization 2002).

5.4 The role of parent efficacy

The concept of self-efficacy is similar to notions of individual agency and control⁶². A person’s efficacy or agency is expressed in how they think and feel and how they act. According to psychosocial explanations, levels of available support and reward as well as the control or ‘mastery’ which a person has within

⁶² ABC Radio National (November 1998). Mastering the control factor: four part series. *ABC Radio National; The health report*. <http://www.abc.net.au/rn/talks/8.30/helthrpt/index/hrChrono1998.htm> [Accessed 14/09/05].

their living / working environment determines the health and well-being consequences of the demands and stress of living in the most disadvantaged circumstances (see Chapter Two). In this section there will be a number of sub-sections. In the first and second of these, data from the *Families at Risk* survey interviews concerning caregiver feelings of control over their lives and their parenting confidence and satisfaction will be outlined. In the third sub-section, survey data will be drawn on to describe the associations between measures of parent efficacy and reported concerns about children's health and well-being. In the fourth section, these findings will be extended and critiqued using understandings about parenting competence developed from analyses of the accounts provided by mothers and their service providers in the in-depth interviews.

These interpretations from the qualitative data demonstrate that how people think, feel and act are enabled and constrained by societal norms and access to resources and opportunities, which are in turn mediated by a person's position(s) in social hierarchies. From this perspective, parental efficacy is both individual and social. Used without reference to social context, the concept of self-efficacy can represent individualised risk and a deficit view; that is, something else 'problem parents' are lacking (Deacon and Mann 1999; Ungar 2004).

5.4.1 Feeling in control

In the second *Families at Risk* survey interview primary caregivers were asked to consider the open-ended question - what would give you more control over your life as a parent? Responses related primarily to material, social support, relationship and neighbourhood factors as well as to self-efficacy, including skills to manage children's behaviour, sense of freedom, self-confidence and self-control

(see Figure 7 in Appendix I for details). The most frequently mentioned control factor was money. Individual matching of the 39 caregivers who nominated ‘money’ with their responses to the question about the adequacy of their household income (in the first survey interview), revealed that 10 respondents who said that they had ‘plenty of money’ or ‘some left over’ also claimed more money would give them more control over their lives. The next most frequently mentioned control factors were ‘more support’ and ‘managing children’s discipline’ (16 each); more help from (ex)partner (12); and access to paid work (11).

Fifty-nine responses were categorised as ‘don’t know’ or ‘nothing’: either the respondent couldn’t think of anything that would give them more control or they already had all the control they wanted or needed. The question of what would give someone more control is a complex one, perhaps too multi-dimensional for a broad open-ended question. It is likely that the quick responses ‘money’, ‘don’t know’ and ‘nothing’ reflect dominant discourses related to agency and control which emphasise consumption and self-reliance. In addition, a key message from research into lay concepts and ideas concerns the strongly ‘moral’ quality of coping, health and well-being. However the terms are understood, few people wish to say they are anything other than ‘going well’ and ‘in control’ (Blaxter 1990; Williams 2003).

5.4.2 Parent confidence and satisfaction

Also in the second *Families at Risk* survey interview, respondents were asked to rate their satisfaction with being a parent/caregiver. Sixty-three percent reported feeling a “great deal of satisfaction”; 33.2% - “quite a bit”; 3.6% (18 parents) – “a little”; and 0.2% (1 parent) – “not at all”. Similarly, in response to a series of questions in the first survey interview, a large majority of respondents described themselves as skilled, confident resources for their children.

- 94% of respondents described themselves as being “a good parent” all or most of the time.
- In response to the question – “Overall how confident are you about parenting?” - 39% rated themselves as ‘very confident’ and 46% as ‘confident’ with the remaining 15% feeling ‘less confident than I’d like’ or ‘far less confident than I’d like’.
- Fewer than 6% of parents felt unable to work out “normal problems I might have with my children” all or most of the time.
- 69% assessed the statement “it makes me depressed to think about all there is to do as a parent” as completely false or mainly false. Another 13% (65) of parents said they felt ‘uncertain’ whether this statement was true or false.
- 95% of parents felt confident or mostly confident to “teach their children new things”, while 88% assessed the statement “I know enough to be able to teach my kids many things they will have to learn” as completely true or mainly true.
- 67% of parents described the statement “I’m doing a good job taking care of my kids” as completely true and 30% as mainly true. Almost 3% (14) parents felt uncertain and 2 parents assessed the statement as mainly false.

These questions about control and parenting confidence and satisfaction generated ‘thin’ descriptions when compared to the accounts from the in-depth interviews, illustrating the different sorts of evidence quantitative and qualitative approaches can produce. It seems likely that participants’ overwhelmingly positive self-assessments were influenced by the sorts of contextual factors already outlined, including strong societal norms about ‘good’ parenting and the threat of children

being ‘taken away’ from ‘bad parents’, as well as the context of being interviewed by someone from the University whom they were meeting for the first time.

5.4.3 The relationship between caregivers’ concerns about their children’s health and parental self-efficacy

In the second survey interview, additional data regarding participants’ concerns about their children’s health and well-being was collected using the authorised Australian version of the Parents’ Evaluation of Developmental Status (PEDS) questionnaire⁶³. Also in this second interview, the Generalized Self-Efficacy Scale was administered (Jerulsaem and Schwarzer 1992)⁶⁴. Not surprisingly, analysis of the associations between parents’ concerns about children’s health and well-being and parental self-efficacy revealed that a high PEDs score (a high number of concerns) was inversely related to self-efficacy - that is, the higher the PEDs score, the lower the self-efficacy score. The total PEDs problem score added across all children within the family bore the strongest relationship with self-efficacy, reflecting the challenges of caring for multiple children and concerns about their health and well-being.

Analysis of the associations between parent self-efficacy and parent’s age and weekly income generated the following observations:

⁶³ Developed in the USA by Frances Page Glascoe and tailored for Australia by the Centre for Community Child Health in Melbourne (Wright and Oberklaid 2003). The instrument was originally developed as a rapid screening tool for use, for example in general practice or community health settings. It elicits parent concerns about their child’s health and developmental status with reference to learning, communication, fine and gross motor skills, behaviour, social-emotional skills and ‘any other concerns’.

⁶⁴ Participants responded to 10 items scored on a 1-4 scale – ‘not at all true’ to ‘exactly true’. Items relate to: problem solving – for example, ‘I can always manage to solve difficult problems if I try hard enough’, ‘When I am confronted with a problem, I can usually find several solutions’; coping – ‘I can usually handle whatever comes my way’, ‘I remain calm when facing difficulties because I can rely on my coping abilities’; and goal achievement – ‘It is easy for me to stick to my aims and accomplish my goals’.

- Self-efficacy appeared to increase with age (0.11 – 0.12 per age-year) and this relationship was not confounded with variation in income or PEDs problems
- Self-efficacy increased with income – and this trend became stronger when age and PEDs problems were taken into account
- Self-efficacy decreased with increasing PEDs problems – and the decrease was ‘sharper’ when age and weekly income were taken into account.

However, the ability of these three variables to predict self-efficacy, while statistically significant, was still modest. They could explain at best around 10.5% of all the variation in self-efficacy.

These findings and those from the survey’s ‘control’ and ‘parent confidence and satisfaction’ questions appear to have limited explanatory value with regard to the causes of effective (or ineffective) parenting in contexts of serious disadvantage. Thicker descriptions of how material, practical and emotional support and personal resources shape parent effectiveness were developed from the accounts of mothers and their service providers in the in-depth interviews.

5.5 Parenting competence – accounts from mothers and service providers

As outlined in Chapter Two, the relative contribution of structural and individual factors to health and well-being outcomes has been the subject of much debate in the literature. In their descriptions during the in-depth interviews of strengths and resources they considered key to coping in disadvantaged contexts, mothers and service providers generally portrayed structural and individual factors as interwoven. In these accounts, the impact of upbringing on parenting style and competence, their ‘strength of character’, personal skills and the adverse effects of

feeling judged and blamed, were named most frequently. Each of these is discussed in detail in the sub-sections which follow. Other valued resources raised in the interviews included the joy of being a parent⁶⁵, having supportive relationships, access to services, and other resources and opportunities such as adequate housing and entertainment for children.

5.5.1 The effects of family history

Having had a positive experience of ‘normal family life’ as a child was perceived by service providers and mothers alike as key to learning positive values about care and love for children, knowing about the basic needs of children and how to go about parenting. All the mothers expressed concern about the effects on their children of current and past stressful life events, experiences and environments. Some mothers described their upbringing as education about how not to parent and others the value of these lessons in hardship to them now as parents.

Leanne attributed her ability to cope day-to-day with complex and unstable family relationships and two small children with developmental problems to her childhood experiences. At the same time she hinted at the legacy of being robbed of ‘normal’ childhood.

I was 7 years of age when my real father left my mother. Now when he left, my mum went through a very severe and bad nervous breakdown and I was the one... I had to take the role of looking after my two sisters plus I was going to school, looking after the house, looking after my mum and everything else. ... As my mum says, I grew up to be 17/18. I didn't really get to live the end of my childhood and my teenage years, I grew up too

⁶⁵ Including: feeling your children’s love and being able to enjoy, nurture, educate and comfort them.

quick. ... Like my mum helped out and that but she was going through that bad of a nervous breakdown and I saw her get put in hospital. Us kids had to go down to crisis care every second weekend... As my mum says if it wasn't for me she wouldn't be here now.

Others identified their “shit background” as motivating them to parent differently but also as making it harder to cope with life as a parent. As well as acknowledging the influence of what their parents did, some women worked hard to resist repeating old patterns:

I thought I was a really bad mother and that the child would be better off without me. I thought I was going to repeat patterns, my parents were quite dysfunctional, I thought to myself I'm going to screw their lives up the way my parents screwed mine up. That's very much how I felt at that time
(Karen)

My parents never hugged us, never kissed us. I love to call my kids 'sweetie'. I love to hug them. I love to kiss them. I love them. My parents were the opposite (Emma).

5.5.2 Strength of character

How a mother/parent dealt with life's difficulties and the priority they gave to their children and to their own self-development were strong themes in mothers' and service providers' accounts of what determined parent effectiveness. In response to an open-ended *Families at Risk* survey question respondents also named various personal qualities as important resources for coping with parenting including: hope, persistence, will power, determination, self-reliance, patience and having a “realistic view of a positive future”.

5.5.3 Positive self-identity

A strong theme in mothers' and service providers' accounts was the view that knowing what you want, being able to recognise your own strengths, being self-confident or having high self-esteem were crucial especially to withstanding criticism and judgement about your children and your parenting from self and from others. "*Being strong in your own mind and not allowing others to control or manipulate...*" was considered fundamental to surviving unequal social/power relations.

5.5.4 Putting children's needs first

From the mothers' and service providers' accounts, perhaps the most important signifier of 'strength of character' was the mother's willingness to give priority to her children's needs ahead of her own. Karen illustrated this commitment:

...if you're doing your budgeting right, you come last, you know.

Unfortunately I see it all the time where kids miss out because their parents want their drugs and stuff. I'm not like that, even though I did use drugs and alcohol that came last. I always made sure that everything was paid for first.

There was food, nappies, everything else came before my own habit.

Adequate provision of material necessities was for Emma, a mother of 5 children, the bottom line of good parenting. Her implication that other parents at her children's school who did not provide adequately for their children were 'wasting' their money on something else suggested the 'moral worth' of adequate provision even in the face of poverty:

We've got some other people who can't supply their kids with food, like they have sandwiches every night because they can't afford to feed them. We try to not waste our money so that we've got money for our children.

Blaxter (1997) pointed to the psychological significance, perhaps especially in contexts of multiple and persistent disadvantage, to one's self-esteem and self-worth of being able to do the best for one's children (cited by Popay 2005).

5.5.5 Personal skills

Personal skills relevant to self-efficacy and central to 'being there' for your children were described variously as: knowing what to do to help them, being consistent in your approach (especially to managing children's behaviour) and being able to solve problems as they arise. Leanne, a mother of two children with disabilities, described the problems in her own and her children's lives as "hurdles to be got over and through". She described her success in using rational problem solving as a life control strategy:

I put it out in front of me, put everything that coincides with it, when that problem started, what was happening at the time when it started, what's been happening since, and work ways out either to take that problem out of the picture completely or at least start to work on that problem and sort it out.

The notion that individuals have 'choices' they can make whatever their circumstances was a strong theme in the accounts of mothers and their service providers. The ability to recognise those choices, make a choice or decision, and be active and focused in its implementation was described as fundamental to coping.

The skills of household management and, in particular, managing time well, being able to keep track of things and organising stimulating activities for the kids were named by participants as important to effective parenting. It also helped if you were self-aware - "*I recognise when I'm getting to boiling point and take time out*

by locking myself in the toilet.” - as well as open to developing your skills and prepared to seek help when you needed it.

5.5.6 ‘Responsibility’, judgement and blame

‘It’s a woman’s responsibility...’

As already described, the commitment of parents to their children and to wanting the best for them, stood out from the analyses of open-ended survey responses and in-depth interviews. Another aspect of parent commitment and responsibility was expressed in the idea held by many participants that it is a mother’s responsibility to look after her own children - “...*it’s not anyone else’s burden to look after my kids*”. ‘Responsibility’ was expected of mothers and mothers expected it of themselves.

In the context of societal expectations about women’s responsibility to care for and protect children and other family members, it was not surprising that many mothers felt responsible when things went wrong. Sue described this attribution of blame⁶⁶:

I’ve lived with it [verbal abuse and lack of support] for the ten years I’d been with my husband and everything was my fault. It’s your fault [husband] is drinking, it’s your fault the kids are running wild, it’s your fault because you haven’t done this and that....

Dominant ideas about ‘proper parents’ and ‘normal families’ were standards against which mothers judged themselves and each other. Mothers reported that they faced significant barriers in being prepared to ask for help when needed because of the secrecy and shame of having problems. Feeling responsible for the problem(s) and the fear of judgement about being not good enough parents had at

⁶⁶ The belief that women / mothers are responsible for violence and abuse perpetrated by partners / fathers is widespread (Morris 2003).

times prevented them from accessing services or help when needed. The generally shared expectation that mothers will cope (take responsibility) can create adverse effects when one doesn't cope or cope well enough.

5.5.7 'Good' and 'bad' mothers

Feeling shame and/or outrage at the injustice of being unfairly judged as a 'bad' or not 'good enough' mother can seriously add to the stress of parenting. In the in-depth research conversations several mothers used the example of children's 'bad' behaviour in shopping centres to illustrate the pervasiveness of judgement from others and the feeling that it may be impossible to do anything right. Margie, a sole mother of 6 children, gave a clear description:

Like when you go shopping with your all your kids by yourself and they're running amok and you've got people looking at you like 'can't you control your kids?' You tell them off or you don't – doesn't matter, they'll look at you like 'can't you tell them off?' Or you tell them off and it's like 'What are you telling them off for?'

Many mothers reported anxiety and criticism related to knowing what to do to best help their children and meet the standards of being a 'good' mother. Kirsty highlighted the effects of generalised expectations of coping, including feeling criticised and isolated, when she described the circumstances leading to her being hospitalised with depression soon after the birth of her second child .

I just felt like I'm supposed to be happy now I've got this new baby, but I'm not happy at all and I'm really upset... I'd thought, you know, come home and everything's going to be fine, [I'm] going to be looked after and yeah, but mum was just like, "I coped all right", sort of thing. ...I felt because

[partner] went back to work he thought I was fine ...and he just went to work and left me here with these kids.

Dominant ideas of 'proper parents' and 'normal families' can also have exclusionary effects. Pat, a community midwife, recalled the responses of other group members to a mother with an intellectual disability when she joined a post natal support and learning group:

...once she'd gone out of the room the other women would start to say "should women like that be allowed to have babies?" and things like that. Like straight away there's judgement...and you think, don't go down that track.

5.5.8 The knowledge of 'experts'

Later in that same interview, Pat gave a different illustration of the influence of dominant ideas about 'good' mothers, this time on judgements made by lay support workers. She referred to the involvement in community midwifery of support workers, trained to provide practical support to new mothers following discharge from the birthing hospital.

...we often get feedback that the [support worker] is quite distressed about the house and how clean it is and that the baby hasn't been bathed for a few days ... for us [community midwives] that has become 'normal'. The [support workers] ... think they're bad mothers or want to report them [notification of child neglect]... They don't really know what has gone on in that woman's life and why cleaning the house is a fairly low priority in the scheme of things.

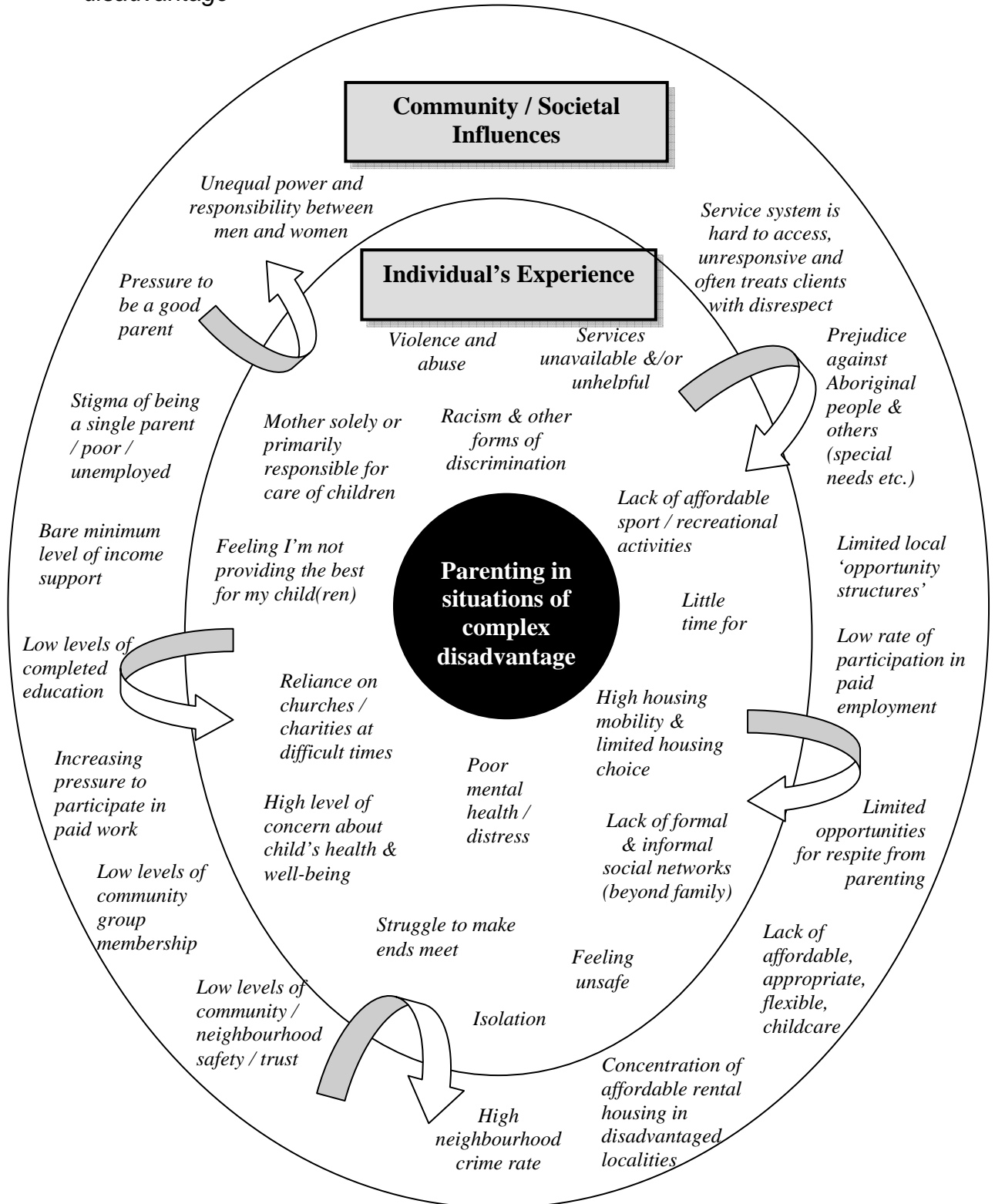
Lisa, a child health nurse, reflected on the ways social norms and expectations combine with professional knowledge to create judgements which might contradict the professional provider's intention to support the 'strengths' of mothers with 'at risk' children:

...the knowledge of child development and the expectations of where they should be at a certain age. I think that tends to encourage a certain kind of judgement if the child is not where it is meant to be in their development. There are expectations around, benchmarks out there in our society, that a child should be doing this and should be doing that. I think society plays a part in putting up these benchmarks which can probably stimulate some sort of judgement.

5.6 Parenting in situations of complex disadvantage

In this chapter, associations between socioeconomic inequalities, health and well-being outcomes and parent efficacy have been described and explored. The ways in which individual agency contributed to resilience in contexts of disadvantage and at the same time was determined by those contexts have been highlighted. This notion, that outcomes for parents and children are (re)produced both structurally and individually, underpinned the study's original research question - for 'families at risk' what are their strengths, resources, access to services and barriers? The question carried the implication that 'solutions' were to be found in improving access to resources (including services) and supporting or developing individual and family strengths.

Figure 3: Effects and mediators of parenting in situations of complex disadvantage



The challenges of conceptualising the complex interrelationships between determinants of health and well-being have been illustrated in Figure 3 which was drawn from the evidence presented in this and the following chapter to illustrate the consequences of parenting in situations of disadvantage as well as factors at the community and societal level which mediate these effects⁶⁷.

Various aspects of the experiences of caregivers, identified through the study and supported by evidence from relevant research literature, appear in the inner circle. In the outer circle some important societal and social policy contexts which influence (and are influenced by) parenting in situations of multiple disadvantage are listed. The experiences and factors *within* each circle and *between* the two circles (and the even broader political, global, environmental and temporal base or background upon or within which the two circles exist) are linked in ways which are interwoven and multi-directional as broadly indicated in Figure 3 by the curved arrows.

These complex interrelationships were illustrated when Mina, a sole mother of a toddler, spoke at length about the impact of school failure and ‘problems at home’ on her aspirations and opportunities:

I would like to get a really nice job, you know like working in a factory. I wouldn't mind being a receptionist or even having a bit of retailing business behind me. I don't have anything like that you know and it's like that if I did know how to read and write properly and done really well at school, which I didn't, I'd probably be in that position now. ... It wasn't just because of school. I

⁶⁷ Developed after a similar model in (Green 2004)

had problems at home. Like closed doors, problems inside our home which no-one knew about. Before I knew it, I was a teenager and then I rebelled sort of thing and that was it. I had fun but I'm paying for it now. ... I just feel if I'm going to get a job it'll be back to cleaning and I'm sick of cleaning. That's all I can get is a cleaning job and if I get any other job -. I can't hold a job other than cleaning.

The understanding that structural factors are not static 'object states' but complex and fluid in nature reflecting the dynamics of social/power relations may provide a link between structural and individual explanations (Williams 2003). Unequal social relations mediate people's access to resources and opportunities for health and well-being as well as people's choices and agency. The dynamics of inequality (re)produce their experiences of powerlessness, resistance, shame, responsibility and social isolation.

People with little or no power are made to believe that there is no point in raising their voices, as it will make no difference. That they will not be listened to by those who have power and control. This habit becomes so strong that some people almost forget that they have opinions of their own, and so they just endure the hardships they suffer (C McCormack, People's Parliament, Voices for Change Scotland, 1999 cited in: Commission on Poverty Participation and Power 2000).

In conclusion, the patterns and dynamics of inequality presented in this chapter lend support to both a critical social theory perspective and to what are broadly termed

‘psychosocial’ explanations for the links between disadvantage and poorer health and well-being (Navarro and Muntaner 2004; Wilkinson 2004; Marmot 2005). Policies and action to change the unequal distribution of resources and opportunities for health and well-being and the dynamics of this unequal access (including and especially, power and social exclusion/inclusion) are central to improving outcomes for ‘families at risk’. The focus of this chapter has been on evidence regarding the impact of structural and material factors and individual agency on outcomes for families and children. In the following chapter, the contribution of social networks/relationships will be explored.

CHAPTER 6: DEALING WITH DISADVANTAGE: SOCIAL SUPPORT, SERVICE PROVISION AND 'COMMUNITY'

In this chapter the explanatory value of the 'social support' hypothesis discussed in Chapter Two, regarding the links between socioeconomic disadvantage and poorer health and well-being for families with young children, will be explored. In the first *Families at Risk* survey interview, data was collected about caregivers' sources of informal support with the care of young children and their access to and use of formal support from services:

- *informal level* - involving partners, ex-partners, close family members, friends and neighbours;
- *formal level* – through agencies, institutions (childcare, kindergarten, schools and community-based services) and specialist service providers (doctors, specialists, counsellors).

In the second survey interview, respondents answered questions about their membership of community groups and perceptions of community-level trust, safety and social cohesion. Data from the in-depth interviews with mothers and their service providers has been used throughout this chapter to provide additional insights, especially in relation to the effects of social isolation/social connection and the dynamics of social exclusion/social inclusion.

The evidence presented in this chapter will broadly confirm known associations between people's access to social support and social capital and social/health inequalities in that the social patterns revealed included:

- reliance on family and close others for instrumental, informational and emotional support

- reliance on medical services for child health concerns
- lower level of community group membership
- lower feelings of trust and safety
- lower sense of ‘community’/ social cohesion.

In addition, the evidence points to the value of social relationships in:

- mediating access to various forms of support for parenting and health and well-being
- contributing to feelings of recognition and worth as well as to ‘self-formation’
- providing opportunities for reciprocal friendship, local participation and a sense of belonging
- facilitating individual agency and collective action for support and change (empowerment).

There are different dimensions to social support including access to resources and assistance; the number of people with whom support is exchanged; and people’s experiences of the quality of that support (House, Landis et al. 1988; Astone, Nathanson et al. 1999). In addition, other ‘primary pathways’ to health and well-being which are related to social support include social influence/power, belonging and participation (Berkman, Glass et al. 2000). Aspects of social support such as how many people are in a support network and formal membership of community groups are easy to measure whereas the social relations of support and the dynamics of social exclusion are more difficult. In addition, it seems likely that both quantity and quality of support rather than being fixed or stable change over time, even within the life of a stressful event.

6.1 Close others – the main source of support

In the first survey interview, four options were provided to indicate the number of people respondents felt they had around them to support them as parents – no-one; one or two; a few; or many. Just over thirty six percent of respondents had ‘many’⁶⁸ and 6.5% (32 respondents) reported having ‘no-one’. Twenty seven percent (134) felt supported by ‘one or two’ people and 30% by ‘a few’.

As there was no ‘control’ group there are no comparable statistics with which to evaluate the adequacy of this level of perceived support (is it ‘high’ or ‘low’?). Further, there is broad agreement in the literature that adequacy is as much related to ‘quality’ of support as to numbers or network size. In this section, quantitative measures of different sources of support are presented followed by an exploration of issues of ‘quality’.

In the first survey interview, a follow-up question to caregiver reports of their child health problems/concerns was - *Overall, if you were to seek help with your child(ren), what kind of help would you say you use most of all?* As shown in Table 7 below, responses to this question highlight reliance on family.

Table 7: Help-seeking related to child health problems / concerns

Source	%
Don't use any	0.6
Family	61.3
Friends	11.7
Neighbours	1.4
Medical services	16.0
Community services	6.1
Social services	0.8
Other	2.0

Note: Number of responses - 489

⁶⁸ The percentage of Aboriginal parents feeling this level of support was slightly higher at 48.5% perhaps reflecting the higher average number of adults in those households.

When asked more specifically about their informal (family, friends, neighbours) sources of help with their child(ren)'s problems/concerns in the past 12 months, respondents clearly indicated their reliance on their own family, primarily their mother and siblings, with much less reliance on more distant family and friends and minimal use of neighbours or acquaintances.

In the second survey interview, respondents were asked more specific questions about sources of informal support with parenting and daily living in relation to practical (instrumental-IA) help, parenting advice (appraisal and information-A) and emotional support (EC)⁶⁹. Analysis of this data (Table 8 below) showed a similar pattern of reliance on partner, family (particularly the parent's own mother) and friends in all domains. The non-custodial parent, neighbours, the parent's father, children, aunt(s)/uncle(s) and other relatives were little relied on for any type of help or support. Table 8 shows the most frequently relied upon sources of support and domains (using an arbitrary cut-off point of 25% of respondents).

⁶⁹ Seven domains of support were classified using House's scheme : *emotional concern* (EC=liking,love); *instrumental aid* (IA=services); and *appraisal* (A=information for self-evaluation). (House, Landis et al. 1988)

Source of support/help	Domain
Parent's mother	Childcare/babysitting (IA)
Parent's father	Shopping (IA)
Parent's partner	Cooking/cleaning (IA)
Parent's child(ren)	Gardening/home maintenance (IA)
Parent's brother(s)/sister(s)	Transport (IA)
Aunt(s)/Uncle(s)	Advice on parenting (A)
Other relative(s)	Shoulder to lean on/emotional support (EC)
Non-custodial parent	
Friends	
Neighbours	

Table 8: Sources and domains of support upon which at least 25% of respondents rely

Source and Type of Support	Domain	%
Partner:		
• helping with gardening, home maintenance	IA	44.4
• providing emotional support	EC	40.0
• babysitting, caring for children	IA	37.1
• doing shopping	IA	30.2
• doing cooking, cleaning	IA	29.3
• providing transport	IA	27.3
Parent's mother:		
▪ babysitting, caring for children	IA	43.4
▪ giving advice on parenting	A	41.50
▪ providing emotional support	EC	38.0
Friends:		
• providing emotional support	EC	42.9
• giving advice on parenting	A	42.0
• babysitting, caring for children	IA	37.1
Parent's brother(s)/sister(s):		
• Babysitting, caring for children	IA	29.3

Note: Number of responses - 205

Fewer than 25% of respondents indicated that they relied on their partners for advice about parenting, perhaps indicating the extent to which mothers in this research population carried the responsibility for raising children⁷⁰. Respondents relied on their mothers, siblings and friends for advice about parenting, emotional support and for babysitting/childcare, but not as much for other forms of instrumental aid. A closer look at sources of help with childcare follows.

6.1.1 Childcare: an example of reliance on close others

In the first survey interview, a specific question was asked about all sources of support and help with childcare/babysitting in the past 12 months. The low-level of reported

⁷⁰ From her observations one field researcher suggested an alternative explanation for this lack of reported reliance on partners for advice. That is, many mothers may talk to their partners about concerns related to their children but might take it so much for granted that they didn't think it worth reporting or didn't regard it as help/advice but rather as 'sharing the problem together' (S Jarrett, personal communication).

use of childcare services shown in Table 9 below is of particular interest in the context of current public policy emphasis on childcare to enable mothers' participation in paid work.

Table 9: Sources of childcare/babysitting in the past 12 months

Source	Number	%
Family	509	53.0
(ex) Partner	168	17.5
Friend	104	10.8
Childcare centre	83	8.6
Family day care	29	3.0
Neighbour	23	2.4
Out of school hours care	14	1.5
Acquaintance	11	1.1
Kindergarten	10	1.0
Other	3	0.3
Respite care	3	0.3
FAYS	2	0.2
Playgroup	2	0.2

Note: Total number of sources of help with childcare - 961

The qualitative data from the in-depth interviews provided some insights into this low-level use of formal (other than family or friends) childcare services by these families. Of the fourteen mothers involved in the in-depth interviews, five used a form of formal childcare. Mothers who did use formal childcare services identified time out from caring for children, having access to services/providers supportive of parents, and support for children's healthy development as the main benefits. According to Dianne:

...whether I'm looking for work or not childcare gets paid for by the government. I get it for free. My girls go 3 days a week and I get one overnight care per fortnight which is great for when I go out with [current partner] on my own without the kids. It gives the kids a break from me and me a break from them. If I have a really bad day sometimes I can actually ring up...put the kids with them at short notice. Family day care is fantastic. ... I might hang around

for five minutes and tell [the care provider] a bit of stuff that's happening at home or this and that about the kids...

For others, childcare which was easy to access, flexible, affordable, and acceptable to both child(ren) and mother was difficult to find. Some mothers and service providers identified the lack of availability of occasional childcare for pre-school age children as a significant gap and barrier to access to service support. One service provider described local women as not feeling safe leaving their child all day in someone else's care but at the same time needing access to care "just for respite, you know, half a day or two half days a week". Sue, the mother in this same interview, agreed that occasional care would best suit the needs of local women:

...they don't want to book them in [to a childcare place] because once you start booking them in you've got to, to keep that place, you've got to keep booking them. I mean you don't want that sort of thing...when I had the two boys I used to think I haven't got nowhere to leave them. I know I could leave them at mum's but mum wasn't in a situation where she wanted to look after kids, you know. So it was day in day out with the kids, you know, morning and night sort of thing...

For some mothers their high level of housing mobility (characteristic of the research population as a whole) affected their use of childcare services.

Within the context of the strong social belief that 'it's a mother's responsibility to care for her own children' described in Chapter Five, the use of out-of-home childcare services can represent an abandonment of this responsibility. Emma, a mother of five children, demonstrated this normative belief:

Pretty much my main support is my mum; she's probably the only person who looks after my children for me. ... I've got a lot of friends but I don't really like asking them...I just don't think it's their burden to look after my kids. I suppose that's the way a lot of people feel. I don't want someone else to look after my kids 'cos then I feel like a bad mother. ... it's [childcare] a private thing, private to family.

Kirsty, mother of a baby and a two year old, who participated in a support service for 'at risk' mothers and young children which had both women's support and childcare components, talked about the undermining effects of her own mother's negative attitudes to childcare services:

...the idea I had from Mum was that childcare is not acceptable... [Mum] thought I was trying to dump [toddler], like he's a difficult child. ... I used to leave him at Gran's for a couple of hours a couple of times a week... Mum just said to me, you shouldn't be leaving him with Gran.when I said I was going to take him around to the childcare centre he's in now, it was like I had to have a job, you have to have a reason to put him in there, you need a reason...not just dump them on a childcare centre.

6.1.2 Bonding social capital

The extent of reliance on close others for support revealed by the data presented so far is characteristic of the network relations of the poor (see Chapter Two). As social relationships and networks exist within social, economic and environmental contexts, not all caregivers had access to support when needed and not all support was associated with positive outcomes. There is broad agreement in the literature that 'bonding' or 'embedded' social capital has a downside which includes isolation and

exclusion. From a life course perspective, pregnancy and caring for infants and young children are critical stages in which people with fewer social connections are even more vulnerable.

This evidence of reliance on a very narrow base of support appears to contradict the notion of generalised reciprocity which underpins Putnam's notion of social capital and, in particular, the perception that in communities with a high level of unemployment people rely on reciprocal exchange (Portes and Landolt 1996; Gittell, Ortega-Bustamante et al. 2000; Mcclenaghan 2000; Williams and Windebank 2000).

This evidence also reflects 'life-stage' and the gendered nature of social support and may indicate that idealised notions of extended family and close community support for family life ('it takes a village to raise a child', or the rhetoric of 'strong families, strong communities') were far from realised in this research population.

6.1.3 The value of supportive relationships

The proposal that friendships and social networks are particularly important to women (Weber 2004) was confirmed by the accounts provided in the in-depth interviews. Experiences of feeling supported and trusted, being listened to, not judged or blamed, knowing that others are experiencing the same struggles, as well as access to material resources (including practical help) were fundamental to coping, to their sense of self-worth and to overcoming social isolation.

The ideal of dependable family support was reflected in one community midwife's admiration for the way Margie, a solo mother, was able to provide a stable home environment for her six young children. She attributed Margie's success to:

Good family, a mum she can rely on. Her mum came round after the birth, took all her washing away, did it and brought it all back for her. It's such a valuable thing to know that they're there and they'll do that for you, that you can call on them (Pat).

However, having a partner and family didn't always translate into support as illustrated by Mina:

My partner didn't have any family and friends and I was the same. We weren't close to anyone; we were just close to each other no-one else sort of thing. They [family] were around but at the end of the day, if we had a problem we couldn't go to them. So lack of support in every way. ...it was hard because of the fact that I had a partner but he wasn't there 'cos he was working constantly...his body was there but he wasn't exactly there for us.

For Sheila, a mother of a four year old who had been abused by her former partner, the views of family and friends had the effect of increasing 'self-doubt':

...friends, family and stuff like that say well he shouldn't behave like that ... and then you start looking at him and you start thinking, well yeah he is being really naughty but how will I change that? ...you start thinking have I done something wrong? ...I think my main problem is that I listen to too many people and their opinions of the fact that [son] is being naughty...I'm taking that criticism on board.

For some women, the intensive demands of providing full-time care particularly for babies and young children contributed to their social isolation – they had no-one to talk to and no-one listening. Even with a house full of people, mothers could feel left

alone to cope with young children and provide support and care for other adults (partners, siblings, parents and so on). Quite clearly there is an important role for services in filling the void created by the lack of supportive relationships, particularly in some new mothers' lives. According to another community midwife:

Many young women don't have that [supportive friendship], they're so alone. It would be good if we could provide someone for them who could offer that sort of support. Sometimes all it needs is friendship. I look after women that I'm sure the only thing I can give to them is to be friends with them for a short period of time. I find that very frustrating (Debbie)

Whilst some women reported valuing the support they received from their mothers, they needed more than practical help. Kirsty recalled her birthing experience, postnatal depression and having no access to post-discharge support:

The only help I had really was from my mother just helping me with the housework and stuff like, but there was no help really for me. Just to help me, just to cope with having a baby, just emotionally and physically, yeah mentally, and that sort of thing. ... Just having someone you can say what you, it might be just a stupid thought, only thoughts, just to speak them. It just gets rid of them and you don't sit there and, it's just that I haven't had anyone to be able to talk to.

Unequal power and responsibility relationships and the dynamics of social exclusion fundamentally shape women's experiences of social support. The responsibility that women/mothers feel for the care of children and others, which requires them to put the needs of others ahead of their own and implies personal failure or dependence if help

is needed, can further reduce some mothers' already limited access to support. The accounts of these mothers and service providers stressed the social relations and dynamics of social support. From this perspective, the relationships and practices of service provision are of critical interest.

A strong theme in the in-depth interviews with mothers and service providers was the emphasis they placed on the value of talking and listening to other women / mothers. It helped to share experiences and ask others - "What would you do in this situation?" Knowing that there were others with similar problems they reported feeling less alone with the problem. Some mothers nominated talking to friends and family as their most valued resource for coping with the everyday demands of parenting young children:

When you talk to your friends or your family they can give you ideas. They know what you're talking about because they've done it or been through it or whatever. Knowing that everyone's sort of the same. You think this is just happening to me but they're like, no that's what my kids are like too or whatever...(Margie)

The experience of reciprocal friendship can provide practical and emotional / psychological support. The benefits mothers reported of friendship and participation in community groups included feeling more visible, appreciated and less to blame - "If the same thing is happening for them it can't be just me, just my fault". The detrimental effects on their health and well-being of not being listened to or believed and of feeling judged and blamed confirmed other evidence (for example: Morris 1999; Bagshaw, Chung et al. 2000; Taft 2003).

Feeling heard and developing critical understandings of their life situations can contribute to positive identity formation (“*I’m an OK person*”, “*...not just a mother, daughter, sister...*”) and collectivity. According to Sarah, a women’s health counsellor:

...there are commonalities that [women] join together to talk about. I think that kind of creates a really important sense of community. It doesn’t matter what the commonality is...it’s that opportunity to come together to talk about issues that have a common thread. That joins people together and allows more freedom to talk about things they have as a common interest. ...it’s also the acknowledgement of other people in understanding what it is you’re talking about which creates the sense of commonality. So it’s the speaking, the hearing, the understanding that’s really important.

These processes of empowerment will be returned to in Chapters Seven and Eight.

In this section, both the intrinsic (for example: sense of belonging; recognition and worth; identity formation; development of values and aspirations; emotional strength) and extrinsic (for example: child minding; information; transport; financial help) potential of close ties have been explored. The complexities of reliance on family and close others as sources of help/support with parenting which have so far been revealed, suggest that the notion of informal support networks being effective because they offer “flexible, appropriate and non-stigmatised” forms of support (Healy and Darlington 1999) may be simplistic.

It is clear that both the quantity and quality of support available to parents can change in different contexts and at different times. The helpfulness (quality) of support may

be compromised by family conflict and in particular, intimate partner violence/abuse. The isolating and sometimes traumatising effects of inequalities commonly meant family relationships and friendships were disrupted and/or conflictual so that many mothers could not rely on support from family and close others. A parenting support worker observed:

...when a huge amount of crisis comes up and it happens to a lot of us, normal supports or friendships or family relationships that might be there, they don't, people don't in general cope. People get a bit scared and they move away. You can lose people (Julie).

In the following section the focus shifts from 'close others' to the provision of services.

6.2 *Patterns of service use*

There is evidence that the availability of services and amenities in an area impacts directly on health and well-being both through the direct provision of services and indirectly through their role in facilitating connections, social interactions and participation (see Chapter Two). The accounts of mothers and service providers in the in-depth interviews provided evidence to support the role and the potential of service relationships to challenge or contribute to the reproduction of social health inequalities.

When asked to describe her main sources of support for managing life with few resources and five children, Lesley included tenancy support and other local service providers:

...I don't have any major other supports as such but...I've got family. I'm not very close to my mum, my dad's passed away, ummm other than like [tenancy

support worker] or the support down there [Anglicare] I don't have any major support but I've got like a friend of 21 years, I've got a boyfriend, I've got a brother, so I'm not by myself without no support but any major support, no...

A theme in the mothers' accounts was the positive value of having access to *ongoing* support (whether provided by close others or formal services) with the everyday, ever-changing situations and demands of caregiving. Debbie, the community midwife quoted earlier on the value to mothers of supportive friendship, pointed to the limited supply of the sort of support 'struggling' families need:

...some families that I see struggle with mothering or struggle with the basic care of their children perhaps emotionally more than physically... It's an ongoing thing, its not just a month after the baby is born... I get frustrated at times because I need to discharge the family ... you feel quite anxious about the child in that situation. They're not being abused but they [the parents] need some support in how to go about parenting and bringing up the child. ...there isn't any support or organisation out there that can offer that to families. It's probably a big ask I know. ...there's a big gap from when we discharge the baby and often it's not until the child reaches kindy or preschool that there's any other support there available to that family...

In the first *Families at Risk* survey interview, respondents were asked to recall their use in the previous 12 months of formal services for help/support with their concerns about their children's health and well-being. This data provided a picture of instances of service use in response to problems or concerns but did not indicate how many

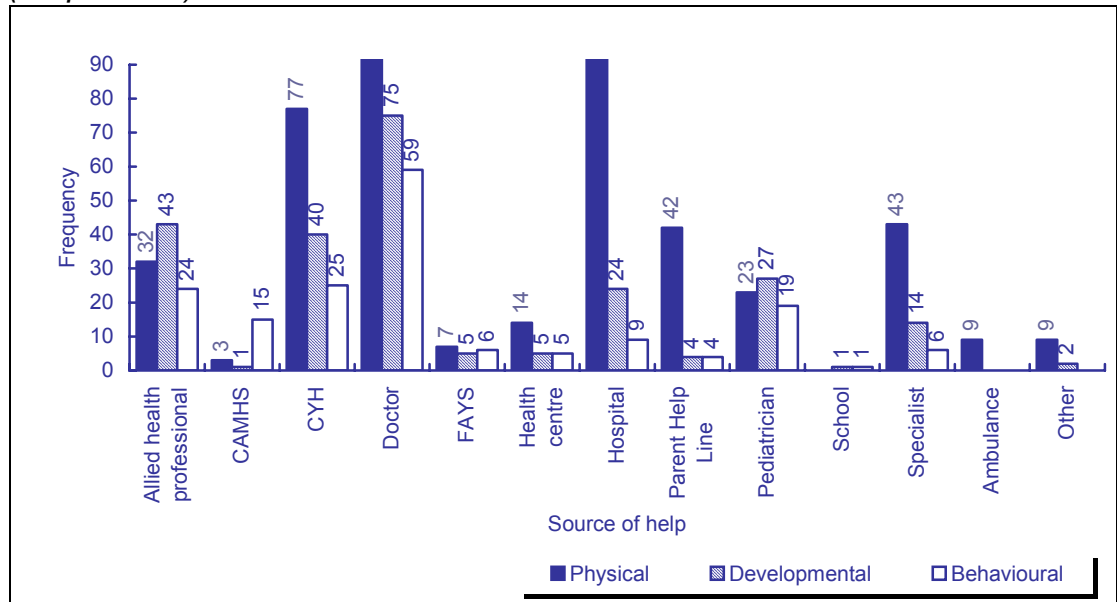
parents had access to the ongoing support outlined above and which was highlighted so clearly in mothers' and service providers' accounts as an important need. In addition, the following data relates only to services used in relation to children's health (broadly defined) and gives no information about service use related to caregivers' own physical and emotional health or other fundamental supports such as: housing, education, and employment.

In the sub-sections which follow three aspects of caregivers' access to formal sources of support with their concerns about their children will be examined - reported levels of use of health/human service agencies and providers; patterns of help-seeking; and barriers to service access.

6.2.1 Formal sources of help with child problems or concerns

Respondents reported that *general medical practitioners* were their most used formal source of help for all concerns regarding their children's health and well-being. As shown in Figure 4 below, in the 12 months prior to the survey interview, 462 caregivers had sought help from GPs for their children's physical health problems, 75 for developmental concerns and 59 for their children's behavioural/emotional problems. While it was not possible on the basis of this data to draw conclusions about whether this constituted 'high' or 'low' use of GPs, there is other evidence that socioeconomic disadvantage is associated with comparatively greater use of GP and hospital services (Centre for South Australian Economic Studies 1993; Glover, Shand et al. 1996; Turrell, Oldenburg et al. 1999; Government of South Australia 2003).

Figure 4: Caregivers' use of formal sources of help with physical, developmental, and behavioural/emotional problems /concerns about children (frequencies)



This pattern of reliance on GPs draws attention to the critical role of general practitioners as first point of contact in the lives of families with young children and to a range of issues related to people's access to doctors, including: the almost complete disappearance of GP practices which bulk-bill; the relative under-supply of GPs in some of the most disadvantaged geographic areas; and other issues related to parents' and children's health and well-being such as the role of GPs in child protection and domestic violence/abuse (Glover, Shand et al. 1996).

Some of the important and complex social relations involved in GP responses to child abuse were illustrated by the experience of Sheila, a mother whose young child had been physically abused by her defacto:

My main problem is that I blame myself, as much as what everyone can say 'don't blame yourself, it's not your fault', when you put your child in a house and you leave that house trusting that person ... and you take that child to

medical people to ask their opinion ... And two medical practitioners tell you there's nothing wrong with your child, your child may have a medical, like a blood problem, something like that. And then after your child has been so sick, taking them to the [children's hospital] and them telling you that your child's been abused. ... That is very hard to handle because you trust medical practitioners ... you trust them with your child's life and because each day after I took my child to a doctor ... I took him home to that person.

There are numerous implications for services which arise from Sheila's account of her experiences; in particular, the ways in which services can support and enable rather than re-traumatise, re-victimise, stigmatise or collude (often unwittingly) with the perpetrator and undermine (albeit unintentionally) mothers in their efforts to do the best for their children⁷¹. An exploration of evidence from the in-depth interviews related to effective service responses will be the focus of Chapters Seven and Eight.

Returning to the data presented in Figure 4 above, after GPs the second most frequently used service for 'physical' health concerns was *hospitals* (238), followed by Child and Youth Health (CYH) nurses (77), medical specialists (66), the Parent Help Line⁷² (42), allied health professionals (32) and community health centres (14). For 'developmental' concerns, after GPs, the second most used services were allied health professionals (43), followed by medical specialists (41), CYH nurses (40), and hospitals (24).

⁷¹ For many other references related to improving service responses see the Australian Domestic & Family Violence Clearinghouse. <http://www.austdvclearinghouse.unsw.edu.au>

⁷² Over the telephone advice to caregivers provided by the Department of Health, Child and Youth Health Service.

For ‘behavioural’ concerns, after GPs, CYH nurses and medical specialists were the second most used services (25 each), followed by allied health professionals (24), and the Department of Health’s specialist Child and Adolescent Mental Health Service (CAMHS) (15).

The pivotal role of general medical practitioners in supporting caregivers’ concerns and children’s health and well-being stands out from this data. This finding endorses primary health care and health reform policy recommendations for the development of strong local service networks which include GPs and multi-disciplinary approaches to service delivery (see Chapter Three).

6.2.2 Some observations about help-seeking

Statistical analysis of the survey data revealed associations between:

- higher formal service use and higher use of both informal and community level sources of support.
- respondent’s age and use of all three levels of help and support. The older respondents were the less they sought instrumental aid and parenting advice from informal sources. No relationship between age and use of others for emotional support emerged. Teenage mothers were higher service users for physical health concerns (sickness and injury), but lower users for developmental, emotional/ behavioural problems or concerns.
- higher formal service use and higher number of concerns about children’s health and well-being.

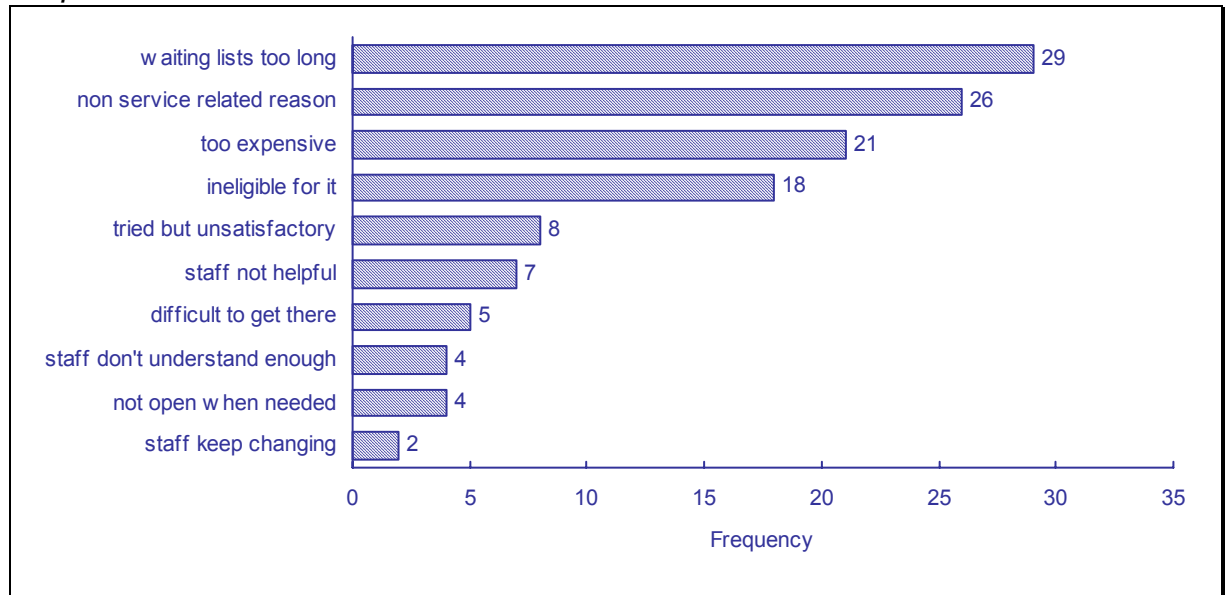
An initial hypothesis of the *Families at Risk* project was that there would be an inverse relationship between use of formal and informal sources of support. Parents

with strong connections to family and community would be shown to need or make use of fewer services; and parents who made higher use of services did so because they lacked family or community support. However, the findings appeared to contradict these ideas, indicating instead that higher formal service use was very strongly linked with higher use of close other and community sources of support. Parents who were high 'help-users' sought help and support from all levels, giving weight to the suggestion that help-seeking may be an individual attitude or capability (Keller and McDade 2000; Young 2004). Understood within the context of considerable barriers to accessing helpful help, it is likely that 'help-seeking' can be learned and actively supported.

6.3 Barriers to accessing services

Another of the *Families at Risk* project's initial hypotheses was that families not accessing formal services were prevented from doing so by actual or perceived barriers to access. This was largely confirmed by evidence from the large scale survey and the in-depth interviews. In the second survey interview respondents were asked - *Are there services that you wanted to use but did not in the last 12 months? For what reasons were you unable to use them?* Their responses are shown in Figure 5 below. Analysis of data from the in-depth interviews generated some similar and some additional themes related to mothers being able to access services when needed.

Figure 5: Reasons for not using services respondents had wanted to use in the past 12 months



In the in-depth interviews, perhaps not surprisingly, more service providers than mothers identified access to services as a major challenge in response to the broad question – *what do you see as the most important challenges for parents of young children?* The challenges related to service access mothers did identify were access to information about what services are ‘out there’, access to practical support with a new baby, access to someone to talk over problems with, access to childcare and affordable/secure housing.

In addition to these, service providers named access to medical services which bulk-bill, financial support for unexpected needs, parenting support services, the need for advocacy and information to facilitate parents’ access to services and issues related to unhelpful services, including ‘systems abuse’ and the effects of parents’ negative perceptions and experiences of some services on their willingness to seek help or use certain services.

The following six themes were drawn from the NUD*IST analysis of text from the in-depth interviews related to ‘barriers to service access’.

6.3.1 Experiencing shame and fear of judgement, often based on previous experiences of judging or unhelpful services.

Some mothers described acknowledging the need for help and then overcoming the shame and finding the courage or taking the risk to ask for it, as the most important ‘first hurdle’. The dynamics of respect and judgement are central to this thesis and are raised again in the next chapter. Most service providers talked about parents needing to be supported to access the services they need. Mothers reported a sense of being overwhelmed and powerless in accessing information about what was available and said they needed help to negotiate their way through service systems. They found it helpful when service providers acted as advocates and accompanied them, especially to appointments with specialists. Both mothers and their service providers highlighted the significance of the first contact with a service provider in clarifying expectations and choices and laying the groundwork for trust. Several mothers recounted negative first contact experiences with services which had them saying “I’ll *never* come here again”.

6.3.2 Information about what services were available

Accessing information about what services were available to mothers of young children should they need them was a concern of many of the mothers and service providers. Some providers referred to their agency’s efforts to find innovative ways to inform the public and share information with other services. Others identified their service(s) as so under-resourced that the last thing they wanted to do was advertise and add to their waiting list or not be able to respond. Some mothers talked about the

helpfulness of their service provider being able to access information about other services for them.

6.3.3 Getting there

For some of the mothers having no transport or having to rely on public transport made access to services difficult. Some mothers experienced home visits as helpful although some service providers noted with caution the possibility of home visiting compounding social isolation. Some mothers and service providers talked about the difficulty for women to find or make time to seek help or participate in community groups, particularly given the time and effort required to care for babies and young children and the stresses of living in poverty with low levels of support. Another barrier to women getting to services raised by some mothers and service providers was the isolating effects of violence and abuse, including lack of control over money and decision-making.

6.3.4 No service / inappropriate service / gaps in services

Despite the best efforts of some mothers and service providers to find a service appropriate to their needs, there sometimes was just no such service available. Sometimes appointments were only available at inconvenient times and the length of time spent waiting (for example, for hospital antenatal appointments) was experienced as frustrating and sometimes unacceptable. Some women reported not feeling comfortable with the service approach - for example, in a group program, or with an individual service provider. For some women, the cost of the service or program could be prohibitive.

6.3.5 Service boundaries and ‘gatekeeping’

Fixed service priorities, tight eligibility rules and requirements worked to exclude many people at the same time as they intended to ensure service support was received by those ‘most in need’. One mother was assessed as ineligible for literacy program support because her estranged partner earned too much, even though her partner refused to pay for the program. Several young mothers didn’t have the references they needed to access the private housing rental market because they hadn’t rented before or rented on their own. After her son was abused one mother was assessed as ineligible for emergency housing because she had a current private rental even though, in order to maintain her custody of her son and protect him from the perpetrator, she was barred from living in it.

Service providers were often able to access information/support from other services (with whom they 'share a language') not easily accessed by mothers. Some mothers had experienced charities and other services wary of getting ‘scammed’ being more helpful when a service provider vouched for their 'deservingness'.

Some service providers echoed the frustration expressed in a recent Anglicare report that many families became eligible for the support and services they needed only when their experiences of the effects of poverty reached a crisis point.

Because you have to portray yourself as being absolutely hopeless, worthless, useless and a failure in order to access services like ours, we actually have an ingraining of that in people’s psyches. So when they are trying to access other services like private rental they use the same strategy and of course it is totally counter productive. ...much earlier intervention, accurate information and

options would have lessened the impact of poverty (Anglicare Australia 2003: 50).

Another theme in both mothers' and service providers' accounts was the tendency for mothers'/women's needs to be invisible and their caregiving efforts/responsibilities to be taken-for-granted and largely unsupported (“...just like a piece of the furniture in children's lives”) especially in service contexts where the primary focus was child support/protection (including: birthing/infancy, child protection, child health). This lack of recognition and the general social undervaluing of motherhood (especially solo mothers) was a barrier to accessing effective support services for themselves and their children and contributed to their social isolation.

6.3.6 Linkages and co-work between services and sectors

When services carefully guard their boundaries (for example by using definitions of 'core work', 'eligible populations' and priority waiting lists) people can be excluded from services they need and service providers can find themselves in a difficult situation as 'the meat in the sandwich' between a mother and another service. According to most of the service providers, limited resources, tight service eligibility criteria, and inconsistent or incompatible ways of working between services had resulted in information not being shared, 'buck-passing' and agencies 'covering their own backsides'.

Service providers concerned to protect developing and sometimes fragile working relationships with other agencies and providers were not willing to have their experiences of this quoted. However, broad descriptions included instances of feeling pressured to support the child protection agency's or provider's view of a mother as

untrustworthy and blame-worthy. Another example was a drawn-out dispute between agencies about who should fund home support with infant care to enable a new mother (a client of a disability agency) and her baby to be discharged from hospital. The answer to the ‘who’s responsible?’ question in this latter dispute was assumed to lie in whether the problem was defined as the mother’s or the baby’s. The ‘problem’ from the perspective of positive health and well-being outcomes for mother and child was of course the need for both mother and child, and their relationship, to be supported.

In this section, examination of patterns of service use has made clear the potential of services to provide necessary support to families at risk and facilitate their access to other resources, connections and opportunities for health and well-being. The evidence presented suggests that help-seeking from formal or informal sources may be an individual capability, an aspect of ‘agency’ but which must be understood within the context of significant barriers to accessing either form of help. Caregivers’ reliance on general medical practitioner and hospital outpatient services highlights practice and service organisation issues; in particular, those related to women’s mental and emotional health, violence and abuse and the extent to which GPs are linked to local community and service networks. The accounts of service providers in the in-depth interviews emphasised the ways in which inadequate resources and the vigorous application of ‘new public management’ tools to contain costs and manage demand (see Chapter Three) seriously affect the potential of services to provide necessary support.

6.4 Social capital and 'community'

So far this chapter has been concentrated on individual access to social support. In this section the focus will be on community-level factors including neighbourhood safety, generalised trust, social cohesion and civic participation, all of which are fundamental to notions of social capital and community. To begin this section, data from the survey interviews will be presented followed by an exploration of the meaning of 'community' informed by the accounts of mothers and service providers in the in-depth interviews. In general terms, these findings confirmed existing evidence that lower levels of trust and communal support are associated with socioeconomic disadvantage and highly mobile populations (Forrest and Kearns 2001; Irwin 2001; Walklate 2001; Ziersch, Baum et al. 2005).

6.4.1 Collective measures of safety, trust and group membership

Questions about perceptions of neighbourhood safety and trust, community group membership, and watching out for children were included in the first *Families at Risk* survey interview. Aggregated measures derived from responses to these questions are shown in Table 10 below. Perceptions of safety were measured on a four-point scale in relation to the question - *To what extent do you feel your neighbourhood is a safe place?* Scores of less than two (somewhat safe) were taken to indicate low to very low levels feelings of safety and scores of three or higher, feelings of being safe. Results indicated a prevailing 'low' sense of safety amongst respondents with no scores in any of the neighbourhoods studied reaching the 'safe' level of 3.0.

Perceptions of safety and levels of trust are inevitably linked. Respondents were asked two questions about trust. The first asked about how many of their neighbours they trusted, and the second, to what extent neighbours could be relied on to 'keep an eye

out for the children'. In relation to the first trust question, scores were clustered around 2 (on a scale of 1–4) indicating perceptions of there being few people in the neighbourhoods to trust. Although there were differences in scores between areas, indicating a range of perceptions about trust and safety, no neighbourhood had average scores indicating respondents felt safe, or experienced high levels of trust in others.

Table 10: Perceptions of Neighbourhood Safety, Trust and Community Group Membership (Mean Scores for Collection Areas)

Metropolitan area	Number of families interviewed	Safety* (N = 500)	Trust* (N = 493)	Community group memberships (N = 500)*	Watch out for children* (N = 473)	No. of adults** (N = 500)
Northern area 1	27	1.7	2.0	1.3	2.0	1.7
Northern area 2	121	1.9	2.2	1.6	2.1	1.7
Northern area 3	47	2.1	2.1	1.6	2.1	1.8
Northern area 4	81	1.9	2.1	1.6	2.2	1.7
Northern area 5	93	2.0	2.1	1.4	2.3	1.9
Inner West area 1	27	1.7	2.2	1.5	2.1	1.5
Inner West area 2	21	1.6	2.1	1.7	2.3	2.0
Coastal West	14	2.4	2.2	1.6	2.3	1.4
Southern area 1	32	2.2	2.7	1.8	2.3	1.7
Southern area 2	23	2.1	2.1	1.5	2.2	1.7
Southern area 2	14	2.1	1.8	1.8	2.4	1.5
Entire sample	500	1.9	2.1	1.6	2.2	1.7

Note. *Questions on Safety, Trust, Community Membership, and Watching out for Children were all measured on a 4-point scale. Higher scores indicate higher ratings.

**Figures on number of adults in house are from demographic data collection, and represent average numbers of adults in the house at the point of data collection in 2002.

On the second 'trust' question - about the extent to which 'people in the neighbourhood keep an eye out for each other's children' – scores ranged between 2.0 and 2.4. Close to two-thirds (62.5%) of respondents chose the categories 'a little' or 'not at all'. While these scores indicated a low level of trust, the relative consistency

between neighbourhoods may indicate a generalised expectation of trust when children are concerned.

The number of community groups to which respondents said they belonged provided an indicator of levels of community engagement. Table 10 reveals low levels of community group membership. A score of 1 on the scale indicated membership in *no* community groups and the mean scores (1.3 – 1.8) showed that respondents ranged between the 'none' and 'very few' categories of community group membership.

6.4.2 Social cohesion

The second survey interview contained a similar question about neighbourhood trust as well as questions about the sense of connection and agreement in the neighbourhood⁷³. For each statement in Table 11 below, respondents were asked to indicate their agreement on a five-point scale ranging from definite agreement to definite disagreement.

Table 11: Neighbourhood Social Cohesion (N = 206)

Scenario question	Score					Item Mean Score
	1 Definitely agree %	2 Agree %	3 Neither agree or disagree %	4 Disagree %	5 Definitely disagree %	
People are willing to help others	18.4	43.7	21.4	11.2	5.3	2.4
This is a close-knit neighbourhood	12.6	21.4	26.1	28.3	11.7	3.0
People in this neighbourhood can be trusted	7.8	16.5	31.1	24.8	19.5	3.3
People here generally <i>don't</i> get along with each other*	6.8	19.4	32.0	34.0	7.8	2.8
People here <i>do not</i> share same values*	14.6	28.6	33.5	20.9	2.4	3.3

Note. *Reverse scored

Nearly two-thirds of respondents perceived people in the neighbourhood as being 'willing to help others'. However, nearly 45% of respondents felt that people in their neighbourhood could not be trusted. Forty percent of respondents perceived their

⁷³ (Sampson, Raudenbush et al. 1997; Sampson, Morenoff et al. 1999)

neighbourhood as *not* being close-knit, compared to 34% for whom it was close-knit. Just over a quarter of respondents agreed that people in their neighbourhood ‘don’t get along with each other’ compared with 42% who perceived they did. Forty-three percent agreed with the statement that people within their neighbourhood did *not* share common values. Less than one quarter of respondents believed values were shared.

Overall the findings demonstrated clumping around the ‘neither agree nor disagree’, the point of non-commitment. This cautious stance was most obvious on the questions about mutual trust, shared values and people getting along with one another. In summary, respondents perceived low levels of trust, shared values and cohesion but believed that people were willing to help others in their neighbourhood if needed. One of the most socially isolated mothers who participated in the in-depth interviews described her ideal of ‘community’ as people helping each other out, but indicated that this generalised willingness might not translate into action, except perhaps in crisis situations.

I don’t have a lot of people who come and say “can you help me?” I’d say “can you help me?” to people in my community if I had to (Lesley).

6.4.3 The meaning of ‘community’

The ideal of building community and family capacity to provide support, reciprocity and inclusion has great rhetorical appeal (see Chapter Two). However, in social and political contexts where social inequalities and the values of competitive individualism are increasingly dominant, the ‘cosiness’ of community (or family) is not matched in reality. The in-depth interviews with mothers and their service

providers provided some ‘thick’ descriptions of the complexity of meaning(s) and outcomes related to ‘community’. Participants were asked directly to explore the meaning and place of community in their lives and, in addition, references to community in their responses to other questions were picked up in the NUD*IST analysis of the interview texts.

In the in-depth interviews ‘community’ was used to refer to both a particular community and to the idea or ideal of community. Particular communities were defined in terms of geography; common values or shared history; kinship; specific shared purposes or practices; and club or group membership. Both mothers and service providers used ‘community’ in terms of local/neighbourhood social connections/networks and amenities (including support agencies) – “only 15 minutes walk down the road”; “the people I know who live around here”; “neighbours interacting and helping each other”; “the people I know” through school, church, children’s sport, TAFE course. In this sense, people generally belonged to a number of different and overlapping communities and to ‘communities within communities’. ‘Community’ was a source of contacts for help and friendship and an antidote to social isolation.

In broad terms, the ideal of community is the view that the greatest good will be achieved by fostering altruism and the development of shared collective values such as reciprocity, shared responsibility, care and civic participation (Giddens 1998; Etzioni, 2000 #30; Etzioni 2000). These ideals resonated with central themes in the mothers’ and service providers’ accounts, including the value of social support and

friendship, feeling connected and cared for, and having people they can trust to look after their children. In the interview which also involved her community midwife, Emma described community as:

...a group of friends or something like the community midwife that you are able to reach out when you need it and help you. I suppose churches are like that because they're like family. You need something that's like a family to be able to develop into a community.

Another mother described the positive sense of belonging she gained from her membership of an 'adults only' discussion group at a local drop-in centre:

[the group] help like in a community way, not with anything specific but you're just talking and listening and you're just being there, you know? Just being friends (Sue).

The value of friendship and the benefits of community-building – spending time together talking and listening and feeling acknowledged, trusted, believed and understood - were raised earlier in this chapter and are raised again here in this context. Ruth, a victim support counsellor, reflected on her experiences of parents getting together to share their experiences of trauma:

...just the power of their stories and their ability to support each other, which is so important, and really understand each other. A counsellor is, can be, valuable but a support group can be stronger in a kind of way.

In the following chapter it will be argued that these collective processes of 'social learning' (Labonte, Polanyi et al. 2005) are fundamental to challenging problem

definitions, transforming power relationships and developing action to redress inequalities.

In communitarian thought, the individual cannot be conceptualised apart from the practices, culture and values of their community. That is, the individual is recognised as a “thinking, feeling, acting person embedded in social relationships and institutions” (Frazer and Lacey 1993). From this viewpoint, communal practices, public provision and social institutions which recognise and develop common and mutually supportive aspects of people’s lives are fundamental to creating a ‘good society’ (Self 2000). The political arrangements which flow from these social values and practices are debated but a common theme is participation in ‘civil society’.

Rather than citizenship conceived in terms of rights or status in which people are self-interested, autonomous bearers of rights (and responsibilities) the notion of citizenship is one of active participation “for the good of the wider community” (Lister 1998).

For some service providers the language and practices of social capital or community capacity building represented a welcome alternative to individualised and isolating notions of responsibility. Some mothers and service providers recounted experiences of working together for the ‘common good’. One mother referred to her experiences of working with others to clean up a local Scout hall:

You work together because if you don’t its not going to be there...it closes down because you’re not looking after it. That’s what I think community is you know, being part of something (Sue).

However, in some versions of communitarian thinking the values of shared responsibility are central to a 'remoralisation' of social life (Deacon and Mann 1999). For Etzioni, the 'new golden rule' is the combination of individual autonomy and the common good (Etzioni 1996).

Communities are social webs of people who know one another as persons and have a moral voice. Communities draw on interpersonal bonds to encourage members to abide by shared values.... Communities gently chastise those who violate shared moral norms and express approbation for those who abide by them (Etzioni 1993).

This conservative and controlling communitarian model has a clear prescription for what constitutes a 'good society'. Voluntary associations and other institutions of civil society are the 'third leg' - the other two being the market and the state - and should be strengthened by the reduction of state provision and the 'return' of a whole range of services and responsibilities to families and local communities. Examples include: 'community care' for mentally ill people, 'community work' for unemployed people, and increasing reliance on voluntary labour and public donation.

That 'community' can be controlling and conservative was another strong theme in mothers' and service providers' accounts. The 'moral consensus' which binds some communities can be heard in one mother's description of how she responded on her doorstep to a loud, angry outburst from the mother of a child she was providing family day care services to at the time:

I said I **live** here, these are my neighbours. I said we don't behave like that, they don't behave like that, and you won't behave like that here (Heather).

Communities can feel unsafe, intrusive and be isolating. For example, a service provider described the people in the local community in which she works as “quite isolated within themselves, they won’t go out and explore” beyond their geographic and social boundaries. In another example, one mother expressed mistrust of others in her geographic community, but wanted her comments to remain anonymous:

...it is such a small community. I don’t want everyone to know my business. Like if we ever get anything new I say to my kids don’t tell anyone you’ve got this because everyone knows where we live. If they wanted to come here they know exactly what you’ve got and everything.

Several women referred to the negative effects of not meeting the expectations of particular communities. For example:

They [the church community] wanted me to be a good wife and married and have three children and one on the way...if I had a problem, [I should] run to the pastor and talk to him... I’m classed as a rebel. I don’t do what the church says...I’m outside the square (Talia).

That was part of what my community was but it wasn’t working, it was a dysfunctional community - people that are selling or using drugs. In parenting it doesn’t go together, not if you want to successfully raise children to not follow down that same path. So my community wasn’t there (Karen).

The value of access to community resources and amenities and of participating in and belonging to communities stands out from the accounts of mothers and their service providers in the in-depth interviews. At the same time, the evidence of generally low

levels of safety, trust, social cohesion and civic participation must be understood within the context of unequal social/power relations and barriers to access to material resources and to membership of communities.

Some people cannot escape their ‘communities within communities’ whilst others can join by the exercise of ‘choice’ at some level. Membership of some communities confers access to resources, including power, to a far greater extent than others (Frazer and Lacey 1993). In versions of communitarianism which advocate that we ought to assume greater responsibility for each other (particularly young and vulnerable people) the critical question is who are ‘we’? In reality it is women who are expected to carry out (largely unpaid) the parenting, emotional and physical care work on which families and communities depend (Young 1997; Levitas 1998).

6.5 *Understanding inequality as social practice*

The intention of Chapters Five and Six was to present a picture of a range of multi-layered and inter-related effects of social/health inequalities and to contribute to this investigation of the explanatory value of different theories concerning the mechanisms or processes which link disadvantage and poorer health and well-being outcomes (introduced in Chapter Two). Improving the health and well-being of families at risk requires both entitlement and access to appropriate material needs and the capability to benefit from them. Both these are shaped by social/power relations. This emphasis on social/power relations supports understandings of health and well-being as being (re)produced by social position and people’s access to resources and opportunities for health and well-being. From this critical perspective, ‘health’ is a resource for daily living which inheres in the daily practices and processes of living. How societal

structures and processes influence health and well-being outcomes for individuals and population groups (such as ‘families at risk’) is of central interest.

Understanding the causes and effects of inequalities as multi-layered and interlinked supports the notion that different causal explanations are interrelated and all have some explanatory value. In broad terms, this argument is that societal factors such as class, gender, legal and social institutions are fundamental (the ‘causes of the causes’) in that they (re)produce social hierarchies which mediate people’s access to resources and opportunities for health and well-being.

Intermediate social and economic factors such as income, occupation, housing, education and social networks have direct impacts on people’s access to these resources and opportunities. At the same time, the effects of these social inequalities change over a person’s life course, are different for different people, and can be different for the same person in different contexts. Individual biology and agency including their help-seeking actions have important mediating effects on the various impacts on individuals and families of social inequality.

The data from the *Families at Risk* survey interviews provided a picture of social disadvantage, high stress, reliance on close others for support, low levels of community engagement, trust and safety. The qualitative data from the in-depth interviews enabled more complex descriptions which showed that important mediators of the impacts of social disadvantage and social exclusion included: individual skills and ‘strength of character’; support, friendship and participation; and access to helpful services. The adverse effects of societal factors including expectations of ‘good

mothering' and 'well behaved children'; family conflict, violence and abuse; social isolation; and barriers to service access were also important mediators. Inseparable from all these were unequal social relations and processes of power: including gender and other social inequalities, social exclusion, respect and recognition, and effective talking and listening.

Following this, societal, individual and community-level 'causes' can be understood as being 'wired' together by the social relations of inequality, the 'electricity' which connects/feeds this 'web' of causation. Rather than a 'hierarchy of causes' approach and a requirement for a 'central causal mechanism' (Young 2004), the dynamics and practices of social inequality can be understood as a connecting or driving mechanism linking material, social support/social capital and psychosocial causes and effects.

This focus on the dynamics of disadvantage/advantage is consistent with developments which have extended poverty research and policy debate by focusing on the dynamics of social exclusion as a process by which health and well-being inequalities are (re)produced. Because social exclusion and injustice inhere not just in distributional inequality but also in social institutions and practices which reproduce exclusion and injustice, simply targeting services to resource poor families with young children will address a symptom not a cause and therefore will not in itself produce more equal outcomes for these families (Young 1997). The processes, for example, which construct gender and social inequality will continually and structurally reproduce inequalities and disadvantage unless they themselves are the subject of critical scrutiny and change (Eveline 1993; Frazer and Lacey 1993; Moore 1993).

CHAPTER 7: DEALING WITH DISADVANTAGE: THE CASE FOR A PARADIGM SHIFT

This thesis has provided a great deal of evidence to support the argument that inequitable social power relations which constitute social hierarchies are the fundamental determinants of health and well-being. These power relations encompass both measurable conditions of powerlessness (for example, inadequate income) and subjective feelings about one's worthiness, competence, value and so on.

In this chapter, conclusions drawn from the accounts of mothers and their service providers who were engaged in 'helpful' service relationships will be used to argue the need for a paradigm shift. The dominant ways in which the problems of mothering young children in situations of disadvantage are defined, and who defines them, tend to (re)produce social health inequalities and unequal power relations in services for mothers and children. Formal and informal social institutions, including dominant discourses of motherhood and childhood and of 'health' and welfare, fundamentally shape these problem definitions and service responses.

The in-depth interviews explored the 'expert' knowledge of mothers and their front line service providers who were engaged in practice examples reflecting to varying extents the early childhood policy consensus outlined in Chapter Three. From analyses of these interview texts, conclusions have been drawn about what kinds of service frameworks and practices can be helpful for women with young children living in contexts of complex disadvantage.

In broad terms, they describe helpful service models as ones which acknowledge the major responsibility women take in their children's lives and recognise the many other

contributing factors to parenting and health and well-being outcomes for women and children. While their descriptions of ‘helpful help’ broadly align with the current policy consensus these experiences were usually exceptions, illustrating the gap between policy and effective implementation discussed in Chapter Three.

In this chapter, themes derived from the women’s experiences and perspectives on helpful service frameworks will be explored in their wider contexts of dominant discourses, public policy and service organisation. The concept of ‘health’ upon which helpful services are built and different constructions of women/mothers and their needs will be examined. In Chapter Eight, specific aspects of the practices of ‘helpful help’ and their impact on social health inequalities will be explored.

7.1 *The early childhood consensus*

The broad consensus that a different paradigm of service support for families with young children is needed was raised in Chapters One and Three. Current service models are seen as: not sustainable; not effective with population groups with the least access to resources and opportunities; and unable to address the complexity of the problem situations of many families. This thesis project will add to growing evidence that current service models are not generally effective in building connections between people (and services) or engaging people and communities in their social health development and, in some instances, contribute to worse inequalities.

There is a broad consensus in the early childhood, family, women’s and public health literature that substantial social investment by governments is required to effectively redress social health inequalities. Further, it is generally agreed that to implement the early childhood policy consensus service responses should:

- be universal and comprehensive;
- intervene early at transition points across the life-course (birth, pre-school, school, adolescence and so on);
- be holistic – that is, respond to the context of barriers and opportunities for health and well-being which operate in people’s lives at individual and population levels;
- tailor interventions to the life situations of individuals/families;
- involve communities, service-seekers and front-line service deliverers in decision-making about policy and services;
- focus on prevention and building social connection;
- focus on women’s health and safety;
- create child and family-friendly communities and workplaces;
- build resources and opportunities in the most disadvantaged localities and populations;
- entail continuous and coordinated commitment in all sectors and at all levels to address the multiple and interwoven challenges for families with young children.

These commitments are widely reflected in the language of current child and family health and well-being policy. However, as previously argued, radical versions of these policy commitments are based on values of entitlement and justice which represent significant challenges to historical and current institutional practices and to the unequal social power relationships upon which they are built. In many ways they contradict the values of governments intent on overcoming ‘dependency’ and achieving a more distant relationship between individuals and the state. Examples of

other progressive social policies (including social inclusion and population health) were raised in Chapter Three which in their implementation have been conservative or have served to worsen inequalities. Without critical ‘problem’ understandings and practices this early childhood consensus is likely to be similarly conservative or ineffective in its implementation.

7.2 Challenging ‘problem’ understandings

Interpretations of problems and needs based on understanding motherhood / parenthood and service policy and delivery as social practices (a concept first introduced in Chapter One) may be able to avoid the unhelpful use of ‘problem’ categories which are distant and irrelevant to people’s lived experiences. Understanding parenthood as social practice frames the complex and dynamic relationship between parents as individual agents and the social structures they inhabit in ways which go beyond fixed categories based on individual characteristics or social categories (for example, ‘at risk mother’). From the viewpoint of social practice, an individual's actions, identity and self-worth are shaped by her/his interdependent relationships with others and with social structures. How people are seen and how they see themselves (their identity) is not unitary or fixed but is relational and changes from one context to another as people act in a variety of ways to creatively manage or survive their situations, including the use they make of services.

According to Williams (1999) the concept of social practice enables services to be understood as systems which themselves carry:

...hierarchies and social relations of power and inequality. How do these interweave with existing patterns of inequality and subordination? What do people themselves make of formal support, how do they reconstitute it, the role

it can / could play in their lives, the costs / benefits to them, and how these meanings transcend or are underpinned by class/race/gender etc. as well as by discourses of welfare (Williams, Popay et al. 1999).

This focus on unequal social power relations differs substantially from that of most health and well-being research (including the large scale survey methodology of the *Families at Risk* project) in which the social context is understood as a descriptive backdrop or in terms of cause and effect relationships. At the same time, analysis of the survey data has allowed comparisons to be made between aggregated individual responses and universalist theories (such as child development, social network and coping theories). In interpreting the in-depth interview texts the main question has been whether or in what ways other evidence and theory could illuminate mothers' and service providers' accounts and vice versa.

7.2.1 Concept of 'health'

Despite broad policy consensus about a 'social' definition of health and well-being (see page 33) and the need for a reorientation of services towards prevention and 'capacity building', funding and practice remain focused on treatment and protection. Yet, confirming other evidence, the mothers' and service providers' accounts described 'health' more in terms of their experiences of context, capacity and connectedness than their experiences of problems or disease (Popay, Bennett et al. 2003; Williams and Popay 2006). Their descriptions included the following:

Physical health Feelings of hope Sense of purpose Social networks – access to resources for emotional and practical support; friendship; a sense of belonging	Feeling safe Feelings of recognition and worth Sense of control and learning Adequate material resources Healthful living environments
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These descriptions accord with social liberal ideals of ‘human capabilities’ and ‘universal human needs’ which understand ‘health’ to include: a sense of relatedness or belonging, feeling competent, capable of independent thought and action, and connection to the broader social institutions (including for example, school, employment, civic life) (Nussbaum 2001; Stanley, Richardson et al. 2005).

The theory-laden nature of approaches to achieving improved health and well-being outcomes for families and children can be illustrated by a simple hypothetical example of two midwives concerned to develop improved midwifery services. One sees the task and her clients in terms of birthing outcomes (for example, ‘normal’ delivery, baby’s birth-weight, Apgar scores), the other in terms of the mother’s birthing choices and lived experiences. The first is driven by professional and system concerns (although producing a healthy, live baby is also a concern for mothers) and in the latter, the midwifery service is just one entry point into the more complex lives of women, which include their experiences of support, poverty, gendered violence and so on.

In Table 12 below, Labonte’s (1992) typology of approaches to improving health has been applied to the health and well-being of families with young children. These different models entail different problem definitions, different formulations of what

success looks like and require different epistemologies and methodologies for determining effectiveness.

Table 12: Different approaches to improving the health and well-being of families with young children Developed from (Labonte 1992)

	Bio-medical	Behavioural	Social/societal determinants
‘problem’ definition	Disease categories and physiological risk factors	Behavioural risk factors	Psychosocial, socio-economic and environmental risk conditions
examples of problem focus	Childhood diseases Low birth weight Immunization Health screening	Poor parenting skills Poor stress coping Smoking during pregnancy	Poverty Isolation Gendered violence Unsafe, impoverished environments
level of intervention	Disease intervention Tertiary prevention (preventing illness)	Secondary prevention (improving health behaviours) Primary prevention (creating healthy ways of living)	Primary prevention (creating healthy ways of living) Health promotion (creating healthful living conditions)
program development	Professionally managed	Community-based approach ⁷⁴	Community development/empowerment approach ⁷⁵
examples of criteria for success	Decreased morbidity and mortality Decrease in prevalence of physiological risk factors	Behaviour change Intervention earlier in the life-course Healthy public policy related to health behaviours (eg. smoking bans, food labelling)	Personal empowerment Increased social connection Group or community action to achieve more equitable social distribution of resources and opportunities for health

In practice the boundaries between these ideal types often overlap and different approaches are combined or implemented at the same time. Only the last column reflects the research findings and, in particular, the experiences and understandings of mothers’ and providers’ drawn from the in-depth interviews. All three approaches can contribute to better health and well-being outcomes but there is evidence to show that

⁷⁴ Community-based’ programming refers to the process in which service providers or agencies define the problem, develop strategies to address the problem, involve community members and groups in their implementation with the goal of eventually transferring responsibility for on-going program and health improvement to community members and groups (Labonte 1992). This description fits the currently popular (in human services policies and systems) process of ‘capacity-building’.

⁷⁵ ‘Community development’ programming refers to the process by which individuals and community groups are supported to identify their concerns, issues and aspirations and to plan and implement strategies to act on them (Labonte 1992).

individual characteristics and risk behaviours explain only modest variance in the incidence of numerous problems and diseases. Without changes in the conditions which produce or support poor health experiences and persistent social health inequalities, sustained improvements in individual and population health will not occur.

Critique of risk factor approaches

The research findings support the critique of downstream, behaviourally-oriented approaches to improving health and well-being in which it is argued that an emphasis upon individuals and risk behaviours to the exclusion of societal determinants is problematic.

Most epidemiological studies contain clues, if not evidence, of the effect of broader-level factors impacting on health where interventions could be aimed...

Yet changing the errant behaviour of individuals remains a favourite.... Many settings-based interventions [for example, in neighbourhoods, workplaces and schools] are in effect individual-based approaches in another guise, using a particular setting to deliver messages on individual behaviour change...(Shaw 2002).

As nurse home visiting programs, the dominant implementation model for early childhood policy, can be understood as another 'settings-based intervention' specific aspects of this critique are worth noting here.

- most of the risk factors for 'childhood vulnerability' have relatively 'weak' effects when considered in isolation, but the interplay between them can have powerful cumulative effects (Rose 1992; Silburn 2003).

- there is increasing evidence that risk reduction strategies focused on behavioural change have limited effectiveness with disadvantaged groups (Gillies 1998; Raphael and Bryant 2002; Raphael 2003).
- a focus on ‘lifestyles’ can foster ‘victim blaming’; assumes that individuals are responsible for and can control their ‘health choices’ and ignores the structural determinants of health which shape and constrain people’s choices (Campbell and Gillies 2001; Raphael and Bryant 2002; Labonte, Polanyi et al. 2005).
- standardised ‘risk’ variables and broad categories hide difference and make invisible the complex interplay and the blurred nature of boundaries between categories (Jupp and Norris 1993; Oakley 1999). In focusing on individual characteristics and behaviours only one part of people’s experience is abstracted as the focus for attention, usually in both a static and atemporal fashion (Maynard 1994).
- by targeting the poor, those ‘at risk’ or with the poorest outcomes, programs work to ‘fill a gap’ and leave untouched the core social processes which systematically generate inequities between children growing up in advantaged and disadvantaged environments (Vega and Irwin 2004; Graham and Kelly 2005; Spencer and Alperstein 2005).

It has been argued in this thesis that when policy and services focus on downstream behavioural approaches and neglect alternative visions of societal health determinants and pro-equity public policy, efforts to promote population health approaches are undermined.

A paradigm shift is required so that a social determinants approach is predominant. The dominance of bio-medical and behavioural paradigms is sustained by social power relations in which expert professional knowledge is required to assess problems and develop responses. From this perspective, social determinants whilst their significance may be acknowledged appear outside the role of health services. A social determinants approach to improving health provides a framework for understanding what there is to be changed and what the contribution of services could be.

7.2.2 Motherhood as social practice

The concept of social practice provides a different viewpoint from the dominant one in which motherhood is seen as an ‘individual identity’ within which women carry certain risk factors (Sevenhuijsen 1998). Within this identity framework, strengths and problems are most often seen as personal and the responsibility of the individual. That a person is experiencing problems can be seen as a negative reflection on their character and worth, so that ‘the person’ and ‘the problem’ come to be seen as one and the same (White 2000). From the perspective of social practice, poorer outcomes are recognised as being linked to unequal social power relations and the effects of inequalities in access to resources.

Social practices are not located in a single sphere but work at a number of levels – that is, motherhood cannot be reduced to patterns of care within the family. Furthermore, motherhood is not just one, unified social practice but a series of changing social practices expressed in various settings including: cultural representations of motherhood and fatherhood, expert standards of childrearing, medical practices and technologies, legal frameworks, family support structures and services and, “last but

not least the way in which care is valued as an aspect of the human condition (Sevenhuijsen 1998)". Within these practices women develop a sense of who they are and how they belong and find ways of giving shape to their relationships with their children and with others. Within the complex and adverse landscapes they inhabit and within everyday situations, the difficulties women face, the possibilities open to them and the ways they act to manage their situations are constantly changing (Williams 2003).

Discourses of mothering

Feminist scholarship has revealed the historical and cultural contexts and has demonstrated that every facet of motherhood is socially constructed or mediated (Flax 1990; McMahon 1995; Smart 1996; Hrdy 2000; Johnston and Swanson 2003). Ideologies of mothering prescribe how 'good' mothering should take place, and are currently based on ideas of "intensive mothering", the expectation that mothers will "expend a tremendous amount of time, energy, and money in raising their children (Hays 1996: x)". While it is expected that mothers' time and energy will be used in intensive mothering, their expertise is less valued. Good mothering is believed to unfold from heeding the 'scientific' advice of experts. Yet Hays provides numerous examples of the ways in which each wave of expert advice can contradict the 'scientifically-based' advice of the previous decade (ibid).

As expectations of 'good' mothering increased over the second half of last century, the 'decline' of communities and extended families brought about a corresponding shrinkage of the sphere of who bears responsibility for care and development of children (Gordon 1990). McMahon points out that, through the almost exclusive

attachment of mothers to children, the mother/child relationship became scrutinised by professionals, so that women were increasingly “regulated through discourses of precious children and proper motherhood (McMahon 1995)”. Feminist scholars have argued that, because there are class and race biases in dominant motherhood ideologies, there are many mothers who categorically fail to qualify as ‘good mothers’ including teenage mothers, solo mothers and Indigenous mothers (Glenn 1994; Silva 1996; Johnston and Swanson 2003).

The development of mothering ideologies and scrutiny of mothering have been accompanied by theories such as Bowlby’s attachment theory, which is key to ‘common-sense’ views of mothering, and usually an underlying theory in nurse home visiting programs (Olds, Henderson et al. 1999). Described by Birns as “an inoculation model of parenting [whereby] love (i.e. early attachment), like inoculations against measles, provides lasting protection (Birns 1999)” it has the effect of holding mothers responsible for all the problems of their children. At the same time it minimises the effects of poverty, inadequate access to services, lack of community support, and male violence on children, and on mothers’ capacity to provide care as they would wish. In addition, the “maternal bliss myth – that motherhood is the joyful fruition of every woman’s aspirations” in practice attributes any maternal unhappiness to failure of the mother (Johnston and Swanson 2003).

As ideologies and standards of ‘good’ mothering shape service models and professional practice as well as ‘common-sense’ views, they are also internalised by women. They manifest themselves on the one hand as women’s commitment and

intentions to do the best for their children and on the other as its shadow form, self-blame (O'Grady 2005). Sennett explains the adverse effects of 'standards' - when we take up the invitation to compare ourselves unfavourably with others we lose self-respect (Sennett 2003). What is expected of 'good mothers' is most often defined from perspectives which are quite distant from the everyday experiences of mothers. The variety of ways all women manage the ever-changing and everyday situations of parenting and the issues they engage with are often invisible or inadequately portrayed in these imposed definitions of 'good' mothers and mothering.

The loud and constant presence in women's lives of what is expected of a 'good mother' and the 'right' and 'wrong' things to do stood out from the text analysis of the mother/service provider research conversations - "you should spend 'quality time' with your children"; "you should look after your own children, not give them to others to look after"; "you're too young to have so many children"; "your children should be quiet and well behaved" particularly in shopping centres; and "you should control your children or they'll control you"; were messages recounted over and over again. At the same time, all the service providers and mothers shared an understanding that the expectations and practices of motherhood are created and shaped by social and economic contexts, cultural expectations and the ways things are talked about.

Scrutiny and judgement

Karen, a mother of two toddlers, recounted some of her experiences of the effects (both enabling and disabling) of judgement and the stigma associated with single parenting:

We were sitting on the bus and this lady commented that the way I spoke to my son, she liked it, and she wished that she'd see more of it. That made me feel good as a parent, it was like, wow, I must be doing something right 'cos it's so hard to please older people.

... all that stigma about single parenting ... that's been very unhelpful for me. People automatically presume that I had children just to continue being on welfare ... your child is somehow going to, you know, turn out bad 'cos, you know, you can't possibly discipline them properly if there's just you. ...I know that they do need male figures ... I can agree with some of that but I've seen some good single parents out there...you know their children have grown up to be successful. Sometimes you don't choose to be in that situation. I mean, in my opinion it's better for you to be single than put up with an abusive man who's going to cause all other problems for your kids ...It just shits me that not everyone can think like that, that they have to think the negative.

In this account, as well as resisting dominant conceptions of solo mothers, Karen appeared to accept at least some of their prescriptions - for example, that boys need male role models. That dominant ideas of good mothering are not just imposed by experts but are held by women themselves was illustrated by Sue, a mother of three children. In contrast to her experiences with other mothers, she did not feel subject to scrutiny by her service provider:

...[the service provider] doesn't judge, she doesn't judge your children the way they are. I mean she listens but she doesn't judge them or say "well you've got a naughty child" like some mothers would. Mothers would do that, they do that. They say "can't you control them?" or "can't you do this or that?"

In the in-depth interviews, mothers provided many examples of the ways in which their sense of responsibility “for everything” had resulted in feelings of guilt, self-blame, self-doubt and loss of hope when problems arise. In addition, they described the effects of feeling judged as an unfit or incapable mother, of feeling powerless and not believed by people in/with authority, and of physical, emotional and verbal abuse as significant barriers to realising their aspirations for their own lives and for the care of their children. In one interview, a mother described her experience of judgement and scrutiny during a child protection investigation and the helpful effects of feeling believed by Lisa, her child health nurse:

I was being judged as an unfit mother, that I didn't now how to look after my kids and everything else. I think the only one that does believe me on the situations that have happened for the kids...is [Lisa]...It's good to know that I've got someone there who at least believes me that I would not in any way endanger my kids...makes me feel better within myself, makes me believe that yes, I am a really good mother. I'm the best mum I could be for my kids (Leanne).

Expectations of 'responsible' mothers

Whilst the views of all the service provider participants reflected the policy consensus that a broad range of factors influence parents' and children's lives, this is most often outweighed in practice by the notion of individual responsibility (Parton 1997). Even being aware of violence or inadequate housing, service providers can still expect women to take actions based on their sole responsibility for children and on the opposite notion that they are 'free' agents who can make decisions as though they are

independent of dependent children and disabling circumstances. Not making the 'right' choices in the 'best interests' of their children is deemed the mother's failure and taken as evidence of her personal deficit. Thus, in practice, the limiting effects of violence and abuse, poverty and other constraints on mothers' capacity to respond to service providers' demands may not be recognised.

When disabling circumstances including the violence of others towards children are redefined as a mother's failure to protect her child(ren) the system provides narrow and often poorly co-ordinated responses which leave mothers, often the least resourced individuals, responsible for overcoming the devastating experiences of poverty, domestic violence and child abuse (Thorpe 1996; Edleson 1998; Morris 1999; Scourfield 2003; O'Neil 2004). When services expect women to take all the responsibility for children, including responsibility for circumstances over which they have little control, the responsibility which these services should rightfully be assuming is displaced (Morris 2003).

In the in-depth interviews, one mother recounted the effects of being required by the child protection agency to relinquish her home and take sole responsibility for her child's care after it was discovered that her partner had abused her child:

They [services] expect you to do everything. It's your responsibility. People [services] you think will be there to help you because they say they'll help you, don't. It's very very hard and knowing that the person who's done it is walking around scot free...still able to work, still able to live his life... Whereas I lost everything. I lost my home. I lost my life. I lost my work. I lost being able to trust (Sheila).

Supporting capabilities

Services which are focused on the ways mothers resist, cope with or overcome the effects of social inequalities may lend support to their efforts and lead to interventions which challenge established social orders and taken-for-granted practices. The service providers who participated in the research conversations shared the belief that families with young children need and should be entitled to material, practical and emotional support, care and advocacy.

Most families at some time or other need support in their life. Some families will need support all the way through until their children are able to care for themselves. I don't think that's acknowledged (Jill, parenting support worker).

Along with the notion that needing support is 'normal' rather than 'needy', the service providers shared an attitude of respect and recognition for the hard work of mothering and a position of belief in the capabilities of their clients. Some providers described this position of belief and respect as the basis of their practice. For example, in community midwifery:

...our care is meant to be at least in partnership with the woman if not woman led, led by what she wants and what she thinks is important because there are many different ways to do birth and many different things that women want around birth and everyone is an individual. ...its part of being a midwife that you take your direction from the woman (Pat).

I believe women make great choices about their babies, know their bodies and are able to birth their babies. If there's a problem there, things aren't going as they should, if you tell the woman explain it to her, she'll make the decision

what is needed. They won't do anything that would harm the baby, basically (Debbie).

At the same time, most service providers emphasised the many constraints against women living their lives as they themselves might choose, including the unequal power relations between women and men, the inequitable distribution of parenting responsibilities and family support carried by women and the expectation that women's needs will always come last (after children, men and family). In this context, the service provider 'is there' for the woman and the woman feels 'special' and 'believed'. The focus of service relationships is the woman - her life situation, her goals and in particular, the ways she has fought against or survived the negative effects of various influences in her life (Epston and White 1990; White 1995).

Most of the service providers talked about being inspired by women's strengths and acknowledged the contribution of their own experiences as women and as mothers to their work. A childcare worker in an 'at risk' young mothers support program, recognised her own story repeated in many of the young mothers' lives -

...I feel like I've walked a mile in the women's shoes. I believe their stories and I know what they're saying is right. I really respect and acknowledge the huge input that they've had with their children before they even come here. I want to be supporting of that. I don't want to judge them. So the very first family that came here, that mother is now going off to Uni and I feel a real sense of pride from what she was when she came in and now... and I think WOW (Wendy)!"

This recognition of the responsibility and commitment of mothers as central to the well-being of children and families leads services to flexibly respond and collaborate with the woman to support where she is in her life and how she wants things to be.

7.2.3 Constructions of ‘responsibility’ and ‘dependence’

In dominant service models ‘responsibility’, when used in relation to mothers, generally refers to the perceived failure of some mothers to satisfactorily support and protect their children and to meet their expected obligations. Responsibility is not usually spoken of in positive recognition of mothers’ commitment and contribution to their families and communities, nor is it used to recognise their ‘response – ability’ or coexistence (with children) as individuals in their own right. It was clear from mothers’ and service providers’ accounts that the intense focus on the mother-child relationship within dominant constructions of ‘good’ motherhood could contribute to ‘mother blame’ and/or to inappropriate attributions of responsibility.

Most commonly service systems are built around either a child or a family to intervene when things go wrong and mothers are almost always the focus of interventions as the cornerstone of problems manifest in her children. Women are held to standards which are different for men/fathers. In isolation from addressing fundamental social and structural issues, the inevitable result will be poorer outcomes. “Social issues cannot be solved one case at a time (O’Neil *ibid*: 45)”.

The ways in which service support can become yet another disabling influence, undermining women’s capacity to care adequately for their children was clear from the mothers’ accounts in the in-depth interviews. ‘Support’ can be (albeit unintentionally) debilitating and even dangerous in situations where women and/or

children are being subjected to violence and abuse. By focusing on the woman's deficits and primary responsibility for children rather than supporting her access to resources (including and importantly, power) to deal with the disabling and sometimes dangerous situation she is in, services can replicate the situation women and children face when they are subject to violence (Morris 2003).

Policies and services work to control and regulate women when they are based on constructions of mothering in which mothers are viewed as having primary responsibility for children and in which the primary role of professionals is surveillance and treatment/correction of mothers' deficits (Fraser 1989; McMahon 1995; Smart 1996; Franzblau 1999). Services which are centred in an understanding of the shifting contexts and relationships and the constraints which operate in the lives of a woman and her children, can enable her and her caring and mothering capabilities. Julie, a parent support worker, described as problematic the expectation of responsibility without access to adequate resources:

...we expect families, in a most vulnerable time, and their most poorest time, after you've had a baby is the poorest time in your life, we expect families to start attaching themselves to services and going places and being able to ring around when your phone might have been cut-off 'cos you've got no money to pay your bills. We expect people to do everything with things they don't have, that we have and we wouldn't do things without....It's OK if you have a poor week, or a poor month, but not a poor several years.

The interdependence of social relations

Current use of the term ‘dependence’ is another problematic and contradictory facet of discourses which influence the provision of family support and the experiences of mothers of young children. As described in Chapter Three, it is most often used in welfare debates to portray the support needs of particular groups as an unnecessary and immoral burden on taxpayers and the state. When used in relation to mothers and particularly solo mothers, it works to disguise the interdependence of social relations and to deny the legitimate and valuable work of caring for children and is usually spoken of in opposition to ideas of responsibility and independence or self-sufficiency.

Independence defined as “the disposition to care for, and take responsibility for, oneself and avoid becoming needlessly dependent on others” primarily means having a well-paid job sufficient to support oneself and to support one’s children to develop the capacities to achieve such jobs themselves (Galston 1991). The ‘problem’, especially with solo mothers, is that they are often not independent in this sense – they are often poor because their caring responsibilities make work outside the home difficult or impossible, jobs are hard to find, women’s wages and conditions are lower than men’s, women tend to work part-time in low paid and insecure jobs and affordable and appropriate childcare is sometimes unavailable (Young 1997; Siemon 2000). The constraining effects of the discourse of dependency on the lives of mothers living in situations of complex disadvantage warrants some further exploration in this chapter.

One use of the term ‘dependency’ based on traditional liberal notions of the rational individual who can make choices and enter into contracts in ‘his’ own best interests, views dependency or ‘free-riding’ as an outcome of rational individual choice; for example, between the options of welfare and work. However, as previously argued, motherhood is not a social context which fosters self-interested individuality. For many mothers, their caring responsibilities, social isolation and inequalities in resources and power seriously limit their and their children’s access to information and opportunities which inform choice. Moreover, these notions of individual choice and independence render invisible the many relationships of interdependence based on the unpaid caring work of mainly women, which so-called independent individuals participate within (Pearce 1990; Yeatman 2000). These caring relationships are neither contractual exchanges amongst equals nor are they necessarily entered into voluntarily. People are relational and interdependent, not autonomous individuals who are the bearers of rights and choices. From this, a framework for family support should recognise vulnerability and need; redress unequal social relations; as well as build relationships of care.

However in direct contradiction to this understanding, another use of the term dependency refers to an individual trait similar to “lack of willpower or excessive emotional neediness (Fraser and Gordon 1994)”. Welfare recipients, in particular, are seen to lack the character and competencies to make socially responsible choices and act responsibly to help themselves and their children out of their current situation. In this conception, agencies and service providers (as agents of the state) have an important role in helping and sometimes coercing people to develop and sustain their

capacity for self-regarding and ‘socially responsible’ choices; for example, by being compelled to participate in training or in welfare to work programs (Mead 2000; Raper 2000; Yeatman 2000). From the accounts of mothers and their service providers engaged in services which support and value women’s capacities to mother under difficult circumstances, this emphasis on control and regulation is unhelpful and undermining.

The current emphasis on overcoming welfare dependency constructs a false distinction between dependence and independence in which difference is constructed in hierarchical terms. When dualisms are posed as opposites (as in independence and dependence, rational and emotional, self and other, normal and needy) the first member of each pair derives its meaning from its assumed superiority to its counterpart (Maynard 1994). The social relations of advantage/disadvantage are importantly shaped by and reflected in the language used. Labels such as ‘welfare dependent’, ‘passive’ and ‘underclass’ are explicitly stigmatising, whilst constant references by government to their willingness to help ‘hard working families’ are implicitly negative for families in which no person is in paid employment (Fraser and Gordon 1994).

...one can almost hear the unspoken “decent” before ‘hard-working’, recreating historically rooted divisions between “deserving” and “undeserving” poor. Stigmatising language is not only harmful to those it describes. By “othering” those in poverty as different from the rest of us, it also serves to distance “us” from “them” (Lister 2004).

People on the ‘underside’ are often in positions of invisibility so that their experiences and the meanings they give to those experiences tend to remain hidden. Sevenhuijsen (1998) argues:

What is important here is that these are not just individual distinctions, but that together they form a whole system of hierarchy, control and exclusion. ...[they] are embedded in cultural and political norms, and explicitly and implicitly structure various kinds of representations and modes of thinking, acting and judging (Sevenhuijsen 1998).

The ‘active welfare subject’

In service delivery, just as ‘thin’ notions of mothers and young children as ‘needy’, ‘damaged’, ‘dependent’ or ‘irresponsible’ recipients of services are unhelpful, so are individualised notions of ‘resilience’ and ‘strength’. Williams (1999) observes that the rhetorical power of ‘dependence’ has had influence across the political spectrum (political parties, social movements and consumer groups) as evidenced by the common concern to create an “active welfare subject” – as opposed to the passive or dependent recipient of benevolent or controlling health and welfare policies and services. This welfare ‘citizen’ or ‘consumer’ is constructed as an autonomous “agent of their welfare destiny” – whether through the market, moral obligations or through participation and empowerment (Williams, Popay et al. 1999). In the same way that other policy concepts such as social inclusion/exclusion and population health (see Chapter Three) can in practice be radically or conservatively interpreted, so too the notion of agency implied in the concept of an active welfare subject.

Beyond problem-focused services

The accounts of service providers have suggested that services primarily organised and delivered according to categories which reflect professional and administrative ways of thinking may not be relevant to women's everyday experiences and can even have adverse effects. According to Mathews (2003), a paradigm shift is fundamental to preventing families at risk from falling through the "cracks" in service systems. His observations are worth quoting at length:

I have observed first hand how young people and their families, once entangled in these systems, become subjected to our professional categories of relevance and cease to be whole persons. We place clients on the proverbial Procrustean bed and cut, dissect and rearrange the order and meaning of their lives and difficulties so that they make sense to *us*. Narrow conceptual and theoretical frameworks, used thoughtlessly and routinely in support services, program evaluation and research, can create "pathologies" out of behaviours that are, in fact, adaptive when viewed against their chaotic or dysfunctional context (Mathews 2003).

In one in-depth interview, a community development worker illustrated this argument when she recounted an experience of defending a decision not to give a 'problem' name to a weekly women's discussion group held at a local 'drop-in' centre:

[a worker from another agency said to me]...“well if you're not telling the women it's a parenting group, how are you going to control what they talk about..?” I said it's not about controlling ...you get ten women with children in a room what are they going to talk about? ... if they're not talking about their children but they're talking about their mother or they're talking about their -

who cares? It's not about parenting as such, it's about them as a woman and that's why I never wanted to call it a parenting group because that's just one little factor of their being, that they're a mother (Judy)

Constructions of motherhood work to deny women identities and selfhood outside of motherhood and other familial roles (Glenn 1994). One mother with a newborn emphasised the positive impact on her life of an earlier decision to participate in adult education:

...I'm a person down there [adult education campus], not somebody's mum and I'm not somebody's daughter or sister or whatever. I'm me down there, which is very important and something I want to keep going (Liz).

In the context of the education centre, Liz experienced a "me" for whom there is little space in the context of the demands of her other life positions.

The problematic use of 'responsibility' and 'dependency' might be overcome if the interdependence of social relations and the interplay between structure and agency were recognised and caregiving work was (re)valued as legitimate and time-consuming work which is crucial to society (Fraser and Gordon 1994; Held 1995; Nussbaum 1995; Young 1997; Nussbaum 2001). If caregiving work was acknowledged and valued, mothers would become worthwhile and contributing citizens whose status was not diminished by the work of caring for children. The concept of 'social parenthood' provides one such framework, underpinned by a vision of 'the common good' and values of entitlement, equity and inclusion. The strengths and resources of families are framed in terms of their access to resources and

opportunities and, in particular, access to publicly provided resources. The effects of disadvantage and advantage are understood to be cumulative and compounding over generations and each life-course (Jamrozik and Sweeney 1996).

If greater value was attributed to women's caregiving work the responsibilities involved in their work could then be acknowledged, alongside their responsibilities to themselves as citizens, as people in their own right. At the same time, it is challenging to find ways to value and celebrate the relationships between mothers and children (and other care relationships) without suggesting that, because of their biological connection, it is 'natural' for women (as mothers, wives, daughters) to be the primary carer and have the primary responsibility for children's (husband's, parents) well-being. Greater resourcing of their mothering work would spread more widely the responsibilities of caring for children, instead of inscribing responsibility solely upon mothers.

7.3 Incorporating structure and agency

The relative contributions of structure and agency to health and well-being outcomes for families and young children was an important theme in service providers' accounts of their practice and is central to this thesis. As it is likely that this dualism will never be resolved, working with both explanations at the same time is a significant challenge for service provision. It would however be misleading simply to merge structural and individual explanations, as there are important tensions between them. These tensions can be illustrated by the following excerpt from Julie, a family support worker:

...one of the biggest barriers [to coping] is possibly women's low self-esteem and the belief that they're responsible for a lot of things that often they're not. I think we're all responsible for our own reactions to things and can perhaps try to work on some of our emotional responses to help ourselves get through things a bit better. We're not responsible for everything that does happen. You can't predict a car accident or how you're going to cope with a new baby who's been ill and all of that.

Constrained as it was by upbringing, 'life's accidents' and access to support, self-development was perceived by Julie as the key to coping and positive living. She continued:

...self-development is actually really important 'cos you can't always change the rest of those things, you can only try to change how you manage that and try to build some more support systems to get you through that. ... quite often your background and your childhood just puts the lid on your wonderful ability to create and be out there and feel good and positive about what you do.

From this viewpoint, 'life's accidents'⁷⁶ and socio-economic contexts cannot be controlled and/or they seem hard or impossible to do anything about, but people can and should be in charge of their reaction to them. In the context of service delivery, it is people's individual agency which appears most amenable to change – it is after all,

⁷⁶ Interestingly, this parenting support worker's view that you can't predict life's accidents and therefore can't be responsible for them is contradicted by epidemiological evidence. According to Mary Shaw:

'Accidents' are not randomly distributed events, in either lay or statistical terms. Instead they are patterned by social, cultural and environmental factors... Accidents are what Durkheim would term 'social facts', existing *sui generis* over and above individuals... the word 'accident' is inappropriate for events that are both predictable and preventable (Shaw 2002) p525.

what service providers have (and are trained) to work with. As previously argued, whilst the contribution of social and economic factors to parenting outcomes, health and well-being are often acknowledged, explanations focused on individual agency tend to lead to policies and practices focused on improving individual parent's capacity to 'choose health'.

Helpful service models acknowledge that women and their children are embedded within relationships of care and development and at the same time understand that mothers are complex individuals dealing with the effects of disabling environments. Pollock et al (2004) described an approach to working with individuals and families affected by alcohol and drug use in which people's behaviours and choices were seen within their social, cultural and political contexts, rather than viewed as pathological. The reported impact of this critical 'problem position' on mothers who accessed these services was that they felt themselves treated with more respect and recognised as individuals with complex lives rather than so completely and problematically labelled and categorised (Pollock, Tomkins et al. 2004).

These reports accord with those from the in-depth interviews in which mothers described their experiences of respectful acknowledgement as supportive and empowering. One mother compared her current service relationship with a previous relationship in which she had felt judged and discounted:

...when people are speaking to me right you feel good about yourself. You don't feel like you're being let down or anything. When people are listening they take on board what you said...if you're wanting something to be done they will either do it or organise it...or talk to you more, not disregard what you said. ...my

mental health worker disregarded what I was trying to say...she was hearing what she wanted to hear but no more...(Gillian)

7.3.1 Focus on context, capability and commitment

When the focus of the service relationship is the woman's life/health experiences within her broader social context, the provider takes her lead from the woman. Rather than attempting to follow prescribed service priorities or strategies the provider believes that people have knowledge about what is helpful to them and focuses her curiosity (investigation, diagnosis or assessment) on finding out or helping the woman to recall this 'life knowledge'. In a conversation between a service provider and a mother the focus may be on the issues about which the provider has specialised training but the woman may want to spend more time on other important issues in her life.

From this whole-life perspective, an intense focus on 'the problem' can serve to marginalise people and fragment their sense of who they are and what they are capable of. In the words of a parent support worker and a women's health counsellor:

It doesn't seem to help to focus on the lack of something because we all drown in it. People don't always believe in themselves and may have had a lifetime of people not believing in them (Julie).

I think when a woman taps into the strengths part of her life the problem perhaps is not so big. That's not to minimise the problem that's there but in utilising and recognising those strengths then it's about engaging the woman to use those strengths to work with the problem (Sarah).

Service providers reported taking a stand against discourses which are harmful to their clients such as those asserting that certain mothers (solo mothers, disabled, teenage, drug using, living with drug using or violent partners) are ‘bad’ mothers. They understand some of the ways in which these issues make parenting more difficult. They focus their attention and support on the actions mothers take to resist the effects of these constraints and to ensure that their children are safe and well cared for.

For the mothers in the in-depth interviews ‘helpful help’ is supportive of their relationships with their children and other family members and is delivered in ways which focus on their capabilities and commitment to do the best for their children. As argued previously, this contradicts the common focus on the child as ‘client’, which renders the mother ‘invisible’ or shapes a relationship with the mother which is based primarily on assessments or perceptions of her negative impact on the child (Morris 2003; Status of Women Canada 2003). Feeling invisible in hospital birthing processes was described by several of the mothers during the research conversations as contributing to their experiences of postnatal depression:

I was just an incubator, that’s how I felt...it was just like you’re a container that walks through the door and they do certain things to you and out the door you go and that’s it...you just have the baby and come home from hospital and that’s it, they just leave you, forget about you (Liz).

For many of the service providers it was important to make visible and take a stand against practices in children’s services in which women were invited or required to take responsibility for the impact on the children of things outside their control. These

practices sometimes worked to position the woman in opposition to or as a threat to her children. One mother described her experience with a service provider from the child protection agency:

I didn't like the way she would speak to me as if I didn't know nothing about my kids and I didn't know what I was doing. ...she thought she was all high and mighty to walk into my house as if she owned it and tell me how to look after my kids and what to do with them and...never explain situations to me (Leanne).

When it is recognised that women's and their children's interests are not, in lived experience, separate, the mother-child relationship becomes the client as much as the individual child and woman. Pollock and colleagues (2004) give a clear description:

The children of our adult clients ARE our clients...The way we view all this is not a binary, that is what is best for the parent on one side, and what is best for the child on the other. In reality, what is best for the child is best for the parent and vice versa – we don't see them as competing (Pollock, Tomkins et al. 2004).

When services support the mother in a variety of ways, including seeing her as an individual rather than a source of risk to her child, they also support the relationship of care with her child. When asked what advice she would give services to achieve better outcomes for mothers and children Liz, the mother involved in further education quoted earlier, concluded:

I would probably tell services that want to support mums with young children they should treat the mothers like people and put the mothers' needs, find out what she needs first, before the kids. I think that's what I would do because there's no point in doing anything until the mother is happy, don't you think?

The women-centred model that Liz was proposing is consistent with the early childhood consensus revisited early in this chapter and was a guiding framework for many of the service relationships which have been examined for this thesis. In this chapter the paradigm shifts needed to frame the ‘problem’ of poor families with young children as a social issue fundamentally shaped by the inequitable distribution of resources and opportunities for health and well-being, have been examined. Critical understandings of health, motherhood, individual agency and service support are key dimensions. In the following chapter, key aspects of service delivery practice generated by this framework will be considered.

CHAPTER 8: HELPFUL HELP: THE SHIFT TO EMPOWERMENT

In this thesis it has been argued that communal practices and social provision help people to develop their common, personal and family lives and that investment in improved social provision is the base upon which individual and collective capacity can be built. This redistributionist agenda and the challenging and alternative problem definitions and service models presented in the previous chapter require ‘transformational’ practices for their implementation (Culpitt 1999; Mathews 2003). The potential of family support services as powerful sites for challenging unequal social power relationships has been made clear. The interviews with front-line service providers and mothers who were their clients provided some ‘thick descriptions’ of several aspects of these challenging or ‘transformational’ practices and these will be drawn upon in this chapter.

Empowerment, egalitarian relationships and the practices of social citizenship are the subjects of an enormous literature all of which is broadly relevant to these lay accounts. It is clear from this literature that the notion of empowerment is complex and highly contested (Friedmann 1992; Cruikshank 1999). The focus of this chapter will be confined to aspects of transformational practice concerning more equal service relations. In particular, the dynamics of recognition and respect; ‘empowering’ practices; and a brief consideration of the implications of these for service organisation.

8.1 A theory of power

Like ‘social capital’, empowerment has *relational*, *material* and *political* components (Hawe and Shiell 2000). ‘Relational’ refers to the processes of power. ‘Material’ relates to resources accessed through the transformation of power and ‘political’ means challenging or reproducing unequal relationships of power and advantage. The close-up look at ‘helpful help’ enabled by the narratives of mothers’ and service providers’ in the in-depth interviews is of particular interest because the service relationships themselves were situated within the unequal social relations of power which go with ‘provider/professional’ and ‘client/lay person’. Who controls the definition of the problem/need, available options and resources, whose knowledge and authority is most valued and whose 'language' is spoken all reflect power differences between client and provider. It follows, as argued in the previous chapter, that the notion of empowerment and interventions which aim to challenge unequal social power relations interventions should be based on a theory of power (Wallerstein 2002).

There are several aspects of ‘power’ relevant to the experiences of mothering young children considered in this thesis. Three clear themes can be drawn from the mothers’ and service providers’ accounts.

- Having possession (or not) of the material resources to enable choice and action (resource power).
- Exercising control over others’ choices or having one’s choices subject to control by others (decision-making and action).

- The power of discourse, norms and expectations to define what is right or wrong, true or false and to control people's perceptions of themselves and their own capabilities (meaning and identity).

In lived experience these aspects of power and their effects are interwoven and expressed simultaneously in individual agency, in social relationships, institutional and organisational structures, and in the distribution of resources and opportunities for health and well-being at group or population levels (Wallerstein 1992; McCubbin and Cohen 2002; Navarro 2004). Power is not a 'thing', in the sense of either you possess it or you don't ('powerful' or 'powerless'). Rather, because people both exercise power (agency) and are shaped by its structures and practices, individuals who are less powerful in one context by virtue of one structure (or set of practices) can be "beneficiaries of power or practitioners of domination" in another context (Frazer and Lacey 1993).

The original hypothesis for this thesis project was that implications or recommendations for service policy can be informed by 'more equal, respectful and empowering' service delivery practices which effectively support people's agency and challenge systems and practices which contribute to social health inequalities (see Chapter 1: 7-8). In what follows, insights into these helpful practices have been drawn from mothers (clients) and service provider accounts and from theories which were able to illuminate their interpretations.

8.2 *Empowering practice*

As service providers are generally more powerful than service seekers (although service providers may feel relatively powerless within their service organisations) empowering practice means a redistribution of the power which the provider holds

over the client. This is often described as a paradigm shift from ‘power over’ to ‘power with’. Lesley described the impact of her tenancy support worker’s empowering strengths framework:

I've enjoyed working with Christina because she is so supportive; she's very friendly which makes her an easy to get along with person you're involved with. Everything we've spoken about basically something's been resolved in one way or another. In some aspects it might have been harder than what I thought or easier than what I thought but in one way or another we've achieved a goal out of it. Between me and Christina we've worked well together.

According to Labonte (1992), empowering practice can be described as more “equitable and emancipatory” relations between providers and clients. Empowered people (individuals and groups) have the capacity to define, analyse and act upon the problems in their lives and living conditions (Labonte 1992; Young 1997; McCubbin and Cohen 2002). According to the service providers’ accounts in the in-depth interviews, the goal of empowering practice is to enable people’s self-definition and their capacity to act according to the values they cherish and to achieve their preferred ways of living.

More commonly however, women are held primarily responsible for the support and protection of children, and service systems are focused on the assessment and management of ‘risk’. These ‘problem’ definitions shape the role of the service provider as one of ensuring that women act in ways the service/standards regards as ‘appropriate’. The actions women are expected to carry out often contradict their own sense of what is needed or what is safe. From his study of child protection practice in the UK, Scourfield observed:

...where perceptions of risk differ between parents and professionals, inevitably some coercive practices are used, so those subject to the system, the 'clients', will experience coercion. The adults in the front line are far more often women. ...any system set up to scrutinise child-rearing will inevitably bear down on women, since it is women who do the work (Scourfield 2003).

Here, the unequal power relationship between provider and client is used to coerce, not to support and acknowledge and build on mothers' capabilities. Drawing attention to these unequal power relations in child protection, an Australian study recommended that child protection workers "should seek to *empower* women, rather than adopt judgemental practices which punish[ed] through the removal of their children, women who were themselves victims of violence from their male partners (Irwin, Waugh et al. 2002)".

An 'empowering strengths perspective'⁷⁷ was outlined by Lesley's (quoted earlier) housing tenancy support worker (*italics added to highlight themes reflected in other service providers' accounts of their practice frameworks*):

I come from a social work background and I certainly work a lot with empowering strengths perspective in that I would never want to be a judgemental worker but I think there's sometimes *things people can do to change situations*. I would never say that it was always their fault. I just wouldn't use that approach. I think that by *focusing on people's strengths you are going to get a better outcome at the end*. If you pick off even the really tiny thing that someone was able to get out of bed that day, for that person that was

⁷⁷ There is an extensive literature on the strengths perspective in social work practice. See for example: (Saleebey 2002).

an *accomplishment and recognising* that. I think it is really important to be *aware of your own role* as a worker as well - is it there to judge? I also think that I come from a feminist perspective ... so that whole issue of imbalance of power and all those things. ...if I'd come in and said it's your fault it would never ever have accomplished anything - I would have isolated myself from Lesley, I wouldn't have the *relationship and the support network* that we have with each other now. So I think it is really about knowing *the impact of your own thoughts and feelings* on your behaviour and how that impacts on a client (Christina).

This excerpt from Christina and the earlier one from her client Lesley, raise a number of practice issues which arise from the tension between structure and agency previously explored. Critical learning and problem solving practices, the impact of the service provider's power to assess and judge a client's deficits, and the value of supportive and respectful relationships were fundamental to their notions of 'helpful help'. In the remainder of this chapter, three empowering practices will be examined – challenging 'expert' knowledge and power, 'working together' and reflexive practice.

8.2.1 Unequal knowledge

The need for problem understandings and service models which acknowledge and build on women's capabilities and commitment to wanting the best for their children was argued in the previous chapter. These understandings generate practices which value the "life knowledges" of mothers (clients) and create 'safe spaces' in which their experiences can be told (White 2003). Ruth, a family counsellor, described her approach to working with families dealing with the effects of child abuse as "really respectful of parents" and wanting to work in partnership with them.

...What are the resources within the family and how can we sort of join with the family in trying to find solutions and make changes? ...[acknowledging] the resourcefulness that families can have and the wisdom and the strength that families can have in dealing with awful stuff that can happen in their lives ...and yet still being able to survive...still wanting the best for their kids even if at the time they're making some choices that aren't really helpful ...

For a parenting support worker wanting to understand her client's aspirations and 'needs' rather than relying on 'expert' assessments made by other service providers, a process of relationship building - "getting to know each other" - over time was fundamental.

I tend not even to read other people's notes when I get a family ...I don't want to have a picture of a person that is developed by someone else...I just needed to know ...where she was at and from there we start, we get to know each other and we do that partly through the children, partly through how people do their problem solving. Some people problem solve beautifully in one area and flounder in another so you get to know where you don't need to support people. It's a long process really of a few months...(Julie)

These service practices resist the assumption that the helper has 'expert' knowledge, skills and authority which the service seeker lacks. This assumption of superior knowledge works to undermine the client's sense of power; in particular, in relation to their confidence and sense of competence to manage or resolve difficult issues in their lives. A young mother with six children who had experienced emergency specialist

intervention and follow-up related to the births of two of her children, provided one illustration of this dynamic:

...when you go to the hospital...sometimes you can understand them but other times when they start talking to you you're like "yeah, yeah" and when you leave you're wondering what they were talking about. You don't want to ask 'cos you're thinking they're probably thinking that you should have known what they were saying to you (Margie).

Margie's experiences reflect the knowledge and social hierarchies which produce the distance between medical specialists and the client, a distance which is (re)produced by the authority and capacity of the provider to make professional assessments or judgements. Foucault used the term 'professional gaze' to draw attention to the ways in which professional training and the assumption of power serve to distance the professional viewer and facilitate judgement (Rawlinson 1987). Earlier, this distance was described as fundamental to services' 'regulation' of mothering. Even service providers who wished to avoid categorising their clients and to resist concentrating on and diagnosing their particular individual deficits, reported that they sometimes found their professional training and expert knowledge made this difficult. In Chapter Five, Lisa (a child health nurse) was quoted reflecting on the tendency of developmental standards set by experts to elicit judgement, even when the provider's sincere intention is to support and assist. As Sennett (2003) observed, in helping relationships there is "a membrane so porous between caring and controlling that it dissolves at the slightest touch..." (Sennett 2003).

In their accounts of their practice during the in-depth interviews, service providers stressed their commitment and the effort required to avoid taking a position of knowing the ‘truth’ about people and their needs. According to van den Bok (2004), “we risk fostering dependency, if it is our knowledge that is privileged over the knowledge of those who consult us” (van den Bok 2004). It may be that the less investment the service provider has in identifying the problem as the woman’s ‘fault’ or deficit and intervening to ‘correct’ it, the less likely it is that a dependent relationship will ensue. In the in-depth interviews, the service providers reported they had chosen an alternate position in relation to the client - that of believing that women / people have the resources to respond to the challenges they face even though those resources may have been obscured, overlooked or overshadowed to some degree. A helpful service relationship is one which teases out these resources, pays attention to what is being overlooked, and ‘re-minds’ people (White 2003). According to one service provider, “a story that keeps being told” in women’s lives is that they have no space to be listened to without judgement. From this she reported coming to the first meeting with a new client curious about the woman’s daily living experiences and her thoughts about those experiences.

The questions I have in my mind are: What's the structure of the day – like, what do you do every day? What are your routines? and On reflection how does that look to you? (Nancy)

Professional training and practice can encourage authoritative and distancing approaches and discourage the more equal relationships in which needs are defined with a woman and/or children within the context of their lived experiences. The formulation of needs

from a distance produces formulaic responses which take away from women's and service providers' capacity to flexibly respond to the complex circumstances of women's lives. Commonly, expert assessments of problems replace women's own understandings of their situation. Gillian, a mother of an infant and a toddler, spoke of the way an expert's assessment of her post-natal depression contributed to her feelings of self blame:

I've had depression since I was 4 [but] I had a doctor tell me that my problems were because of [the infant]. ...well basically I felt like it was my fault because I had the child, and when your doctor's saying that, well he's supposed to be the professional.

8.2.2 A 'power with' relationship

In their emphasis on supporting women in the choices they make, several service providers described their role as that of a 'resource', travelling 'alongside' their clients for part(s) of their life journeys. Service providers can also be constrained by expectations. Many clients expect that service providers will be caring and sensitive, have answers, know what to do, and they risk being viewed as deficient if they do not. In the interview which involved Sheila, the mother of a three year old who had been abused by her partner and Ruth, the family counsellor quoted earlier, Sheila expressed her feelings of desperation related to not knowing what to do to help her child whose 'bad' behaviour was causing her a great deal of concern. The following excerpt is intentionally long as it raises some of the complexities of a 'power with' relationship.

M (researcher): You've talked about wanting to work in that respectful partnership way that recognises strengths and resources and wisdom and the aspirations that Sheila has for [her son] and herself. Have there been

times in your relationship with Sheila where this approach hasn't gone as well as you would have aspired to?

Ruth: I think that right through I've really had a sense of partnership. I mean, Sheila has described the fire and the energy that she had in her when I first met her ... even if I hadn't wanted to be a partnership, well it was bloody well going to be a partnership! She wanted the best for her little boy. ... But I think perhaps that there was a lot of frustration for Sheila that I couldn't find quick answers and I can hear that in you again today Sheila that sense of is there always going to be a problem? Should we make him talk and talk about it [the abuse] or do we not make him talk about it? What do we do in order to try to get life back to normal as quick as possible?

Sheila: Is it going to be back to normal?

Ruth: Yes, those are your questions. I guess I could bring to that the children I've worked with and the reading I've done, all of that would suggest very clearly some things we could do together and Sheila could do as a parent that would be helpful but it doesn't bring guarantees of what the results will be. I think for Sheila there was a kind of a hope that I would have some expert magic that would be there. Perhaps that there was a bit of magic but it wasn't magic enough?

Sheila: I think it's more that it went so good and now it's gone a bit backwards and I think have I done something wrong?

M (researcher): So the self-doubt has come back in?

Sheila: The self-doubt has come back in. Am I doing something wrong? Is there something I've let lapse or have I, I don't know? I am a person who needs reassurance and needs help with answers and things like that....

This excerpt illustrates well the tensions which are inherent in service providers' intention to act as a resource or develop a 'power with' rather than a 'power over' relationship based on authority and expert knowledge. Despite the intentions of equality there may always be power differences. In the in-depth interviews, the effects of these differences were illustrated when mothers were asked whether there had ever been times when they had been unhappy or dissatisfied with their service provider. One mother's initial response to this question was:

...it is very hard to say I'm uncomfortable or unhappy with something's she's done. I don't want to come across as a trouble maker... I want to make sure it's not me and then when I've worked out it's not me I might say something. ...I don't want to hurt (Mina).

Later in the interview she was able to recall an occasion when she'd felt affronted by comments her provider had made, which she had chosen not to raise at that time. It could be that, in addition to unequal power, there are other possible interpretations for Mina's reluctance to criticise her service provider, including: the 'ethic of care' which is characteristic of women's relationships (Belenky, Clinchy et al. 1997; Sevenhuijsen 1998); her respectful consideration of the efforts and positive intentions of the service provider; as well as her intention to be responsible for her feelings and actions.

8.3 The dynamics of recognition and respect

When women are understood as encountering life difficulties rather than causing them, service providers do not become caught up in admonition. Their relationship becomes one of respectful partnership and a process of social learning or ‘co-research’ to “understand the culturally oppressive means and influence of a problem on a person and the liberating influence of a person over a problem” (Lobovits and Seidel 1997). Empowerment as a professional practice requires a genuine and often passionate commitment from the service provider to hearing people’s lived experiences and aspirations; understanding these in the words people use to express them; recognising their accomplishments and constraints; and negotiating action to improve those situations which people want to change (Labonte 1992; Rappaport 1995; Mann and Russell 2002). Recognition and respect are inevitably intertwined with social power relations. Sennett (2003) describes the problem of lack of respect in an ‘age of inequality’ and argues that communicating respect is critical to challenging social power inequalities.

Lack of respect, though less aggressive than an outright insult, can take an equally wounding form. No insult is offered another person, but neither is recognition extended; he or she is not *seen* – as a full human being whose presence matters (Sennett 2003 596).

The recognition which is granted to ‘full human beings’ can take a variety of forms and is the subject of a literature too large to explore in any depth here. Briefly stated, forms of recognition include: legal rights and entitlements, including the provision of public goods; mutual acknowledgement (*‘I see you – I am here’*); respecting the needs

of those who are unequal; and respecting the viewpoints of others whose needs and interests are different from one's own (Lister 2002). There is potential to challenge inequalities in the distribution of all these forms of recognition through social investment, strategies for inclusion and the grant of respect. Like 'power', respect is not a fixed commodity but is developed (or reduced) through social relations. There is a significant tension, expressed in the question of whether respect (or power) can be 'given' by the service provider or must be 'earned' or 'taken up' by the client. Through a critical examination of the processes of 'respectful partnership' between the mothers and their service providers these processes may be illuminated.

When service providers viewed their clients as capable and attempted to understand their life/health experiences within their broader social contexts, women reported feeling 'special', 'worthy', 'listened to', 'believed' and 'competent'. They most often described these experiences in contrast to their more usual negative or detracting experiences with services. The providers' commitment to 'listening for strengths' and creating spaces for women's experiences to be told, differs greatly from the more usual criticism and isolation they experience. A women's health worker described the increased sense of control, decision making and capacity for action which was reported by her client in their interview:

[she] become much stronger in her own view and less inclined to go with what other people were saying. That need to please people become less and the urge to stand on her own two feet and listen to herself become more (Sarah).

Recognition that a woman's opinion is of equal value and encouragement to express that opinion lead her to understand that she has (and has always had) opinions which

are valid and strong; that she *does* know how she wants things to be. She comes to understand more about "...how she could take hold of more of that and let go of that compelling thought and feeling that she had ...that she had to do what other people said, even though that was not what she wanted to do" (Sarah).

In a different interview Dianne expressed her frustration in relation to a previous service experience - "I never got any ideas whatsoever sorting out the problem...she was telling me that my problem was not a problem..." In contrast, she described Jill, her current parenting support worker as:

...about the only person who will listen and not contradict what I'm saying, not saying to me 'oh, that's wrong'. She'll often point out the positives rather than the negatives and that makes me feel a lot better, because I've got someone who's listening instead of my mother constantly contradicting everything I say... It's got me seeing a lot more positives now and it's given me strength to fight through to what I say I want to do because I'm not really that bad. I'm not really looking much at negatives anymore (Dianne).

The parenting support worker described her understanding of Dianne's needs and her role as something like an ally and advocate in relation to the external influences in Dianne's life situation:

I certainly saw it [the 'problem'] as Dianne having lots of guilt, actually not believing in herself, not actually believing that she actually was able to deal with the situation. She was doing a lot of good stuff but it was in conflict with herself because other people were saying other things. So that made it really, really difficult for [her]... (Jill)

8.3.1 The grant of autonomy

Drawing on postmodern theory, Shawver (2004) describes a ‘paralogical dialogue’ as one in which, instead of the provider and client “talking past each other or down to each other, they learn from each other, or they try to” (Shawver 2004). Through this dialogue, the client’s own knowledge is given more weight than it has been given in the past and the provider’s concern is to find out about the client’s own preferred pathways. In ‘helpful help’, the provider joins with the woman in discussion about “where she is, what position she’s in and what can we do in that space of time to be able to assist her to be wherever she wants to be (Sarah)”. Sennett (2003) describes the social relation in which one person treats another’s experiences, understandings and goals with respect as the “grant of autonomy”.

...we grant autonomy to teachers or doctors when we accept that they know what they are doing, even if we don’t understand it; the same autonomy ought to be granted the pupil or the patient, because they know things about learning or being sick which the person teaching or treating them may not fathom (Sennett 2003).

In this conception, autonomy is a developing and changing social relation and, when the grant of autonomy is mutual, it is a “powerful recipe for equality” (ibid.). In the words of one parent support worker: “[the client] has always been upfront and honest with me and I feel I can do no less for her”.

8.3.2 A ‘close’ relationship

Both mothers and service providers emphasised the value of trust and a ‘close’ relationship in their descriptions of ‘helpful help’. Many of the mothers described their experiences of their service provider as “like part of the family”; “she helped me

like a sister” or as a “friend”. Each woman felt that their provider was “there for me”. Part of this close relationship was the woman experiencing the provider as “not above me, I’m not below her...she shares some of her personal situation and you think “gee they’re just like us, they’re not higher than us because they’ve got a counselling job (Sue)!” In conventional thinking about the helping relationship, service providers are warned to maintain ‘professional distance’ to ensure ‘objectivity’ and discourage dependency. The experiences of these clients challenge these notions.

The positive effects of experiencing a relationship of trust were raised in every in-depth interview. The relationship which is built by the service provider and the woman in “travelling the journey” some of the way together, can provide a base from which they can work together, particularly when crises or further difficulties arise. When Mina was charged with assault following a violent incident with her partner, her child was taken from her care. During their in-depth interview, her parent support worker reflected on the role of trust and mutual respect in their response to this crisis:

...we had to really learn to trust each other and work with each other and support each other. I needed your information to be able to help you and [Mina] took on a massive, an absolutely massive workload in terms of the number of services [Mina] then had to make connection with (Julie).

From Mina’s perspective, the practical support she gained from Julie advocating and facilitating her access to other services was particularly helpful. In the following excerpt she explains how with Julie’s advocacy she was able to sort out having no money to buy food and to pay off debts:

...I didn't have a car and we went out in her car and solved my bills. Julie came along and did that speaking for me...used [her] government ways of explaining, of telling them that she's got a problem, she needs help. ... Basically government people don't listen to people like us because they just think, well that's not our problem... It's your problem so you're the one who has to solve it... When I come along and said "Look, I can't give you that money, help me, try to help and understand me" and they wouldn't (Mina).

Julie: Those services get scammed all the time so if you have someone who can vouch for you or verify that yes you are in need, they do respond more quickly.

'Distance' may more aptly describe the position of the service provider in relation to 'the problem'. Through developing a critical understanding of the woman's and children's life situation the client and service provider can join forces against 'the problem's' influence in the woman's life or in support of alternative ways of living. At the same time, 'closeness' may be a problematic description of the provider's relationship to the woman. Whilst many of the mothers reported experiencing their service provider as a friend, there are important ways in which 'helpful help' differs from friendship. Friendships neither could nor should bear the weight of providing sustained effective help. Further, service systems create and enforce boundaries around the provider's role; for example, with caseload targets, time limits and statutory reporting requirements. Even in a close helping relationship "the caseworker hopes eventually the client will be able to loosen the bond (Sennett 2003: 195)".

The service provider's role has some similarities with that of a coach in providing challenges and ideas, building on strengths, encouraging decision-making and

supporting a woman's action to achieve her goals. Whilst the provider might make multiple suggestions, no single suggestion carries the weight of authority. A child health nurse spoke about the challenge which hospital based nurses experience when they are learning to provide community-based services – "...being on their [clients'] territory....you learn... they won't come back and see you if they thought you were too prescriptive...In the hospital you control them but you can't control them, we've got no control...it's really coming to grips with that (Lisa)".

For Sheila, specific behaviour management ideas offered by her service provider Ruth, were particularly helpful:

Sheila: She'd [Ruth] always give me suggestions, she would never tell me "do this, do that" because I think I would have rebelled on that, whereas Ruth always gave me suggestions to think about and maybe act on, and that was a great help. Yeah, knowing that there were suggestions there and things you could read up on and everything.

M (researcher): So ... the idea that what you need is the resources, that you have the capacity yourself and that with some resources you will use those that fitted your ideas...

Sheila: For me it was that I needed the reassurance that what I was doing was OK ...Ruth gave the reassurance that what I was doing was OK and these are suggestions about maybe how to go about this or how to go about that.

In this excerpt, Sheila qualified the researcher's possible implication that, as she was independently capable, her only need was for information, by stressing her need for reassurance from her service provider. However, it was clear from this and other interviews that service providers must be willing to relinquish the expectations that go

with their position of power and authority. When service providers let go of expectations of how a client's life 'should' be, they find they "don't feel let down or disappointed". In all the service providers' accounts of their practice they stressed a belief that there is not one 'right' way for women to act – that if she made a decision which turned out to be the wrong one, there were always other decisions she could make. "...it is very rare that you can't manage to change paths somewhere down the road".

8.3.3 Critical engagement - the value of talking and listening

The feminist claim that 'the personal is political' points to how the knowledge and skills of women (and other people who are relatively powerless and excluded) are devalued when 'objective' or 'expert' knowledge and practices are asserted to be superior to personal experiences. The value of 'story telling' and of developing shared understandings which make it possible for people to interpret their own and each others' feelings and actions, connect to others and to the wider community is widely acclaimed (Pitt 1998; Silent Too Long 2000; Williams, Labonte et al. 2003; Barnett, White et al. 2004; Green 2004).

Following the influential work of Paolo Freire, story telling can be used as a method to reveal the many circumstances which limit women's opportunities to speak about and enact the ways of living they cherish and to challenge dominant social structures and improve the practices of service provision (Freire 1974; Shor and Freire 1987). Story telling can 'heal' when opportunities and processes to support the "identification, acknowledgement and honouring" of women's knowledges and skills lead to their "re-membering" that which has been devalued and subjugated (White

2003). These story telling opportunities can open up options for action (individually or collectively) to achieve change in people's life situation(s) and in health-determining conditions (Williams and Popay 1999).

Talking and listening are central to the processes of 'conscientisation', the value of which is well-known in empowerment, community development and education strategies (Labonte 1999). Conscientisation or collective empowerment refers to the processes through which relatively powerless people come to understand the social sources of their powerlessness by engaging in dialogue with each other. Through this 'consciousness-raising' talk they shape a sense of who they are and how they belong. They recognise that their individual lives are similarly constrained by social expectations and institutions, power relations and economic forces and develop a sense of mutuality and solidarity.

In the in-depth interviews several mothers described their sense of relief when they connected with other women encountering similarly difficult life situations and realised that they themselves were not the problem. The opportunity provided by a 'safe space' in which to talk about issues and develop a critical understanding of their experiences enabled them to no longer feel alone. They reported that a sense of belonging and experiences of friendship could reduce the deleterious effects of being isolated at home with babies and young children, family conflict, living in poverty and other constraints.

8.4 *Helpful help*

In summary, the following tenets of 'helpful help', exemplified by Christina's account cited earlier in this chapter, were common to the practice models espoused by service providers in the in-depth interviews:

- Recognise the effects of unequal social power relations
- Resist the discourses and dynamics of judgement and shame
- Facilitate people's access to resources and practical support
- Believe in people's agency and capacity to participate in social development and learning
- Recognise and respect people's accomplishments and build on their strengths
- Reduce social distance and social exclusion by facilitating connections and building trust relationships
- Reflect critically on the processes and role of help / helper in challenging or contributing to inequalities.

Various aspects of these practices and the ways they can work to redress the adverse and isolating effects of unequal social processes have been examined in these last two chapters. In highlighting the value of empowering and connecting practices, it seems ironic that service providers themselves often feel powerless and work in contexts of isolation. Most often agencies are dominated by individualised approaches to service delivery and 'boundary-driven' processes for management and decision making. In the following and final section of this chapter, aspects of agency organisation fundamental to supporting the practices of helpful help, which have been drawn from service providers' accounts, will be briefly outlined⁷⁸.

⁷⁸ There is a great deal of literature related to the organisation and management of human services which could provide the context for a much deeper exploration of these issues than is possible within the limits of this thesis. See for example: (Donovan and Jackson 1991).

8.5 Implications for service organisation

To encourage and support the implementation of ‘transformational’ policy and practice, agency and program structures and processes which challenge dominant organisation and management forms and trends are required (Wallerstein 1992; Ife 1997; Leonard 1997; Mann 2005).

8.5.1 A learning culture

All the service providers who participated in the in-depth interviews emphasised the value to their practice of critical reflection processes which encouraged deliberate attempts to make sense of complex and challenging work experiences (Gergen and Gergen 1991; Steier 1991). They valued opportunities to be reminded that they were not alone in their attempts to respond to the effects of inequalities in women’s lives. Rather they were linked to shared problem understandings and actions being taken by many different people in many different contexts. They named a range of organisational practices which support ‘praxis’. These included:

- Conversations and processes in which each worker’s passion and commitment to their work, and for learning and change, are acknowledged.
- A variety of formal and informal opportunities for debriefing and to gather ideas which help with the dilemmas and difficulties of their work.
- Opportunities to ask and to explore difficult questions about the how and why of services to determine the ways in which they might subtly foster dependence and powerlessness or better contribute to changing social health inequalities.
- Opportunities to discuss with other workers (including those from other agencies) about the many different ways in which work can be done.

- A workplace culture based on the idea that, rather than an individual worker (or agency) having to know the ‘answer’ (or risk being judged as less than competent), these ‘answers’ can be generated through learning conversations and collaborative planning and action.
- Opportunities for worker involvement in program evaluation, research and continuing education.

Also in the in-depth interviews, service providers stressed the importance of effective agency and program leadership in supporting their work. From their accounts, effective leadership is characterised by respectful and inclusive processes. ‘Good managers’ are knowledgeable about each provider’s work and their skills, experiences and commitments. They actively ‘care’ for their staff, encourage flexibility and continuous learning. The service providers stressed that managers should be ‘visible’ and available to provide support when needed.

8.5.2 System change

Findings from the second *Families at Risk* survey interview confirmed that many caregivers, particularly those with multiple concerns regarding their child(ren)’s health and well-being, have a great deal of interaction with ‘the system’ (illness care, education, welfare, housing, social security, justice, and so on). The difficulties they reported having with this interaction included: difficulty getting access to services and/or individual providers; lack of continuity in providers; inconsistent information; disrespect; feeling judged or blamed; and a general lack of response to their concerns and needs.

As argued in previous chapters of this thesis, these barriers are associated with dominant forms of service organisation and delivery are caught up with managing,

predicting and controlling ‘problems’ in ways which maintain the social health status quo and even contribute to worsening inequalities. Even where there is policy agreement about what system change is needed, the difficulties of achieving transformative change seem likely to be overwhelming. However, with an understanding of the ‘politics of health’, it has been possible for agencies (or parts of them) and some service providers to free themselves from dominant ‘power-over’ tendencies to successfully challenge dominant forms of service organisation and delivery.

8.5.3 Working together

Rather than ‘boundary driven’, professionally defined services focused on particular problems, their primary concern is to fit the service to the person (or population group), not the person or group to the service. Flexible structures, collaborative practices, and advocacy and support for people to negotiate service systems, are necessary to achieve this paradigm shift. Two important ingredients are worker continuity and sufficient time to develop a trust relationship in which the authority to define ‘needs’ and actions is taken up by the person or group. Providing necessary worker continuity over extended time periods has implications for funding, staffing arrangements and employment contracts as well as for service provider training and skills.

A third ingredient, which has been highlighted as a feature of much policy rhetoric, is ‘joined up’ planning and action between sectors and agencies relevant to families’ and children’s health and well-being (see Chapter Three). To achieve this collaboration, more flexible and/or integrated structures may be needed. Service organisations need to open their ‘borders’ and develop links, exchanges and dialogue with other

sectors/agencies as well as with ‘clients’ and potential service seekers. This may mean giving up, or at least sharing, resources (including power) and being willing and able to join others to address concerns and achieve common goals (van Eyk and Baum 2002). In the in-depth interviews, service providers described the ways in which planning processes which are based on shared values and an inspiring vision can unite workers (and service users / groups) in common understandings and commitment, as well as provide the framework for deciding service goals and strategies. They emphasised the considerable time and resources required for visioning and planning activities and for participation in critical reflection about service goals and ways of operating.

8.5.4 Service seeker and community engagement

Participation by service users, groups and communities in policy and program planning, implementation and evaluation can contribute in at least two ways. First, increasing the openness of service organisations to information and learning can facilitate continuous improvement and more responsive services. Second, participation can increase the power and control exercised by individuals and groups in relation to the factors which affect their health and well-being. This thesis project follows other studies in providing an example of the valuable insights which lay knowledge can contribute to understanding the realities of living and providing care in situations of multiple disadvantage. However, it is a considerable and ongoing challenge for policy makers and services to find ways to listen to people’s experiences, connect them to each other, and build on and use their strengths. The

following recommendations for supporting client and community engagement were drawn from the in-depth interview texts.

- Services should be locally based and locally responsive and include as much participation and control by service users as is feasible. In addition, services should be accountable to the communities in which they operate and/or the population groups they serve.
- Implement strategies to eliminate barriers to people participating in policy, program and service development. These strategies could include providing practical support and resources – for example: transport, childcare, ‘sitting’ fees and learning support – as well as recognising and allowing space for the ways in which the challenges of caregiving in contexts of disadvantage limit people’s ability to participate and confidently contribute.
- Develop innovative strategies to obtain people’s input into policy and program development – for example, using ‘community art’ and participatory action research.
- Use different strategies appropriate to different contexts and different population groups/communities.
- Create opportunities and foster the development of supportive networks for mothers to come together so that their stories can be told, common issues and priorities can be identified, and priorities and agendas for action can be developed.

8.5.5 Worker autonomy

This emphasis on engaging service users, groups and communities in policy and program planning, implementation and evaluation raises the issue of worker

participation in organisational decision making processes. As clients and community members are recognised to be capable and knowledgeable, service providers should be recognised by managers and employers in similar ways. Decision making processes should aim to be inclusive of all those likely to be involved or affected so as to value and draw upon a wide range of resources. An implication of the emphasis in this thesis on the social relations of support and service provision is the need to trust and delegate decision making about service responses to service providers and mothers/service users at a local level. Service providers argued that when decision making is centralised or concentrated high up in an agency, worker autonomy is reduced and workers are effectively deskilled.

When control of work is delegated to individuals and teams of service providers, their flexibility to be 'client-led' in deciding the best service approach and being able to respond accordingly is supported. Within a workplace culture which expects and supports self-accountability and personal responsibility, protocols which guide service decisions should also be flexibly held. According to service providers, centralised planning and micro-systems such as triaging, case load targets, and limits on length and number of visits, work to constrain and delay preferred service responses. In their experiences, increasingly sophisticated data collection systems drive rather than record service delivery. There is a pressing need to develop data collection systems focused on the achievement of 'client's' goals and which are able to record the value of building trust and social connection, the communication of recognition and respect and the impact of processes of critical reflection in women's lives.

In conclusion, there is little doubt that these aspects of organisation structure and process recommended by service providers in the in-depth interviews represent a

significant challenge to dominant forms and trends in ‘new public management’ (see Chapter Three). At the same time, theory and literature from a number of fields are available to support these alternative forms. Community organisation and development; adult and community education; and ‘settings’ for health promotion are just three of these fields (Auer, Repin et al. 1993; Grossman and Scala 1993). Vision-led, devolved, and participatory processes also underpin more mainstream ‘learning organisation’ and change management theories and practices which contradict more dominant ‘command and control’ models (Senge 1994).

CHAPTER 9: ACHIEVING HEALTH EQUITY – IMPLICATIONS FOR POLICY AND SERVICES

The Australian Research Council *Families at Risk* project, of which this thesis project was one component, reflects the growth in research and policy interest in the extent of child and family health inequalities in Australia. Despite this interest and increasing evidence about how these inequalities can be addressed, there remain significant gaps between evidence and its transformation into policy and service provision. In this thesis key components of evidence, policy and implementation (services) together with the gaps which exist between them have been examined in detail. Even though there are examples of policies, particularly those related to children, which have been developed in line with the evidence which demonstrates the need for them, they are not necessarily – one might even argue ‘not often’ – implemented by the allocation of the necessary resources and development of appropriate service models and practices. The intentions may be excellent, but the practice does not match. When it is acknowledged that research, policy development and implementation occur within political, cultural, social and economic contexts it is possible, through critical analysis, to reveal the ideologies and powerful interests which shape their directions. Fundamental to this thesis exploration of the implications of the *Families at Risk* findings for policy and services was the recognition that the authority to determine needs and the decision about which needs are legitimate or have priority are value-laden and political.

A review of relevant policy contexts in Chapter Three concluded that while the principles of social inclusion and the goal of reducing social health inequalities are now generally a feature of health and early childhood policies, they are contradicted by more dominant economic and social policy driven by market

imperatives and the ‘necessity’ for individual responsibility and self-reliance. These policies, which are largely based on the values of competitive individualism and the concept of an ‘autonomous individual’, do not fit mothers’ experiences of their social world. Within the health system, the dominant paradigms are biomedical and the ‘new managerialism’ and the most powerful voices are those of medical and other professionals and the administrators of large institutions, including hospitals. Despite current use of ‘social determinants’ discourse in many health, welfare and education policies, effective action to tackle social health inequalities seems unlikely without substantially different political values and commitments. At the same time, the example provided by Sweden has demonstrated that denial of access to environments and relationships which support and promote health and well-being is not inevitable for people in the lowest social positions in advanced capitalist countries.

9.1 Challenging ‘problem’ language

It has been argued in this thesis that the way in which policy (and research) constructs its focus group is crucial in shaping the policy’s primary objectives and strategies. Policy and ‘problem’ language are imbued with meaning and influence thinking and action. Constructions of ‘risk’ and a focus on ‘the disadvantaged’ concentrate on the ‘symptoms’ of social exclusion and injustice and leave their fundamental causes untouched. Research, policy and services which ‘target’ those with the worst outcomes are themselves reflections of the unequal social relations which reproduce inequality.

The complex and contested natures of the concepts of ‘risk’ and ‘needs’ are obscured in the *Families at Risk* survey instruments (Appendix C) in which ‘needs’ are largely equated with the problems or concerns of individual parents and children. The notions of ‘strengths’ and resources (or ‘capacity’) appear to be

the ‘other side of the coin’ from this deficit notion of ‘needs’. However, when used in relation to individual behaviour and lifestyle they too can be conceived and analysed as characteristics of ‘discrete and self-contained’ individuals (Shim 2002).

The large scale survey interview methodology employed by the *Families at Risk* project assessed a range of factors related to disadvantage (including access to formal and informal support) and various aspects of individual behaviour and self-reported health and well-being. Analysis of this data confirmed a great deal of existing evidence of associations between health and well-being and individual ‘host characteristics’ and multi-level risk factors as well as of persistent patterns of serious social health inequalities. What is missed by this data are the political, social and relational processes which connect advantage/disadvantage and individual thought and action.

The participants in the thesis research interviews provided ‘thick descriptions’ of the nature and variety of ways in which ‘disadvantaged’ mothers act to manage and resist the effects of inequality and injustice. Without this ‘data’, the *Families at Risk* findings would represent yet another report about ‘pockets of misery’ and disparities in access and outcomes and would imply that the ‘solutions’ entail improvements in these disadvantaged people rather than the need to redress steepening social health gradients. While the intention is not to deny that serious disadvantage and poorer health and well-being are experienced by the *Families at Risk* population, its description is little relieved by a ‘weak’ (individual) version of strengths, needs and resources. Accumulating evidence of worsening social health inequalities has so far achieved a broad child and family health and well-being policy consensus but has produced little change in program responses and service delivery. The deficit and criticism implied in the emphasis on ‘targeted’ notions

of risk and need make it difficult to honour the competence and subjectivity of those whom policy makers and service providers seek to change. As alternatives to ‘victim’ language and descriptions of ‘suffering’, participants in the thesis research interviews recommended language which is able to convey recognition and respect for mothers’ commitment, capability and aspirations. Rather than the term ‘target’, Labonte (1992) advocated use of the term “individuals, groups or communities of interest”, suggesting that its deliberate use would encourage the critical question – why are we interested in this group and not others (Labonte 1992)?

9.2 *Early childhood services consensus*

A review of the early childhood literature demonstrated a broad consensus about the policy and service implications of the evidence that people’s life course trajectories are determined by the quality of the environments they experience when young. According to this consensus, service responses should:

- be universal and comprehensive rather than residual or targeted;
- be holistic to meet the full range of physical, social, mental and emotional health and well-being issues which people face;
- focus on prevention, early intervention and social connection;
- encourage community participation in changing and developing strategies to achieve improved services and better health and well-being for all;
- build capacity in the most disadvantaged localities and populations; and
- entail continuous and coordinated commitment in all sectors and at all levels (‘joined up action for joined up problems’).

However, despite the evidence and this consensus there remains seriously inadequate public provision (a “non-system”) of health and early childhood development in Australia and other countries in which the individualistic principle, that each person/family should be responsible for themselves, is predominant (Hertzman 2002).

In proposing policy and service implications, this thesis has been informed by debates and developments in the health inequalities literature, particularly those concerning how structural inequalities ‘get under the skin’ to influence people’s health and well-being. A better understanding of these mechanisms or pathways would greatly assist the task of developing proposals for how best to contribute to improving the health and well-being of families at risk. To achieve this clarity, however, a methodology different from that adopted by the *Families at Risk* project was required. A ‘micro-level’ examination of service relations and mothers’ and service providers’ narratives of their experiences of parenting and parent support enabled an exploration of the dynamics and meanings as well as the consequences of disadvantage.

9.3 Entitlement to support

The narratives of participants in the thesis project have contributed to understanding the stresses and challenges in the daily lives of parents, and particularly of mothers of young children living in situations of multiple and complex disadvantage, and have highlighted their considerable hope, commitment and effort in the face of these challenges. They want the best for their children. Full-time parenting is demanding work with long hours, no holidays, no pay, little recognition and the need to constantly adapt to the challenges of children’s growth and development and the needs of other family members. Even more demanding is full-time parenting with limited financial resources, limited social networks,

limited support and few affordable, accessible opportunities to entertain children. Adopting a view that it is 'normal' for parents of young children to need support and that both 'coping' and 'not coping' are to be expected for **all** parents suggests that support for parents and children should be an entitlement and be provided in a whole variety of ways.

At the broadest level these findings confirm the early childhood policy consensus that service policy and programs should be more focused on building and maintaining supportive structures and practices - such as access to safe, adequate housing, recreation and play, adequate income, practical support, education, childcare, health services, community networks and opportunities for friendship - than on individual 'deficits' in parents' skills, lifestyle, behaviour or responsibility. Living in disadvantaged places on a low income and with the effects of gender and socioeconomic inequalities is in many ways a sufficient explanation for poorer health and well-being in particular populations and localities. At the same time, people's ability to 'get through' and construct a sense of identity and purpose in very difficult and constraining circumstances points to the value of psycho-social and biography and life-course explanations.

9.4 Naming unequal 'power' and participation

Missing from the consensus about the design and delivery of early childhood services is the recognition that the unequal power relations, which commonly characterise the relationships between help seekers and professional or formal sources of help, are a key dimension of the experiences of 'families at risk'. Through the accounts of mothers and front-line service providers engaged in more equal service relationships, it has been possible to contribute insights into the interactions between the experiences and actions of individuals and the generative rules and resources which comprise social structure (Giddens 1979). Further,

these examples of ‘helpful help’ suggest the potential of service relationships as sites for challenging the social processes of inequality.

In a broad sense, the aspects of living and parenting in contexts of serious disadvantage highlighted by mothers and service providers in the in-depth interviews were not surprising. There are many other studies in which people with direct experience of poverty and other social health inequalities have described the isolating and debilitating effects of inadequate resources, low social position, their sense of unworthiness, powerlessness, ‘voicelessness’ and lack of choice. Health ‘consumer’ organisations and social movements have stressed the value to individuals and groups (for example; women, disabled people and people with a mental illness) of the grant of recognition and respect. Communicating respect through careful listening and participatory service relationships are fundamental tenets of social work training and practice. There is evidence that forms of participation which increase people’s sense of their own agency and make governments more accountable to those who have the least power and access to resources are themselves a direct way of reducing social health inequalities.

What is interesting then, in proposing implications for services, is the question why the gaps between evidence, policy and implementation appear to be so persistent.

The accounts of mothers and their service providers confirmed that material deprivation and social isolation are not ‘object states’ but unequal and corrosive social relations (Frohlich, Corin et al. 2001; Lister 2002). Their causal narratives reflected what Gerhardt (1989) referred to as a ‘deprivation-domination’ model, in which poorer individual (and family) health and well-being are linked to societal

structures of power and the ways societal processes shape (and are shaped by) persistent patterns of inequality in these structural determinants (cited by (Williams 2003) (see also (Bartley 2003).

9.5 Critical population health policy and practice

In this thesis, use of the concept of social practice in which structure and agency are viewed as interdependent, has enabled the ‘problems’ of families at risk to be theorised as more than a lack of individual resilience and poor health ‘choices’ and more than something pre-determined by structural disadvantage. In broad outline, the ‘problem’ definitions upon which recommendations for policy and service development made in this thesis have been built include:

- This research population of caregivers and children have inadequate and inequitable access to material, relational and political resources and opportunities for health and well-being;
- Unequal attributions of responsibility for the care and protection of children to mothers who, at the same time, do not have access to necessary resources (including power) are oppressive;
- The commitment and capability of women as mothers and carers are often not recognised, not celebrated nor supported.

The recommendation that policy and services should be primarily focused on achieving changes in the conditions and processes which create poorer health experiences and reproduce social health inequalities is confirmed by these problem definitions. Instead of services being primarily focused on the provision of one-to-one services, a whole-population, whole-environment perspective is required. From this perspective, concern with the distribution of health-determining

conditions and the potential of services to contribute to achieving health equity and to redressing unequal social relations are issues of fundamental importance.

9.6 Redistributive social policy implications

The *Families at Risk* survey findings demonstrated that in families with young children occupying the lowest social positions women, and in particular young women, are the primary caregivers. It follows that ‘gender’ and ‘youth’ lenses need to be applied to parent support issues and to policy and service development with a focus on providing and facilitating adequate and supportive resources and environments for young mothers and children. Along with strong evidence from the literature that young age, financial hardship and a low level of completed education are associated with women’s lack of safety and poorer outcomes for children’s development, health and well-being, it is clear that redistributive social policy is required to ensure more adequate provision for their basic needs.

Fundamental to this redistribution are strategies which reduce women’s/young women’s poverty so that their (and their children’s) basic needs can be met and which enable them to direct their resources to other aspects of their lives, including completing school education and participating in further education and employment programs. The research findings affirmed the current emphasis of education and social inclusion policies on school retention and participation in further education.

9.6.1 Housing

Living conditions, in terms of both housing and neighbourhood characteristics, are a major determinant of health and well-being. More than four-fifths of the *Families at Risk* survey respondents rented their homes publicly or in the private rental market and more than half had moved house three or more times within the

past five years. Almost three-quarters of participants perceived that they had little or no choice about their current housing circumstances, their choice being limited by affordability and location of public housing stock as well as their vulnerability (to domestic violence and other unsafe situations). Their residential mobility poses challenges for service delivery, particularly in relation to service continuity and coordination, and challenges also for caregivers to be fully aware of available community-based services. Furthermore, frequent house shifting is likely to disrupt established support and limit the development of supportive neighbourhood relationships. The vulnerability of this population to urban planning and housing allocation decisions supports current policy thinking related to the future development of public housing, in particular:

- Addressing issues of availability and affordability of housing, particularly for young mothers;
- Avoiding the concentration of public housing stock in particular localities; and
- Addressing the current problems of concentration through strategies which address the social determinants of health and well-being, including local employment, neighbourhood development, education and childcare opportunities, and so on.

9.6.2 Childcare

In the light of the wealth of evidence concerning the benefits of participation in quality childcare for early childhood development, the low-level use of childcare services by this research population should be of significant concern. In addition, caregivers need access to childcare if they are to engage in paid work, participate in education, or in their community(ies). The research participants recommended

that childcare not only needs to be flexible, affordable, conveniently located and accessible (in terms of hours, cultural sensitivity and suitability for children with differing abilities), but it must meet their personal ‘standards’ for them to feel comfortable leaving their children there. These standards vary and are related to caregiver’s values, upbringing and other experiences. Women with experiences of domestic violence and/or neglect or abuse as a child may be unwilling to leave their children in someone else’s care unless or until a trusting relationship is established. More research may be needed to investigate how their use of formal childcare services could be better supported.

Alongside this evidence of low-level use of formal childcare, the research participants stressed the need for time out from the demands of caring for children. For women who parent alone and/or who have little or no support from other family members there are few opportunities for respite. Clearly, there is a role for services in ensuring parents have opportunities to take time out for themselves while their children are safely cared for.

9.6.3 Investing in social capital development

The extent of this research population’s reliance on ‘close others’ for all forms of parenting support (‘bonding’ social capital) may contribute to their social isolation and limited access to resources and opportunities for improved health and development. Publicly provided resources and opportunities for mothers (particularly young mothers) of young children to participate and receive support and recognition are fundamentally important to the development of ‘bridging’ or linking social capital. Public resources which participants in this research reported they valued included: playgroups, occasional childcare, childcare supporting their enrolment in adult education, women’s/young women’s support groups, local illness/health and community services, home help services, safe and fun public

parks and playgrounds, and other local 'opportunity structures' such as shops, cafes, community halls and meeting places.

9.6.4 Universal and comprehensive services

The findings which showed the predominant use by this research population of easily accessed publicly provided services (especially GPs and hospitals), supports the policy proposal that the most effective support strategies will be those which are universal and comprehensive. Examples include population-based parent support and early childhood development programs such as nurse home visiting, community midwifery programs, parent support networks, enriched centre-based childcare and pre-school programs. Universally and locally provided services also have the potential to be used as settings for health development, parent/family and community support and participation. An example is the range of 'health promoting schools' strategies which have been implemented in South Australian pre-schools and schools. In addition, support for 'additional needs' should be linked to publicly provided universal programs. Health Action Zones in the United Kingdom have produced examples of how additional resources can be targeted to particular populations or geographic areas by building on locally provided universal services⁷⁹.

9.6.5 Community development

In addition to access to adequate resources including services and social support, there is strong evidence that better health and well-being are associated with neighbourhood characteristics. The *Families at Risk* research findings, which showed a low level of social connection other than that with close others, exist alongside evidence of high local crime/social disorder rates, low levels of neighbourhood trust and sense of safety and low levels of community involvement

⁷⁹ See www.haznet.org.uk for these examples.

within the neighbourhoods from which the research population was drawn. To reduce social isolation and provide safe and supportive environments for all families with young children, improved amenities and investment in neighbourhood community development are required. Examples of what could be done include:

- Create safe, attractive physical environments – including parks, playgrounds, streets and buildings;
- Subsidise programs and provide transport to encourage children to participate in sport and recreational activities;
- Develop comprehensive community-based initiatives which connect residents in communal activities, including those to protect and improve the health and safety of women and children; and
- Provide opportunities particularly for women, to learn advocacy and leadership skills which they could apply towards community development initiatives.

9.7 How has this thesis ‘added value’ to other forms of evidence?

In relation to research and service delivery to ‘families at risk’, people with first hand experience have most often had little ‘voice’ other than to tell their stories over and over again to researchers and professionals who then apply their ‘expert’ knowledge and authority to extract conclusions. As demonstrated in this thesis, the accounts of mothers and front-line service providers are not simply sources of a different form of data about service use or coping for extraction by researchers. Their narratives have ‘co-constituted’ descriptions of the ‘real world’ and

contribute to understanding how social structures and practices shape individual life-course and determine health and well-being.

Seeking and using lay knowledge are an important part of a broader agenda in which disadvantage is recognised as being as much about the dynamics of inequality as it is about material deprivation. This leads to an emphasis on the citizenship rights of marginalised people to participate in society more generally and to have greater control over their lives and on valuing the voices of those who are least heard and often not believed.

A fuller and more nuanced analysis of the ‘strengths and resources’ of parenting in situations of complex disadvantage has been achieved by using lay knowledge alongside more conventional forms of evidence. As is typical of findings from participatory research, the perspectives of mothers and their service providers have emphasised the interconnections between different aspects of poverty and ‘risk’ and, in particular, how unequal power relations structure people’s access to resources (Beresford, Green et al. 1999; Brock and McGee 2002; Lister 2002; Williams 2003; Lister 2004).

9.8 *Empowering research and service support practices*

There are parallels between participatory approaches to research and practices of service support. The findings of this thesis project support the argument that mothers who are the primary caregivers in ‘families at risk’ should:

- be recognised as having authority; their knowledge respected and seen as legitimate;
- have greater control over the various processes of help and service support;

- have more influence over decision-making at a number of levels related to policies and practices which affect their lives and the lives of their children;
- have more opportunities to connect to others and participate in social development and learning;
- have opportunities to reflect critically on the processes and role of help and service support in challenging or contributing to inequalities.

Just as the collaborative approach in the *Families at Risk* project fell short of its aspirations (see Chapter Four), this thesis research project did not entirely match its participatory ideals. In line with the tenets of critical population health research, Bennett and Roberts (2004) define participatory research practice as ‘interactive’ rather than ‘extractive’: concerned “not to use people taking part in research only as sources of information, but to establish relationships with them and also give something back, with a view to achieving some positive change (p5)”. Ideally conceived, the *Families at Risk* and the thesis project would have involved several stages in which caregivers, service providers and policy makers were involved in deciding the original research agenda, how they wanted the research to be undertaken and in developing the findings and recommendations. In terms of the ideals of critical population health research, it seems unlikely that the caregiver participants will ever know if their contributions ‘made a difference’.

9.9 Achieving health equity – supporting families’ (women’s) and children’s relationships of care

To effectively redress inequalities, public policy must address the political, material and relational components of achieving health equity. Achieving equity means more than improving outcomes for those most at risk. It means reducing

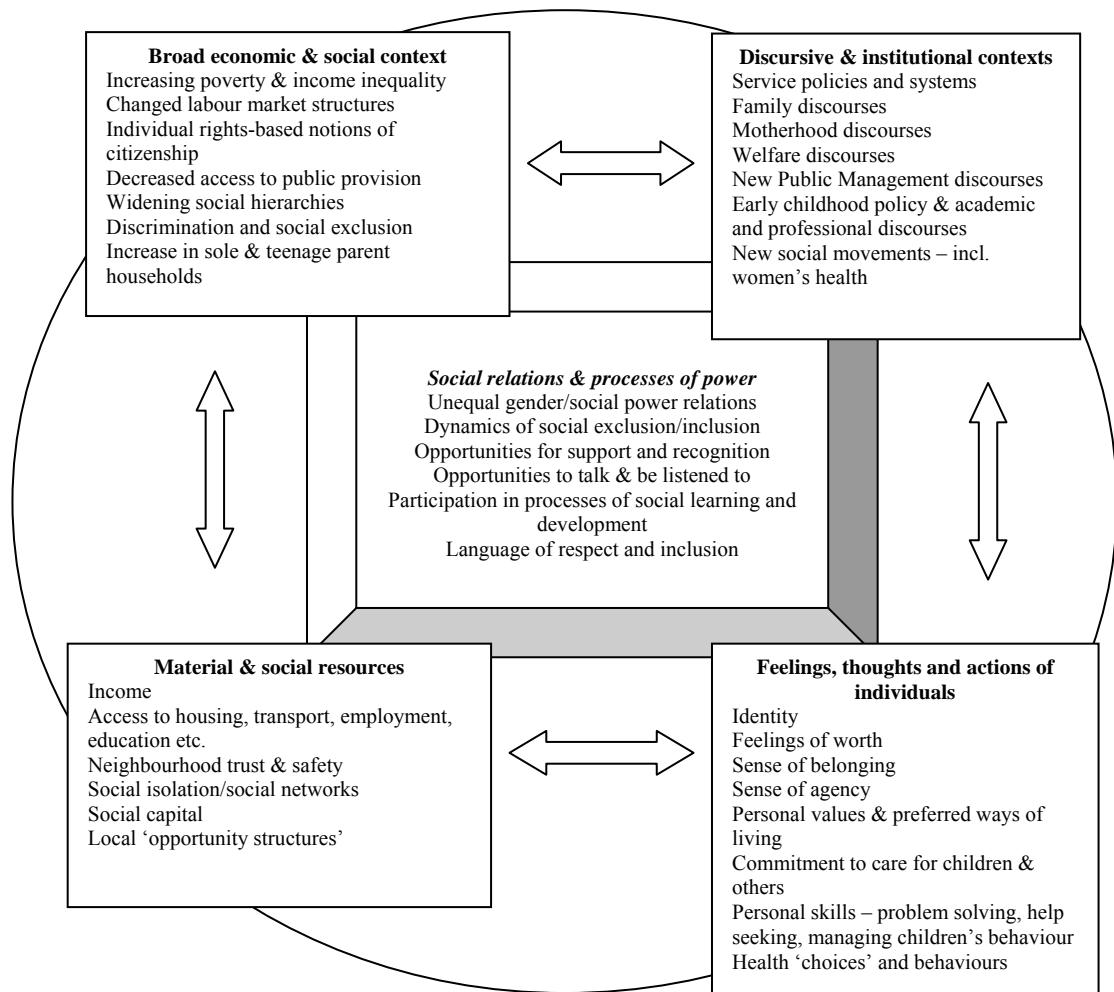
social, economic and physical (place) gradients rather than ‘simply’ eliminating barriers for people with the worst outcomes. Structural inequalities, and the unequal power relations upon which they are based, can be made visible by being recognised as providing the ‘infrastructure’ and the ‘electricity’ for parents’ and children’s health. Services (planning, organisation and implementation) should be critically conscious of tendencies to manage, predict, control and operate in ways which contribute to maintaining the status quo. Achieving change in the distribution of resources and the use of power requires advocacy and action which is co-ordinated and well supported.

The argument that all parents and children ‘need’ access to resources and opportunities to support their health and development is based on evidence, justice values and ideology. Visions of a ‘collective good’ (for example: ‘health for all’; ‘it takes a village to raise a child’) and values of moral worth imply social redistribution and social development. In addition to having access to adequate resources (including power) and ‘opportunity structures’ (including local environments, amenities and publicly provided services), people need to feel safe, supported, connected, and be actively engaged in social learning and development and in creating the conditions of their own lives. All these are crucial to the achievement of social or ‘full’ citizenship.

Within this radical health equity framework, along with redistributive measures to alter fundamental social inequalities (such those included in the specific social policy recommendations made earlier), program or service interventions are required which (1) reduce the effects of occupying a low social position (referred to as ‘social vulnerability’ in dominant policy discourses) and (2) target care and urgent support services to those with the worst health and least access.

Figure 6 below replicates the research framework presented in Chapter One to provide a ‘key ideas’ summary of the evidence which has contributed to the main arguments in this thesis.

Figure 6: The Research Framework Revisited



It has been demonstrated in this thesis that because women, especially women who occupy the lowest social positions, are the main caregivers to children and others, their health is fundamental to children’s and family health and well-being. Women’s experiences of health have been shown to depend on access to resources and on social relations which support their care responsibilities. One mother

(quoted in Chapter Seven), recommended that services could better support ‘families at risk’ if women’s (mothers’) needs were visible and seen as a priority:

...treat the mothers like people ... put mother’s needs, find out what she needs first... there’s no point in doing anything until the mother is happy, don’t you think (Liz)?

Liz’s views are supported in recently developed women’s health policy:

Women are the principal carers of children, the frail and elderly, people with a disability and people with a mental illness – all groups who are significant users of health services. Getting women’s health right is therefore good for the whole community (Government of South Australia 2005).

In summary, in addition to fundamental redistributive measures, health and welfare policy, programs and services could better support mothers’ relationships of care by:

- rebalancing the focus of policy so that the health and well-being of women / primary caregivers have priority alongside that given to protecting and supporting children;
- providing more services based on critical and feminist understandings of health and motherhood and the goal of supporting the aspirations and capabilities of each woman;
- developing forms of service organisation and supporting service practices which encourage women’s, families’ and children’s participation in social learning and development.

Policy based on political principles of ‘full’ citizenship including entitlement and equal moral worth would provide the basis for ensuring material and social support and fostering the capacities of all people individually and collectively to achieve

their preferred ways of living. However, challenging unequal social relations and a vision of health equity contradict and “will be at a cost to the current social order” and therefore, can expect to be resisted (Forbes and Wainwright 2001).