



MINISTRY OF SOCIAL DEVELOPMENT
Te Manatū Whakahiato Ora

Sole parenting in New Zealand:

An update on key trends and what helps reduce disadvantage

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Disclaimer

The views expressed in this report do not necessarily represent government policy or reflect the views of participating agencies. Any errors or omissions in the findings summarised in this publication are the responsibility of the relevant research teams.

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Executive Summary

This report forms part of a cross-agency and cross-sector research programme that aims to improve the knowledge base for public policy by:

- increasing our understanding of the vulnerability to disadvantage among some sole-parent families
- identifying sources of resilience which can enable vulnerable sole-parent families to achieve good social and economic outcomes
- identifying policies and interventions that are effective in reducing vulnerability and building resilience.

The research programme was partly motivated by the disproportionate number of sole-parent families who, based on our national surveys, appear vulnerable to disadvantage. While most sole-parent families fare well, across domains ranging from living standards and poverty, to mental and physical health and criminal victimisation, the proportion of sole-parent families experiencing disadvantage is high, both in absolute terms, and compared to two-parent families.

The purpose of this report is to draw together and summarise findings from projects undertaken as part of the research programme to date. Some of these findings update key trends. Others build our understanding of vulnerability to disadvantage. The findings also include new qualitative research that tells us about some sources of resilience, and a review of the evidence on effectiveness for some of the measures that can reduce vulnerability and enhance resilience.

Findings

The proportion of families headed by a sole parent

Between 2001 and 2006, the number of sole-parent families levelled off and the proportion of families headed by a sole parent fell slightly after climbing for the previous 25 years.

Growth in sole parenthood in the late 1980s and 1990s is likely to have been at least partly linked to the effects on family formation and family stability of high unemployment and the associated structural changes in the labour market.

There was a gradual downward trend in the proportion of families with younger children headed by a sole parent between the late 1990s and 2007, a period of sustained economic growth.

As this new generation of families ages and makes up a growing share of the population of families with dependent children, it is possible that we will see further reductions in the rate of sole parenthood, although this may be offset if a new rise in sole parenthood occurs with the current high levels of unemployment.

Employment

Since 1991, the proportion of sole parents in employment has trended upwards, narrowing the employment rate gap between sole and partnered parents.

From the late 1990s, virtually all of the increase in sole mothers' employment has been driven by growth in full-time employment rates. Changes in the composition of the sole-parent population, economic growth and policy reforms are all likely to have contributed to this increase.

The proportion of sole parents in employment levelled off between 2007 and 2008 and fell in 2009.

Incomes and income poverty

In 2009, 90 percent of sole-parent families had incomes below the median household income for all households, with or without children. Sole parents and their children have significantly higher poverty rates than parents and children in two-parent families.

On the measure used in this report, poverty rates fell for people living in families with dependent children overall between 2001 and 2009. In 2009, the poverty rate for sole parents and their children was 43 percent, a fall from the much higher rates that prevailed from 1992 to 2001 (around 70 percent).

As a result of a sharper decline in poverty rates for children in two-parent families, children of sole parents increased as a proportion of all children living in households with income below the poverty threshold, making up more than a half for the first time in 2007 and 2009.

The high poverty rate of parents and children in sole-parent families is related to their high rate of benefit receipt. An estimated 73 percent of sole parents were in receipt of a benefit in 2009.

Mental health

A cross-sectional prevalence study of mental health undertaken as part of the research programme found that an estimated 43 percent of New Zealand sole parents met the criteria for a diagnosable mental disorder in the 12 months prior, compared to 19 percent of partnered parents. Anxiety disorder was the most common type of disorder among both groups.

While most sole parents had no disorder, after adjusting for differences in age, gender and ethnicity, sole parents were more than two times more likely than partnered parents to meet the criteria for a mental health disorder.

A wide range of factors can influence mental wellbeing in adulthood. Given the cross-sectional nature of the available data, this study could only estimate the extent to which the excess risk of mental health disorders was associated with differences between sole parents and partnered parents in a number of measures of current circumstances (income level, employment, physical health, and co-residence with other adults as a proxy for social support).

A third of sole parents' excess mental health risk was found to be associated with low socio-economic position, with employment having only a minimal independent association once income was controlled for. Not having a co-resident adult was associated with a similar proportion of the excess risk (about one-third). Physical illness had a small association with rates of depression only.

The combination of low socio-economic position and not having another adult living in the household was associated with virtually all sole parents' excess risk for suicidal ideation; two-thirds of the excess risk for anxiety disorders; just over half of the excess risk for mood disorders; but only one-quarter for substance abuse disorders.

To the extent that the associations found are causal, the findings could suggest that sole parents who are well supported financially, emotionally and socially are more likely than others to experience good mental health. However, it is not possible to draw firm conclusions about whether any direct causal relationships underlie the associations. In practice, they are likely to reflect a complex mix of different mechanisms:

- They are likely to partly reflect causal effects, for example living on a low income and living without other adults as a result of sole parenthood will contribute to mental health problems in some cases.
- They are likely to also partly reflect reverse causality, for example pre-existing mental health problems might increase the likelihood of parenting alone and also increase the likelihood of having low-income and living without other adults in some cases.
- To some extent, they will reflect no direct causal association between current circumstances and mental health at all, but rather the cumulative effects of early disadvantages that increase the likelihood of sole parenthood, and also increase the likelihood of low income, living without other adults and having poor mental health.

The role of early disadvantages

Our study linking benefit data with the Dunedin Multidisciplinary Health and Development Study found significant associations between time spent receiving benefits in young adulthood and a range of disadvantages in childhood and adolescence.

These included measures of low family socio-economic status and stability, poor maternal mental health, physical and sexual abuse in childhood, behavioural and mental health problems in childhood and adolescence, unemployment after leaving school and early parenthood.

There is still much to learn about the causal paths that underlie the associations found. But even without further analysis, they clearly indicate the early disadvantages that some current longer-term benefit recipients have experienced.

Given the high proportion of sole parents who receive benefits, these findings confirm that disadvantages that pre-date parenthood will partly explain the relatively high rates of mental health problems and other vulnerabilities of sole parents overall in cross-sectional surveys. Women who have children at an early age – a group that on average tends to have difficulties prior to becoming parents and has an elevated risk of longer-term

benefit receipt – are over-represented among those who are sole parents at any point in time.

The findings also highlight the possibility that persistent poverty associated with very long periods of benefit receipt may compound disadvantages for some.

What helps – the voices of teenage parents

Our small qualitative study followed up on the experiences of 13 women who parented in their teens. These young mothers' accounts of their lives over the past seven years demonstrated a range of factors associated with resilience.

They described individual characteristics such as being motivated, having goals and taking responsibility. They also acknowledged the importance of family and whānau, and new partners in providing social, emotional and practical support.

Those who attended a teen parent unit or received support from other community-based services saw these organisations, and the adults they had contact with through them, as a key to moving forward with their lives.

These young women's views and experiences suggest that addressing challenges to resilience, such as poor mental health, lack of support, financial hardship, and children's emotional and behavioural concerns, is important to ensure teenage mothers and their children reach their potential.

Many participants in this study defy stereotypes of teenage mothers. While most would not recommend teenage motherhood, their stories show how giving birth as a teenager can be a steeling experience that, with appropriate resources and support, can unlock potential.

What helps – approaches and interventions

This section reviews evidence from the research literature on approaches that have been shown to be effective in reducing vulnerability to disadvantage and promoting resilience. We have focused on approaches in three broad areas:

- measures to promote better mental health
- measures to reduce disadvantages early in the lifecourse
- measures to improve support for vulnerable young parents.

Measures to promote better mental health

There is good evidence demonstrating the effectiveness of a range of psychological and pharmacological treatments for most mental health problems. There is also evidence that mental health promotion and prevention programmes can reduce mental health symptoms for people subject to key stressors.

For some sole parents, mental health problems may be interrelated with other difficulties. Evidence on the effectiveness of different treatments and preventative programmes specific to this vulnerable group is more limited, but a number of approaches that promote coping skills and build social support appear promising.

The findings indicate a need to ensure awareness of the high rates of mental health problems for sole parents among agencies and health professionals working with this group, and to promote access to primary mental health care, including alcohol and drug rehabilitation services.

Measures to reduce disadvantages early in the lifecourse

There is an extensive evidence base demonstrating that early intervention for vulnerable children and families can improve child wellbeing and reduce vulnerability to disadvantage over the life course. Successful approaches include:

- early and intensive support by skilled home visitors for vulnerable families who are expecting a first child
- very high-quality, centre-based, early education programmes for young children from low-income families
- two-generation programmes that provide direct support for parents and high-quality, centre-based care and education for families experiencing significant adversity
- intensive services that address recurrent child abuse or neglect, severe maternal depression, parental substance abuse, or family violence.

However, not all programmes have been found to be effective. The literature suggests that effective programmes:

- have clear goals based on a strong theoretical foundation
- are implemented with strong programme fidelity (high commitment to initial desired outcomes and processes)
- tailor their services to the needs of the individual families (including high-intensity and long-lasting services as appropriate)
- are sensitive to families' cultural differences
- use professional (or very highly trained para-professional) staff
- support staff with appropriate training, supervision and low staff-to-child ratios.

Measures to improve support for vulnerable young parents

Research suggests that it is possible to support some young people to delay parenting through the provision of comprehensive sex education and easy access to sexual health advice and a range of contraceptive options.

There is also evidence that early intervention strategies for disadvantaged children, such as high-quality early childhood education, can reduce their likelihood of parenting early, as can holistic youth development programmes which promote engagement with education, pro-social relationships, and ambition.

For vulnerable young people who do parent early, comprehensive support can promote better outcomes for both parents and children. This is one means of breaking inter-generational cycles of disadvantage since children of very young parents are at a higher risk of a range of disadvantages, including becoming very young parents themselves.

There may be opportunities to leverage off early contact with vulnerable young people through the benefit system to promote better access to comprehensive antenatal care in pregnancy and ensure that parents and their children are well supported.

Discussion

There is no single, simple solution to the vulnerability to disadvantage experienced by some sole-parent families.

Uncertainty remains surrounding the origins of vulnerability, how to intervene to prevent or alleviate it, and how to build resilience. In the context of uncertainty, and given the high likelihood that causal factors have their effect by acting in combination across the lifecourse, a portfolio of interventions that addresses disadvantages and builds resilience in childhood, adolescence and adulthood is likely to be most effective.

Disadvantages co-occur at a high rate, and this highlights the need for interventions and services to be long-term, co-ordinated and multi-modal for some individuals and families.

A broad focus on improving the wellbeing of both vulnerable parents and their children appears likely to offer the best prospect of improving the overall wellbeing of sole-parent families into the future. This need not require a trade-off between investing in the needs of the current generation of vulnerable parents and investing in the current generation of vulnerable children – improving the adequacy of parents' incomes, making high-quality early childhood education more readily available to vulnerable families, and improving vulnerable parents' mental health, for example, is likely to have benefits for both children and parents.

To some extent, the disadvantages that some sole parents experience are not unique to them. They require general solutions, which, if successful, can be expected to reduce vulnerability among sole parents as well as other groups. However, solutions that connect with the circumstances of vulnerable sole-parent families and focus on particularly vulnerable subgroups, including very young sole parents, are also required.

1 Introduction

The purpose of this report is to draw together and summarise findings from projects undertaken to date as part of a research programme focussed on sole-parent families.

About the research programme

The research programme is a cross-agency and cross-sector initiative that aims to improve the knowledge base for public policy by:

- increasing our understanding of the vulnerability to disadvantage among some sole-parent families
- identifying sources of resilience which can enable vulnerable sole-parent families to achieve good social and economic outcomes
- identifying policies and interventions that are effective in reducing vulnerability and building resilience.

The research programme comprises a number of discrete projects. This report brings together and summarises some of the findings to date. These include:

- updates of long-term trends in the rate of sole parenthood, and employment and poverty rates (sections 2–4 of this report)
- analysis that helps build our understanding of the high prevalence of mental health problems among sole parents (section 5)
- findings that highlight the role that early disadvantage, and an associated high representation of mothers who parent early, plays in accounting for vulnerability to mental health problems, hardship and other disadvantages (section 6)
- findings from a small qualitative study that tell us about the sources of resilience that a group of young women who became parents at an early age have drawn upon in order to improve their circumstances (section 7)
- a review of measures that can be effective in improving mental health, reducing early disadvantage, and supporting young parents to achieve better outcomes (section 8).

Why focus on sole-parent families?

Sole-parent families consistently stand out in our national surveys. Across domains ranging from living standards (Jensen et al, 2006) and poverty (Perry, 2010, forthcoming) to mental and physical health (Sarfati and Scott, 2001) and criminal victimisation (including confrontational offences involving a partner) (Mayhew and Reilly, 2007; Mayhew and Huang, 2009), the proportion of sole-parent families experiencing disadvantage is very high, both in absolute terms, and compared to two-parent families.

There is a need to better understand and respond to these high rates of disadvantage. But it is also important to recognise that most sole parents and their children do very well, and that where disadvantages do occur, some of the root causes and ways to build resilience may be the same regardless of the number of parents in the family (Fergusson et al, 2007; Mackay, 2005).

How do we define sole-parent families?

This report is focused on sole-parent families with dependent children, where:

- a sole parent is defined as a parent without a partner, living with one or more dependent children in a household with or without adult children or other adults
- a dependent child is defined as a person aged less than 18 years who is not in full-time employment.¹

A limitation of the quantitative research presented is that it is based on existing data collections and classifications which do not adequately reflect the diversity that exists in family form and in arrangements for the financial support and care of children (Statistics New Zealand, 2007; Callister and Birks, 2006).

For many children in sole-parent families there will be a parent living in another household who is actively involved in their care and financial support. Some will share their time between parents living in different households, and some will be cared for by other family members as well as their parent or parents.

In addition, some of the children in families with two partnered adults will have only one adult committed to their care and financial support.

The circumstances of families with these different types of arrangements are not able to be examined using existing survey data.

Recognising dynamism and diversity

Sole parents are not a homogeneous group, but encompass a range of people in different circumstances. Nor is sole parenthood an unchanging status; rather people move in and out of sole parenthood (sometimes on repeated occasions) and may be sole parents for shorter or longer periods of time.

Spending at least some time in a sole-parent family is a relatively common experience. The most recent estimates are that around one in two mothers have spent some time as a sole parent by the time they reach 50, and that a third of children have lived with a sole mother for some time by age 17.²

Sole-parent families' circumstances differ by their route into sole parenthood (which may be as a result of bereavement, the imprisonment of their spouse, separation, or birth outside of a live-in relationship, for example), and by the parent's gender, age, health, education, labour market history and preferences around work and parenting. They also differ by the age, number and health of the children, and by the amount and nature of the involvement by the children's other parent.

Older and younger sole parents have experienced very different periods of social and economic change and may come to sole parenthood with different expectations.

¹ Differences in source data mean that some studies in the research programme have a slightly different definition or focus. Where this is the case, this is noted.

² Based on a nationally representative retrospective survey – the New Zealand Women: Family, Education and Employment (NZWFEE) survey undertaken by the University of Waikato in 1995 (Dharmalingam et al, 2004).

The experience of sole parenthood also differs across ethnic and cultural groups. Many sole parents across all groups have support from extended family or whānau, but the likelihood of being able to draw on this type of support, and the likelihood of living with extended family, may be greater in groups with strong traditions of wider kin-based responsibility for the care of children (Ministry of Women's Affairs, 2004; Warburton and Morrison, 2008).

Some sole-parent families will experience no disadvantages. Others will experience multiple disadvantages in different areas of life, and the difficulties they face may be interrelated.

This report begins by updating longer-term trends in the proportion of families that are headed by a sole parent, the proportion of sole parents who are employed, and the poverty rates of parents and children in sole-parent families.

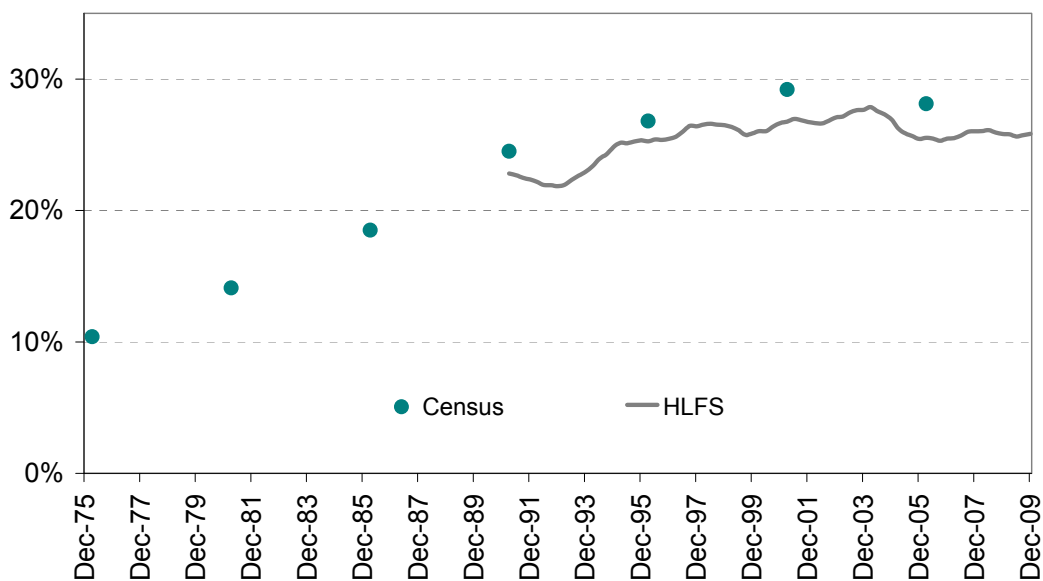
2 The proportion of families headed by a sole parent

Figures from every census over the 25 years to 2001 showed an increase in the number and proportion of families with dependent children headed by a sole parent.

However, between the 2001 and 2006 census dates, while the number of families headed by a sole parent increased slightly, the number of two-parent families increased by a larger margin. As a result, the proportion of families headed by a sole parent fell slightly from 29 to 28 percent (Figure 1). This shift was also seen in the Household Labour Force Survey, the best information source between census dates.³

The pattern of growth and levelling off was similar for sole parents of both sexes, although the number of families headed by a sole father increased at a faster rate, particularly in the late 1980s and late 1990s. Sole fathers accounted for 17 percent of all sole parents with dependent children in 2006, an increase from 14 percent in 1986.

Figure 1: Proportion (%) of families with dependent children headed by a sole parent



Sources: Statistics New Zealand: Census tables; Household Labour Force Survey, customised tables, annual averages for people in working-age households

A similar pattern of recent levelling off in the proportion of families headed by a sole parent has been observed in other countries: Australia, the United Kingdom, Canada

³ The rate of sole parenthood obtained from Household Labour Force Survey (HLFS) tends to be lower than the rate obtained from the census. This reflects a higher enumeration of two-parent families in the HLFS than in the census. The number of sole parents enumerated in the two sources is similar. The reason for the higher count of two-parent families in the HLFS is not clear, but it may reflect differences in response rates across different social groups. The HLFS is a sample survey and data is re-weighted to adjust for non-response. This re-weighting does not seek to achieve consistent totals by family status.

and the United States. To some extent, the social and economic forces that contributed to this pattern are likely to be common across western nations.

Factors associated with the rise of sole parenthood in the 1960s and early 1970s include changes in social norms and behaviour regarding premarital sex and childbearing, marriage, divorce and cohabitation; the contraceptive revolution; increased female employment after marriage; and a shift in values towards greater individual autonomy (Lesthaeghe, 1995; Lewis, 1997; Ermisch et al, 1987).

The movement of a large generation through the childbearing ages at this time of social change contributed to the scale of the increase. A number of governments responded to the rising numbers of sole-parent families by extending social assistance on the grounds that, without a male breadwinner, such families were at risk of poverty (Royal Commission on Social Security, 1972; Finer, 1974).

Sole parenthood in New Zealand grew rapidly in the late 1970s and 1980s, the number of sole parents increasing by a third between each five-yearly census. Relationship breakdown was the main factor driving the growth in sole parenthood, evidenced by rising divorce rates and growing numbers of separated and divorced sole parents. A second contributing factor was an increase in the number and proportion of pregnant single women who did not marry or place their child for adoption (Pool et al, 2007; Sceats, 1985).

Between the 1986 and 1996 census dates, the growth in sole parenthood was likely to have been at least partly linked to the effects on family formation and family stability of high unemployment and the associated structural changes in the labour market.

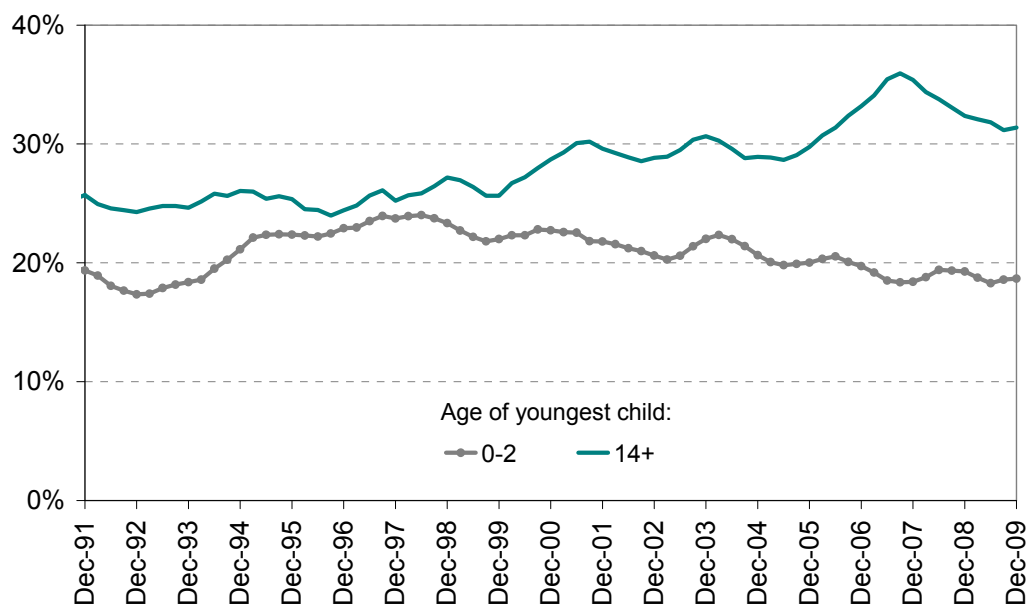
The New Zealand economy was virtually stagnant between 1986 and 1993. The official unemployment rate rose sharply to peak at 11 percent in 1991/1992, with rates around two and a half times this level for Māori and Pacific people who were concentrated in the industries and occupations most affected.

The more severe loss of employment occurred among Māori men. This may have contributed to the particularly rapid growth in sole parenthood among Māori in the 1980s (Whiteford, 1997:457 in Goodger and Larose, 1999). More generally, labour force participation rates for males with low educational qualifications fell most (Dixon, 1996), reducing their ability to be the primary earner in a couple (Callister, 1998).

While links between these changes and the growth in sole parenting in the 1980s and 1990s seem likely, we lack New Zealand evidence on the scale and nature of the relationship. In particular, we lack evidence on whether the way in which social assistance was structured for sole and partnered parents affected by unemployment played a role (Nolan, 2008).

The recent decline in the rate of sole parenthood partly reflects a gradual downward trend in the proportion of families with younger children that are headed by a sole parent. This trend is apparent in Household Labour Force Survey data between 1999 and 2007, a period of sustained economic growth (Figure 2).

Figure 2: Proportion (%) of families with dependent children headed by a sole parent, by age of youngest child



Source: Statistics New Zealand: Household Labour Force Survey, customised tables, annual averages for people in working-age households

Census data suggests that a rise and subsequent decline in sole parenting among families with young children was experienced by all ethnic groups (Table 1).⁴ The proportion of babies living with a sole mother fell between 2001 and 2006 for all ethnic groups other than Pacific peoples.

Table 1: Proportion (%) of infants under 1 year living with a sole mother, by ethnic group of child, 1986–2006

Ethnic group of child	1986	1991	1996	2001	2006
European	9	14	16	16	14
Māori	29	40	39	37	36
Pacific	23	30	33	30	32
Asian	6	8	10	12	10
Other	18	20	22	23	20
Total	13	19	21	20	19

Source: Statistics New Zealand, unpublished census data

As the new generation of families ages and makes up a growing share of the population of families with dependent children, one possible outcome is that we may see further reductions in the overall proportion headed by a sole parent. However, this may be offset if a new rise in sole parenthood occurs with the current high levels of unemployment.

⁴ Children identified with more than one ethnic group are counted once in each ethnic group reported. To maintain consistency over time, children identified as 'New Zealander' in 2006 have been included in the European ethnic group.

3 Employment

At the 2006 Census, 54.1 percent of sole parents were in paid work, with 35.6 percent employed full-time (defined as 30 or more hours a week) and 18.5 percent in part-time employment (Table 2).

Sole fathers were more likely to be employed than sole mothers, reflecting higher rates of full-time employment. Both sole mothers and sole fathers had lower employment rates and higher unemployment rates than their partnered counterparts.

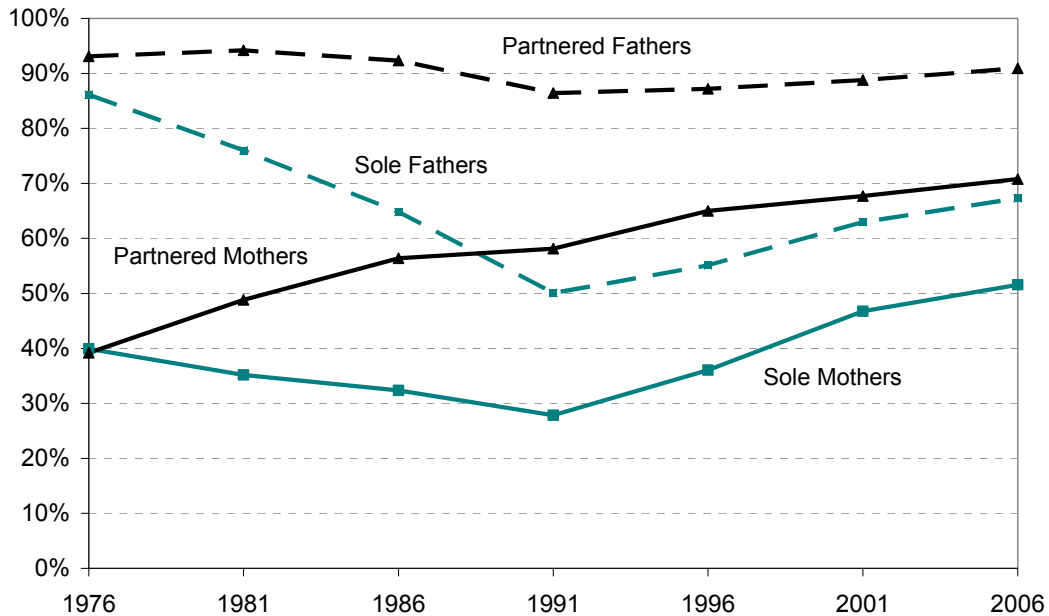
Table 2: Employment and unemployment rates of parents with dependent children, 2006

	Employment rate			Unemployment rate
	Full-time	Part-time	Total	
Mothers				
– Partnered mothers	40.4	30.4	70.8	3.5
– Sole mothers	31.0	20.6	51.6	13.9
– All mothers	38.1	28.0	66.1	5.7
Fathers				
– Partnered fathers	86.2	4.7	90.9	2.0
– Sole fathers	59.3	8.0	67.3	8.9
– All fathers	84.6	4.9	89.5	2.3
All parents				
– Partnered parents	63.1	17.7	80.8	2.7
– Sole parents	35.6	18.5	54.1	12.9
– All parents	58.6	17.8	76.4	4.0

Source: Statistics New Zealand, Census of Population and Dwellings 2006

In 1976, similar proportions of sole and partnered mothers were employed, while a slightly higher proportion of partnered fathers than sole fathers were employed (Figure 3).

Figure 3: Proportion (%) of parents of dependent children employed, 1976–2006



Source: Statistics New Zealand, Census of Population and Dwellings

During the late 1970s and 1980s a gap between sole and partnered mothers' employment rates opened up, and the gap between sole and partnered fathers' employment rates increased.

The proportion of sole mothers in employment fell from 40 percent at the 1976 Census to 28 percent at the 1991 Census, the second lowest rate in a study of 20 countries (Bradshaw et al, 1996). The reason for the fall was not a decline in the number of sole mothers employed, but rapid growth in the number of sole mothers. This occurred in the context of high unemployment which increased the numbers of sole mothers not in employment more rapidly than the number in employment (Goodger and Larose, 1999).

Since 1991 the proportion of sole parents employed has increased. From the late 1990s, virtually all of the increase in sole mothers' employment has been driven by growth in their participation in full-time employment (Table 3).

Table 3: Proportion (%) of sole and partnered mothers employed, full-time, part-time, by age of youngest child, years ended December 1999 and 2009

	Sole mothers		Partnered mothers	
	1999	2009	1999	2009
Employed full-time				
0–2 years	6.6	9.8	16.6	22.8
3–5 years	14.4	21.0	30.2	31.4
6–13 years	25.3	38.5	43.1	47.4
14+ years	44.9	54.4	54.5	58.2
Total	19.9	31.2	33.8	38.3
Employed part-time				
0–2 years	9.6	9.8	26.8	26.4
3–5 years	19.0	22.6	32.0	36.1
6–13 years	26.7	24.0	34.7	32.7
14+ years	19.5	14.7	25.4	25.6
Total	19.2	18.6	30.4	30.2
Total employed				
0–2 years	16.2	19.6	43.4	49.2
3–5 years	33.4	43.5	62.2	67.5
6–13 years	52.0	62.5	77.7	80.1
14+ years	64.4	69.1	79.9	83.9
Total	39.1	49.8	64.2	68.5

Source: Statistics New Zealand, Household Labour Force Survey, customised tables, annual averages for people in working-age households

After a period of economic stagnation, the economy showed a strong recovery in 1993, with the rate of growth slowing from 1996. This slowing was punctuated by short, shallow recessions in 1998 and 1999 before a resumption of economic growth through to 2007.

Economic growth over the 1993 to 1997 and 1999 to 2007 periods is likely to have been an important driver of the increase in sole mothers' employment since 1991.

Changes in the composition of the sole-parent population are also likely to account for some of the growth. Between the 1991 and 2006 census dates, the proportions of sole parents with a range of characteristics associated with low employment rates – no qualifications, pre-school children and young age, for example (see Warburton and Morrison, 2008 for a review) – have fallen (Table 4).

However, the proportion of sole mothers with no qualifications remains considerably higher than that for partnered mothers. At the 2006 Census, two in five mothers with dependent children with no qualifications were sole mothers, while one in five mothers with school or post-school qualifications were sole mothers.⁵

⁵ Statistics New Zealand: 2006 Census of Population and Dwellings, unpublished tables prepared for the Ministry of Women's Affairs.

Table 4: Proportion (%) of families with characteristics associated with low parental employment rates, by family type, 1991 and 2006

	One-parent families		Two-parent families	
	1991	2006	1991	2006
No qualifications (mothers)	49	29	31	14
Youngest child 0–4 years	42	33	44	42
More than 1 child	47	48	67	64
Mother under 30 years	37	24	20	12
Māori parent ⁽¹⁾	29	29	11	12
No motor vehicle	26	11	3	1

Source: Statistics New Zealand, Census of Population and Dwellings

Note: (1) For two-parent families, the data refers to mothers only.

Policy changes are also likely to have contributed to the growth in sole parents' employment since 1991:

- A period of rapid growth in sole parents' employment rates between 1998 and 2002 coincided with a period in which sole parents with school aged children receiving Domestic Purposes Benefit or Widow's Benefit faced stronger expectations that they should work (Ministry of Social Development, 2007).
- The Working for Families changes to Childcare Assistance and the Family Tax Credit, are estimated to account for two-thirds of the growth in sole parents' employment rates between 2004 and 2007 (Ministry of Social Development and the Inland Revenue Department, 2009).

Despite their rebound, sole-parent employment rates in the mid-2000s remained low when compared with other OECD countries, but similar to those in Australia and the United Kingdom. These are countries with which we have historically shared broadly similar social assistance regimes and social norms (OECD, 2007).⁶

The proportion of sole parents in employment levelled off between 2007 and 2008 and fell in 2009 with high unemployment.

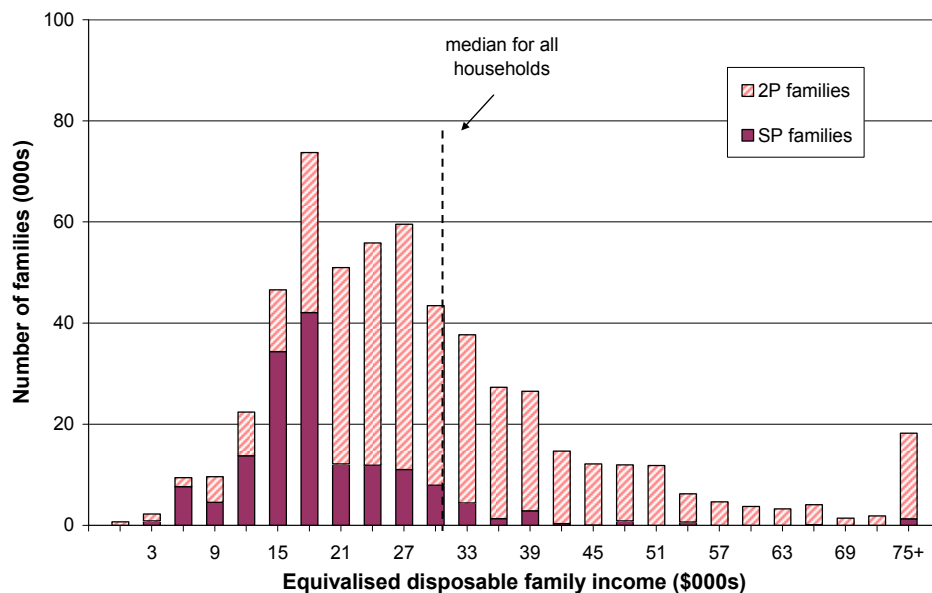
⁶ See OECD, 2007 Table 1.1. At 53 percent in 2005, the employment rate for sole parents in New Zealand was similar to Australia (50 percent) and the United Kingdom (56 percent) but higher than Ireland (45 percent). The OECD average employment rate was 71 percent. In some countries with high maternal employment rates, mothers on parental leave are counted as employed.

4 Incomes and income poverty

In 2009, 90 percent of sole-parent families had incomes below the median household income for all households, with or without children.⁷ For two-parent families, the proportion was 55 percent (Figure 4).

The relatively low incomes of sole-parent families reflect in the main the low full-time employment rate for sole parents (around 35% in 2009). An estimated 73 percent of working-age sole parents were receiving a main benefit in 2009⁸ and 15 percent of these sole parents had declared earnings. These families are clustered in the lower part of income distribution.

Figure 4: Distribution of family income, by family type



Source: Perry (2010, forthcoming), using Statistics New Zealand's 2008-09 Household Economic Survey

Although New Zealand does not have an official income poverty measure, it is clear from Figure 4 that whatever measure is used, the proportion of those in sole parent families with incomes below the selected threshold (the income poverty rate) will be high in itself, and also higher than for those in two parent families.

The poverty measure used in this section is based on family incomes after deducting housing costs, with the threshold or poverty line set at 60 percent of the 2007 median household disposable income, with 25 percent deducted to allow for average housing costs. The threshold is adjusted for inflation to keep it fixed in real terms.⁹

⁷ This is for family or household income adjusted for family or household size and composition ('equivalised' household income). Using unadjusted family income makes little difference to this finding (95% rather than 90%).

⁸ Calculated using benefit administration data as the numerator and HLFS-based estimates of the number of sole parents as the denominator, as at September 2009.

⁹ This measure in effect establishes a 2007 benchmark and applies that same standard backwards and forwards. Reported poverty rates in a given year vary considerably depending

On this measure, poverty rates fell for people living in families with dependent children overall between 2001 and 2009. In 2009, the poverty rate for sole parents and their children was 43 percent, a fall from the much higher rates that prevailed from 1992 to 2001 (around 70 percent) (Table 5).¹⁰

Poverty rates rose sharply between 1988 and 1992 for people in families with dependent children. The rise was most dramatic for people in sole-parent families.

Reductions in benefit rates in 1991, together with the non-indexation of benefits in the preceding three years, were important drivers of the rise. This was also a period in which the number of sole parents increased rapidly, and the proportion in employment dropped.

Table 5: Proportion (%) of individuals living in households with income below the poverty threshold, 1988–2009

(Using after housing costs, constant value, 60 percent threshold poverty measure¹¹.)

Individuals in different family types with dependent children	1988	1990	1992	1994	1996	1998	2001	2004	2007	2009
Sole-parent families overall	27	39	68	68	69	62	71	54	49	43
– living on their own	37	52	88	81	83	77	87	72	59	56
– within wider households	5	12	31	33	35	33	30	26	30	18
Two-parent families	19	20	32	35	30	28	26	22	14	13

Source: Perry (2010, forthcoming) Table G.4, p 94

Poverty rates for people in sole-parent families fell a little between 1996 and 1998. Possible contributors include the changes to tax credits and tax rates introduced in 1996 which had the effect of lifting incomes for some sole-parent families, the 1996 introduction of a part-time abatement regime which allowed sole parents receiving Domestic Purposes or Widow's Benefit to keep more of their earnings from employment, and the 1997 introduction of 'reciprocal obligations' aimed at encouraging movement into employment (Ministry of Social Development, 2007).

Reasons for the increase in poverty rates between 1998 and 2001 are less clear. This was a period in which the value of family tax credits and the Accommodation Supplement slowly eroded as a result of non-indexation. The proportion of sole parents employed full-time increased, but it is notable that the increase occurred most rapidly for sole parents with a youngest child aged 14 or over. Domestic Purposes and Widow's Benefit recipients with children in this age range were subject to a full-time work test from 1999, accompanied by the removal of the part-time abatement regime (Ministry of Social Development, 2007). The effect for some may have been to lower their incomes.

on which poverty measure is used. However, the main relativities and trends in this section are not greatly impacted by the choice of measure. For further information and detail on trends and levels using other measures, see Perry (2010, forthcoming).

¹⁰The figures in this section are for individuals living in families with dependent children.

¹¹As defined in the text above.

The introduction of income-related rents from 2000, the introduction of Working for Families between 2004 and 2007, and sustained economic growth, are likely contributors to the decline in poverty rates between 2001 and 2007.

Around one-third of sole-parent families live in households with other adults. People living in these sole-parent families have significantly lower poverty rates than people in sole-parent families living on their own because of the wider household resources available to them (Perry, 2010 forthcoming; Friesen et al, 2008). In 2009, the poverty rate for people in sole-parent families living on their own (56 percent) was three times that of people in sole-parent families living with other adults in the household (18 percent).

In 2009, sole parents and their children had significantly higher poverty rates than parents and children in two-parent families (43 percent and 13 percent, respectively). The poverty rates of people in sole-parent families were much higher in 2009 than they had been in 1988, while those of people in two-parent families were lower.

Poverty among children in sole-parent families¹²

On the measure used in this report, poverty among children in sole-parent families fell considerably from 2001 to 2009 (Figure 5). In 2009 the proportion of children in sole-parent families living in households with income below the poverty threshold was 46 percent, down from 74 percent in 2001. Compared to 1988, child poverty rates in 2009 were lower for children in two-parent families (14 percent, down from 21 percent) but still much higher for children in sole-parent families (up from 30 percent).

In 1988, children in sole-parent families made up around a quarter of all children living in households with income below the poverty threshold (Figure 6). Between 1988 and 1992, their proportion increased sharply and fluctuated around two-fifths from 1996 to 2004. Between 2004 and 2007, as a result of a sharper decline in poverty rates for children in two-parent families, children of sole parents increased as a proportion of all children living in households with income below the poverty threshold, making up more than a half for the first time in 2007 and 2009.

The relatively high poverty rate for these sole-parent families is partly related to their high rate of benefit receipt.¹³ While sole parents' increased levels of full-time employment have reduced their reliance on benefits since 1991, rates of benefit receipt remain relatively high. Of the estimated 73 percent of sole parents in receipt of a benefit in September 2009,¹⁴ 90 percent were in receipt of a Domestic Purposes Benefit.¹⁵

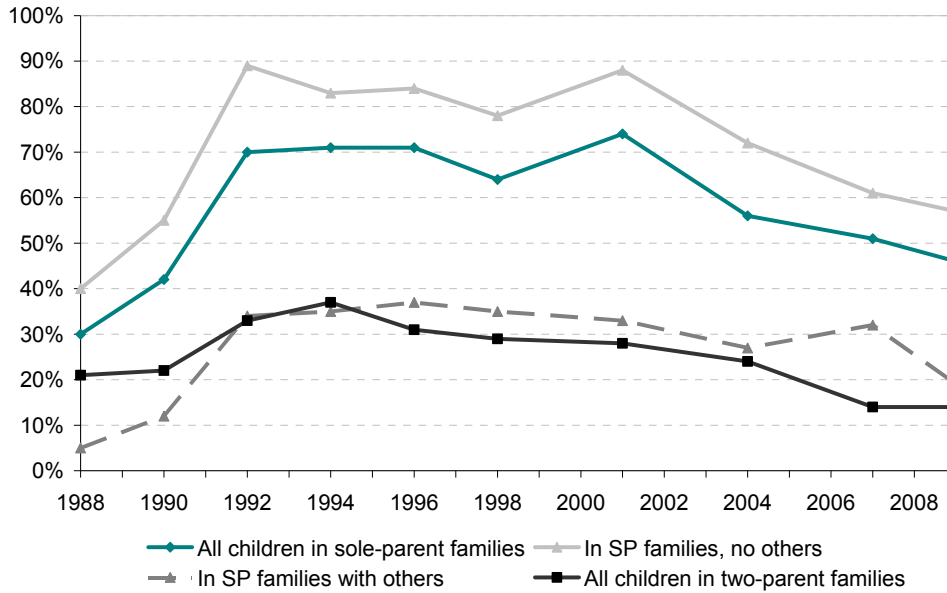
¹² The figures in this section are for children under 18 years living in families with dependent children headed by one or two parents.

¹³ In this report, the term 'benefit' is used to refer to main social security benefits. The New Zealand social security system contains several distinct tiers of provision: main benefits; supplementary assistance payments; and tax credits. Each of these tiers contains a range of different provisions. Main benefits include the Unemployment Benefit, Training Benefit, Sickness Benefit, Invalid's Benefit, Widow's Benefit, Domestic Purposes Benefit, and Emergency Benefit.

¹⁴ Note that it is possible for a sole parent to work full-time and receive an abated rate of Domestic Purposes Benefit.

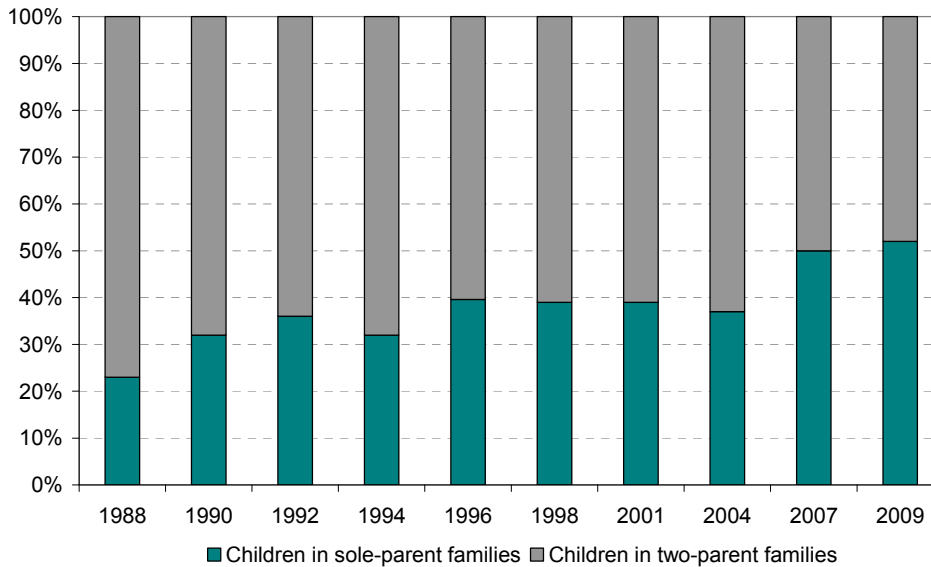
¹⁵ New Zealand has little data on the persistence of child poverty. Benefit administration data, which provides an indicative and partial source, suggests that one in five children born in the

Figure 5: Proportion (%) of children under 18 years living in households with income below the poverty threshold, by family type, 1988–2009
 (Using after housing costs, constant value, 60 percent threshold poverty measure)



Source: derived from Perry (2010, forthcoming) Table H.3 A¹⁶

Figure 6: Composition of the child population living in households with income below the poverty threshold, by family type, 1988–2009
 (Using after housing costs, constant value, 60 percent threshold poverty measure)



Source: Derived from Perry (2010, forthcoming) Table H.3 B

early 1990s was supported by benefits for more than half of their childhood (Wilson and Soughtton, 2009).

¹⁶The figure shows the proportion of the children in each family type in poverty, using the poverty measure described above.

5 Mental health

Sole parenthood has been linked to an increased risk of physical and mental health problems in New Zealand studies (Sarfati and Scott, 2001; Baker and Tippin, 2004; Worth and McMillan, 2004) and in overseas research (Butterworth, 2003; Crosier et al, 2007; Jayakody and Stauffer, 2000; Burström et al, 2007; Benzeval, 1998; Macran et al, 1996).

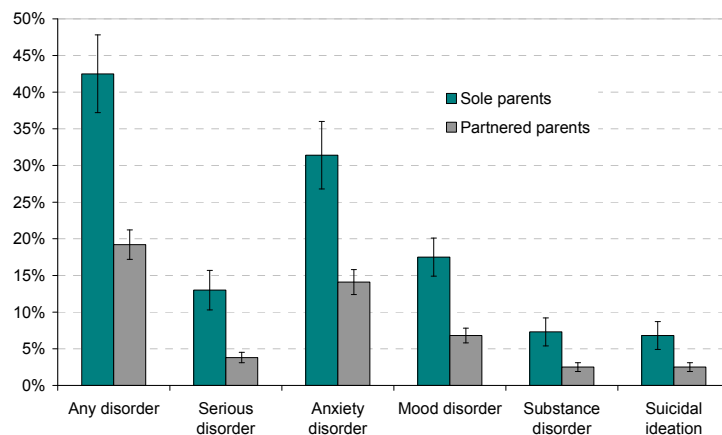
A study undertaken as part of our research programme quantifies (for the first time) the excess risk of specific diagnosable mental disorders experienced by New Zealand sole parents using a nationally representative sample (Tobias et al, 2009).¹⁷

The study also estimates the extent to which the excess risk was associated with differences between sole and partnered parents in measured current circumstances that may indicate mental health risks, or alternatively the presence of factors that can be protective.

Descriptive findings

Overall, an estimated 43 percent of New Zealand sole parents¹⁸ surveyed in 2003 and 2004 met the criteria for a diagnosable mental disorder in the 12 months prior, compared to 19 percent of partnered parents (Figure 7). Anxiety was the most common disorder.

Figure 7: Proportion (%) with a diagnosed mental disorder in the last 12 months
(Before adjustment for differences in age, sex and ethnic composition)



Source: Derived from Tobias et al (2009) Table 1.¹⁹

¹⁷The analysis was based on Te Rau Hinengaro: The New Zealand Mental Health Survey, a nationally representative survey of almost 13,000 adults undertaken in 2003 and 2004. Mental disorders were defined in terms of 12 month prevalence, using the Composite International Diagnostic Interview (CIDI) version 3, a widely used computer assisted structured interview that yields diagnoses according to the Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV).

¹⁸Parents were defined as respondents aged 16 to 64 years living with either their own or their partner's child (or children), with the youngest child in the household aged under 16 years. Partnered parents were those who self-reported that they lived with their "legal husband or wife" or their "partner or de facto, boyfriend or girlfriend". Sole parents were the remaining parents.

¹⁹Error bars represent the 95 percent confidence interval.

While most sole parents had no disorder, after adjusting for differences in the age, sex and ethnic distributions of the sole and partnered parents in the survey, sole parents were 2.6 times more likely than partnered parents to have experienced any type of mental disorder in the last 12 months and 2.9 times more likely to have had a serious disorder that significantly impacted on their life.

Compared to partnered parents, sole parents' risk of specific disorders was 3.6 times higher for substance use disorders (which consisted mainly of alcohol abuse and dependence), 2.6 times higher for mood disorders, 2.5 times higher for suicidal ideation and 2.2 times higher for anxiety disorders.

Male and female sole parents were equally likely to have any mental disorder. In contrast, female partnered parents were more likely to meet the criteria for any mental disorder than their male counterparts, but were still significantly less likely to experience disorder than female sole parents.

Sole parents receiving a benefit were more likely than sole parents who were not receiving a benefit to have a diagnosed disorder, although this difference did not reach conventional levels of statistical significance (perhaps reflecting relatively small numbers in the latter category in the survey).²⁰

Measured factors associated with the excess risk

A wide range of factors can influence mental wellbeing in adulthood. As well as current circumstances, these include individual factors (some of which may be heritable), experiences in childhood and adolescence, and prior experiences in adulthood.

Given the cross-sectional nature of the available data, this study could only estimate the extent to which the excess risk of mental health disorders was associated with differences between sole parents and partnered parents in a limited number of measures of current circumstances (physical health, income, employment status and co-residence with other adults as a proxy for social support).

Because this variable set comprises only a very limited subset of all possible influences on mental health, it is not possible to interpret the results of this analysis as causal influences on mental health. However, the analysis does show that there were quite large associations between mental health status and these measures of current circumstances.

Lower employment and income levels were associated with an estimated third of the excess mental health risk for sole parents (more for anxiety disorders and suicidal ideation, less for mood disorders and substance use disorders) (row 4 in Table 6).

A higher likelihood of not having another adult living in the household was associated with almost as much of the excess risk as lower income and employment levels (row 5 compared with row 4). This held for all types of disorder except substance use disorder,

²⁰In supplementary analysis, there was no significant difference between rates of disorder between sole and partnered parents receiving benefits.

which was more likely to be experienced where other adults were resident in the household.

Lower employment levels, independent of income, were associated with relatively little of the excess risk (row 4 compared with rows 3 and 2).

Poorer physical health status was associated with only a small amount of sole parents' excess risk of poor mental health – except with regard to mood disorders, where poorer physical health was associated with about one-tenth of the excess risk (row 1).

Table 6: Estimated proportion (%) of the excess risk of mental disorder experienced by sole parents compared to partnered parents associated with various measured factors

(After adjustment for differences in age, sex and ethnic composition)

Factors	Any disorder	Serious disorder	Anxiety disorder	Mood disorder	Substance disorder	Suicidal ideation
1 Chronic physical illness	4	2	7	13	5	6
2 Not employed	7	13	10	9	10	4
3 Low-income	29	34	43	28	20	52
4 Not employed and low-income	32	39	46	30	24	51
5 No co-resident adult	23	42	27	27	-12	53
6 Not employed, low-income, no co-resident adult	44	63	57	45	9	81
7 Combination of all factors	48	65	64	58	14	87
8 Unexplained excess risk	52	35	36	42	86	13

Source: Tobias et al (2009), Table 5

The combination of lower income, lower employment levels and a greater likelihood of not having another adult living in the household (row 6) was associated with virtually all the excess risk for suicidal ideation; two-thirds of the excess risk for anxiety disorders; just over half of the excess risk for mood disorders; but less than one-quarter for substance use disorders.

To the extent that the associations found are causal, the findings could suggest that sole parents who are well supported financially, emotionally and socially are more likely than others to experience good mental health. However, in practice, associations of this nature are likely to reflect a complex mix of different mechanisms (Mackay, 2005; Jayakody and Stauffer, 2000):

- They are likely to partly reflect causal effects, for example living on a low income and living without other adults as a result of sole parenthood will contribute to mental health problems in some cases.
- They are likely to also partly reflect reverse causality, for example pre-existing mental health problems might increase the likelihood of parenting alone and also increase the likelihood of having low-income and living without other adults in some cases.
- To some extent, they will reflect no direct causal association between current circumstances and mental health at all, but rather the cumulative effects of disadvantages experienced earlier in the lifecourse that increase the likelihood of both sole parenthood and poor mental health, for example childhood sexual abuse (Fergusson et al, 2008) and the lifetime experience of physical and sexual violence (Butterworth, 2004), which have been found to be strongly associated with adult mental health.

The results of this study confirm the higher prevalence of mental disorder experienced by New Zealand sole parents, and raise important questions about the social, economic, psychological and developmental processes that lie behind associations between mental health, socio-economic position and sole parenthood in New Zealand.

Policies that may promote better mental health are discussed in section 8.

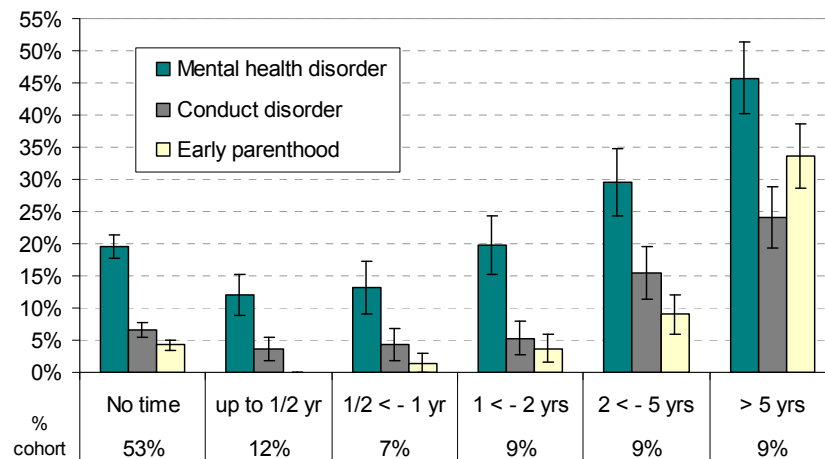
6 The role of early disadvantages

New research drawing on the longitudinal Dunedin Multidisciplinary Health and Development Study (the Dunedin Study) is building our understanding of the wider lifecourse experiences of people who receive benefits for longer periods in young adulthood, many of whom are sole parents.

Early findings show that the amount of time members of the study spent receiving benefits between age 19–20 and age 32 had significant associations with a range of disadvantages in childhood and adolescence (Welch and Wilson, 2010).²¹ These include measures of low family socio-economic status and stability, poor maternal mental health, physical and sexual abuse in childhood, behavioural and mental health problems in childhood and adolescence, unemployment after leaving school and early parenthood.

Figure 8 shows differences in the diagnosed 12-month prevalence of any mental health disorder and conduct disorder at age 15²² and early parenthood (before age 21), comparing those who spent different lengths of time receiving benefits.

Figure 8: Proportion (%) of study members with any mental health disorder at age 15, conduct disorder at age 15 and early parenthood, by time spent receiving benefits between age 19–20 and age 32



Source: Derived from Welch and Wilson (2010)

²¹ The research draws on Ministry of Social Development benefit data which has been integrated into the Dunedin Multidisciplinary Health and Development Study (the Dunedin Study), a longitudinal study of a cohort born in Dunedin, New Zealand, in 1972/1973. Of study members who were assessed at age three and formed the base study population, 96 percent participated in the age 32 assessment in 2004/2005. At this assessment, 97 percent consented to Ministry of Social Development data on their receipt of benefits being integrated into the study database, giving a study population of 940. See also Seth-Purdie (2000) where, based on the Christchurch Health and Development Study, associations between early disadvantages and receipt of benefits at age 21 are examined.

²² At the age 15 assessment, the Diagnostic Interview Schedule for Children (DISC) structured interview was administered (Costello et al, 1982). This was used to diagnose mental health disorder according to the criteria of the DSM-III (American Psychiatric Association, 1980).

A limiting feature in the analysis is the lower than average representation of Māori, Pacific peoples and other minority ethnic groups in the Dunedin Study sample. These population groups make up a growing proportion of young people, and Māori especially are over-represented in benefit uptake. It is possible that there are risk and protective factors that are particular to these groups, or that the factors identified in this study may operate in different ways in different cultural contexts.²³

There is still much to learn about the causal paths that underlie the associations found. But even without further analysis they clearly indicate the early disadvantages that some young adults who receive benefits for longer periods have experienced.

Early parenthood is often a marker of childhood difficulties. While circumstances preceding and following birth can vary widely (for example levels of support from extended family or whānau) studies indicate that young people who are already disengaged from schooling and have already experienced economic, mental health and other disadvantages have a higher than average likelihood of becoming a parent at a young age (Boden et al, 2008; Jaffee et al, 2001a; Jaffee et al, 2001b; Bradbury, 2006).

New Zealand-wide data for people of all ages newly taking up a Domestic Purposes Benefit as a sole parent confirm an association between age at entry to parenthood²⁴ and the duration of benefit receipt (column 1 in Table 7).²⁵

²³ However, data comparing the Dunedin Study participants to their same-aged peers who took part in the New Zealand National Health survey in 1996/1997 revealed very few differences between the Dunedin and national populations. Findings may be more generalisable to similar-aged New Zealanders than previously thought. See Fergusson et al, (2003).

²⁴ Inferred from the age of the oldest child included in the benefit at entry.

²⁵ See also Barrett et al, (2003) for multivariate analysis from the perspective of children.

Table 7: Benefit receipt for new entrants to Domestic Purposes Benefit in year to June 1998

	1	2	3	4
Age when oldest child at entry born	Median total time on all benefits in the 10 years from 1998 entry (years)	% remaining on or back on benefit at 30 June 2008	Composition of the overall 1998 new entry cohort (%)	Composition of members of the 1998 new entry cohort who remained on or were back on benefit at 30 June 2008 (%)
under 18	7.3	32	8	13
18–19	6.6	28	16	23
20–21	5.1	20	16	16
22–24	4.2	17	21	18
25–29	4.1	15	24	18
30–34	4.5	15	11	8
35+	5.6	15	5	4
All	5.0	20	100	100

Source: Ministry of Social Development: Benefit Dynamics Dataset

Note: Domestic Purposes Benefit includes Domestic Purposes Benefit–Sole Parent and Emergency Maintenance Allowance. A new entrant is defined as someone newly granted one of these benefit types who had not received either benefit type in the previous four years.

This data also demonstrates that those who spend longer receiving benefit are more likely to be in the cross-section of benefit recipients on a given date (column 2, and column 4 compared with column 3).²⁶

As a result of this dynamic, when the benefit histories of all New Zealand sole parents receiving benefits at June 2008 are examined, half appear to have become parents before age 23,²⁷ and the median share of time spent on benefits in the previous 10 years (or a shorter period in the case of younger groups) is 83 percent (mean: 72 percent).²⁸

Given the high proportion of sole parents who receive benefits, these findings indicate that disadvantages that pre-date parenthood will partly explain the relatively high rates of mental health and other vulnerabilities of sole parents overall in cross-sectional surveys.

²⁶ See also Bane and Ellwood (1994).

²⁷ Estimated by taking the person's age when the oldest child they had included with them in any benefit they received as a sole parent back to 1993 was born. This is an approximate measure.

²⁸ For those aged 28 or over (72 percent of sole parent benefit recipients at 30 June 2008), the median share of the previous 10 years spent receiving benefits was 83 percent (mean 72 percent). For those aged under 28 (28 percent of sole parent benefit recipients), the analysis looked at the share of time spent on benefit since age 18, or since the date of first benefit receipt for those who had received benefit as a 16 or 17 year old. The median share of time spent on benefit for this younger group was 79 percent (mean: 71 percent) (Source: Ministry of Social Development, Benefit Dynamics Dataset).

Women who have children at an early age – a group that on average tends to have higher rates of difficulties prior to becoming parents and has an elevated risk of longer-term benefit receipt – are over-represented among those who are sole parents at any given point in time.

These findings also highlight the possibility that persistent poverty associated with very long periods of benefit receipt may compound disadvantages for some.

7 What helps – the voices of teenage parents

While the focus of much of the research to date has been on quantitative analysis to better understand vulnerability to disadvantage among some sole parents, one part of the research was a small qualitative study of resilience in young women who had been teenage mothers (Collins, 2010). The study examined competencies and positive outcomes in the presence of adversity.²⁹

The study was a follow-up to one undertaken in 2001. That earlier study interviewed 18 teenage mothers on their views and experiences of teenage motherhood (Collins, 2005).

In 2008, 13 of the original participants were located and agreed to individual, in-depth interviews. Their ages ranged from 24 to 29 years of age, with 10 identifying as Pākehā and three as Māori. Nine were former students of a teen parent unit attached to a secondary school.

The findings from the study need to be considered in the context of it being a small, qualitative study of young mothers who were all in supportive relationships with service providers seven years earlier. In the quotes presented here, study participants are referred to by pseudonyms.

Sources of resilience

These young mothers' accounts of their lives over the past seven years demonstrated a range of factors known to be associated with resilience.

They described individual characteristics such as being motivated and taking responsibility; having goals, aspirations and pride in achievements; using insights into their past as a means of moving forward; having a strong sense of identity; and seeing their lives in a wider context.

“The difference is because I have goals and ambitions. My drive is ‘I can’t give my kids a future if I don’t have one.’ I stick to that. My kids now do have a future. I’ve got a future and so do they. I just really am going to keep going, and say that nothing is unachievable, ever. You can make bad decisions. You can make bad judgment calls. But what you take from that experience is where you’re going to end up later on.” (Erica)

Many also acknowledged the importance of family, whānau and peers in providing social, emotional and practical support.

“It’s not just me that’s brought him up. I mean, I’ve got my parents there, my grandparents, my aunties, my uncles. They’re all there to support me, and I couldn’t have done the things I did, and all the things I do now, without them.” (Hannah)

Longer-term, stable relationships provided opportunities for many young women to move on with their lives. Some noted how, in contrast to birth fathers, stable new relationships

²⁹ For more information on these concepts see Hawley, 2000; Luthar and Cicchetti 2000; Luthar et al, 2000.

also brought consistency to their children's lives. Young mothers who had focused on the best interests of their children found this a useful way of resolving conflict with their children's birth fathers.

Those who had attended a teen parent unit experienced a comprehensive and intensive service that provided opportunities to continue their education, gave focus to their lives, provided access to skilled and competent adults, and provided a range of on-site services for themselves and their children.

"It gave me routine ... it gave me something to get up for every morning rather than lazing in bed or sitting around watching crappy old soaps or talk shows. I had a purpose. I had to get up every morning ... It was really important and without it I don't think I would be quite where I am today either. I would still be driven, but not with the same outcome, I don't think. It was devastating when I left, because it was safe. I knew what to expect there. ... Just the encouragement and the opportunities that they presented. ... They were genuine options, and genuine hands of help. So without judgment. There is enough judgment out there without having more." (Erica)

Some who had attended the teen parent unit maintained contact with supportive staff and associated community-based support agencies many years after leaving the unit. Those whose circumstances and attitudes sometimes made them difficult students particularly appreciated staff who stuck with them and were non-judgmental.

"She's never given up. She's never given up on me. And I know that she's had people say to her, 'Why haven't you given up on her yet? She's no hope.' Because I was stuck in that rut for quite a bit of time until I started the lithium, and actually was able to have clarity of mind and start living properly. Prior to that, I know that she's had people say that. But it's still been unwavering support ... I think (worker's name) and her family have been the biggest support that I have had. I wouldn't have made it without it. ... (Daughter) will go for the weekend and she will come back with a couple of bags of groceries which is just enough to get us through to payday, and some weeks we really need that. She has just been an angel." (Becky)

Others who had not attended a teen parent unit found community-based services provided opportunities to develop new skills, make connections with others in similar circumstances, share life experiences, and access information and support.

"If you can do other stuff, what you've got to deal with is not so bad. Like ... if you can go in and have fun somewhere, and you've got to go home to a little bit of milk and not much sugar, it is not that bad. Because you've just had a bit of fun, and you've got somewhere to go the next day." (Zoe)

All the children of the young mothers in this study had participated in early childhood care or education. Those whose children had been in childcare associated with the teen parent unit valued the on-site service and the support to enhance their parenting.

While all participants had received benefits at some time in their lives, and some had undertaken tertiary education while receiving it, in 2008 most were in paid employment. Of the seven participants receiving a benefit in 2008, only one was not in work,

education, or training. Young mothers who had engaged with further education and/or were in paid work saw themselves, their children and their families as being better positioned for the future.

The experiences of these young women emphasise the importance of a supportive family, and of comprehensive early intervention services that address multiple and often complex needs for mothers and children. Such services had helped these young women build their skills and competencies, and supported educational, social and economic participation.

Challenges to resilience

All participants described many ways their lives had improved over the past seven years, but some experienced ongoing challenges.

Mental health concerns and family violence affected some, and several had children with health difficulties. Children's emotional or behavioural issues were of greatest concern, with six mothers seeking help for their children. Mothers saw these issues as arising from their own new relationships, contentious child custody disputes, or experiences of family violence.

Mothers sometimes lacked support, and problems in their wider families sometimes affected their access to emotional and material assistance. Several experienced difficult custody and access issues with birth fathers. Others lacked suitable or stable accommodation, had financial difficulties, or could see no pathways to suitable employment.

These young women's views and experiences suggest that addressing challenges to resilience, such as poor mental health, lack of support, financial hardship, and children's emotional and behavioural concerns is important to ensure young mothers and their children reach their potential.

Many participants in this study defy stereotypes of teenage mothers, and show what can be achieved when young mothers are well supported.

While most would not recommend teenage motherhood, their stories show how giving birth as a teenager can be a steeling experience that, with appropriate resources and support, can unlock potential.

“Yes, I am a statistic, in the sense that I had my children young. But don't judge me. You don't know me. I'm not sitting on a benefit going nowhere with my life. I work. I care for my children. They're educated. They're healthy. They're happy.”
(Erica)

“I just hope that my brothers and sisters see me as a role model and that they can accomplish these things as well, despite the fact that all the odds were against me as a young Māori mother of two children at age 20. The odds were already against me.” (Ripeka)

8 What helps – approaches and interventions

This section reviews evidence from the research literature on approaches that have been shown to be effective in reducing vulnerability to disadvantage and promoting resilience. We examine approaches in three broad areas:

- measures to promote better mental health
- measures to reduce disadvantages early in the lifecourse
- measures to improve support for vulnerable young parents.

While the focus here is on ways that individuals and families can be helped to improve their circumstances, it is acknowledged that broader social policies and economic forces play a major part in determining the wellbeing of individuals and families. Policies which seek to reduce the level and depth of disadvantage in society more generally are likely to have broad positive impacts for vulnerable families (Fletcher and Dwyer, 2008; Waldegrave, 2005; Ambert, 2006; Butterworth and Berry, 2004).

Measures to promote better mental health

Findings from part of our research programme highlight mental health as a significant issue (Tobias et al, 2009). Mental health problems can adversely affect parents (Baker and Tippin, 2004; Jayakody and Stauffer, 2000; Loprest et al, 2007) and their children (Smith, 2004; Tough et al, 2008; Tunnard, 2004), and can go unrecognised, and untreated (Kohn et al, 2004).

The findings indicate a need to ensure awareness of the high rates of mental health problems for sole parents among agencies and health professionals working with this group, and to promote access to primary mental health care, including alcohol and drug rehabilitation services.

There is good evidence demonstrating the effectiveness of a range of psychological and pharmacological treatments for most mental health problems. Continuous treatment and good client-practitioner rapport are considered important to recovery (Ellis and Smith, 2002).

There is also evidence that many mental health promotion and prevention programmes can reduce mental health symptoms for people subject to key stressors (Doughty, 2005; Butterworth and Berry, 2004).

For some sole parents, mental health problems may be interrelated with other difficulties including financial stress, social isolation, children's health, or behavioural problems or stress related to separation or custody disputes (Butterworth, 2003).

Evidence on the effectiveness of different treatments and preventative programmes specific to this vulnerable group is more limited,³⁰ but a number of approaches that promote coping skills and build social support appear promising (Emery et al, 2001; Balaji et al, 2007; Craig, 2004).

³⁰For example, the evidence base is still being developed for social support interventions for vulnerable populations (NICE, 2007, p 43).

An important mechanism for improving access to mental health services is stable access to affordable primary health care and an ongoing relationship with a health professional. This makes identification or disclosure of mental health needs more likely (The MaGPie Research Group, 2004).

The expansion of funding for primary mental health services in primary health organisations since 2005 is aimed at increasing services for those with mild to moderate mental health problems (Ministry of Health, 2008). New services appear to have been well received by users and have addressed some previously unmet needs (Dowell et al, 2007).

Given the high rates of mental health problems among sole parents receiving benefits, an important question for consideration is whether Work and Income can help in promoting access to services. Potential strategies include a continued focus on building links to local service providers, encouraging and financially supporting clients to regularly see a primary health provider, introducing proactive screening and referral of at-risk clients (Kroenke, 2001), or the direct provision of health-focused case management (Markle-Reid et al, 2002).

While improved access to primary mental health care and preventative programmes is likely to play an important role in improving health status, our findings caution against a solely clinical response (see also Lee and Curran (2003)).

The high rates of mental disorder for sole parents may, at least in part, reflect a causal, health-damaging effect of living on low-income for long periods. Enhancements to financial assistance, combined with continued efforts to promote improved incomes through paid employment, could improve some sole parents' mental health.

To some extent the high rates of mental disorder for sole parents will reflect the complex interrelationships between early disadvantages, child and adolescent mental health, and childbearing, income, relationships and other outcomes in adulthood. Measures to address disadvantages from earlier in the lifecourse may therefore have the greatest prospect of enhancing the mental health status of this population group into the future (Butterworth, 2004).

Measures to reduce disadvantages early in the lifecourse

There is a strong link between children's early experiences and environment and later outcomes. Negative early experiences, such as a lack of positive stimulation, insecure attachment, or exposure to neglect, abuse or chronic stress, can have detrimental effects on brain development, affecting physical and social development, the ability to learn and the capacity to regulate emotions (Fish, 2002; Shonkoff and Phillips, 2000).

Much of the impact of disadvantage is evident by the time children reach school age, with gaps remaining stable or increasing as children age (Waldfogel, 2004; Karoly et al, 2005).

While the independent impact on children of poverty may be modest (Mayer, 2002), where it is associated with a cluster of other difficulties, this accumulation of

disadvantages tends to predict poor outcomes later in life (Fergusson et al, 1994; Mayer, 2002).

There is an extensive evidence base demonstrating that early intervention for vulnerable children and families can improve child wellbeing and reduce vulnerability to disadvantage over the lifecourse (Fergusson et al, 2005; Karoly et al, 2005; Shonkoff and Phillips, 2000). The Center on the Developing Child identifies the following approaches which have been shown to be effective:

- For vulnerable families who are expecting a first child, early and intensive support by skilled home visitors can produce significant benefits for both the child and parents.
- For young children from low-income families, high-quality, center-based, early education programs can enhance child cognitive and social development.
- For young children from families experiencing significant adversity, two-generation programs that simultaneously provide direct support for parents and high-quality, centre-based care and education for the children can have positive impacts on both parents and children.
- For young children experiencing toxic stress from abuse or neglect, severe maternal depression, parental substance abuse, or family violence, interventions that provide specialized services matched to the problems they are intended to address can promote better developmental outcomes (Center on the Developing Child, Harvard University, 2007).

The Perry Preschool Project in the United States is an early childhood education intervention demonstration project which worked with high-risk children and their families. The trial ran for five years and then followed children to adulthood. It found significant impacts for those who had been part of the programme including more high school graduation, lower teenage pregnancy, more employment, higher earnings, and less criminal offending. The benefit-cost ratio at age 40 was estimated to be \$17.07 for every dollar spent (Karoly et al, 2005).

However, not all programmes have been found to be effective (Olds et al, 2007). The literature suggests that effective programmes:

- have clear goals based on a strong theoretical foundation
- are implemented with strong programme fidelity (high commitment to initial desired outcomes and processes)
- tailor their services to the needs of the individual families (including high-intensity and long-lasting services as appropriate)
- are sensitive to families' cultural differences
- use professional (or highly trained para-professional) staff
- support staff with appropriate training, supervision and low staff-to-child ratios (Karoly et al, 2005; Moran et al, 2004; Sykora, 2005).

A number of early intervention initiatives that aim to support disadvantaged children and their families are already in place in New Zealand.

Our reading of the research suggests that the provision of high-quality services for at-risk children and families can be effective in bringing about short-term gains for both parents and children. They can also be effective in generating enduring improvements to children's wellbeing across the lifecourse. This can deliver significant long-run returns on the investment through a reduction in both the public and private costs of poor outcomes.

Measures to improve support for vulnerable young parents

Our findings affirm the importance of strategies that better support vulnerable young parents.

Research suggests that it is possible to support some young people to delay parenting through the provision of comprehensive sex education and easy access to sexual health advice and a range of contraceptive options.

There is also evidence that early intervention strategies for disadvantaged children such as high-quality early childhood education can reduce their likelihood of parenting early, as can holistic youth development programmes which seek to promote engagement with education, pro-social relationships, and ambition (Harden et al, 2006; Swann et al, 2003; Kirby, 2007).

Rapid-repeat pregnancies can compound the challenges faced by young parents. Research on programmes to reduce rapid-repeat pregnancies has yielded mixed results. The most important factor in supporting such efforts may be the strength of the relationship between the teen mother and the individual working with her (Klerman, 2004). Approaches including comprehensive support services, early childhood education and making available long-acting contraceptives have shown some promise (Corcoran and Pillai, 2007; Harden et al, 2006; Stevens-Simon et al, 2001).

For vulnerable young people who do parent early, comprehensive support can promote a range of improved outcomes for them and their children (Harden et al, 2006; Swann et al, 2003; Kirby, 2007; Coren and Barlow, 2001). This is one means of breaking inter-generational cycles of disadvantage, since children of very young parents are at a higher risk of a range of disadvantages, including becoming very young parents themselves.

Nurse Family Partnership in the United States is an example of a high-quality home visiting programme, which begins during the mother's pregnancy and continues until the child is 2 years old. Extensive research has demonstrated short-term improvements in pre-natal health, fewer subsequent pregnancies, increased intervals between births, increased employment for mothers, and reduced injuries and lower rates of abuse and neglect for children. Longer-term impacts for children included fewer arrests and convictions, fewer sexual partners and lower rates of consumption of alcohol and cigarettes at age 15. The benefit-cost ratio at age 15 was estimated to be \$2.88 for every dollar spent. The benefit-cost ratio was higher (\$5.70:\$1.00) for high-risk families (low-income unmarried mothers) and relatively modest (\$1.26:\$1.00) for low-risk families (Olds et al, 2007).

Teen parent units are a good example of programmes offering both social and educational support. An initiative to introduce Teen Parent Co-ordinators to help provide care and support to vulnerable teen parents was implemented in 2007.

There may be opportunities to leverage off early contact with vulnerable young people through the benefit system to promote better access to comprehensive antenatal care in pregnancy and to ensure that young parents and their children are well supported.

Our qualitative research with young women who had been teenage parents shows the powerful positive influence that an adult in a supportive role can have, but also emphasises the importance of offering support in a way that does not compound existing stigma.

Discussion

There is no single, simple solution to the vulnerability to disadvantage experienced by some sole-parent families.

Uncertainty remains surrounding the origins of vulnerability and how best to intervene to prevent or alleviate it, and how best to build resilience. In the context of uncertainty, and given the high likelihood that causal factors have their effect by acting in combination across the lifecourse, a portfolio of interventions that addresses disadvantages and builds resilience in childhood, adolescence and adulthood is likely to be most effective (Jacobsen et al, 2002).

Disadvantages co-occur at a high rate, and this highlights the need for interventions and services to be long-term, co-ordinated and multi-modal for some individuals and families (Fergusson et al, 2003).

A broad focus on improving the wellbeing of both vulnerable parents and their children appears likely to offer the best prospect of improving the overall wellbeing of sole-parent families into the future. This need not require a trade-off between investing in the needs of the current generation of vulnerable parents and investing in the current generation of vulnerable children – improving the adequacy of parents' incomes, making high-quality early childhood education more readily available to vulnerable families, improving vulnerable parents' mental health and supporting their parenting, for example, is likely to have benefits for both children and parents.

To some extent, the vulnerability of some sole parents is not unique to them. General solutions are required, which, if successful, can be expected to reduce vulnerability not only among sole parents but also among other vulnerable groups. However, solutions that connect with the circumstances of vulnerable sole-parent families and give focus to particularly vulnerable subgroups, including very young sole parents, are also required.

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