

**The challenge of greater economic and social participation:
Describing the disadvantage of lone mothers receiving income support**

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Background

Reform of the welfare system is a policy priority of the Commonwealth Government. A central element of welfare reform, both in Australia and internationally, is an emphasis on participation in work or work-like activities as a prerequisite for receipt of welfare payments rather than passive income support (e.g., Saunders, 2002). Promoting involvement in economic and/or social activities is a strategy to promote or maintain welfare recipients' self-sufficiency and independence. In Australia the government has stated that each person's participation requirements will match their circumstances and capacity (FaCS, 2000a). Further, a range of services and programs will support individuals to achieve their personal goals and assist those with substantial barriers to participation (e.g., Personal Support Program, Personal Advisors).

Barriers to employment

Parents, including lone mothers, are one of the customer groups targeted by the reforms (FaCS, 2000b). However, international research suggests many lone mothers on welfare have personal characteristics that make it difficult for them to achieve employment. Much of the research examining barriers to employment has emphasised the human-capital characteristics of lone parents such as their poorer educational attainment, lack of job-relevant skills and experience, or housing circumstances (e.g., Olsen & Pavetti, 1996). Using Australian data, Gray, Qu, de Vaus and Millward (2002) recently demonstrated the relationship between variables such as level of educational attainment, number of children, regional location and renting and employment for both partnered and lone mothers. Policy responses often target these barriers (e.g., transition-to-work; JET program).

An area where there is less, but growing recognition is the extent that psychological and personal characteristics such as poor mental health, substance use problems, physical disability, and experience of domestic violence are likely to limit employment and self-reliance. This presentation explores the prevalence of these disorders, conditions and experiences among lone mothers receiving income support payments in Australia. Five different types of barriers, including human capital barriers, are considered.

Mental health is increasingly recognised as an important predictor of employment outcomes and welfare receipt (Derr, Hill & Pavetti, 2000; Lennon, Blome & English, 2001). The clinical and epidemiological study of low-prevalence disorders (one aspect of the National Survey of Mental Health and Wellbeing; Jablensky et al. 1999) found that 85 percent of people with psychotic disorders rely on government payments. However, common mental disorders such as anxiety and depression are much more prevalent than psychotic disorders and also make it difficult to find and maintain employment (Derr, Hill & Pavetti, 2000; Kessler & Frank, 1997, Lennon et al., 2001). There is extensive research demonstrating the relationship between mental health and characteristics such as unemployment, poverty, and sole parent status (Dohrenwend et al., 1992; Rodgers, 1991). Thus, it is likely that lone mothers on welfare have elevated levels of mental disorders. I have undertaken analysis that confirms that the prevalence of common mental disorders amongst Australian income support recipients is substantially greater than that in the general population (Butterworth, submitted).

Harmful ***substance use or dependence*** disorders are also more prevalent among welfare recipients (Olsen & Pavetti, 1996). Alcohol and illegal drug use is commonly cited as a major impediment to the movement from welfare into employment (see Jayakody, Danziger & Pollack, 2000).

Lone mothers on welfare also report greater levels of *physical disability* and poorer *physical health* than those not receiving welfare (e.g., Danziger, Kalil & Anderson, 2000; Olson & Pavetti, 1996). A recent review by Baker & Tippin (2002) concluded that poor physical health was a barrier to employment for lone mothers on welfare.

This analysis also considers lone mothers' *experience of physical and sexual violence*. Experience of domestic violence is a barrier to employment, both indirectly through an association with poor mental and physical health, and directly through abusers interference in the workplace or with efforts to improve skills or education (Danziger, Corcoran et al., 2000; Tolman & Raphael, 2000). Experience of significant trauma may inhibit help-seeking behaviours (Miranda & Green, 1999). Experience of abuse or trauma (particularly early in life) can be considered a measure of broader disadvantage (Pearlin, 1989). Many researchers hypothesise that mental disorders and substance-use disorders are often a consequence of earlier traumatic experiences. It could be that welfare recipients have greater exposure to trauma (e.g., Turner, Wheaton & Lloyd, 1995) or, alternatively, have fewer resources (financial, social support, resilience, coping skills) to adequately manage life's stressors (e.g., McLeod & Kessler, 1990).

Multiple barriers

Lone mothers on welfare with these conditions and experiences are likely to have more difficulty finding and maintaining employment and the presence of such barriers is likely to restrict their participation options. However, US evidence indicates that the presence of multiple barriers is much more limiting than a single barrier, particularly when the barriers are from different domains (e.g., a mental health problems together with physical disability; Danziger, Corcoran et al., 2000; Danziger, Kalil et al., 2000; Olson & Pavetti, 1996).

The aim of this paper is to estimate the prevalence of the individual types of barriers amongst Australian lone mothers receiving income support payments, as well as exploring the extent to which these barriers co-occur.

Survey and respondents

This paper reports analysis of data from the National Survey of Mental Health and Wellbeing (NSMHWB) conducted by the ABS in 1997. The survey was designed to provide data on the prevalence of common mental disorders, the associated levels of disability, and health service usage in Australia. The survey was based on a representative sample of persons aged 18 or over in Australian households. There were 10,641 respondents, with a response rate of 78%. However, this analysis is restricted to female respondents of workforce age (that is those under 60) who have children (i.e., a child aged 16 or under in the home and previously given birth to a child).

Three groups were identified:

- (a) women who reported that government allowances or pensions were not their main source of income regardless of relationship status (non-recipients; unweighted N = 1409)
- (b) women who reported that they were married or living in a de facto relationship and that government allowances or payments were their main source of income (partnered income support recipients; N = 425)
- (c) (the group of primary interest) women who reported that they did not have a partner (separated, divorced, widowed or never married) and that government allowances or payments were their main source of income (unpartnered income support recipients; N = 398)

Specific measures

The measures examined within each of the five categories of barriers are presented in Table 1.

Table 1: Description of measures examined within each category of barrier.

Type of barrier	Specific measures comprising barrier
<i>Human capital barriers</i>	<ul style="list-style-type: none"> • Labour force history - any labour force experience; • Household structure - number of children; • Educational attainment - completion of secondary education; • Housing tenure – renting; • Housing location - living in rural centre • Housing location - living in area in lowest quintile of relative socio-economic disadvantage). <p>Human capital barrier present if three + individual measures</p>
<i>Mental health</i>	<ul style="list-style-type: none"> • Composite International Diagnostic Interview (WHO, 1994) using International Classification of Diseases – 10th revision classification to identify: <ul style="list-style-type: none"> • any anxiety disorder during past 12 months • any depressive disorder in past 12 months • K10 (Kessler, Andrews, Colpe et al., 2002) scale identified respondents with substantial psychological distress (score of 20 or greater). • Psychosis screening questions identified respondents likely to have schizophrenia or schizoaffective disorder
<i>Substance use disorders</i>	<ul style="list-style-type: none"> • CIDI identified respondents meeting the ICD-10 criteria for <ul style="list-style-type: none"> • harmful alcohol use • alcohol dependence • harmful drug use • drug use dependence
<i>Physical conditions and disability</i>	<ul style="list-style-type: none"> • Belloc, Breslow & Hochstim (1971) 12 item scale identified common chronic physical conditions <ul style="list-style-type: none"> • asthma, chronic bronchitis, anemia, high blood pressure, heart problems, arthritis, kidney disease, diabetes, cancer, stomach or duodenal ulcer, chronic gallbladder or liver problems and hernia or rupture • SF-12 (Ware, Kosinski & Keller, 1996) physical health summary score - standardized score below 40 identified those with moderate or severe disability. <p>Physical health barrier if any physical conditions or physical disability</p>
<i>Experience of traumatic events (physical and sexual violence)</i>	<ul style="list-style-type: none"> • Personal experience of physical and sexual violence indexed by items from post-traumatic stress disorder component of the CIDI. Lifetime experience of: <ul style="list-style-type: none"> • rape • sexual molestation • serious physical assault or attack • attack with a weapon or torture

Results of analysis

A series of univariate logistic regression models examined the association between group membership and each category of barrier. For each type of barrier, one comparison contrasted lone mothers receiving income support with those mothers not receiving government payments and a second contrasted partnered and unpartnered income support recipients. Data were weighted to reflect the probability of selection within the population

The odds ratios and 95% confidence intervals (Table 2) show that lone mothers receiving welfare were more likely to experience each of the five types of barriers than those not receiving income support and partnered income support recipients.

Table 2: Odds ratios and 95% confidence intervals for each category of barrier comparing lone mothers on welfare with i) non-recipient mothers and ii) partnered mothers receiving welfare.

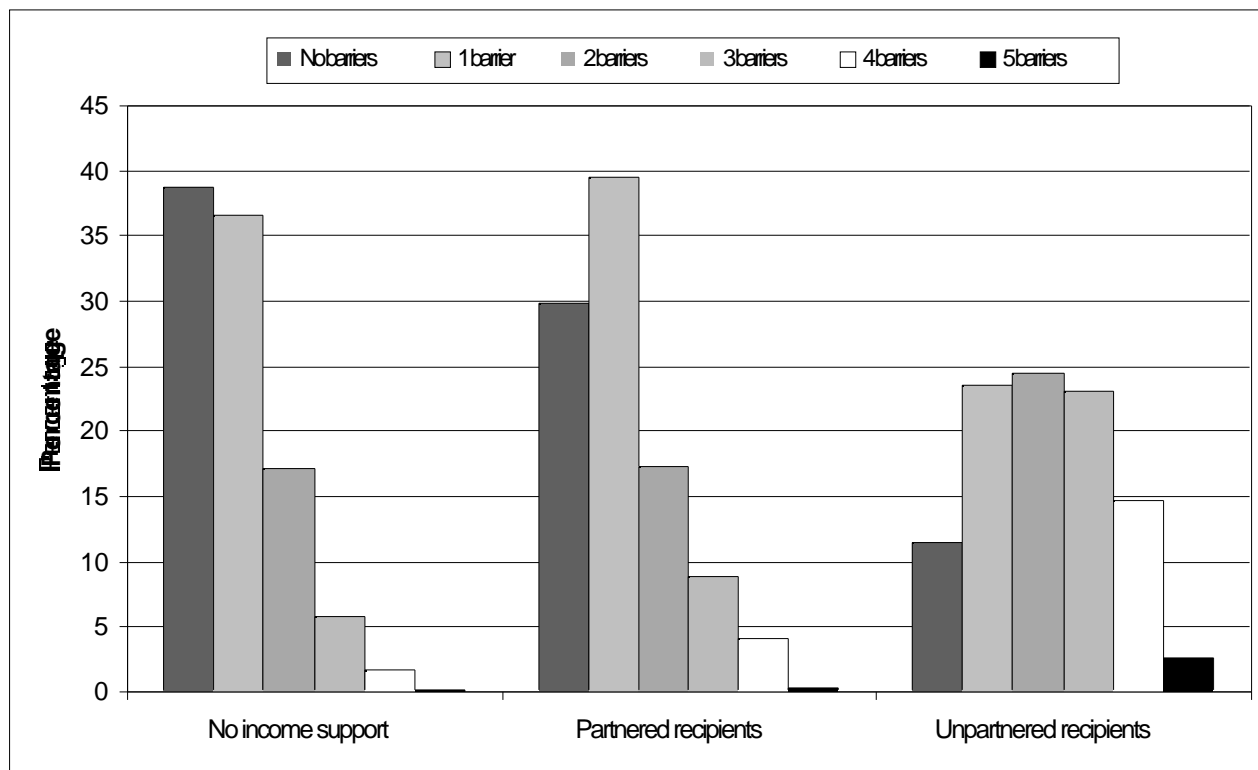
	Lone mother recipients vs non-recipients		Lone mother recipients vs partnered recipients	
	Odds Ratio	95% CI	Odds Ratio	95% CI
Human capital barriers	6.86	5.07 – 9.28	3.21	2.29 – 4.50
Mental health barriers	3.20	2.39 – 4.29	2.38	1.69 – 3.34
Substance use barriers	4.09	2.48 – 6.74	3.28	1.75 – 6.14
Physical disability	1.91	1.44 – 2.55	1.84	1.32 – 2.57
Traumatic life events (physical/sexual violence)	3.41	2.54 – 4.58	3.01	2.12 – 4.27

Human capital barriers most strongly differentiated lone mothers on welfare from those who were not receiving income support payments. This could reflect that current poorer financial circumstances are a consequence of welfare receipt. However, the differences in education and previous work history imply that the increased prevalence of human capital barriers reflects long-term differences. Lone mothers on welfare were four times more likely to have a substance-use disorder and over three times more likely to have a mental health problem or have had a personal experience of physical/sexual violence.

The differences between lone mothers and partnered mothers receiving welfare were somewhat less pronounced than the previous comparisons, particularly the prevalence of human capital barriers. Nonetheless, lone mothers were still three times more likely than partnered mothers to demonstrate a human capital barrier, a substance use barrier or to have experienced physical or sexual violence. Mental disorders and physical disability are also much more common.

Figure 1 presents data on the number of barriers experienced by each of the three groups. The data show that around 75% of non-recipients had none or only a single type of barrier. Similarly, about 70% of partnered women on welfare had one or no barriers. For this group, less than five percent had four or more barriers. In contrast, the majority of lone mothers receiving income support (around 65%) had two or more barriers. Almost 20% had four or more barriers. Lone mothers on welfare were over five and a half times more likely to experience multiple categories of barriers than non-recipients (OR = 5.61, 95% CI 4.15 – 7.58) and over four times more likely than partnered recipients (OR = 4.21, CI 2.98 – 5.94).

Figure 1: Number of categories of barriers experienced by each of the three groups.



Conclusions

This presentation has demonstrated, consistent with international research with welfare recipients, that lone mothers in Australia receiving income support experience substantially elevated levels of disadvantage. Lone mothers are more likely to have mental health problems, substance use disorders, physical disabilities and experiences of trauma. A substantial proportion of lone mothers also showed a high co-occurrence or interconnection between these psychological, personal and social barriers. For this sub-group of women, the co-occurrence may reflect the systemic and entrenched nature of their disadvantage.

While many lone mothers have substantial employment barriers, the data do not necessarily provide evidence to counter the introduction of participation requirements for this group. Rather, the identification of the extent of the disadvantage experienced by many within this group provides an incentive for action. Efforts to improve engagement and participation will provide the opportunity to assist lone mothers to overcome their barriers and improve their social functioning and economic circumstances. However, it is also critical that appropriate support and services are available for those who require assistance. This data and policy directions adopted internationally support an emphasis on the identification of those with barriers to participation (through screening and assessment processes), promoting knowledge and awareness of these barriers, and consideration of how program/service responses can best assist clients or link them with other services.

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