

From the smallness of the community, comes the strength of the community: sole mothering in rural and remote Australia

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ABSTRACT

A recent study of the well-being of sole mothers, using data from the Australian Longitudinal Study on Women's Health (Women's Health Australia – WHA) revealed that they were more likely to experience economic stress and poor psychological health than other women.

To further investigate the health and economic well-being of sole mothers a series of focus groups were held in metropolitan and regional NSW. Although WHA analyses revealed few differences between urban and non-urban sole mothers on measures of health and economic well-being, the qualitative study indicated that the factors that underlie economic and psychological well-being did tend to differ by area of residence. Sole mothers from inner metropolitan areas experienced higher housing costs than sole mothers from rural and remote areas. However, urban sole mothers also experienced benefits, such as access to public transport, bulk billing general practitioners and some ancillary health services, while sole mothers who lived outside of metropolitan areas tended to face difficulties accessing transport and health services. In comparison to women from urban areas, women from rural and remote areas experienced personal benefits of small town living, including a strong sense of community and good social support, which helped to reduce stress, but personal costs of small town living were also apparent. For example, a lack of privacy led to increased stress for some women. Sole mothers from the remote area experienced additional problems, such as difficulty in accessing higher education, the need to travel long distances in order to access health care, a lack of consistency in psychological health services and difficulty in obtaining legal representation.

Recommendations include a review of the costs incurred by non-urban sole mothers in obtaining health care for themselves and their children, and investigation into the level of staff turnover among mental health professionals in remote areas.

INTRODUCTION

Twenty per cent of Australian families with children aged less than 15 are headed by a sole mother.¹ Around 27% of 18 year olds have spent some time living in a sole mother family.² Australian sole mother families have a higher risk of poverty and are more likely to experience financial stress than other family types.^{3,4} The high cost of metropolitan housing has contributed to a tendency for income support recipients, including sole parents, to move from metropolitan to non-metropolitan areas.⁵ However, relatively little is known about sole mothering in rural and remote Australia. The purpose of the current paper is to examine the nature of any geographic differences in the health and economic well-being of sole mothers.

Few differences in health between urban and non-urban Australian women have been found⁶, although women from non-urban areas were found to be less likely to have access to bulk

billing services and faced higher medical expenses than urban women.⁷ While past research has indicated that sole mothers tend to have poorer health than other women⁸⁻¹⁰, no research was found that had examined the health of Australian sole mothers by location.

The relatively poorer health of sole mothers compared to other women has been partly attributed to the lower economic well-being of sole mothers relative to other women.¹⁰⁻¹¹ Both paid work participation and education have the capacity to impact on economic well-being. Sole mothers tend to have lower education¹²⁻¹³ and paid work participation levels than other women.¹⁴ Sole mothers experience multiple barriers when seeking education and paid work, including job suitability¹³, family responsibilities and childcare^{13,15}, poor health⁸, transport, a lack of recent experience and job availability.¹³⁻¹⁵ It is possible that regional differences in employment rates found among Australian women¹⁶ might also have an impact on the paid work participation of sole mothers, since sole mothers have been found to be more susceptible to changes in employment rates than partnered mothers.¹⁴

The current paper examines differences between urban and non-urban sole mothers on measures of mental and physical health, education, paid work participation and economic well-being by analysing representative data from the Australian Longitudinal Study on Women's Health (ALSWH). In addition, this paper will explore the experience of sole mothers who live in rural and remote Australia by analysing the results of qualitative focus groups.

METHOD

The quantitative analyses were conducted using ALSWH data. ALSWH is a longitudinal survey of the health and well-being of three cohorts of Australian women, and has been described in detail elsewhere.¹⁷⁻¹⁸ The project uses mailed surveys to collect self-report data on health and related variables from three cohorts of Australian women, who were aged 18–23 years (younger), 45–50 years (mid-age) and 70–75 years (older) when the project began in 1996. Over 40000 women were randomly selected from the Australian population, with the national health insurance database (Medicare) as the sampling frame, and systematic over-sampling of women living in rural and remote areas. The project is designed to run for twenty years, with the overall goal being to conduct a series of interlocking data analyses. The research conducted for this paper used data from the first and second younger and mid-aged cohort surveys.

The qualitative study was conducted with 11 focus groups conducted in nine towns and suburbs in NSW.

Quantitative analyses

Participants

The first younger survey data were collected by ALSWH in 1996. At the time of Survey 1, the younger cohort was aged from 18–23 years. Of the women who were randomly selected from the Medicare database and invited to participate, 14792 completed Survey 1 (response rate of 41%). The second younger survey data were collected in 2000. At the time of Survey 2, the younger cohort was aged from 22–27 years and 9689 women participated (response rate of 70%).¹⁸

The first mid-aged survey data were collected by ALSWH in 1996. At the time of Survey 1, the mid-aged cohort was aged from 45–50 years. Of the women who were randomly selected from the Medicare database and invited to participate, 14100 completed Survey 1 (response rate of 54%). The second mid-aged cohort survey was conducted in 1998. At the time of Survey 2, the

mid-aged cohort was aged from 47–52 years and 12338 women participated (response rate of over 90%).¹⁸

With regard to area of residence, 155 sole mothers from the younger cohort first survey lived in an urban area while 215 sole mothers lived in a non-urban location. At younger cohort Survey 2, 123 sole mothers lived in an urban area, and 199 women lived in a non-urban location. Of the first survey mid-aged cohort, 147 sole mothers lived in an urban area while 191 sole mothers lived in a non-urban location. At mid-aged Survey 2, 116 sole mothers lived in an urban area, and 157 women lived in a non-urban location.

Measures

Sole mothers were identified as women who were unpartnered and living with a child under the age of 16 years. Respondents were coded as living in an urban or non-urban area using a classification system developed by the Australian Department of Primary Industries and Energy and the Department of Human Services and Health.¹⁹

Psychological health was assessed by the Mental Health Component Score (MCS) of the Medical Outcome Short Form Health Survey (SF-36).²⁰ Physical health was measured by using the Physical Component Score (PCS) of the SF-36. The PCS and MCS generate scores that range from 0–100, where higher scores reflect better health.

Financial stress was measured by asking women to indicate how stressed they were about money. Responses of “not at all”, “somewhat”, and “moderately” stressed were coded as “not financially stressed”; responses of “very” and “extremely” stressed were coded as “financially stressed”. Respondents were considered to be undertaking paid work where they indicated any number of hours spent in part time, full time or casual paid work. Education was measured dichotomously (more than a Year 10 education v. less than a Year 10 education).

Qualitative study

Informants

A total of 48 sole mothers attended 11 focus group discussions held in 9 towns and suburbs in NSW during 2003. Women’s ages ranged from 20 to 56 years, with an average age of 37.2 years. The participants had between one and four children, with an average of 1.8. Children’s ages ranged from four months to 34 years, with an average age of 8.8 years. Women had been sole parents from between four months and 26 years; the average length of time as a sole mother was 7.6 years.

Focus group schedule

The schedule was centred on three main areas of inquiry, economic concerns related to raising children without a partner, the impact of economic concerns on health and well-being and the impact of the local area on lifestyle, health and well-being. The questions on the schedule were open ended. Where appropriate, participants were prompted to elaborate on the areas of interest (eg Can you tell me more about ...? How did you feel about...? What happened next?).

Analysis

Audiotapes were transcribed verbatim and entered into the QSR NVivo qualitative analysis program. Data were coded for the subject areas that were the focus of the enquiry, that is, all segments of data that pertained to education, employment, income, economic well-being, health, and area of residence were coded. Each subject area was then examined for themes.

RESULTS AND DISCUSSION

Health

Analysis of variance (ANOVA) analyses of ALSWH data yielded only one significant result for health: urban sole mothers were significantly less mentally healthy than non-urban sole mothers in the second survey of the mid-aged cohort, when women were aged 47–52 years. The quantitative health results are summarised in Table 1.

Table 1 Mean mental and physical health scores among sole mothers in urban versus non-urban areas

Mental health (SF-36 MCS)	M	SD	df	F	p
Younger 1					
Urban	46.48	11.05	1	0.85	.356
Non-urban	47.56	10.83			
Younger 2					
Urban	46.11	10.88	1	2.86	.092
Non-urban	48.26	10.92			
Mid-aged 1					
Urban	45.02	10.61	1	1.09	.298
Non-urban	46.32	11.41			
Mid-aged 2					
Urban	45.04	10.96	1	6.20	.013
Non-urban	48.49	11.18			
Physical Health (SF-36 PCS)					
Younger 1					
Urban	44.75	12.80	1	1.32	.251
Non-urban	46.21	11.19			
Younger 2					
Urban	47.58	10.59	1	0.10	.747
Non-urban	47.17	10.88			
Mid-aged 1					
Urban	52.33	9.51	1	2.04	.154
Non-urban	50.76	9.93			
Mid-aged 2					
Urban	50.07	10.41	1	1.55	.215
Non-urban	48.28	12.25			

It is currently unclear why non-urban sole mothers aged 47–52 years would have better mental health than urban sole mothers of the same age, particularly when this difference was not apparent among other age groups. It is worth noting that the result was significant at the .05 and not the .01 level, and furthermore, the strength of the association was quite low. Therefore this result should be considered tentative and in need of further research.

The qualitative study revealed that sole mothers from non-urban areas talked about experiencing similar health problems as sole mothers from urban areas. These included stress related problems and mental health problems including depression and anxiety. However, differences in the experiences of non-urban compared to urban sole mothers arose when discussing access to health services, as might be expected from past research.⁷

While both non-urban and urban sole mothers talked about having difficulty accessing dental services, the lack of bulk billing general practitioner services was raised in all but one of the

non-urban groups and was not raised as an issue by urban sole mothers. In the remote area, accessing medical specialists involved travelling 500 kilometres to the nearest large city.

Sole mothers from non-urban areas also talked about having difficulty, or finding it “impossible” to access ancillary and allied health services, such as physiotherapists and chiropractors. Psychological and counselling services were the most frequently mentioned as being inaccessible or unsatisfactory. Accessing counselling services commonly involved long waiting periods, for both sole mothers and their children. Many sole mothers felt as though they had had to “fight” or “push” in order to obtain counselling services. However, women in this position may not always have the emotional strength or confidence to verbalise their degree of need. Several sole mothers felt that the screening procedures used by services to determine their degree of need were inappropriate. For example,

I needed help, (I tried to) make an appointment at the hospital, and umm, they asked me a few questions over the phone, like, was I suicidal? I said no, and so immediately you say you're not suicidal then you kind of go on the waiting list... You may not be the best person to assess whether or not you're suicidal. So if I had've been (suicidal) and hadn't made it through, it could've been a pretty bad result.

A further problem with accessing counselling concerned the consistency of service in the remote area:

P1: You might build a good rapport with a counsellor, that's great, and then they'll leave town!

P4: Exactly! And then you've gotta go through telling your whole life story to another, I've done that four times!

P6: And it's hard enough for some people to actually speak to somebody...

P1: To be able to open up to be able to trust them.

P4: And then they up and leave, well, I can't, I've had four counsellors since I was 15, and I've only just turned 20, in five years, four counsellors, is just, yeah. Every 12-18 months, “Oh, sorry, gotta leave town, I gotta go somewhere else.”

The value of psychological and counselling interventions was exemplified by sole mothers who had managed to find and use appropriate services:

... that psychologist was personally generous, and uh, he gave his time free one day a fortnight to people like myself. And within that group there were 12 people and we were like new people after two years. And you're armed with life skills thereafter that benefit you for the rest of your life and that then also prevent anxiety.

Economic well-being

There were no significant associations between area of residence and financial stress or paid work participation among sole mothers, in Chi-square analyses of ALSWH data (results reported in Table 2). However, the qualitative study revealed differences in the types of expenses incurred by non-urban compared to urban sole mothers.

Table 2 Associations between area of residence and economic well-being among sole mothers

Survey	Economic well-being								
	Financial stress			Paid employment			Education		
	N	df	²	N	df	²	N	df	²
Younger 1	356	1	0.02	358	1	0.96	366	1	0.92
Younger 2	327	1	2.38	320	1	0.76	315	1	0.22
Mid-aged 1	330	1	0.18	337	1	3.05	330	1	10.70**
Mid-aged 2	269	1	0.70	230	1	1.52			

Note. Education was not measured in Survey 2 of the mid-aged cohort.

** $p < 0.001$.

As the findings for health in the current study and past research have also found⁷, the costs of accessing health care in non-urban areas was higher than that experienced by sole mothers in urban areas. In addition, transport to access health services was a major expense for sole mothers in non-urban areas.

The cost of transport was frequently mentioned by non-urban sole mothers, while transport tended not to arise in urban focus groups, where discounted public transport was available. Most of the sole mothers who lived in non-urban areas had their own cars. These sole mothers felt that running a car was essential because of a lack of discounted public transport and because of the distances they needed to travel in order to obtain goods and services. However, cars were often old and unreliable, and women found it difficult to afford maintenance and running costs:

The excess of four cents a litre fuel, which can, which really hurts me. I feel punished because I can't afford a nice modern car that I'd love, that didn't ruin the environment with its lead, but it's impossible. I'm lucky to hang on to the old '83 model that I've got...And the review of regional and small town high costs to fuel, for example, we're less than two hours away from (regional centre) and it's ten cents a litre cheaper...

A further expense mentioned by sole mothers in both of the groups that were held in the remote area concerned the cost of accessing legal services. These sole mothers had experienced difficulty in obtaining legal representation because their ex-partners had spoken with every solicitor in the area, and thus created a conflict of interest. These women had had to seek legal services from solicitors based in the nearest city, around 500 kilometres away:

P1: I, I didn't have a lawyer for the first two court cases I went through because I couldn't get one here in town, because he went to every other lawyer and made appointments and it gave me a conflict of interest.

P2: So she had to, and to get any contact with that lawyer, how's a single mother with two kids going to, with a car that won't get there, drive 500 k's to see a lawyer?

Distance and transport problems were also mentioned by non-urban sole mothers as barriers to further education. Chi square analyses of ALSWH data revealed that among the mid-aged Survey 1 cohort, area of residence was significantly associated with education level among sole mothers (Table 2). Mid-aged sole mothers from non-urban areas were more likely to indicate they had Year 10 or less as their highest level of education than sole mothers from urban areas, 48% of non-urban sole mothers compared to 31% of urban sole mothers indicated a Year 10 or less level of education.

It is possible that the quantitative results reflected the barriers of distance and transport to further education that were mentioned by non-urban sole mothers in focus groups. However, there may also be an age barrier to further education, because there was no association between education level and area of residence among sole mothers in the younger ALSWH cohort. This

'age barrier' might be reflecting the younger ages of children among the younger cohort sole mothers, whereby sole mothers may not seek further education until their children are older.

Small town living

Detrimental and beneficial aspects of small town living arose in all of the non-urban focus groups. Where towns were perceived as unfriendly or difficult, sole mothers found it more difficult to form social networks, and were concerned about gossip and a lack of privacy. This was particularly pertinent at the time of separation:

As soon as someone's relationship is over everybody, everybody's ear about it, make up other stories, and make things worse for the parties that are involved... (gossip) can cause more grief, um, it can cause bigger problems.

Sometimes you wish you could get under the closest rock and hide, so you've got a bit of privacy.

Where towns were perceived as friendly and supportive, sole mothers felt comfortable, able to "connect" with others and thought that living in a small town was beneficial to their well-being. For example,

I'm here because it's a small community, for the sense of belonging, for the connectedness at a local level, umm, the, the bonds that come together that aren't possible in a city, where I did live. The anonymity of the city prevents that con, connectedness, so the human relationship support network for me as a woman here are profoundly beneficial. For physical, mental, and social well-being of myself and my child...

... from that, the smallness of the community, comes the strength of the community.

CONCLUSIONS

Based on the quantitative findings, the health and economic well-being of non-urban sole mothers was very similar to that of urban sole mothers. However, the factors that underlie well-being were found to differ by area in the qualitative study. In comparison to sole mothers in non-urban areas, sole mothers from urban areas experienced higher housing costs, better access to affordable, adequate transport and greater access to bulk billing general practitioners and some limited access to ancillary and allied health services. By contrast, non-urban sole mothers experienced poor access to bulk billing general practitioners and allied and ancillary health services, and a lack of public transport that led to the need to own a car. Sole mothers from the remote area experienced all of those factors experienced by women in rural areas, in addition to experiencing difficulties that occurred due to distance, such as accessing further education and the need to travel in order to obtain specialist health services. In addition, inconsistency in local psychological health services and accessing legal representation were found to present problems for sole mothers who lived in the remote area.

Small town living had the capacity to both mitigate and exacerbate stress levels among sole mothers. Sole mothers experienced increased stress where the local community was perceived as non-supportive and where detrimental town gossip had been experienced. However, decreased stress among sole mothers occurred where a strong sense of community with high levels of social support was encountered.

RECOMMENDATIONS

It is recommended that:

- the total cost of obtaining health care in rural and remote areas, including associated expenses (eg. transport, accommodation), be determined
- the level of staff turnover among mental health professionals in remote areas be investigated further to determine both the extent of this problem, and factors that might encourage mental health practitioners to remain in remote areas for longer periods of time.

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REFERENCES

- 1 Australian Bureau of Statistics. Australian social trends. 2003. <<http://www.abs.gov.au>>
- 2 de Vaus D, Gray M. Family transitions among Australia's children: How much time do children spend in specific family types, and to what extent do they experience various family transitions? *Family Matters* 2003;65:10-17.
- 3 Saunders P. Towards a credible poverty framework: From income poverty to deprivation. SPRC Discussion Paper No. 131. Sydney: Social Policy Research Centre, 2004.
- 4 Loxton D. What future? The long term implications of sole motherhood for economic wellbeing. *Just Policy* (in press).
- 5 Marshall N, Murphy P, Burnley I, Hugo G. Welfare outcomes of migration of low-income earners from metropolitan to non-metropolitan Australia. Australian Housing and Urban Research Institute, UNSW-UWS Research Centre & Southern Research Centre, 2003.
- 6 Brown WJ, Young AF, Byles JE. Tyranny of distance? The health of mid-age women living in five geographic areas of Australia. *Australian Journal of Rural Health* 1999;7:148-154.
- 7 Young AF, Dobson AJ. The decline in bulk-billing and increase in out-of-pocket costs for general practice consultations in rural areas of Australia, 1995-2001. *Medical Journal of Australia* 2003;178:122-126.
- 8 Jayakody R, Danziger S, Pollack H. Welfare reform, substance use, and mental health. *Journal of Health Politics, Policy and Law* 2000;25:623-651.
- 9 Baker D, North K. Does employment improve the health of sole mothers? *Social Science and Medicine* 1999;49:121-131.
- 10 Hope S, Power C, Rodgers B. Does financial hardship account for elevated psychological distress in lone mothers? *Social Science and Medicine* 1999;49:1637-1649.

- 11 Whitehead M, Burstrom B, Diderichsen F. Social policies and the pathways to inequalities in health: a comparative analysis of lone mothers in Britain and Sweden. *Social Science and Medicine* 2000;50:255–270.
- 12 Rodgers K, Wilson K. (1998). Rights and obligations of families in the Social Security system. *Changing Families, Challenging Futures: 6th Australian Institute of Family Studies Conference*, Melbourne, Australia, 1998.
- 13 Carlile C, Fuery M, Heyworth C, Ivec M, Marshall K, Newey M. Welfare reform pilots: characteristics and participation patterns of three disadvantaged groups. Occasional paper no. 5. Canberra: Department of Family and Community Services, 2002.
- 14 Gray M, Qu L, Renda J, de Vaus D. Changes in the labour force status of lone and couple Australian mothers, 1983–2002. Research paper no. 33, Australian Institute of Family Studies, 2003.
- 15 Dickenson J, Heyworth C, Plunkett D, Wilson K. Sharing the care of children post-separation: family dynamics and labour force capacity. *Family Strengths Conference*, University of Newcastle. Newcastle, 1999.
- 16 Australian Bureau of Statistics. Perspectives on regional Australia: Women’s employment in urban, rural and regional Australia, 2001 census. Report no. 1380.0.55.001. Canberra: Australian Bureau of Statistics, 2004.
- 17 Brown WJ, Bryson L, Byles JE, Dobson AJ, Lee C, Mishra G, Schofield M. Women’s Health Australia: Recruitment for a national longitudinal cohort study. *Women’s Health* 1998;28:23–40.
- 18 Lee C. *Women’s Health Australia: What do we know? What do we need to know?* Brisbane: Australian Academic Press, 2001.
- 19 Australian Department of Primary Industries and Energy, Australian Department of Human Services and Health. *Rural, remote and metropolitan areas classification: 1991 Census Edition*. Canberra: Australian Government Publishing Service, 1994.
- 20 Ware JE, Sherbourne CD. The MOS 36-Item Short-Form Health Survey (SF-36): 1. Conceptual framework and item selection. *Medical Care* 1992;30:473–483.

PRESENTER

Deborah Loxton is a senior research officer in the Research Centre for Gender and Health at the University of Newcastle, whose PhD thesis investigated the effects of violence against women. Dr Loxton has recently completed a research project that investigated the health and economic well-being of sole mothers using quantitative data from the Australian Longitudinal Study on Women’s Health (Women’s Health Australia) and qualitative data collected from a series of focus groups. Other research interests include the health and social effects of intimate partner violence, and social factors, such as paid work participation, that influence women’s health and well-being.