


Understanding the Needs of Children:

A study of needs and their determinants in Limerick and Thurles



Feidhmeannacht na Seirbhíse Sláinte
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Table of Contents

Acknowledgements	vii
Chapter One: Context and Methodology	8
1.1 Introduction	8
1.2 Context	8
1.3 Approach to Measuring Need	9
1.4 Questionnaire to Measure Needs of Children & Parents	10
1.5 Sample of Limerick City	10
1.6 Sample of Barnardos Service Users in Limerick City & Thurles	11
1.7 Data Analysis	12
1.8 Limitations of the Study	12
Chapter Two: Characteristics of Households with Children in Limerick	14
2.1 Introduction	14
2.2 Family Structure	14
2.3 Household Size	15
2.4 Mother's Education	15
2.5 Mother's Employment	15
2.6 Mother's Financial Position	15
2.7 Mother's Nationality	16
2.8 Summary and Conclusion	16
Chapter Three: Needs of Children in Limerick	17
3.1 Introduction	17
3.2 Strength and Difficulties	17
3.3 Perceived Health	20
3.4 Disability	20
3.5 Mother's Perception of Child's Reading Ability	20
3.6 Educational Resources and Expectations in the Home	21
3.7 Child's School Attendance	21
3.8 Services Used by Child	21
3.9 Summary and Conclusion	22
Chapter Four: Influences on the Needs of Children in Limerick	23
4.1 Introduction	23
4.2 Factors Associated with SDQ Scores in the Abnormal Range	24

4.3	Factors Associated with Reading Difficulties	26
4.4	Summary and Conclusion	27
Chapter Five: Well-Being of Mothers in Limerick		29
5.1	Introduction	29
5.2	Emotional Well-Being	29
5.3	Life Satisfaction	29
5.4	Depression	30
5.5	Hopefulness	31
5.6	Perceived Health	31
5.7	Smoking, Drinking and Drugs	31
5.8	Support Networks	32
5.9	Parent-Child Relationship	32
5.10	Parental Discipline Style	33
5.11	Relationship Skills	33
5.12	Perceptions of Neighbourhood Problems	33
5.13	Perceptions of Local Services	34
5.14	Neighbourliness	34
5.15	Summary and Conclusion	35
Chapter Six: Key Influences on Well-Being of Mothers in Limerick		37
6.1	Introduction	37
6.2	Factors Associated with Depression	38
6.3	Factors Associated with Discipline Style	40
6.4	Summary and Conclusion	42
Chapter Seven: Well-Being of Children in Barnardos Services		45
7.1	Introduction	45
7.2	Strength and Difficulties	45
7.3	Perceived Health	47
7.4	Disability	47
7.5	Mother's Perception of Child's Reading Ability	47
7.6	Educational Resources and Expectations in the Home	48
7.7	Child's School Attendance	48
7.8	Services Used by Child	48
7.9	Summary and Conclusion	49

Chapter Eight: Well-Being of Mothers in Barnardos Services	51
8.1 Introduction	51
8.2 Demographic Characteristics	51
8.3 Emotional Well-Being	51
8.4 Life Satisfaction	51
8.5 Depression	52
8.6 Hopefulness	52
8.7 Perceived Health	52
8.8 Smoking, Drinking and Drugs	52
8.9 Support Networks	53
8.10 Parent-Child Relationship	53
8.11 Parental Discipline Style	53
8.12 Relationship Skills	53
8.13 Perceptions of Neighbourhood Problems	54
8.14 Perceptions of Local Services	54
8.15 Neighbourliness	54
8.16 Summary and Conclusion	55
Chapter Nine: Summary, Conclusions and Implications	57
9.1 Introduction	57
9.2 Context	57
9.3 Approach to Measuring Need	57
9.4 Questionnaire to Measure Needs of Children & Parents	58
9.5 Sample of Limerick City	58
9.6 Sample of Barnardos Service Users in Limerick City & Thurles	58
9.7 Data Analysis	59
9.8 Characteristics of Households with Children	59
9.9 Needs of Children in Limerick	60
9.10 Influences on Children's Mental Health Difficulties	61
9.11 Influences on Children's Reading Difficulties	62
9.12 Needs of Mothers in Limerick	62
9.13 Influences on Maternal Depression	63
9.14 Influences on Discipline Practices	64
9.15 Needs of Children in Barnardos Services	65
9.16 Needs of Mothers in Barnardos Services	65



9.17	Implications	65
9.18	Concluding Comment	70
	Bibliography	71

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As with all studies, it is important to emphasise that responsibility for the report rests entirely with the authors.

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Chapter One: Context and Methodology

1.1 Introduction

This chapter describes the context and methodology of the study. The context is set by the objectives for the study which are detailed in Section 1.2. The methodology involves describing the instruments to measure need (Section 1.3), the method of drawing a representative sample of households with children in Limerick city (Section 1.4), as well as a sample of those who use Barnardos services in Limerick and Thurles (1.5), and the method of data analysis (Section 1.5). We conclude by outlining the overall structure of the report in Section 1.6.

1.2 Context

The context for this study was set out in January 2007 in the invitation to tender:

“The purpose of the needs analysis is to explore the range of needs that three groups of children present with:

- i) A representative sample of children living in Limerick city
- ii) Children receiving Barnardos services in Limerick city during the reference period of the study
- iii) A sample of children receiving Barnardos services in Thurles during the reference period of the study

The specific objectives of the needs are to:

- Identify risk and protective factors present in the lives of children attending Barnardos services in Limerick and Thurles and a representative sample of children living in Limerick city across the following domains: living situation; family and social relationships; social and anti-social behaviour; physical and mental health; and education and training
- Investigate the type and level of need among each individual group of children and critically analyse these need groups
- Identify common need groups among each of the three cohorts of children and critically analyse these need groups
- Explore each group of children and families use of services in the Limerick city and/or Thurles area as appropriate
- Compare needs analysis findings from each of the three groupings of children against the domains listed above and against each other

1.3 Approach to Measuring Need

In order to carry out a study of need, it is necessary to begin with a clear definition of need. Children are said to be in need when their well-being is below a threshold that is regarded as either normal or minimal. Need is a multi-dimensional concept covering all aspects of the child's well-being including: physical, psychological, relationship with parents and peers, school attendance, out-of-school activities etc. Children's well-being is also heavily dependent on the well-being of their parents, and for this reason, a proper understanding of children's needs must take into account the well-being of their parents: physical, psychological, relationship with child and with partner, social supports, etc. In addition, since children's needs are influenced by the socio-economic status of their household and the broader physical environment, it is therefore necessary to measure household income, employment and education as well as neighbourhood perceptions. It is this understanding, based on existing research on the needs of children and families¹ which informs our approach to assessing the needs of children in Limerick and Thurles.

We carried out interviews with mothers in all three samples using the same questionnaire instrument. This has the advantage that it provides a consistent source of information about the family, about the needs of mothers, and the needs of her children. It also has the advantage of being the most cost effective way of carrying out a needs assessment without compromising the quality of the data and is the internationally accepted way in which this type of needs analysis is undertaken².

The disadvantage of interviewing mothers only is that the voices of children and fathers are not heard directly. It is recognised that the voice of the child is very important. At the same time, the objectives of the study are not seriously undermined by focusing on mothers only, essentially because children typically under-estimate their needs by comparison with mothers, and many needs would be missed if the analysis relied only the voice of the child. Similarly, the exclusion of fathers is a disadvantage, particularly in two parent households, but is unlikely to seriously undermine the overall objectives of the study given the likely overlap between the views of both parents. Notwithstanding these considerations, it is important to recognise that the decision to interview mothers only, while consistent with the way needs analysis is normally carried out, and is justifiable in terms of both scientific and economic criteria, also carries limitations which need to be borne in mind when drawing out the practical implications of the findings for service development.

1 For example, a recent comprehensive review of research on early childhood development - entitled 'From Neurons to Neighbourhoods' (Shonkoff and Phillips, 2000) - highlighted the multiple influences on children's needs. Similarly, the bio-ecological model of Bronfenbrenner (1979; 2001) sees the child's development as the outcome of influences within the family, school and local community as well as government policies and societal attitudes.

2 See, for example, Glascoe, Maclean and Stone, 1991; Achenbach and Howell, 1993; Dulcan, Costello, Edelbrock, et al, 1990.

The instruments used to measure the needs of children and their parents in this study meet the three criteria identified by the National Children's Office in its recent wide-ranging review of appropriate indicators for measuring child well-being³. The three criteria are:

- Important, i.e. the indicators should cover significant aspects in the child's life;
- Practical, i.e. there is good comparable data for these indicators in order to assess need;
- Robust, i.e. the indicators are measured using valid and reliable instruments.

1.4 Questionnaire to Measure Needs of Children & Parents

The questionnaire draws together a range of instruments which have been tried and tested internationally. Equally important, they have been used in a national study of family well-being in Ireland⁴, and some have also been used in the evaluation of Springboard projects in Ireland⁵, and in the assessment of the mental health needs of children in Ballymun⁶, other parts of Dublin⁷, and Ireland⁸. As such, they provide useful benchmarks against which to measure the well-being of children in Limerick city and Thurles. Similarly, demographic and socio-economic data were collected using questions which allow for comparison with national datasets such as the Census of Population, Quarterly National Household Survey, The Living in Ireland Survey, etc.

1.5 Sample of Limerick City

The terms of reference require a sample of 200 households-with-children in Limerick city. We estimate that the sampling error associated with this sample size, at the 95 per cent level of probability, is in the 4-7 range for each statistic generated from this sample. In view of the pronounced spatial distribution of affluence and deprivation in Limerick city⁹, we decided that a stratified random sample would be the most appropriate procedure for drawing a

3 Brooks and Hanafin, 2005; Hanafin and Brooks, 2005;

4 McKeown, Pratschke and Haase, 2003

5 See McKeown, Haase and Pratschke, 2001; 2004a; 2004b

6 See McKeown and Haase, 2006.

7 McKeown and Fitzgerald, 2007; McKeown and Fitzgerald, 2007a.

8 McKeown and Fitzgerald, 2006b.

9 The random selection of sampling points in each quadrant is made possible by the availability, for all major cities in Ireland, of a neighbourhood-level system of addresses which are classified according to the level of affluence and deprivation. This system is called INCA (Irish National Classification of Addresses) and has been developed by GAMMA in cooperation with Ticket Master and Trutz Haase. INCA has been developed by combining three data sources: (i) the creation of street-level spatial entities based on the grouping of residential delivery points (in effect households) in the Geo-directory, the official database of An Post for all postal delivery addresses throughout the state, (ii) the sales of entertainment tickets through Ticket Master. For this purpose, some two million ticket sales have been geo-coded, i.e., been linked to the exact address location of the purchaser and (iii) the EA-level Index of Relative Affluence and Deprivation, based on the Census of Population. As expenditure for entertainment purposes is deemed a 'superior good', i.e., a good which will be purchased in greater proportions as incomes rise, we can use the sales density for each of the INCA units as a proxy to allow the Index of Relative Affluence and Deprivation to vary around its EA-level value. In order to ensure confidentiality, INCA has been constructed in such a way that each point represents a minimum of sixteen households. The maximum however can reach several hundred households such as in high density apartment buildings. In order to draw the sample in each quadrant, we sorted the INCA points in that quadrant according to the relative affluence, based on the Census of Population. As expenditure for entertainment purposes is deemed a 'superior good', i.e., a good which will be purchased in greater proportions as incomes rise, we can use the sales density for each of the INCA units as a proxy to allow the Index of Relative Affluence and Deprivation to vary around its EA-level value. In order to ensure confidentiality, INCA has been constructed in such a way that each point represents a minimum of sixteen households. The maximum however can reach several hundred households such as in high density apartment buildings. In order to draw the sample in each quadrant, we sorted the INCA points in that quadrant according to the relative affluence

representative sample. This involved selecting a representative sample of 50 households-with-children in each of the city's four sectors – north, south, east and west - yielding a total sample of 200 households-with-children. Within each sector, which is an aggregate of Electoral Divisions (EDs), the sample was recruited at five randomly selected sampling points and interviews were carried out at 10 households-with-children in each of those sampling points, yielding a total sample of 50 per sector. Within each of the selected sampling points, the first household was chosen at random and every fourth household was visited. If no contact was made, the next sampled household was visited, returning to the one where no contact was made on at least three occasions before a replacement household was sought. If a household did not meet the requirement of at least one child aged 4-16, or was unwilling to participate, the next door household was chosen.

Interviews were held with mothers to ascertain their level of well-being; mothers were asked to assess the well-being of one child in the family. In families where there is more than one child, the mother was invited to report on the child whose birthday falls closest to the date of the interview; this procedure is designed to ensure that each child is selected at random. On completion of the interview, each mother was given a token of appreciation amounting to €10.00.

Given that the sample comprises an equal number of households (50) from each of the four quadrants, we re-weighted the data in each quadrant to reflect its true population share in Limerick city, based on the 2002 Census of Population. In addition, we re-weighted the proportion of two parent and one parent households within each of the four quadrants to represent their known distribution of these households in Limerick, based on the 2002 Census of Population.

1.6 Sample of Barnardos Service Users in Limerick City & Thurles

Barnardos has been working in Limerick since the mid-1990s and currently provides services to children and families in Southhill, Moyross and Islandgate, and has been working in Thurles since 1998. According to the RFT, "it is estimated that at any one time, Barnardos services in Limerick work with 80 children and families while the project in Thurles works with approximately 60 families at any one time". We proposed to interview a sample of 100 of service users, 60 per cent in Limerick and 40 per cent in Thurles. In practice, we were only able to achieve a sample of 42 comprising 24 from Limerick - 10 from Southhill, 10 from Moyross, and 4 from Islandgate - and 18 from Thurles. Due to difficulties in recruiting respondents, the effect of which was to reduce the sample's randomness, we cannot be sure that the resulting profile of children and mothers is truly representative of those who use Barnardos services.

1.7 Data Analysis

We use correlation analysis¹⁰ and regression analysis¹¹ to test the level of association between the needs of children (in the areas of mental health and reading) and mothers (in the areas of depression and parenting) - the dependent variables - and a range of individual, family, and socio-economic factors (the independent variables). It should be pointed out that the existence of a statistical association does not necessarily imply causation, since our data is cross-sectional rather than longitudinal, but it may nevertheless be helpful, if taken conjunction with findings from other research on the determinants of well being among children and mothers, in suggesting possible interpretations of those associations as well as possible strategies for addressing those needs.

1.8 Limitations of the Study

It is appropriate to draw attention to some limitations to the study. Four limitations in particular should be borne in mind.

First, the study is based solely on interviews with mothers. This decision was governed primarily by cost considerations, although it has the advantage of providing a consistent source of information about the child, the mother, and the family, and is an internationally accepted way in which this type of needs analysis is undertaken¹². The disadvantage of only interviewing mothers is that the voices of children and fathers are not heard directly. It is recognised that the voice of the child is very important. However, the objectives of the study are not seriously undermined by this exclusion, essentially because children typically underestimate their needs by comparison with mothers, and it is doubtful if any needs have been missed without the voice of the child. The exclusion of fathers may be a more significant disadvantage, particularly in two-parent households, because we lose a perspective which is important in understanding the family system. The absence of this dimension should not be allowed to distract the attention from the role that fathers can play in promoting positive outcomes for children, as a growing body of research shows¹³. Moreover, while it is generally recognised that the support services for families are often inadequate, this inadequacy is even more pronounced for fathers, and especially single fathers¹⁴. It is important, therefore,

10 Correlation analysis measures the extent to which two variables, one designated as dependent, the other as independent, are associated. The correlation coefficient is the percent of variance in the dependent variable that is explained by the independent variable when all other independent variables are allowed to vary. The magnitude of the correlation coefficient reflects not only the unique covariance it shares with the dependent variable, but uncontrolled effects on the dependent variable attributable to covariance which the independent variable shares with other independent variables. This makes correlation analysis more limited than regression analysis.

11 Regression analysis is a method of explaining variability in a dependent variable using information about one or more independent variables; it is referred to as multiple regression analysis because there is more than one independent variable. The regression coefficient is the average amount the dependent variable increases when the independent variable increases by one unit and other independent variables are held constant. The fact that regression analysis holds constant the influence other independent variables makes it a significantly more powerful statistical technique than correlation analysis. In logistic regression, the dependent variable is binary or dichotomous and is used, in this context, to assess the likelihood of a child being, or not being, in the abnormal range of the SDQ. The results of logistic regression are expressed in terms of the odds ratio where 1.0 means there is no relationship, less than 1.0 indicates an inverse or negative relationship, and greater than 1.0 indicates a direct or positive relationship.

12 See, for example, Glascoe, Maclean and Stone, 1991; Achenbach and Howell, 1993; Dulcan, Costello, Edelbrock, et al, 1990.

13 For a review of the evidence on fathers, see Lamb, 2004; see also Carlson, 2006.

14 McKeown, 2001a; 2001b.

not to allow this limitation to distract from considering the type of support services which would enable fathers to play a nurturing role in the lives of their children, thereby adding to their own well-being as well.

Second, the study is limited by the fact that we have not examined how the couple relationship affects child outcomes and the well-being of parents. We know from other research that its effects can be considerable¹⁵, particularly in cases of intense conflict and instability.

Third, we do not analyse the varied neighbourhood contexts which affect the well-being of children and families in Limerick city. It is well known that neighbourhood quality varies significantly within the city, as highlighted in a recent report on the problems in some of Limerick's local authority housing estates: "The overall appearance of Moyross, Southhill, St. Mary's Park, and parts of Ballinacurra Weston, is very poor. There is extensive illegal dumping and littering. The appearance of the estates is made worse by the number of burnt-out houses, which are often the result of criminal activity. The state of housing stock is poor, particularly in O'Malley Park. Much of the refurbishment work that has been carried out has not achieved the results hoped for"¹⁶.

Fourth, all data were collected at a single point in time (between April and May 2007) and from a single source, mothers. Given that the factors which influence the needs of children and parents have a cross-sectional dimension as well as a longitudinal dimension, our reliance on cross-sectional data only, points to the need for caution in making inferences about causality. In addition, exclusive reliance of the reports of mothers makes it difficult to distinguish between the respondent's attributions and the true nature of the phenomenon in question. These considerations imply that care needs to be exercised in drawing inferences from the study about the broader determinants of well-being among parents, children and neighbourhoods.

None of these limitations are particularly unusual in a study such as this. Nor do they invalidate its results, which offer a robust picture of well-being among children and their parents. Nevertheless, it is important to keep the limitations in mind when making inferences to the entire population, or and drawing out the implications for policy and practice within Barnardos.

¹⁵ See McLanahan, Donahue and Haskins, 2005; Carlson and McLanahan, 2006; Harold, Pryor, and Reynolds, 2001; McKeown and Sweeney, 2001: Chapter Four.

¹⁶ Fitzgerald, 2007:6

Chapter Two: Characteristics of Households with Children in Limerick

2.1 Introduction

This chapter describes some socio-demographic characteristics of households in the sample, comparing them with comparable data for Ireland. The household is where all, or some, family members live but the concepts of household and family are not always overlapping, particularly in lone parent households where the father may be living outside the household. In our analysis therefore, and in the design of family services generally, it is appropriate to treat families and households as conceptually separate.

Throughout the analysis, we distinguish between households with a Medical card and those without in order to examine the effects of socio-economic disadvantage on the different variables. Our survey found that half the sample – and therefore half the population of mothers in Limerick city - have a Medical card, significantly higher than in Ireland (28 per cent), based on 2004 data¹⁷. The significance of using the Medical card is that it is a means-tested, income-related entitlement to health services and therefore a reliable predictor of socio-economic status. Unlike many other means-tested benefits, the Medical card has no stigma attached to it with the result that our data on the prevalence of Medical cards in Limerick city is likely to be highly reliable. In addition, the possibility that the Medical card may offer a practical non-stigmatising way of identifying children and families who have particular needs provides an important policy rationale for using this variable throughout the analysis.

2.2 Family Structure

The term family structure is used to describe whether there are one or two parents living in the households. Our survey revealed that the breakdown between one and two parent families is approximately 33 per cent / 67 per cent respectively, compared to 20 per cent / 80 per cent in Ireland. Given that lone parenthood is strongly associated with socio-economic disadvantage – both as cause and consequence¹⁸ – and the fact that Limerick is relatively more disadvantaged compared to Ireland, this result is not unexpected. Lone parenthood is also more heavily concentrated in large urban areas¹⁹, and this would also account for the greater concentration in Limerick compared to Ireland. The strong association between lone parenthood and socio-economic disadvantage is also underlined within Limerick city by the

¹⁷ Nolan, 2007:4

¹⁸ See McLanahan, Donahue and Haskins, 2005.

¹⁹ See McKeown, Pratschke and Haase, 2003

fact that lone parents are nearly five times more likely to have a Medical card compared to those without a Medical card.

2.3 Household Size

The average number of persons in each household in Limerick city is 4.2, each with an average of 2.3 children per household. The average age of children is nine and the average age of mothers is 37. The level of owner occupation is much lower in Limerick city (52 per cent) compared to Ireland (74 per cent) and, within Limerick city, is much lower among those with a medical card (23 per cent) compared to those without a medical card (80 per cent).

2.4 Mother's Education

There is little difference in the age at which mother's completed full-time education in Limerick city and Ireland, with more than six out of ten staying at school after the age of 16. However mothers on a medical card were significantly more likely to leave school early compared to mothers without a medical card. This is also reflected in a lower level of educational qualifications among medical card holders.

2.5 Mother's Employment

More than half (52 per cent) the mothers in Limerick city are in employment, about two thirds of these in part-time employment, similar to the position of women aged 15 and over in Ireland. More than four in ten (43 per cent) are on home duties, higher than the average for women aged 15 and over in Ireland (31 per cent). However the most significant differences are between those with and without a medical card. Mothers with a medical card are much more likely to be on home duties (63 per cent) and, if employed, are much more likely to be employed part-time (25 per cent). In keeping with this, mothers on a medical card are also much more likely to be in receipt of income supports from the State, particularly the One Parent Family Payment (50 per cent).

2.6 Mother's Financial Position

Financial well-being has both an objective dimension (measured by income) and a subjective dimension (measured by one's capacity to live on one's income). Overall, mothers in Limerick are similar to other households in Ireland with the majority (78 per cent) not experiencing financial strain as indicated by 'finding it difficult to manage' or 'in serious difficulties'. However mothers with a medical card are five times more likely to experience financial strain compared to those without a medical card (39 per cent compared to 7 per cent).

It is useful to place this result in the context of a recent report which found that the level of financial strain among Irish households fell considerably between 1994 and 2001 (from 31

per cent to 10 per cent), but also fell for a range of households experiencing poverty including households with children (from 37 per cent to 12 per cent), older people (from 23 per cent to 12 per cent), unemployed (from 54 per cent to 20 per cent), and the ill / disabled (from 48 per cent to 19 per cent)²⁰. Significantly, the level of financial strain among mothers with a medical card in Limerick is well above that experienced not only by Irish households generally but also by reference to specific groups which are vulnerable to poverty. In other words, the benefits of Ireland's recent economic success do not seem to have improved the financial well-being of mothers with a medical card in Limerick city, who constitute half the population of mothers with a child aged 4-16 years.

2.7 Mother's Nationality

The vast majority of mothers (94 per cent) are Irish, higher than the corresponding proportion recorded in the 2006 Census of Population.

2.8 Summary and Conclusion

This chapter has shown that households with children in Limerick are broadly similar to households in Ireland in terms of size, education, employment, and financial strain. The fact that Limerick city is known to be somewhat more disadvantaged than Ireland and the surrounding Mid-West Region, based on the analysis of Small Area Population Statistics (SAPS), is consistent with our finding that the level of owner occupation in Limerick city (52 per cent) is significantly lower than in Ireland (74 per cent). Similarly, given that lone parenthood is strongly associated with socio-economic disadvantage – both as cause and consequence²¹ – and is also more heavily concentrated in large urban areas²², we found that a third of households with children in Limerick are lone parent households compared to a fifth in Ireland.

Our analysis revealed that the most significant variation is not between Limerick city and Ireland but between those households in Limerick city which have a medical card and those which do not. medical card holders are five times more likely to live in rented accommodation, mainly from the local authority, are more likely to have left school early and to have fewer qualifications; they are less likely to be in work and are more likely to experience financial strain. This suggests that entitlement to a medical card is a very effective way of identifying households where there may be significant material deprivation and it is for this reason that we use this indicator of disadvantage throughout our analysis. Given that half of all households in Limerick city have a medical card, this suggests a very high prevalence of material deprivation among families with children in Limerick city.

²⁰ Whelan, Nolan and Maitre, 2005

²¹ See McLanahan, Donahue and Haskins, 2005.

²² See McKeown, Pratschke and Haase, 2003

Chapter Three: Needs of Children in Limerick

3.1 Introduction

This chapter measures the needs of children in Limerick across a range of domains including mental health, disability, reading ability, and school attendance. It is based on a sample of 201 children, comprising slightly more boys (55 per cent) than girls (45 per cent). The largest group of children (50 per cent) are aged seven to twelve, with the remainder divided almost equally between those aged four to six (27 per cent), and thirteen to seventeen (23 per cent). We analyse the results by age and sex and whether the household has a medical card.

3.2 Strength and Difficulties

We used the Strengths and Difficulties Questionnaires (SDQ)²³ to assess the mental health needs of children, based on the perceptions of mothers. These perceptions were then classified according to whether the child falls within the internationally agreed mental health categories of normal, borderline or abnormal since these are used for identifying children whose mental health needs meet DSM-IV diagnostic status²⁴, sometimes referred to as ‘child psychiatric caseness’²⁵. The use of the SDQ to measure the prevalence of children in need within a community requires that account is taken of the narrow definition of need (based on those who score in the abnormal category only) and the broad definition of need (based on those whose scores fall within the borderline and abnormal categories combined). The guidance offered by the author of the SDQ is that “the ‘borderline’ cut-offs can be used for studies of high-risk samples where false positives are not a major concern; the ‘abnormal’ cut-offs can be used for studies of low-risk samples where it is more important to reduce the rate of false positives”²⁶. Given that Limerick city as a whole qualifies as a low risk population, it follows that a narrower definition of need, comprising abnormal cases only, is the appropriate definition of need for this study. However, for certain sub-populations within Limerick city – such as those with a medical card – it may be more appropriate to use the broader definition of need, comprising both borderline and abnormal cases. We present data on both definitions to allow the results to be used as flexibly as possible, according to the context.

23 The SDQ is a validated and reliable instrument for assessing behaviours, emotions and relationships, and was created by Robert Goodman during the 1990s for the purpose of screening children who may have mental health or psychiatric needs²³. It is therefore a useful proxy measure of psychological well-being. It is suitable for 3-16 year olds and can be completed by the child (if over 11), the parent (for children aged 3+), and the teacher (for children aged 3+). Available at www.sdqinfo.com

24 DSM-IV refers to Diagnostic and Statistical Manual of Mental Disorders which sets out the diagnostic criteria developed by the American Psychiatric Association (1994).

25 Goodman, 1999.

26 Goodman, 1997:585.

The survey results, as summarised in Table 3.1, reveals that 8 per cent of children are in the abnormal range and a further 9 per cent are in the borderline range. The main difficulties involve conduct, hyperactivity and emotional problems.

Table 3.1 Percent of Children in Normal, Borderline and Abnormal Ranges of the SDQ

Type of Difficulty	Normal %	Borderline %	Abnormal %	Total %
Conduct problems	76.6	9.3	14.1	100
Hyperactivity	78.6	6.8	14.6	100
Emotional problems	82.1	6.7	11.2	100
Peer problems	84.8	7.9	7.3	100
Pro-social behaviour	90.9	5.5	3.6	100
Total Difficulties	83.0	8.8	8.3	100
Total Families (N)	2,575	272	257	3,104
Estimated Number of Children aged 0-18	11,371	1,206	1,137	13,700

Further analysis reveals that boys present more difficulties than girls, and older children present more difficulties than younger children. As a result, older boys are the most vulnerable group with 17 per cent in the abnormal range. The proportion of children in the abnormal range is ten times higher among families with a medical card (15 per cent) compared to families without (1.5 per cent). This does not imply that most families with a medical card have a child with a mental health difficulty, but it does suggest that this is where most of the children with a mental health difficulty are to be found.

Extrapolating these results to the total number of children aged 0-18 in Limerick city, we estimate that there are 1,137 children in the abnormal range and a further 1,206 in the borderline range; taken together, this is equivalent to nearly one in five children (17 per cent) who have some level of need.

The scale of need among children in Limerick city – when broadly defined to include the borderline and abnormal categories - is similar to the results of other studies in Ireland. Most other studies in Ireland have measured the needs of children using the Rutter Scale²⁷ – which has a high correlation with the SDQ²⁸ – and these show that about 20 per cent of children living in disadvantaged families and communities show evidence of a psychiatric disorder

²⁷ The Rutter Scale is a 26-item screening questionnaire created by Michael Rutter which can be completed by either parents or teachers for the purpose of detecting psychological disorders among children (Rutter, 1967).

²⁸ Goodman, 1997

which mainly finds expression in behavioural problems²⁹. A large study in the UK, based on a representative sample of 10,000 children, found that 10 per cent of children had a clinically defined mental disorder, mainly involving conduct and emotional disorders, with higher rates among boys than girls, and higher rates among older children compared to younger children³⁰. In fact this study, which also used the SDQ, yielded remarkably similar results to our study, and adds confidence to the robustness of our results for Limerick. In the US, a sample of over 9,000 children found a similar pattern of results using a shortened version of the SDQ but with a lower prevalence rate of 5 per cent for mental health difficulties³¹.

Given that this study aims to contribute to the development of services for children in Limerick, it is important not just to assess the prevalence of need but also the depth of need relative to the experience of the 'average' or 'normal' child. By depth of need we refer to the journey which a child in the borderline or abnormal range of the SDQ must travel in order to come within the normal range. This is important information since it throws light on the type and scale of interventions which may be needed to bring these children within the normal range. We do this by comparing the mean scores of children in Limerick with the mean scores of a nationally representative sample of over 10,000 children in Britain³², since there are no corresponding representative studies of children in Ireland using the SDQ. The difference in mean scores is expressed in terms of the effect size³³, a statistic which allows one to assess if the difference in mean scores – and therefore the level of need among children - is small, moderate or large.

The results show that children in the abnormal range have an effect size of 2.47 while those in the borderline range have an effect size of 1.19. This indicates a significant scale of need, particularly among those in the abnormal range. In order to appreciate the scale of need, it is useful to remember that the most effective programmes for children and families tend to achieve effect sizes in the range 0.5 to 0.8 and many, such as the High/Scope Perry Pre-School Programme have achieved much lower effect sizes of 0.36³⁴. In other words, the scale and depth of need among children in the borderline and abnormal categories is

29 Fitzgerald and Jeffers, 1994; O'Connor, Ruddle and O'Gallagher, 1988; McCarthy and O'Boyle, 1986; Porteus, 1991; O'Rourke and Fitzgerald, 1985; Lynch, Fitzgerald and Kinsella, 1987; Barton and Fitzgerald, 1986; Stone, Fitzgerald and Kinsella, 1990; Mohan, Fitzgerald and Collins, 1998; Martin, Carr, Carroll and Byrne, 2005.

30 Meltzer, Gatward, Goodman, and Ford, 2000

31 Simpson, Bloom, Cohen, Blumberg and Bourdon, 2005.

32 See Meltzer, Gatward, Goodman, and Ford, 2000; see also www.sdqinfo.com

33 The effect size is a simple way of standardising and comparing the difference between two groups on a range of test scores. It is typically used in randomised control trials (RCTs) to compare the difference between an experimental and a control group. The formula involves subtracting the mean of the experimental group from the mean of the control group and dividing by their pooled standard deviation. Thus, the effect size is measured in standard deviation units and the score varies from 0.0 to 3.0. The convention established by Jacob Cohen (1988) and referred to as 'Cohen's d', is that a coefficient between 0.2 and 0.5 indicates a small effect, between 0.5 and 0.8 indicates a moderate effect, and above 0.8 indicates a large effect.

34 See for example Schweinhart and Weikhart, 1997; Schweinhart, 2004. This is similar to the results of a meta-analytic review of the effect sizes associated with family support programmes (Layzer, Goodson, Bernstein and Price, 2001) and other pre-school prevention programmes (see Nelson, Westhues and MacLeod, 2003).

considerable and poses a challenge in terms of finding appropriate interventions as well as setting targets that would be realistic and achievable.

3.3 Perceived Health

Mothers rated the health of their children on a five-point scale comprising 'excellent', 'very good', 'good', 'fair', and 'poor'. The results show that 84 per cent of mothers rate their children's health as excellent or very good. None rate it as poor. Boys are rated to have somewhat poorer health than girls and those aged 7-12 years have somewhat poorer health than children in other age groups. However the biggest gap is between mothers with, and without, a medical card with the former rating their children as having poorer health than the latter.

3.4 Disability

Mothers assessed if their child had any form of disability, using a question from the 2006 Census of Population. The survey shows that 19 per cent of children are perceived to have at least one of the disabilities mentioned. This is similar to the prevalence of disabilities (18 per cent) estimated by the National Council for Special Education in 2006 from a range of sources³⁵. It is much higher than the rate (2 per cent) estimated in the 2002 Census of Population which is generally regarded as an underestimate. Results from the 2006 Census of Population, from which we drew our question on disability, will not be available until November 2007. There is a considerably higher prevalence of disabilities among teenage children (30 per cent) and in households with a medical card (25 per cent) compared to those without (14 per cent).

3.5 Mother's Perception of Child's Reading Ability

Mother's were asked to rate their child's ability in terms of English reading, based on the precedent set in a major national study of reading ability where 6,499 children was assessed using the Drumcondra Sentence Reading Test (DSRT) and where parents were also invited to rate their child's reading ability³⁶. This study found that "There is a clear association between the ratings given by parents to their children, and the scores achieved by the children on the DSRT. At each grade level, children who were rated as 'very good' had a significantly higher mean score than those rated as 'OK'. Similarly, at each level, those rated as 'OK' had a higher average mean score than those rated as 'Not Great'³⁷. The results show that overall reading ability in Limerick city is almost identical to Ireland. Reading ability is weaker among boys while mothers with a medical card rated their children as significantly weaker compared to mothers without a medical card; in fact all of the children whose reading

³⁵ McKeown, 2006:72

³⁶ Eivers, Shiel and Shortt, 2004.

³⁷ Eivers, Shiel and Shortt, 2004:81.

ability was described as 'Not Great' were in the medical card category (13 per cent) and is twice the proportion in this category in Ireland (6 per cent).

3.6 Educational Resources and Expectations in the Home

There is a substantial amount of research to show that a child's reading ability is significantly influenced by the amount of educational resources in the home, particularly the number of books and being read to before school-going age³⁸. Households in Limerick city tend to have more books in the home than households in Ireland. This applies to houses with and without a medical card in Limerick city. Similarly, the practice of reading to children before primary school age is also more frequent in Limerick among all categories of household. Access to the internet is greater in Limerick city (50 per cent) compared to Ireland (38 per cent) but slightly lower for those with a medical card (36 per cent). Expectations of when the child will leave school are considerably higher in Limerick city than Ireland with more than half of Limerick mothers (54 per cent) expecting their child to go to college compared to less than half in Ireland (45 per cent). Expectations do not vary by the age of the child but tend to be lower for boys and significantly lower in households with a medical card.

3.7 Child's School Attendance

The school attendance rate among children in Limerick, based on the responses of mothers, is slightly higher than among children in Ireland where the data is based on returns from schools rather than the responses of mothers. At primary school, the national school attendance rate is 94 per cent compared to 96 per cent in Limerick while at post-primary school, the national school attendance rate is 92 per cent compared to 95 per cent in Limerick. Similarly, the proportion of children who are absent from school for 20 days or more is considerably lower among children in Limerick compared to Ireland. However the absentee rate at post-primary schools in Limerick (14 per cent), though less than Ireland (19 per cent), is substantial and we estimate that 1,234 children were absent from post-primary school for 20 days or more during the past year. Girls are nearly three times more likely to be absent and there is a greater likelihood of absenteeism among households with a medical card. The main reason for being absent from school, according to mothers, is that the child was ill (76 per cent) and this is broadly similar for boys and girls and for those with and without a medical card.

3.8 Services Used by Child

The services which were most frequently used by children in the past year are the teacher (79 per cent) and the GP (71 per cent). The Public Health Nurse was used by a quarter of children (25 per cent). Service usage is slightly higher among the youngest age group (4.6), among boys and among those with a medical card.

38 Eivers, Shiel and Shortt, 2004:173.

3.9 Summary and Conclusion

In this chapter we have found that the prevalence of mental health difficulties, as measured by the SDQ, is broadly in line with other population-based studies. We found that 8 per cent of children are in the abnormal range and a further 9 per cent are in the borderline range. The proportion of children in the abnormal range is ten times higher among families with a medical card (15 per cent) compared to families without (1.5 per cent). Extrapolating these results to all children (0-18 years) in Limerick city, we estimate that 1,137 children are in the abnormal range and a further 1,206 are in the borderline range.

The level of need is higher among boys, among older children, and in households with a medical card. This is in line with other studies in Ireland, UK and US. Substantial interventions will be needed to bring children who are in the borderline and abnormal ranges to within the normal range and will need to have an impact which is greater than the scale of improvement that is usually produced by programmes for children and families.

The survey also found that 19 per cent of children in Limerick city are perceived by their mother to have at least one disability. This is similar to the prevalence of disabilities (18 per cent) estimated by the National Council for Special Education in 2006.

Children in Limerick have similar reading ability to children in Ireland but a small proportion of children (13 per cent) – all in households where the mother has a medical card – have reading difficulties. Educational resources in the home – as measured by number of books, being read to before school age, access to computer and internet, expectations of leaving school – tend to be better for children in Limerick city than Ireland. Similarly, school attendance rates seem to be higher in Limerick than Ireland although a substantial proportion of post-primary pupils in Limerick (14 per cent), particularly girls, are missing school for 20 days or more; this is equivalent to 1,234 children.

A significant finding to emerge from the survey is that children in need are most likely to be found in households with a medical card, confirming the well-known social gradient between level of need and socio-economic status. This finding also provides one of the keys to targeting households where children may be in need. With this in mind, we now undertake a further analysis of the factors which are most strongly associated with the needs of children in Limerick. That is the theme of the next chapter.

Chapter Four: Influences on the Needs of Children in Limerick

4.1 Introduction

There is clear evidence of need among children in Limerick city, particularly in households with a medical card. This is consistent with international research which shows that poor child outcomes (as measured by psychological problems and consequent impairments to a range of domains in the child's life) are primarily, though not exclusively, found among families and communities that are socio-economically disadvantaged (as measured by low income and related indicators). However the relationship between child poverty and child outcomes is not a simple one – as exemplified by the fact that many poor children do not experience poor child outcomes – essentially because the effects of poverty and disadvantage are either amplified or moderated by the child's experiences within the family³⁹. In other words, the family environment provides an important buffer zone between the child and the wider socio-economic environment⁴⁰.

A major challenge in planning services for children and young people is how to respond to needs in a way that tackles the underlying structural factors which create and sustain those needs. It is beyond the scope of this relatively small cross-sectional study to provide definitive answers to the underlying causes of children's needs in Limerick city since that would require a much larger longitudinal and comparative study. However it is possible to throw further light on the factors associated with children's needs by identifying why some children in Limerick have poorer outcomes than others.

Our purpose in this chapter therefore is to examine and identify the specific factors which influence two key child outcomes: (i) the psychological well-being of children as measured by the SDQ⁴¹ and (ii) the cognitive development of children as measured by the child's reading ability. The latter is clearly a proxy measure but a reliable predictor of reading ability as measured by more objective methods.

39 One illustration of this is a study of poor children attending Head Start centres in Seattle, USA which found that two thirds did not have behaviour problems because they were buffered from the effects of poverty through positive and effective parenting whereas the one third who exhibited aggressive behaviours had mothers with histories of abuse or psychiatric illness which rendered them "more vulnerable to the stresses of poverty, a vulnerability that becomes expressed in disrupted parenting behaviour. This disruption involves hostile exchanges with children, inconsistent discipline and a negative reinforcement mechanism which contributes to the development of child conduct problems and poor social competence" (Webster-Stratton and Hammond, 1998:120).

40 This is similar to the bio-ecological model of Bronfenbrenner (1979; 2001) which sees the child's development as the outcome of influences within the family, school and local community as well as government policies and societal attitudes.

41 The SDQ measures the following dimensions of psychological well-being: conduct problems, hyperactivity, emotional problems, peer problems, and pro-social behaviour

We use correlation analysis⁴² and logistic regression analysis⁴³ to test the level of association between children in the abnormal range of the SDQ (the dependent variable, sometimes referred to as the outcome variable) and a range of family and socio-economic variables (the independent variables, sometimes referred to as predictors, determinants, or explanatory variables). Our analytical strategy involves the following steps: (i) derive a correlation matrix of the factors associated with the dependent variable; (ii) enter those variables which are statistically significant into the regression analysis; and (iii) derive a separate correlation matrix for each of the factors identified in the regression analysis from the list of significant variables in the first step. The rationale for this analytical strategy is that the analysis remains focused on the factors associated with the dependent variable under investigation, and excludes other associations between the variables.

It should be pointed out that the existence of a statistical association does not necessarily imply causation but it may nevertheless be helpful, if taken conjunction with findings from other research on child well-being, in suggesting possible strategies for addressing the needs of children. This analysis therefore is designed to assist in identifying the type of risk and protective factors that should be targeted in designing strategies to meet the needs of children and their families.

4.2 Factors Associated with SDQ Scores in the Abnormal Range

Our analysis reveals that the three predictors of a child being in the abnormal range of the SDQ are: (i) household has a medical card (ii) mother takes sedatives, tranquilisers or anti-depressants (iii) mother has above average negative affect. Having a medical card is the strongest predictor and the 'odds ratio', which measures the strength of association, indicates that a child living in a household with a medical card is 17.3 times more likely to be in the abnormal range of the SDQ compared to a household without a medical card. Similarly, children whose mothers' takes sedatives, tranquilisers or anti-depressants are 4.9 times more likely to be in the abnormal range of the SDQ compared to children whose mother do not. Finally, children whose mothers have a higher negative affect than average – as indicated by more frequent experiences of negative feelings such as distressed, upset, scared, hostile, irritable, ashamed, nervous, jittery and afraid – are slightly more likely to be

42 Correlation analysis measures the extent to which two variables - one designated as dependent, the other as independent - are associated. The correlation coefficient is the percent of variance in the dependent variable that is explained by the independent variable when all other independent variables are allowed to vary. The magnitude of the correlation coefficient reflects not only the unique covariance it shares with the dependent variable, but uncontrolled effects on the dependent variable attributable to covariance which the independent variable shares with other independent variables. This makes correlation analysis more limited than regression analysis.

43 Regression analysis is a method of explaining variability in a dependent variable using information about one or more independent variables; it is referred to as multiple regression analysis because there is more than one independent variable. The regression coefficient is the average amount the dependent variable increases when the independent variable increases by one unit and other independent variables are held constant. The fact that regression analysis holds constant the influence other independent variables makes it a significantly more powerful statistical technique than correlation analysis. In logistic regression, the dependent variable is binary or dichotomous; this is unlike ordinary regression analysis where the dependent variable is continuous. The results of logistic regression are expressed in terms of the odds ratio where 1.0 means there is no relationship, less than 1.0 indicates an inverse or negative relationship, and greater than 1.0 indicates a direct or positive relationship.

in the abnormal range of the SDQ compared to other children. We now examine in more detail the cluster of influences associated with each of the three factors which predict whether a child is in the abnormal range of the SDQ.

4.2.1 Factors associated with medical card

We know that a medical card is a means-tested entitlement to a range of health services and, as such, is a reliable predictor of low income and other indicators of disadvantage. Low income is also associated with having difficulty coping financially and, in this way, contributes to stresses and strains within the family⁴⁴. Close inspection of the correlation matrix reveals that the medical card, in the context of children who score in the abnormal range of the SDQ, is primarily associated with mothers who have poor mental health as indicated by lower life satisfaction and hope, depression, and using sedatives, tranquilisers and anti-depressants. In addition, the medical card is associated with a weaker relationship between the mother and the child, although it is also associated with reading to the child before primary school age and having a dictionary in the home. The overall significance of this is that the medical card is primarily associated with mental health difficulties among mothers and these are amplified by the financial difficulties associated with socio-economic disadvantage.

4.2.2 Factors associated with taking sedatives, tranquilisers and anti-depressants

The correlation matrix reveals that mothers who take sedatives, tranquilisers and anti-depressants are likely to be differentiated from other mothers in terms of mental health indicators such as depression, negative affect, reduced life satisfaction and hopefulness. Mothers who take sedatives, tranquilisers and anti-depressants also have greater difficulty in coping financially. In addition, use of sedatives, tranquilisers and anti-depressants is associated with a weaker parent-child relationship, including the excessive use of discipline, and not reading to the child before primary school age. It is clear from this that taking sedatives, tranquilisers and anti-depressants is itself symptomatic of severe difficulties in the lives of mothers and these difficulties, in turn, directly affect the child.

4.2.3 Factors associated with negative affect

Negative affect is shaped by two factors. The first is the mother's mental health as indicated by depression, reduced life satisfaction and hopefulness, using sedatives, tranquilisers and anti-depressants, and having difficulty coping financially which itself is strongly with the mother's mental state. The second is a poor relationship with the child, including using excessive discipline and not reading to the child before the primary school age.

⁴⁴ Whelan, Maitre and Nolan, 2007

4.2.4 Service implications of SDQ scores in the abnormal range

These findings provide valuable information on how to identify these children within the community but also point to the type of support services that might help to ameliorate the needs of those children. Beginning with children whose SDQ scores are in the abnormal range – of which there are over 1,000 in Limerick city according to our estimates - it is clear that these children need to be assessed and treated as soon as possible. Given that the primary influence on the mental health of these children is the mental health of mothers, our findings also point to the need for direct interventions with these mothers. In addition to treatment, our analysis also suggests that prevention and early intervention services should focus on improving the mental health of mothers – including reducing the stress associated with financial difficulties - if the objective is to improve the mental health of children. If possible, this strategy should be supplemented by interventions which focus specifically on parenting skills, particularly the skill of setting appropriate limits on children without using excessive discipline. Interventions in the areas of mental health and parenting are likely to mutually reinforce each other since, as we shall see in Chapter Six below, one of the key predictors of parenting skills is the mental health of the mother.

4.3 Factors Associated with Reading Difficulties

We analysed the factors associated with reading difficulties, based on those children whose reading was described by their mother as 'Not Great'. As seen in the previous chapter, 6 per cent of all children, but 13 per cent of those on a medical card, were in this category. The results of the regression analysis revealed that the two predictors of reading difficulties are: (i) mother is a lone parent and (ii) lower parental expectations of the child's educational achievement. Having a mother who is a lone parent is the strongest predictor and children in lone parent households are nearly five times more likely to have reading difficulties compared to children in two parent families. Low parental expectations of the child's educational achievement also increase the likelihood of having reading difficulties compared to other children. We now analyse in more detail the cluster of factors associated with these two predictors of reading difficulties.

4.3.1 Factors Associated with Lone Parenthood

Lone parenthood, according to the results of the correlation analysis, is primarily a phenomenon associated with socio-economic circumstances such as having a medical card, living in local authority accommodation, and having difficulty coping financially. However lone parenthood is also associated with low parental expectations of the child's educational achievement.

4.3.2 Low parental expectations of child's educational achievement

Low parental expectations of the child's educational achievement are associated with two clusters of variables. The first is socio-economic circumstances associated with socio-economic circumstances such as having a medical card, living in local authority

accommodation, and having difficulty coping financially. The second is the educational environment of the home as indicated by the number of books in the home, reading to the child before primary school, having a computer in the home, and the number of days missed at school.


4.3.4 Service implications of children with reading difficulties

A key service implication of our analysis is that lone parents are an important target group in terms of identifying children who may be vulnerable to having reading difficulties. This does not imply that two parent households may not have children with reading difficulties – given that the socio-economic factors associated with lone parenthood also affect some two parent households such as having a medical card, living in local authority accommodation, and having difficulty coping financially – but lone parents are a higher risk group. The main focus of interventions to address reading difficulties should be on the educational environment of the home, and the attitudes and behaviours of mothers towards their child's education. Children's ability to read is improved by the presence of books and a computer in the home, and by a mother who reads to the child early in life and who ensures that the child attends school regularly. The style of intervention may also be important here, focusing on the pleasure and enjoyment that can come from books and reading to children on the one hand, and the natural propensity of children to flourish when their parents are encouraging and expect them to do well at school. There may also be merit in building stronger links between home and school and finding ways to involve mothers in the school. Interventions might also consider using imaginative schemes and incentives to support and reward mothers and children for reading through book clubs, homework clubs, etc.

4.4 Summary and Conclusion

This chapter analysed the key factors which shape the needs of children in Limerick city. We have seen that children with serious mental health difficulties – as indicated by SDQ scores in the abnormal range – are to be found in households where mothers have a medical card, takes sedatives, tranquilisers or anti-depressants, and have an above-average level of negative affect. We have also seen that children with reading difficulties are to be found in households where the mother is a lone parent and has low expectations of the child's educational achievement.

These findings provide valuable information on how to identify these children within the community but also point to the type of support services that might help to ameliorate the needs of those children. Beginning with children whose SDQ scores are in the abnormal range – of which there are over 1,000 in Limerick city according to our estimates - it is clear that these children need to be assessed and treated as soon as possible. Given that the primary influence on the mental health of these children is the mental health of mothers, our findings also point to the need for direct interventions with these mothers. In addition to treatment, our analysis also suggests that prevention and early intervention services should focus on improving the mental health of mothers – including reducing the stress associated



with financial difficulties - if the objective is to improve the mental health of children. If possible, this strategy should be supplemented by interventions which focus specifically on parenting skills, particularly the skill of setting appropriate limits on children without using excessive discipline. Interventions in the areas of mental health and parenting are likely to mutually reinforce each other since, as we shall see in Chapter Six below, one of the key predictors of parenting skills is the mental health of the mother.

Turning to children with reading difficulties, our analysis indicates that lone parenthood is an important target group in terms of identifying children who may be vulnerable to having reading difficulties. This does not imply that two parent households may not have children with reading difficulties – given that the socio-economic factors associated with lone parenthood also affect some two parent households such as having a medical card, living in local authority accommodation, and having difficulty coping financially – but lone parents are a higher risk group. The main focus of interventions to address reading difficulties should be on the educational environment of the home, and the attitudes and behaviours of mothers towards their child's education. Children's ability to read is improved by the presence of books and a computer in the home, and by a mother who reads to the child early in life and ensures that the child attends school regularly. The style of intervention may also be important here, focusing on the pleasure and enjoyment that can come from books and reading to children on the one hand, and the natural propensity of children to flourish when their parents are encouraging and expect them to do well at school. There may also be merit in building stronger links between home and school and finding ways to involve mothers in the school. Interventions might also consider using imaginative schemes and incentives to support and reward mothers and children for reading through book clubs, homework clubs, etc.

Chapter Five: Well-Being of Mothers in Limerick

5.1 Introduction

In this chapter we assess the well-being of mothers in Limerick city relative to the well-being of mothers in Ireland. Our assessment is based on survey data from a representative sample of 201 mothers in Limerick city and 274 mothers in Ireland⁴⁵. In order to establish the extent of need among mothers in Limerick city, we compare their mean scores with the mean scores of Irish mothers generally. We standardise the difference in mean scores between the two groups of mothers using the effect size statistic⁴⁶. We now report the main findings from our analysis.

5.2 Emotional Well-Being

Emotional well-being is measured by each person's experience of positive and negative emotions. Positive emotions increase well-being while negative emotions reduce it. The emotional quality of a person's life can be reliably measured by the Positive and Negative Affect Scales (PANAS)⁴⁷ and this is used here. We also measure the frequency of positive emotions using the Intensity and Time Affect Survey⁴⁸. The survey revealed that Limerick mothers, both those with and without a medical card, are more positive and less negative than their counterparts in Ireland. Similarly they score higher on the love and joy subscales compared to US studies. These results, particularly as they relate to mothers with a medical card, tend to be at variance with other indicators of well-being which we report in this chapter.

5.3 Life Satisfaction

Life satisfaction refers to a person's cognitive and affective evaluation of his / her life. It is sometimes referred to as 'subjective well-being' or 'hedonic happiness' because it focuses on the prevalence of positive feelings and satisfaction with life⁴⁹. Life satisfaction has a substantial genetic component which means that, to some degree, people are born prone to

45 McKeown, Pratschke and Haase, 2003

46 The effect size is a simple way of standardising and comparing the difference between two groups on a range of test scores. It is typically used in randomised control trials (RCTs) to compare the difference between an experimental and a control group. The formula involves subtracting the mean of the experimental group from the mean of the control group and dividing by their pooled standard deviation. Thus, the effect size is measured in standard deviation units and the score varies from 0.0 to 3.0. The convention established by Jacob Cohen (1988) and referred to as 'Cohen's d', is that a coefficient between 0.2 and 0.5 indicates a small effect, between 0.5 and 0.8 indicates a moderate effect, and above 0.8 indicates a large effect.

47 Adapted from Watson, Clark, and Tellegen, 1988.

48 Reproduced in McDowell, 2006:214.

49 Carr, 2004:38-9

be happy or unhappy⁵⁰. However, as one review of the research has noted, “It is not just who we are that matters to happiness, but how we think about our lives”⁵¹. We measured life satisfaction using the Satisfaction with Life Scale⁵². The results show that, in terms of life satisfaction, Limerick mothers without a medical card (28) score considerably higher (28) compared to the US norm (23). However those with a medical card (22) are slightly below the US norm, a result that is at variance with the relatively high level of depression reported by medical card mothers in the next section. The co-existence of relatively high rates of life satisfaction and depression among medical card holders may be due to the fact that these mothers have come to accept their lives as they are.

5.4 Depression

We measured depression using the Depression Scale of the Centre for Epidemiologic Studies (CES), usually referred to as CES-D⁵³. A recent review of the scale noted that “The CES-D is one of the best-known survey instruments for identifying symptoms of depression. It has been extensively used in large studies and norms are available; it is applicable across age and socio-demographic groups, and it has been used in cross-cultural research. It has often been used in studying the relationships between depressive symptoms and other variables”⁵⁴. The overall rate of depression in Limerick among mothers is between 12 per cent (based on the cut-off score of 20) and 17 per cent (based on the cut-off score of 16). However mothers with a medical card (whose rates are between 18 per cent and 25 per cent) are more than three times more likely to experience symptoms of depression compared to mothers without a medical card (whose rates are between 6 per cent and 9 per cent).

Estimates of the prevalence of depression vary widely according to the measurement instrument and the characteristics of the population notably gender (women tend to show higher rates than men), age (older people tend to show higher rates than younger people), income (poorer people tend to show higher rates), and health (people with illness or disability tend to show higher rates). In Ireland, the CES-D was used in a survey of 244 adults (two thirds of them women) attending the Farranfore Medical Centre in County Kerry, which found that 30 per cent of these showed depressive symptoms (based on the cut-off score of 16 or over)⁵⁵. Internationally, a review of evidence on the prevalence of depression among mothers

50 Diener, Lucas and Oishi, 2002:66

51 Diener, Lucas and Oishi, 2002:67

52 Diener, Lucas and Oishi, 2002:70; A recent review of studies based on this scale observed: “Tens of thousands of individuals across several cultures have taken this test. Here are some representative norms: Among older American adults, men score 28 on average and women score 26. The average North American college student scores between 23 and 25; and eastern European and Chinese students on average score between 16 and 19. Male prison inmates score about 12 on average, as do hospital inpatients. Psychological outpatients score between 14 and 18 on average, and abused women and elderly caregivers (both surprisingly) score about 21 on average” (Seligman, 2002:63).

53 The scale is reproduced in McDowell, 2006:350-358

54 McDowell, 2006:355

55 O’Sullivan, 2004.

with young children concluded that “approximately 1 in 10 women with young children experience depression ... with prevalence rates often reaching two times these levels among mothers living in poverty”⁵⁶. In light of these results, it is safe to conclude that the rate of depressive symptoms among mothers with a medical card is comparable with the results of other studies.

5.5 Hopefulness

Hopefulness, as the concept is defined in psychology, refers to a pattern of thought about one’s ability to find ways of achieving goals and having the motivation to achieve those goals. As one leading researcher has put it, “hopeful thought reflects the belief that one can find pathways to desired goals and become motivated to use those pathways”⁵⁷. In everyday language, people are described as hopeful who believe they have the will (‘agency thinking’) and the way (‘pathways thinking’) to achieve their goals. Naturally, there is considerable variation in how people present this quality with some scoring high in their agency thinking but low on their pathways thinking (typically people who are motivated but not very resourceful), and vice versa (typically people who are resourceful but not very motivated). We measured this using the Hope Scale⁵⁸ and found that 80 per cent of mothers are hopeful but 20 per cent are lacking in hope. However mothers with a medical card are five times more likely to lack hope (34 per cent) compared those without a medical card (7 per cent), and these mothers have difficulty finding ‘the will or the way’ to address the challenges which they face.

5.6 Perceived Health

Mothers rated their health on a five-point scale comprising ‘excellent’, ‘very good’, ‘good’, ‘fair’, and ‘poor’. The results show a broad similarity between the self-rated health of mothers in Limerick city and the general population in Ireland. However medical card holders tend to give a lower rating to their health compared to those without medical cards. For example, 48 per cent of those with medical cards rated their health as excellent or very good compared to 82 per cent of those without medical cards; similarly, 15 per cent of those with medical cards rated their health as fair or poor compared to 4 per cent of those without medical cards.

5.7 Smoking, Drinking and Drugs

Health behaviour influences physical health and, for this reason, we collected data on the prevalence of smoking, drinking and drugs. The results reveal that the rate of smoking among mothers in Limerick (49 per cent) is higher than among women in Ireland (33 per cent). However the prevalence of smoking among medical card holders (68 per cent) is

⁵⁶ Shonkoff and Phillips, 2000: 251.

⁵⁷ Snyder, Rand and Sigmon, 2002:257

⁵⁸ Snyder, Rand and Sigmon, 2002:268-270

more than twice that of non-medical card holders (30 per cent). The usage of alcohol is broadly similar between Limerick (65 per cent) and Ireland and between those with medical cards (62 per cent) and those without medical cards (67 per cent). Sedatives, tranquilisers or anti-depressants are prescription drugs, commonly referred to as benzodiazepines, and their usage is 5 per cent among women in Ireland, identical to the usage among mothers without a medical card in Limerick. However 21 per cent of mothers with a medical card in Limerick take sedatives, tranquilisers or anti-depressants which is more than five times the national rate.

5.8 Support Networks

There is extensive research to show that support networks are a significant influence on the well-being of individuals and their families⁵⁹. In addition, positive support networks are known to improve physical health and mental health and to aid in recovery from illness and adversity⁶⁰. It is generally acknowledged that the relationship between support networks and well-being is 'bi-directional' in the sense that happier people tend to have stronger support and friendship networks but these networks in turn also contribute to a person's happiness⁶¹. We measured support networks by asking respondents to rate the supportiveness of the following people, if they needed help: your partner, your parents, your brothers and sisters, your children, your relatives, your friends, people at work, your neighbours, etc. The results indicate that mothers in Limerick, both those with and without a medical card, have slightly stronger support networks than mothers in Ireland.

5.9 Parent-Child Relationship

The parent-child relationship is regarded as pivotal to the healthy growth and psychological well-being of children, particularly in their early years⁶². We used the Parent-Child Relationship Inventory (PCRI)⁶³ to measure four dimensions of that relationship: satisfaction with parenting, involvement with their children, communication with their children, limit-setting for their children, and independence. The results of the survey reveal that mothers in Limerick, both those with and without a medical card, have a slightly better overall parent-child relationship compared to mothers in Ireland. However mothers with a medical card in Limerick are slightly behind the national norm in terms of their effectiveness at setting limits on the child.

59 For a review, see McKeown, 2000:11-13

60 See Scovern, 1999, pp. 272-273; Sprenkle, Blow and Dickey, 1999, p.334, respectively review the evidence.

61 Carr, 2004:20-24; Seligman, 2002:56

62 For a review of the evidence, see Shonkoff and Phillips, 2000:225-266

63 Gerard, 1994.

5.10 Parental Discipline Style

The survey explored the issue of limit-setting in more detail by asking mothers about their methods of disciplining the child. We did this using the Parent-Child Conflict Tactics Scale (CTS-PC)⁶⁴ which asks parents how frequently they used each of 18 different forms of discipline which were then classified into four broad categories: (i) non-violent discipline (eg. 'explained why something was wrong', 'gave the child something else to do instead of what he / she was doing'); (ii) psychological aggression (eg. 'shouted, yelled or screamed at him / her', 'swore or cursed at the child'); (iii) minor physical assault (eg. 'shook the child', 'spanked the child on the bottom with your bare hand'); and (iv) severe physical assault ('hit the child with a fist or kicked him / her hard', 'threw or knocked the child down'). It is clear that some of these forms of discipline, particularly those designated as 'severe physical assault', constitute child abuse as the term is understood in Ireland and elsewhere⁶⁵.

The survey results show that mothers with a medical card in Limerick use significantly more discipline, particularly non-violent discipline and psychological aggression, compared to a national sample of mothers, while mothers without a medical card use significantly less than the national average. Non-violent discipline is the most frequently used form of discipline by all mothers, but mothers with a medical card in Limerick use it much more frequently (36.2) compared to mothers in Ireland (26.7). Similarly, psychological aggression is used more frequently by mothers with a medical card in Limerick (18.2) compared to mothers in Ireland (13.3). Minor and severe physical assaults are used infrequently.

5.11 Relationship Skills

We used the Ineffective Arguing Inventory⁶⁶ to measure the skillfulness of mothers at resolving arguments with partners. Each mother rated her effectiveness at resolving arguments with a current partner or, if they have no current partner, with a previous partner. The results show that mothers with a medical card are less effective at resolving arguments compared to a national sample of mothers, while those without a medical card are more effective. However mothers who are not living with a partner are much less effective at resolving arguments compared to those who are living with a partner.

5.12 Perceptions of Neighbourhood Problems

The exact way in which neighbourhoods influence well-being is difficult to measure and depends in part on how neighbourhood characteristics are defined and how they interact with other variables such as household, family and personal characteristics. Some of the ways in which neighbourhoods impact on well-being include characteristics such as the quality of

64 Straus, Hamby, Finkelhor and Runyan, 1995.

65 Department of Health and Children, 1999; 2002.

66 Kurdek, 1994.

neighbourliness or 'social capital' between families in the area, the degree to which there is a shared sense of trust and values in the neighbourhood, including the value placed on education, the physical appearance and safety of the area, as well as the quantity and quality of neighbourhood resources such as childcare, family centres, recreational facilities, libraries, schools, health clinics, arts and crafts classes, etc. The scale of influence exercised by neighbourhood is estimated to vary between 5 per cent and 20 per cent⁶⁷.

Mothers rated a list of neighbourhood problems on a five-point scale comprising 'very big problem', 'fairly big problem', 'unsure', 'minor problem', 'not a problem'. The results show that, on average, nearly half (46 per cent) of the mothers with a medical card rate all aspects of their neighbourhood as a very big problem or a fairly big problem compared to less than a quarter (24 per cent) mothers without a medical card. The biggest neighbourhood problems, according to mothers with a medical card, are: not safe to walk alone after dark (66 per cent), litter and rubbish (64 per cent), dog dirt (56 per cent), drug problems (52 per cent), and drinking in public places (50 per cent). This result is consistent with the well-documented neighbourhood problems in some local authority housing estates in Limerick city which have been described in a recent report as follows: "The overall appearance of Moyross, Southhill, St. Mary's Park, and parts of Ballinacurra Weston, is very poor. There is extensive illegal dumping and littering. The appearance of the estates is made worse by the number of burnt-out houses, which are often the result of criminal activity. The state of housing stock is poor, particularly in O'Malley Park. Much of the refurbishment work that has been carried out has not achieved the results hoped for"⁶⁸.

5.13 Perceptions of Local Services

Mothers rated a list of local services on a five-point scale comprising 'very poor', 'poor', 'average', 'good', 'very good'. The results show that, on average, medical card holders rate a lower proportion of services as poor or very poor (41 per cent) compared to non-medical card holders (45 per cent). However both groups of mothers agree on what they perceive to be the five services which fit the description of poor or very poor: leisure facilities for teenagers (86 per cent), leisure facilities for young children (81 per cent), playgrounds (83 per cent), football pitches / sports facilities (65 per cent), and green areas / parks (63 per cent).

5.14 Neighbourliness

Neighbourliness was measured by whether mothers trust their neighbours, have done or received a favour for a neighbour in the past six months, and whether they believe that neighbours look out for each other. Overall, the results show little difference between those with and without a medical card. Just over half trust many or most people in the

⁶⁷ For a review of studies, see Sampson, Morenoff and Gannon-Rowley, 2002; see also Pratschke, J., 2002.

⁶⁸ Fitzgerald, 2007:6

neighbourhood, similar to the level of trust indicated in a UK survey which used this instrument. More than eight out of ten mothers have done and received a favour for a neighbour in the last six months and this is the same for those with and without a medical card. This indicates a higher level of neighbourliness compared to comparable data from the UK where about seven out of ten are involved in doing reciprocal favours. Similarly more than eight out of ten mothers in Limerick, irrespective of medical card, believe that neighbours look out for each other.


5.15 Summary and Conclusion

In this chapter we assessed the well-being of mothers in Limerick relative to the well-being of mothers in Ireland based on survey data from a representative sample of 201 mothers in Limerick city and 274 mothers in Ireland⁶⁹. As in previous chapters, we distinguish between households with a medical card and those without in order to examine the effects of socio-economic disadvantage on the different variables and to explore the possibility that the medical card may offer a practical non-stigmatising way of identifying children and families who have particular needs. The results show that mothers in Limerick who have a medical card have significantly lower levels of well-being compared to mothers without a medical card. This applies to most of the scales used but is particularly pronounced in some key domains. For example, up to a quarter of mothers with a medical card show clinical signs of depression, more than three times the rate among mothers without a medical card. Possibly as a consequence of this, a fifth of medical card mothers are on sedatives, tranquilisers and anti-depressants, which is five times higher than the national average. Similarly, more than a third of mothers with a medical card show signs of lacking hope and have difficulty finding either 'the will or the way' to address the challenges which they face. Mothers with a medical card are also significantly less positive in how they perceive their own health, and their smoking rate (68 per cent) is twice the national average.

On the positive side, all mothers in Limerick, irrespective of medical card, have strong support networks, which is higher than the average for Irish mothers generally. Similarly, more than eight out of ten mothers have done and received a favour for a neighbour in the last six months, and believe that neighbours look out for each other. This indicates a higher level of neighbourliness compared to data from the UK where this instrument was also used. Both groups of mothers also give broadly similar ratings to the services which they use. However a significant difference is that mothers with a Medical Card are twice as likely to experience serious neighbourhood problems compared to mothers without a medical card, a finding which is consistent with the well-documented problems in some local authority estates in Limerick⁷⁰.

69 McKeown, Pratschke and Haase, 2003

70 Fitzgerald, 2007:6



In the area of parenting, the differences between mothers who have and have not a medical card are less pronounced and are broadly similar to the scores of mothers in Ireland on the overall parent-child relationship. The one area of difference is the discipline style of mothers: those who have a medical card tend to use significantly more discipline on their children, particularly non-violent discipline and psychological aggression, compared to those without a medical card, and compared to mothers in Ireland generally. This, in turn, may be the reason why mothers with a medical card are somewhat less effective in setting limits on their children. Mothers with medical cards are also less effective at resolving arguments with their current or former partners but those who are not living with a partner are much less effective compared to those who are living with a partner.

In sum, these findings indicate that having a medical card is a strong predictor of needs in a wide range of domains including depression and usage of anti-depressants, lacking in hope, smoking, difficulties in parenting and other relationships, and the experience of neighbourhood problems. We now explore in more detail the specific factors which are most strongly associated with depression (as measured by the CES-D) on the one hand and parenting difficulties (as measured by the CTS-PC) on the other, since these are two key areas which also influence the well-being of children.

Chapter Six: Key Influences on Well-Being of Mothers in Limerick

6.1 Introduction

It is clear from the survey that wide variations exist in the well-being of mothers in Limerick, primarily related to whether or not they have a medical card. We now carry the analysis further by focusing on the factors which are associated with two aspects of maternal well being, namely depression and discipline style. We selected these two indicators not only because they are key aspects of the well-being of mothers but also because they are known to influence on the well-being of children.

As in Chapter Four, we use correlation analysis⁷¹ and regression analysis⁷² to test the level of association between mothers in the clinically depressed range (the dependent variable, sometimes referred to as the outcome variable) and a range of family and socio-economic variables (the independent variables, sometimes referred to predictors, determinants, or explanatory variables). Similarly, we test the association between the mother's use of discipline - indicated by the frequency of using various discipline practices - and a range of socio-economic and family variables. Our analytical strategy involves the following steps: (i) derive a correlation matrix of the factors associated with the dependent variables (ii) enter those variables which are statistically significant into the regression analysis (iii) derive a separate correlation matrix for each of the factors identified in the regression analysis from the list of statistically significant variables in the first step. The rationale for this analytical strategy is that the analysis remains focused on the factors associated with the dependent variable under investigation, and excludes other associations between the variables.

71 Correlation analysis measures the extent to which two variables, one designated as dependent, the other as independent, are associated. The correlation coefficient is the percent of variance in the dependent variable that is explained by the independent variable when all other independent variables are allowed to vary. The magnitude of the correlation coefficient reflects not only the unique covariance it shares with the dependent variable, but uncontrolled effects on the dependent variable attributable to covariance which the independent variable shares with other independent variables. This makes correlation analysis more limited than regression analysis.

72 Regression analysis is a method of explaining variability in a dependent variable using information about one or more independent variables; it is referred to as multiple regression analysis because there is more than one independent variable. The regression coefficient is the average amount the dependent variable increases when the independent variable increases by one unit and other independent variables are held constant. The fact that regression analysis holds constant the influence other independent variables makes it a significantly more powerful statistical technique than correlation analysis. In logistic regression, the dependent variable is binary or dichotomous; this is unlike ordinary regression analysis where the dependent variable is continuous. The results of logistic regression are expressed in terms of the odds ratio where 1.0 means there is no relationship, less than 1.0 indicates an inverse or negative relationship, and greater than 1.0 indicates a direct or positive relationship.

6.2 Factors Associated with Depression

Our analysis reveals that the three predictors of maternal depression are: (i) mother has a medical card; (ii) mother has above average negative affect; and (iii) mother has weak support network. Mothers with a medical card are nearly five times more likely to be depressed compared to mothers without a medical card. Mothers who have a higher-than-average negative affect – as indicated by more frequent experiences of negative feelings such as distressed, upset, scared, hostile, irritable, ashamed, nervous, jittery and afraid – are slightly more likely (1.2) to be depressed. Finally, mothers with weaker support networks – as indicated by the number of people who are supportive when help is needed - are also slightly but significantly more likely (0.54) to be depressed compared to mothers with stronger support networks. We now examine in more detail the cluster of influences associated with each of the four factors.

6.2.1 Factors associated with medical card

The medical card is a means-tested entitlement to a range of health services and, as such, is a reliable predictor of low income and other indicators of disadvantage. However, when seen in the context of maternal depression, the medical card is primarily associated with mothers who have poor mental health as indicated by lower life satisfaction and hope, use of sedatives, tranquilisers and anti-depressants. These mental health difficulties, in turn, are augmented by socio-economic disadvantage which make it more difficult for these mothers to cope financially. In addition, the medical card is associated with having a child in the abnormal range of the SDQ and a weaker relationship between the mother and the child. The significance of this is that the medical card, while indicative of socio-economic disadvantage and the associated difficulties of coping financially, is also a key predictor of mental health and parenting difficulties among mothers.

6.2.2 Factors associated with negative affect

Negative affect, when considered in the context of maternal depression, is strongly associated with two main sets of factors. The first is the relationship with the child, including whether the child is in the abnormal range of the SDQ. Mothers show more negative affect when they have a difficult relationship with their child, particularly if the child has problems with behaviour and hyperactivity. The second is the mental health of mothers such that mothers with lower life satisfaction and hopefulness are more likely to show negative affect. Socio-economic disadvantage adds to these difficulties, and to negative affect, by making it more difficult for mothers to cope financially.

6.2.3 Factors associated with support networks

Support networks seem to act as the mirror image of negative affect and are also influenced by the same set of factors. Firstly, mothers have weaker support networks when they have a difficult relationship with their child, particularly if the child has behaviour problems or hyperactivity. Secondly, mothers have weaker support networks when they are less satisfied with their life and feel less hopeful about their ability to achieve their goals. These problems are augmented by financial difficulties which further weaken the mother's support networks. Given the cross-sectional nature of the data, it is reasonable to infer that the mother's mental health and parenting difficulties are both the cause as well as the consequence of her weaker support networks

6.2.5 Service implications of maternal depression

It is clear from our analysis that maternal depression is influenced by the interaction of four sets of factors. These are: (i) mental health difficulties (ii) parenting difficulties, particularly if the child has difficulties (iii) financial difficulties and (iv) weaker support networks. It is important to emphasise that the factors which influence depression, whether inside or outside the family, do not operate in isolation from each other because it is their interaction effect which creates the susceptibility to maternal depression. Many mothers score high on some of the risk factors but it is only those who score high on all of them that the risk of depression becomes a reality. Equally, these factors operate simultaneously rather than sequentially which means that each is cause as well as consequence because they are linked reciprocally rather uni-directionally. This understanding suggests that problems such as maternal depression might be seen as part of a negative self-reinforcing cycle while, correspondingly, their solution involves creating a positive self-reinforcing cycle. This means that interventions must recognise the systemic nature of the problem being addressed and endeavour to spread the benefits of the intervention to as many domains as possible.

The implications of this for services are quite challenging not just because there are limits to the capacity of what one agency can do – and it is unlikely that any one agency can fully address all of the factors simultaneously - but also because there are limits to the effectiveness of programmes in addressing each of the domains of need. In determining the implications for services therefore, it may be necessary to establish priorities as to the form of intervention that is most likely to be effective in reversing the self-reinforcing cycle of depression. Close inspection of the regression and correlation analysis suggests that the main focus of interventions to address maternal depression should be on the mother and her tendency towards negative thoughts, emotions and behaviours. Existing research suggests that this will require supports to help mothers to think and feel differently about their past, their present and their future⁷³. The analysis also suggests that supports for the mother in terms of improving her parenting skills, particularly the skill of setting appropriate limits on the child, could help create a more positive parent-child relationship. Direct work with the child is

⁷³ Seligman, 2002; for further information on cognitive therapy, see www.beckinstitute.org

also suggested by our analysis, particularly with children who have serious behaviour and hyperactivity problems, since this could help alleviate the burden on the mother while simultaneously setting more consistent and appropriate limits on the child. In addition, advice and assistance to help mothers improve their ability to cope financially would reduce some of the stresses and strains that are associated with depression. Finally, measures to improve the support networks of mothers could also help alleviate the burden of her difficulties. It is clear that all of these interventions would draw on the acknowledged strengths of Barnardos services, but could also be supported by measures to improve the socio-economic context of the household and community, drawing on the resources and skills of other agencies which have responsibilities in this area.

6.3 Factors Associated with Discipline Style

Discipline style, as we have seen in the previous chapter, is a key aspect of parenting. We used two different instruments to measure parenting: (i) the Parent-Child Relationship Inventory (PCRI) which measures the mother's satisfaction with parenting as well as her involvement, communication and limit-setting with the child; and (ii) the Parent-Child Conflict Tactics Scale (CTS-PC) which measures the frequency of using different types of discipline on the child including non-violent discipline, psychological aggression, minor and severe physical assault. We undertook a correlation and regression analysis of both measures of parenting, as reported in the Appendix to Chapter Six, but only report here on the mother's discipline style (CTS-PC). We do this for three reasons.

First, there is much greater variability between mothers in terms of the CTS-PC scale compared to the PCRI which means that the former is considerably more sensitive at detecting needs in this study. For example, using the CTS-PC we found that mothers with a medical card, a reliable predictor of need throughout the study, were significantly different from mothers without a medical card; by contrast, using the PCRI we found no significant differences between these two groups of mothers. This implies, other things being equal, that the CTS-PC identifies a particular area of need within the parenting domain, unlike the PCRI.

Second, our correlation analysis of the factors associated with children's difficulties in Chapter Four, revealed that CTS-PC has a slightly stronger influence than PCRI. Given our interest in finding interventions to address the needs of children and their parents, it seems more appropriate to focus on CTS-PC rather than PCRI in presenting the results of our regression analysis.

Third, in the regression analysis of both CTS-PC and PCRI, the results explain 34 per cent of the variation in CTS-PC scores but only 24 per cent of the variation in PCRI scores. This again suggests that CTS-PS is the more robust measure of parenting need.

Against this background, we now report the results of the regression analysis for CTS-PC. This reveals that the three predictors of discipline style are: (i) mother's negative affect (ii)

child in the abnormal range of the SDQ and (iii) the parent-child relationship. Negative affect is the strongest predictor of discipline style and nearly twice as strong as the influence of having a child in the abnormal range of the SDQ, or the influence of the mother-child relationship. This is a significant finding because it suggests that the frequency and intensity of disciplining the child is related more to the mother's negative feelings than to the child's specific behaviours, or the mother's relationship with the child. In other words, excessive discipline is primarily driven by the mother's negative affect and this needs to be taken into account in trying to address it. This finding also throws light on the finding in Chapter Four which found that the mother's negative affect was one of the predictors of whether a child is in the abnormal range of the SDQ and this, in turn, suggests that negative affect may reduce the well-being of children by virtue of increasing the frequency or intensity of the mother's discipline practices. At the same time, the fact of having a child in the abnormal range of the SDQ has an independent influence on the mother's discipline practices and suggests that these children may be more difficult to manage because of problems with behaviour, emotions or hyperactivity. In order to manage these children therefore, mothers tend to increase the frequency and intensity of discipline, often with negative consequences for both mother and child. It is also significant that the quality of the relationship between mother and child moderates the discipline style such that mothers who communicate and are more involved with the child are less likely to use excessive discipline.

It is clear from these findings that the mother's discipline style is heavily influenced by her own personal characteristics (notably her negative affect), by the child's personal characteristics (notably whether in the abnormal range of the SDQ), and by the relationship between the two (the parent-child relationship). This clearly underlines the systemic nature of the parenting relationship but it also needs to be emphasised that this is not a relationship of equals since discipline style is predominantly mediated through the mother in the same way, as we have seen in Chapter Four, that the child's well being is also mediated through the characteristics of the mother. We now analyse in more detail the cluster of factors associated with these three predictors of discipline practices.

6.3.1 Factors associated with negative affect

Negative affect, in the context of the mother's discipline practices, is shaped by three factors. The first is the mother's mental health as indicated by depression, reduced life satisfaction and hopefulness, and using sedatives, tranquillisers and anti-depressants. The second is the mother's relationship with the child, including whether the child is in the abnormal range of the SDQ. Socio-economic disadvantage adds to these difficulties, and to negative affect, by making it more difficult for mothers to cope financially. This is very similar to the factors associated with negative affect in the context of maternal depression as discussed in the previous section.

6.3.2 Factors associated with child in abnormal range of SDQ

The correlation matrix reveals that a child is more likely to be in the abnormal range of the SDQ if the mother has poor mental health as indicated by depression, reduced life satisfaction and hopefulness, difficulty coping financially, and using sedatives, tranquillisers and anti-depressants. Difficulties in the parent-child relationship as well as difficulties coping financially also contribute to the likelihood of abnormal SDQ scores.

6.3.3 Factors associated with the parent-child relationship

The parent-child relationship, when understood in the context of the mother's discipline practice, is shaped predominantly by the mental health of the mother as indicated by life satisfaction and hopefulness as well as her negative affect, depression, use of sedatives, tranquillisers and anti-depressants, and even her capacity to cope financially. In addition, the one child characteristic which influences the parent-child relationship is the child's SDQ score which in practice means that mothers whose children are experiencing difficulties are likely to have a poorer relationship with that child.

6.3.4 Service implications of mother's discipline practices

Our analysis has shown that the mother's discipline practices are shaped predominantly by her mental health as indicated by depression, negative affect, use of sedatives, tranquillisers and anti-depressants, as well as low levels of life satisfaction and hopefulness; the mother's capacity to cope financially is also an influence and reflects how socio-economic disadvantage directly impacts on her mental health. A subsidiary influence is her relationship with the child, including whether the child is in the abnormal range of the SDQ. This is an important finding from the point of view of services because it suggests that the issue of excessive discipline, possibly fuelled by lack of success in setting appropriate limits on a child who has behaviour problems and hyperactivity, is not due to lack of parenting skills per se but is driven primarily by the mental state of the mother. In other words, interventions to reverse negative thoughts, emotions and behaviours and create more sustained positive experiences are likely, other things being equal, to help the mother become more effective in setting appropriate limits on the child. This suggests, in turn, that parenting programmes for mothers' who have particular difficulties in managing their children, should focus predominantly on the needs of the mother rather than the specific parenting skill of limit setting.

6.4 Summary and Conclusion

The results of our analysis provide clear and statistically reliable guidance on the key factors which influence maternal depression and the discipline practices used by mothers on their children. We found that the three predictors of maternal depression are: (i) having a medical card (ii) having above average negative affect and (iii) having weak support networks. Similarly, we found that the main predictors of the mother's discipline practices are: (i)


negative affect (ii) child in the abnormal range of the SDQ and (iii) the parent-child relationship.

The findings on maternal depression are quite challenging from the point of view of service provision not just because there are limits to the capacity of what one agency can do – and it is unlikely that any one agency can fully address all of the factors simultaneously - but also because there are limits to the effectiveness of programmes in addressing each of the domains of need. In determining the implications for services therefore, it may be necessary to establish priorities as to the form of intervention that is most likely to be effective in reversing the self-reinforcing cycle of depression. Close inspection of the results suggests that the main focus of interventions to address maternal depression should be on the mother and her tendency towards negative thoughts, emotions and behaviours. A growing body of research in positive psychology suggests that this will involve supporting mothers to think and feel differently about their past, their present and their future⁷⁴. The analysis also suggests that supports for the mother in terms of improving her parenting skills, particularly the skill of setting appropriate limits on the child, could help create a more positive parent-child relationship and, other things being equal, reduce depressive symptoms. Direct work with the child is also suggested by our analysis, particularly with children who have serious behaviour and hyperactivity problems, since this could help alleviate the burden on the mother while simultaneously setting more consistent and appropriate limits on the child. In addition, advice and assistance to help mothers improve their ability to cope financially would reduce some of the stresses and strains that are associated with depression. Finally, measures to improve the support networks of mothers could also help alleviate the burden of her difficulties. It is clear that all of these interventions would draw on the acknowledged strengths of Barnardos services, but could also be supported by measures to improve the socio-economic context of the household and community, drawing on the resources and skills of other agencies which have responsibilities in this area.

Turning to the mother's discipline practices, our analysis suggests that interventions to reverse negative thoughts, emotions and behaviours and create more sustained positive experiences are likely, other things being equal, to help the mother to become more effective in setting appropriate limits on the child. The rationale for this is that excessive discipline is not due to lack of parenting skills per se but is driven primarily by the mental state of the mother. This suggests, in turn, that parenting programmes for mothers who have particular difficulties in managing their children, should focus predominantly on the needs of mothers rather than the specific parenting skills such as limit-setting.

An encouraging finding is that almost any intervention to help alleviate negative affect and depression among mothers, in addition to the direct mental health benefits, is also likely to have a positive effect on her parenting and discipline practices, and on the well being of her child. In this sense, and if one had to choose one form of intervention over all others, then

⁷⁴ Seligman, 2002; for further information on cognitive therapy, see www.beckinstitute.org



the focus should be directed at the mental health of mothers through cultivating positive thoughts, emotions and behaviours.

Chapter Seven: Well-Being of Children in Barnardos Services

7.1 Introduction

This chapter measures the extent of need among children whose mothers use Barnardos services in Limerick and Thurles. We used the same instruments which were used in the general survey of children in Limerick city. Assessments were completed by mothers on 42 children of whom 24 were from the Barnardos service in Limerick - 10 from Southill, 10 from Moyross, and 4 from Islandgate – and 18 from the Barnardos service in Thurles. The proportion of boys and girls is exactly equal but there is a strong concentration on pre-teenage children aged 4-12 years who comprise 88 per cent of the total. Due to difficulties in recruiting the sample, we cannot be sure that the profile of children in this chapter is truly representative of those who use Barnardos services.

7.2 Strength and Difficulties

Children are deemed to be in need if their scores on the SDQ fall within either the borderline or abnormal ranges. Given this definition, the level of need is very different between those attending Barnardos services in Limerick and Thurles, as revealed in Table 7.1. In Limerick, 58 per cent of children are in the abnormal range and a further 8 per cent are in the borderline range, equivalent to more than two thirds (67 per cent) of the total. By contrast, Thurles has 22 per cent of children in the abnormal range and 5 per cent in the borderline range, equivalent to just under a third (28 per cent) of the total. In both services, the main problem areas for children are conduct and hyperactivity. Possible reasons for the difference between the two services include differences in the catchment areas served, differences in referral in referral patterns, and differences in the representativeness of both samples.

Given that this study may contribute to the development of services for children in Limerick and Thurles, it is important not just to assess the prevalence of need but also the depth of need relative to the experience of the 'average' or 'normal' child. By depth of need we refer to the journey which a child in these services – particularly a child in the abnormal range of the SDQ - must travel in order to come within the normal range. This is important information since it throws light on the type and scale of interventions which may be needed to bring these children within the normal range. We do this by comparing the mean scores of children in services with the mean scores of a nationally representative sample of over 10,000 children in Britain⁷⁵, since there are no corresponding representative studies of children in Ireland using the SDQ. The difference in mean scores is expressed in terms of the effect size, a statistic which allows one to assess if the difference in mean scores – and

⁷⁵ See Meltzer, Gatward, Goodman, and Ford, 2000; see also www.sdqinfo.com

therefore the level of need among children in Barnardos services - is small, moderate or large.

Table 7.1 Percent of Children in Normal, Borderline and Abnormal Ranges of the SDQ

Category	Normal %	Borderline %	Abnormal %	Total %
Barnardos Limerick				
Conduct problems	25.1	16.7	58.2	100
Hyperactivity	37.5	16.7	45.8	100
Emotional problems	49.9	16.7	33.4	100
Peer problems	58.2	8.4	33.4	100
Prosocial behaviour	79.2	4.0	16.7	100
Total Difficulties	33.4	8.4	58.2	100
Barnardos Thurles				
Conduct problems	38.8	11.2	50.0	100
Hyperactivity	55.8	16.5	27.7	100
Emotional problems	83.5	5.4	11.2	100
Peer problems	88.8		11.2	100
Prosocial behaviour	94.6	5.4		100
Total Difficulties	72.3	5.4	22.3	100
All Limerick				
Conduct problems	76.6	9.3	14.1	100
Hyperactivity	78.6	6.8	14.6	100
Emotional problems	82.1	6.7	11.2	100
Peer problems	84.8	7.9	7.3	100
Prosocial behaviour	90.9	5.5	3.6	100
Total Difficulties	83.0	8.8	8.3	100

The results show that children in the Limerick service who are in the abnormal SDQ range have an effect size of 2.30 while those in the Thurles service have an effect size of 2.43. This indicates a huge scale of need among these children, who constitute over 40 per cent of all the children in the survey. In order to appreciate the scale of need, it is useful to remember that the most effective programmes for children and families tend to achieve effect sizes in the range 0.5 to 0.8 and many, such as the High/Scope Perry Pre-School Programme have achieved much lower effect sizes of 0.36⁷⁶. Significantly, the Springboard family support programme in Ireland also used SDQ as one of its outcome measures and found impacts equivalent to effect sizes of 0.30 (based on mother's responses), 0.27 (based

⁷⁶ See for example Schweinhart and Weikhart, 1997; Schweinhart, 2004. This is similar to the results of a meta-analytic review of the effect sizes associated with family support programmes (Layzer, Goodson, Bernstein and Price, 2001) and other pre-school prevention programmes (see Nelson, Westhues and MacLeod, 2003).

on children's responses), and 0.16 (based on teacher's responses)⁷⁷. In other words, the scale and depth of need among children in these services is considerable and poses a challenge in terms of finding appropriate interventions as well as setting targets that would be realistic and achievable.

7.3 Perceived Health

Mothers rated the health of their children on a five-point scale comprising 'excellent', 'very good', 'good', 'fair', and 'poor'. The results show that the proportion of mothers who rated their children's health as excellent or very good is much lower for children using Barnardos in Limerick (54 per cent) compared those using Barnardos in Thurles (78 per cent), and both are significantly below the rating of a representative sample of mothers in Limerick city (84 per cent).

7.4 Disability

Mothers assessed if their child had any form of disability, using a question from the 2006 Census of Population. The survey shows that 67 per cent of children attending Barnardos services in Limerick and 44 per cent of children attending Barnardos services in Thurles have at least one of the disabilities mentioned. This compares to 19 per cent in our sample of Limerick city which is also similar to the prevalence of disabilities (18 per cent) estimated by the National Council for Special Education in 2006 from a range of sources⁷⁸.

7.5 Mother's Perception of Child's Reading Ability

Mothers were asked to rate their child's ability in terms of English reading, based on the precedent set in a major national study of reading ability where 6,499 children was assessed using the Drumcondra Sentence Reading Test (DSRT) and where parents were also invited to rate their child's reading ability⁷⁹. This study found that "There is a clear association between the ratings given by parents to their children, and the scores achieved by the children on the DSRT. At each grade level, children who were rated as 'very good' had a significantly higher mean score than those rated as 'OK'. Similarly, at each level, those rated as 'OK' had a higher average mean score than those rated as 'Not Great'⁸⁰. The results show that overall reading ability of children in the Thurles service is similar to the norm in Limerick and Ireland; however 21 per cent of children in the Limerick service are described as 'not great' compared to only 6 per cent in Limerick city and Ireland. This is clearly consistent with the higher prevalence of SDQ difficulties, and disabilities, within the Limerick service.

77 McKeown, Haase and Pratschke, 2006:21

78 McKeown, 2006:72

79 Eivers, Shiel and Shortt, 2004.

80 Eivers, Shiel and Shortt, 2004:81.

7.6 Educational Resources and Expectations in the Home

There is a substantial amount of research to show that a child's reading ability is significantly influenced by the amount of educational resources in the home, particularly the number of books and being read to before school-going age⁸¹. We have already seen in Chapter Three that households in Limerick city tend to have more books in the home than households in Ireland, have greater access to the internet, are more likely to read to their children before primary school age, and are more likely to expect their child to go to college. Applying these measures to children using Barnardos services in Limerick and Thurles, we find that these children have much fewer books in the home, particularly children in the Limerick service. The frequency of being read to before school-going age is also much less, particularly among children in the Limerick service. Similarly, access to a computer and the internet is dramatically lower for children in both services, but particularly in the Limerick service. Finally, expectations of when the child will leave school are also lower for children in Barnardos services.

7.7 Child's School Attendance

The school attendance rate among children attending Barnardos services (94 per cent), based on the responses of mothers, is identical to the school attendance rate in Irish primary schools (94 per cent), based on returns from schools. The absentee rate in Ireland, defined as those who are absent from school for 20 days or more, is significantly higher in post-primary schools (19 per cent) compared to primary schools (11 per cent). In light of this, it is significant that the absentee rate among children in Barnardos services – most of whom are still of primary school age – is 20 per cent in Limerick and 15 per cent in Thurles, both of which are higher than the national norm. The main reason for being absent from school, according to mothers, is that the child was ill (86 per cent in Limerick and 92 per cent in Thurles) which is higher than the corresponding proportion in the representative sample of Limerick (76 per cent).

7.8 Services Used by Child

Children who use Barnardos services are much more likely to use other services by comparison with the average child in Limerick. For example, children using Barnardos service have used an average of five services in the past year (5.2 in Limerick and 4.2 in Thurles), compared to an average of two (2.2) in the representative sample of Limerick city. The most frequently used services by children in the past year are the teacher and the GP but there is also frequent use of the Social Worker (42 per cent in Limerick and 34 per cent in Thurles), the Public Health Nurse (38 per cent in Limerick and 28 per cent in Thurles), and psychiatrists / psychologists (33 per cent in Limerick and 22 per cent in Thurles).

⁸¹ Eivers, Shiel and Shortt, 2004:173.

7.9 Summary and Conclusion


This chapter measured the extent of need among children whose mothers use Barnardos services in Limerick and Thurles. Due to difficulties in recruiting the sample, we cannot be sure that the profile of children in this chapter is truly representative of those who use Barnardos services, although it nevertheless provides a valuable insight into the range of needs presented by these children. The results show that the level of need among children attending Barnardos services in Limerick is considerably higher than among children attending Barnardos services in Thurles. Notwithstanding this, it is clear from the study that both services are targeting substantial numbers of children in significant need, particularly in the areas of mental health and cognitive development.

We have seen that the more than four in ten children from both services combined are in the abnormal range of the SDQ, particularly in the areas of conduct problems and hyperactivity. The prevalence of these difficulties is more than twice as high in Limerick as in Thurles but the depth of need, as measured in terms of effect sizes, is greater in Thurles (2.43) than in Limerick (2.30). Mothers, particularly those attending the Limerick service, perceive their children's health to be much poorer compared to mothers in Limerick and Ireland. Consistent with this, there is also a very high prevalence of disabilities, particularly in the Limerick service, which is three times the estimated national average. The reading ability of children in Limerick is well below the national norm where there are much fewer educational resources in the home such as books, being read to before school age, access to computer and internet, expectations of leaving school. Children in both services also have poorer school attendance rates compared to children in primary school generally.

The scale and depth of need revealed by the study poses a challenge to these services in terms of finding effective interventions which will help to bring children from the abnormal range to within the normal range, for each of the key domains measured. Our analysis in Chapters Four and Six throws light on the range of factors which contribute to children's needs and this may help in assessing the appropriateness of existing interventions.

In the area of mental health difficulties, our analysis suggests that the primary strategy for improving the mental health of children is to improve the mental health of mothers. The analysis also suggests that this will involve reversing a tendency among many of these mothers towards negative thoughts, emotions and behaviours and this, in turn, will require supports to help mothers think and feel differently about their past, their present and their future⁸². If possible, this strategy should be supplemented by interventions which focus specifically on parenting skills, particularly the skill of setting appropriate limits on children without using excessive discipline. These two forms of interventions will mutually reinforce each other since our analysis also shows that one of the key predictors of parenting skills is the mental health of the mother.

82 Seligman, 2002; for further information on cognitive therapy, see www.beckinstitute.org



Turning to children with reading difficulties, our analysis suggests that encouraging and supporting mothers to read to their child before going to primary school is the most effective way of preventing reading difficulties emerging in the first place. This may not be easy if there is no tradition of reading to children in these homes. However, this may be amenable to change through imaginative schemes and incentives which support and reward mothers, and children, for reading.

Finally, it is worth emphasising that the effectiveness of all interventions can only be tested through systematic evaluation of progress using an agreed set of instruments to measure the well being of each child at regular intervals over the course of the intervention. In that sense, the results of this study might be regarded as a baseline against which the progress of these children might be measured in the future.

Chapter Eight: Well-Being of Mothers in Barnardos Services

8.1 Introduction

This chapter measures the extent of need among mothers who use Barnardos services in Limerick and Thurles. It is based on interviews with 42 mothers of whom 24 were from the Barnardos service in Limerick - 10 from Southill, 10 from Moyross, and 4 from Islandgate – and 18 from the Barnardos service in Thurles. Due to difficulties in recruiting the sample, we make no claim as to its representativeness although it nevertheless provides a valuable insight into the range of needs presented by these mothers. We use the same set of instruments which were used in the larger representative survey of mothers in Limerick city.

8.2 Demographic Characteristics

Around half the mothers attending Barnardos services in Limerick and Thurles are lone parents, considerably higher than in Limerick or Ireland. About eight out of ten have a medical card, nearly three times the national average. These mothers live in rented accommodation, mostly from the local authority, where number of persons per household is a higher than average. They left school earlier compared to the average for Limerick are more likely to work full-time in the home. Nearly half the mothers attending the service in Limerick are experiencing financial strain (46 per cent), twice the proportion of those attending the service in Thurles (22 per cent), which is similar to Limerick generally (22 per cent) but higher than Ireland (15 per cent). About 5 per cent of those attending services are non-Irish, similar to the proportion in Limerick (6 per cent) but half the proportion in Ireland (11 per cent).

8.3 Emotional Well-Being

Emotional well-being is measured by the frequency of experiencing positive and negative emotions. Mothers attending Barnardos services in Limerick and Thurles experience much more negative emotions and fewer positive emotions compared to mothers in Limerick or Ireland. Mothers in the Limerick service are significantly more negative and less positive than mothers in the Thurles service.

8.4 Life Satisfaction

The life satisfaction scores of mothers attending Barnardos services in Limerick (22) and Thurles (20) are slightly below the average for all mothers in Limerick (25). We have no comparable Irish data but the average score for US adults, based on numerous studies, is in

the 21-25 range⁸³. The relatively high scores of mothers attending Barnardos services in Limerick and Thurles would seem to be at variance with the relatively high level of depression reported in the next section, possibly because these mothers have come to accept their lives and its difficulties.

8.5 Depression

The prevalence of depression among mothers attending Barnardos services in Limerick and Thurles is similar and affects up to two thirds of all mothers. This is four times higher than the prevalence found in the population of mothers in Limerick city.

8.6 Hopefulness

Hopefulness is a form of positive thinking about achieving goals such that one is motivated to achieve goals (having 'the will'), and is confident of finding ways to achieve them (having 'the way'). Hopefulness then is having 'the will and the way' to achieve goals. More than a third of the mothers attending Barnardos services in Limerick (38 per cent), and half of those attending the service in Thurles (50 per cent), are lacking in hope. This applies to both dimensions of hope where there is a lack of both 'will' and 'way'. In the survey of mothers in Limerick, about 20 per cent were lacking in hope.

8.7 Perceived Health

Mothers were asked to rate their health on a five-point scale comprising 'excellent', 'very good', 'good', 'fair', and 'poor'. The results show that only 17 per cent of mothers attending the Barnardos service in Limerick rated their health as good or excellent, compared to 34 per cent of those attending the service in Thurles; this compares to 65 per cent of mothers in Limerick city, and 65 per cent of the general population in Ireland. It is clear that mothers in Barnardos have a very low perception of their health compared to the norm in Limerick and Ireland.

8.8 Smoking, Drinking and Drugs

Health behaviour influences physical health and is likely to influence self-perceptions of physical health. The prevalence of smoking among mothers attending the Barnardos service in Limerick is 73 per cent, compared to 55 per cent for those attending the service in Thurles, compared to 49 per cent for mothers in Limerick city, and compared to 33 per cent for women in Ireland. In other words, service users are much more likely to be smokers compared to the average woman in Limerick or Ireland.

83 Seligman, 2002:63

About half the mothers attending the Barnardos services in Limerick and Thurles take alcohol which is lower than the rate in Limerick (65 per cent) and Ireland (70 per cent). However the use of sedatives, tranquilisers and anti-depressants among service users in Limerick (33 per cent) and Thurles (17 per cent) is much higher compared to the general population of women in Limerick (13 per cent) and Ireland (5 per cent). These are prescription drugs, commonly referred to as benzodiazepines, and their usage is probably related to the high rates of depression.

8.9 Support Networks

The importance of support networks for the well-being of individuals and their families has been well documented⁸⁴. The survey shows that mothers who use Barnardos services in Limerick and Thurles have weaker support networks compared to mothers in Limerick and Ireland.

8.10 Parent-Child Relationship

The parent-child relationship is significantly weaker among mothers who use Barnardos services compared to mothers in Limerick and Ireland, particularly among those who use the service in Limerick. The two key areas of weakness in both services involve mothers being dissatisfied with their performance as a parent, and being ineffective in setting appropriate limits for the child.

8.11 Parental Discipline Style

Discipline style is a key aspect of parenting and refers to the types of disciplines used by the mother – non-violent discipline, psychological aggression, minor and severe physical assault - to set appropriate limits on the child. The survey shows that mothers attending Barnardos services in Limerick and Thurles use much more discipline on their children compared to the general population of mothers in Limerick and Ireland. In fact, mothers in these services use nearly three times more discipline compared to the norm in Limerick and Ireland.

8.12 Relationship Skills

Each mother assessed her effectiveness at resolving arguments with her current partner or, if there is no current partner, with a previous partner. The results show that mothers attending the service in Limerick are nearly as effective at resolving arguments compared to a national sample of mothers, while those using the service in Thurles are much more ineffective, particularly those who are not living with a partner.

⁸⁴ For a review, see McKeown, 2000:11-13

8.13 Perceptions of Neighbourhood Problems

The mothers attending Barnardos services in Limerick are twice as likely to perceive problems with their neighbourhood compared to mothers who attend Barnardos services in Thurles. Significantly, the perception of neighbourhood problems by mothers attending the Barnardos service in Limerick (44 per cent) is almost the same as the general population of Limerick mothers who have a medical card (46 per cent). Equally, the mothers who attend the Barnardos service in Limerick identified most of the same problems as mothers on a medical card in Limerick city namely, drug problems (63 per cent), roaming dogs (58 per cent), litter and rubbish (58 per cent), not safe to walk alone after dark (58 per cent), and the state of boundaries and fencing (50 per cent). This result is consistent with the well-documented neighbourhood problems in some local authority housing estates in Limerick city⁸⁵.

8.14 Perceptions of Local Services

There is a small overall difference in how service users in Limerick and Thurles rate local services. Those attending Barnardos services in Limerick rate a smaller proportion of services as poor or very poor (46 per cent) compared to those attending Barnardos services in Thurles (53 per cent). However both groups of mothers agree on what they perceive to be the main services which fit the description of poor or very poor: leisure facilities for teenagers and young children, playgrounds, football pitches, sports facilities, including swimming pool and water sports, as well as green areas and parks. These are also the main services identified as poor or very poor in the general survey of Limerick mothers.

8.15 Neighbourliness

We measured neighbourliness in terms of whether mothers trust their neighbours, have done or received a favour for a neighbour in the past six months, and whether they believe that neighbours look out for each other. Overall, the results show that mothers who attend Barnardos services in Limerick and Thurles are much less trusting of neighbours compared to the general population of mothers in Limerick. For example, four in ten service users trust no one in their neighbourhood compared to less than one in ten of the general population of mothers in Limerick. Equally, the extent to which favours are given and received is significantly less, and the belief that neighbours look out for each other is also much less among service users compared to Limerick mothers generally. These findings are consistent with the lower support networks of service users which we noted above.

⁸⁵ Fitzgerald, 2007

8.16 Summary and Conclusion


This chapter measured the extent of need among 42 mothers who use Barnardos services, 24 in the Limerick service and 18 in the Thurles service. Although not a representative sample, it nevertheless provides a valuable insight into the range and depth of needs presented by these mothers. It is clear that the mothers using Barnardos services, particularly those in Limerick, have substantial needs in a wide range of domains. They experience much more negative emotions and fewer positive emotions compared to mothers in Limerick or Ireland. Many show signs of depression and lack of hopefulness while their self-rated health is substantially below the norm for Limerick and Ireland. Many are smokers and use sedatives, tranquilisers and anti-depressants. There are vulnerabilities in the parent-child relationship which are indicated by feeling dissatisfied with their performance as parents, and an inability to set appropriate limits for the child. Related to this, possibly as both cause and consequence, these mothers use nearly three times more discipline on their children compared to the norm in Limerick and Ireland. Outside the immediate family context, most mothers have weaker support networks compared to mothers in Limerick and Ireland and there is less trust and reciprocity in dealing with neighbours. In addition, there are serious neighbourhood problems and many of the local services are rated as poor or very poor.

This profile suggests that Barnardos services in Limerick and Thurles are well targeted and are engaging with mothers and families who have a high level of need. It is also clear that while these mothers share many of the same characteristics as mothers on the medical card, their needs are deeper and more extensive.

Our analysis in Chapter Six throws light on the areas of intervention which should receive priority, particularly if the objective is to reduce maternal depression and improve parenting skills. The key intervention for both these needs involves reversing the mother's tendency towards negative thoughts, emotions and behaviours, possibly using programmes which facilitate her to think and feel differently about the past, the present and the future⁸⁶. In addition, the analysis suggests that supporting mothers to set appropriate limits on the child could help create a more positive parent-child relationship. Direct work with the child is also indicated by our results, particularly with children who have serious behaviour and hyperactivity problems, since this could help alleviate the burden on the mother while simultaneously setting more consistent and appropriate limits on the child.

These research findings may be helpful to Barnardos for the purpose of reviewing whether existing services are consistent with the pattern of need and its determinants as identified in this report. In addition, they may help to further underline the acknowledged importance of

⁸⁶ Seligman, 2002; for further information on cognitive therapy, see www.beckinstitute.org



regularly assessing if progress is being made. This requires an evaluation system which continuously monitors the progress of each mother and child using measurement instruments which have been tried and tested and for which there is normative data against which to compare progress. The present study could be a useful beginning in that process since we have used a wide range of instruments, some of which could be part of an ongoing evaluation system. Clearly, it is always important to measure progress relative to a baseline at the beginning of an intervention; equally, however it is also important to measure progress in terms of the distance which separates service users from the normal experience of other mothers and children in Ireland. Both measures are complementary and help in making a rounded judgement on the effectiveness of a service while also being mindful of the depth of need that may remain even after an effective service has been delivered. In this chapter, we found that the depth of need among mothers using Barnardos services in Limerick and Thurles, in most of the key domains, had an effect size of around 1.0 even though the most effective programmes for vulnerable parents tend to achieve effect sizes in the range 0.5 to 0.8. This information is important not just for service evaluations but for service providers so that they can set realistic goals about the outcome of their services.

Chapter Nine: Summary, Conclusions and Implications

9.1 Introduction

This chapter summarises the entire report and can be read as an executive summary. It summarises the key findings and draws out their implications by highlighting how the understanding of need which emerges from the study can help to develop and evaluate services in light of these needs and their determinants.

9.2 Context

The context for this study was set out in January 2007 in the invitation to tender:

“The purpose of the needs analysis is to explore the range of needs that three groups of children present with:

- (i) A representative sample of children living in Limerick city
- (ii) Children receiving Barnardos services in Limerick city during the reference period of the study
- (iii) A sample of children receiving Barnardos services in Thurles during the reference period of the study.

9.3 Approach to Measuring Need

In order to carry out a study of need, it is necessary to begin with a clear definition of need. Children are said to be in need when their well-being is below a threshold that is regarded as either normal or minimal. Need is a multi-dimensional concept covering all aspects of the child's well-being including: physical, psychological, relationship with parents and peers, school attendance and performance, out-of-school activities, etc. Children's well-being is also heavily dependent on the well-being of their parents and, for this reason a proper understanding of children's needs must take into account the well-being of their parents: physical, psychological, relationship with child and with partner, social supports, etc. In addition, since children's needs are influenced by the socio-economic status of their household and the broader physical environment, it is therefore necessary to measure household income, employment and education as well as neighbourhood perceptions. It is this understanding which informs our approach to assessing the needs of children in Limerick and Thurles.

9.4 Questionnaire to Measure Needs of Children & Parents

The questionnaire draws together a range of instruments which have been tried and tested internationally. The key instrument used to measure the mental health of children is the Strengths and Difficulties Questionnaire (SDQ) while for mothers we measured different aspects of mental health including depression, positive and negative affect, life satisfaction, and hope, as well as the parent-child relationship (using the PCRI) and the mother's discipline practices (using the CTS-PC). These instruments have been used in a national study of family well-being in Ireland⁸⁷ and some have also been used in the evaluation of Springboard projects in Ireland⁸⁸, and in the assessment of the mental health needs of children in Ballymun⁸⁹, other parts of Dublin⁹⁰, and Ireland⁹¹. As such, they provide useful benchmarks against which to measure the well-being of children and their mothers in Limerick city and Thurles. Similarly, demographic and socio-economic data were collected using questions which allow for comparison with national datasets such as the Census of Population, Quarterly National Household Survey, the Living in Ireland Survey, etc.

9.5 Sample of Limerick City

The study is based on a sample of 201 households-with-children in Limerick city. We estimate that the sampling error associated with this sample size, at the 95 per cent level of probability, is in the 4-7 range for each statistic generated from this sample. We used a stratified random sample by selecting a representative sample of 50 households-with-children in each of the city's four sectors – north, south, east and west - yielding a total sample of 201 households-with-children. Given that the sample comprises an equal number of households (50) from each of the four quadrants, we re-weighted the data in each quadrant to reflect its true population share in Limerick city, based on the 2002 Census of Population. In addition, we re-weighted the proportion of two parent and one parent households within each of the four quadrants to represent their known distribution of these households in Limerick, based on the 2002 Census of Population.

9.6 Sample of Barnardos Service Users in Limerick City & Thurles

A sample was drawn of 42 mothers and their children who use Barnardos services in Limerick and Thurles. More than half of these (24, 57 per cent) were from the Barnardos service in Limerick - 10 from Southill, 10 from Moyross, and 4 from Islandgate – with the remainder (18, 43 per cent) from the Barnardos service in Thurles. It is estimated that, at

87 McKeown, Pratschke and Haase, 2003

88 See McKeown, Haase and Pratschke, 2001; 2004a; 2004b

89 See McKeown and Haase, 2006.

90 McKeown and Fitzgerald, 2007; McKeown and Fitzgerald, 2007a.

91 McKeown and Fitzgerald, 2006b.

any one time, Barnardos services in Limerick work with 80 children and families while the service in Thurles works with approximately 60 families. Due to difficulties in recruiting respondents, the effect of which was to reduce the sample's randomness, we cannot be sure that the resulting profile of children and mothers is truly representative of those who use Barnardos services. Nevertheless it still provides a valuable insight into the range of needs presented by mothers and their children.

9.7 Data Analysis

We use correlation analysis⁹² and regression analysis⁹³ to test the level of association between the needs of children (in the areas of mental health and reading) and mothers (in the areas of depression and parenting) - the dependent variables, sometimes referred to as outcome variables - and a range of individual, family, and socio-economic factors (the independent variables, sometimes referred to predictors, determinants, or explanatory variables). It should be pointed out that the existence of a statistical association does not necessarily imply causation, since our data is cross-sectional rather than longitudinal, but it may nevertheless be helpful, if taken in conjunction with findings from other research on the determinants of well being among children and mothers, in suggesting possible interpretations of those associations as well as possible strategies for addressing those needs.

9.8 Characteristics of Households with Children

The survey shows that households with children in Limerick are broadly similar to households with children in Ireland in terms of size, education, employment, and financial strain. The fact that Limerick city is known to be somewhat more disadvantaged than Ireland and the surrounding Mid-West Region, based on the analysis of Small Area Population Statistics (SAPS), is consistent with our finding that the level of owner occupation in Limerick city (52 per cent) is significantly lower than in Ireland (74 per cent). Similarly, given that lone parenthood is strongly associated with socio-economic disadvantage –as both cause and

92 Correlation analysis measures the extent to which two variables, one designated as dependent, the other as independent, are associated. The correlation coefficient is the percent of variance in the dependent variable that is explained by the independent variable when all other independent variables are allowed to vary. The magnitude of the correlation coefficient reflects not only the unique covariance it shares with the dependent variable, but uncontrolled effects on the dependent variable attributable to covariance which the independent variable shares with other independent variables. This makes correlation analysis more limited than regression analysis.

93 Regression analysis is a method of explaining variability in a dependent variable using information about one or more independent variables; it is referred to as multiple regression analysis because there is more than one independent variable. The regression coefficient is the average amount the dependent variable increases when the independent variable increases by one unit and other independent variables are held constant. The fact that regression analysis holds constant the influence other independent variables makes it a significantly more powerful statistical technique than correlation analysis. In logistic regression, the dependent variable is binary or dichotomous and is used, in this context, to assess the likelihood of a child being, or not being, in the abnormal range of the SDQ. The results of logistic regression are expressed in terms of the odds ratio where 1.0 means there is no relationship, less than 1.0 indicates an inverse or negative relationship, and greater than 1.0 indicates a direct or positive relationship.

consequence⁹⁴ – and is also more heavily concentrated in large urban areas⁹⁵, we found that a third of households with children in Limerick are lone parent households compared to a fifth in Ireland.

Throughout the analysis, we distinguish between households with a medical card and those without in order to examine the effects of socio-economic disadvantage on the different variables. Our survey found that half the sample – and therefore half the population of mothers in Limerick city – have a medical card, significantly higher than in Ireland (28 per cent), based on 2004 data⁹⁶. The significance of using the medical card is that it is a means-tested, income-related entitlement to health services and therefore a reliable predictor of socio-economic status. Unlike many other means-tested benefits, the medical card has no stigma attached to it with the result that our data on the prevalence of medical cards in Limerick city is likely to be highly reliable. In addition, the possibility that the medical card may offer a practical non-stigmatising way of identifying children and families who have particular needs provides an important policy rationale for using this variable throughout the analysis.

The results show that the most significant variation in Limerick city is between those households which have a medical card and those which do not. Medical card holders are five times more likely to live in rented accommodation, mainly from the local authority, are more likely to have left school early and to have fewer qualifications; they are less likely to be in work and are more likely to experience financial strain. This suggests that entitlement to a medical card is a very effective way of identifying households where there may be significant material deprivation and it is for this reason that we use this indicator of disadvantage throughout our analysis. Given that half of all households in Limerick city have a medical card, compared to less than a third in Ireland, this suggests a high prevalence of material deprivation among families with children in Limerick city.

9.9 Needs of Children in Limerick

We measured the mental health of children using the Strengths and Difficulties Questionnaires (SDQ)⁹⁷, and found that 8 per cent of children are in the abnormal range and a further 9 per cent are in the borderline range. This is broadly in line with other population-based studies of children's mental health in Ireland and elsewhere.

94 See McLanahan, Donahue and Haskins, 2005.

95 See McKeown, Pratschke and Haase, 2003

96 Nolan, 2007:4

97 The SDQ is a validated and reliable instrument for assessing behaviours, emotions and relationships, and was created by Robert Goodman during the 1990s for the purpose of screening children who may have mental health or psychiatric needs⁹⁷. It is therefore a useful proxy measure of psychological well-being. It is suitable for 3-16 year olds and can be completed by the child (if over 11), the parent (for children aged 3+), and the teacher (for children aged 3+). Available at www.sdqinfo.com

The main difficulties involve conduct, hyperactivity and emotional problems. Boys present more difficulties than girls, and older children present more difficulties than younger children. As a result, older boys are the most vulnerable group with 17 per cent in the abnormal range.

The proportion of children in the abnormal range is ten times higher among families with a medical card (15 per cent) compared to families without (1.5 per cent). Extrapolating these results to all children (0-18 years) in Limerick city, we estimate that 1,137 children are in the abnormal range and a further 1,206 are in the borderline range.

The level of need is higher among boys, among older children, and in households with a medical card. This is similar to other studies in Ireland, UK and US. Substantial interventions will be needed to bring children who are in the borderline and abnormal ranges to within the normal range and will need to have an impact which is greater than the scale of improvement that is usually produced by programmes for children and families.

The survey also found that 19 per cent of children in Limerick city are perceived by their mother to have at least one disability. This is similar to the prevalence of disabilities (18 per cent) estimated by the National Council for Special Education in 2006.

Children in Limerick have similar reading ability to children in Ireland but a small proportion of children (13 per cent) – all in households where the mother has a medical card – have reading difficulties. Educational resources in the home – as measured by number of books, being read to before school age, access to computer and internet, expectations of leaving school – tend to be better for children in Limerick city than Ireland. Similarly, school attendance rates seem to be higher in Limerick than Ireland although it should be remembered that this is based on the reports of mothers rather than schools, the latter being the normal source of school attendance statistics produced by the National Educational Welfare Board. At the same time it is noteworthy that a substantial proportion of post-primary pupils in Limerick (14 per cent), particularly girls, are missing school for 20 days or more; this is equivalent to 1,234 children.

A significant finding to emerge from the survey is that children in need are most likely to be found in households with a medical card, confirming the well-known social gradient between level of need and socio-economic status. This finding provides one of the keys to the challenge of targeting households where children may be in need.

9.10 Influences on Children's Mental Health Difficulties

The study used correlation and regression analysis to establish the determinants of mental health difficulties among children, as indicated by SDQ scores in the abnormal range. This revealed that children with mental health difficulties are to be found in households where mothers have a medical card, take sedatives, tranquilisers or anti-depressants, and have an above-average level of negative affect. Having a medical card is the strongest predictor of

mental health difficulties and the 'odds ratio', which measures the strength of association, indicates that a child living in a household with a medical card is 17.3 times more likely to be in the abnormal range of the SDQ compared to a household without a medical card. Similarly, children whose mothers take sedatives, tranquilisers or anti-depressants are 4.9 times more likely to be in the abnormal range of the SDQ compared to children whose mother do not. Finally, children whose mothers have a higher negative affect than average – as indicated by more frequent experiences of negative feelings such as distressed, upset, scared, hostile, irritable, ashamed, nervous, jittery and afraid – are slightly more likely to be in the abnormal range of the SDQ compared to other children.

We carried out further correlation analysis into the variables associated with each of these determinants. This revealed that, when the selection effect of the medical card is taken into account, the primary influence on the mental health of children is the mental health of mothers. Mothers with poor mental health - as indicated by lower life satisfaction and hope, depression and using sedatives, tranquilisers and anti-depressants – are significantly more likely to have a child whose SDQ scores are in the abnormal range. These difficulties are augmented by socio-economic disadvantage which makes it more difficult for the mother to cope financially and add to the likelihood of a child being in the abnormal range of the SDQ. In addition, mothers who have a weak relationship with the child and who use excessive discipline are more likely to have a child in the abnormal range of the SDQ.

9.11 Influences on Children's Reading Difficulties

Following regression analysis, we found that children with reading difficulties are to be found in households where the mother is a lone parent and has low expectations of the child's educational achievement. Having a mother who is a lone parent is the strongest predictor, and children in lone parent households are nearly five times more likely to have reading difficulties compared to children in two parent families. Low parental expectations of the child's educational achievement also increase the likelihood of having reading difficulties compared to other children. We carried out further correlation analysis into the variables associated with these two determinants and this revealed reading difficulties are associated with the twin influences of adverse socio-economic circumstances - such as having a medical card, living in local authority accommodation, and having difficulty coping financially – and a home environment that is educationally poor as indicated by the absence of books, not reading to the child before primary school, not having a computer, and missing days from school.

9.12 Needs of Mothers in Limerick

Mothers in Limerick who have a medical card have significantly greater needs compared to mothers without a medical card. This applies to most of the scales used but is particularly pronounced in some key domains. For example, up to a quarter of mothers with a medical card show clinical signs of depression, more than three times the rate among mothers

without a medical card. Possibly as a consequence of this, a fifth of medical card mothers are on sedatives, tranquilisers and anti-depressants, which is five times higher than the national average. Similarly, more than a third of mothers with a medical card show signs of lacking hope and have difficulty find either 'the will or the way' to address the challenges which they face. Mothers with a medical card are also significantly less positive in how they perceive their own health, and their smoking rate (68 per cent) is twice the national average.

On the positive side, all mothers in Limerick, irrespective of medical card, have strong support networks, which is higher than the average for Irish mothers generally. Similarly, more than eight out of ten mothers have done and received a favour for a neighbour in the last six months, and believe that neighbours look out for each other. This indicates a higher level of neighbourliness compared to data from the UK where this instrument was also used. Both groups of mothers also give broadly similar rating to the services which they use. However a significant difference is that mothers with a Medical Care are twice as likely to experience serious neighbourhood problems compared to mothers without a medical card, a finding which is consistent with the well-documented problems in some local authority housing estates in Limerick⁹⁸.

In the area of parenting, the differences between mothers who have and have not a medical card are less pronounced and are broadly similar to the scores of mothers in Ireland on the overall parent-child relationship. The one area of difference is that mothers in Limerick who have a medical card tend to use significantly more discipline on their children, particularly non-violent discipline and psychological aggression, compared to mothers without a medical card, and compared to mothers in Ireland generally. This, in turn, may be the reason why mothers with a medical card are somewhat less effective at setting limits on their children. Mothers with medical cards are also less effective at resolving arguments with their current or former partners but those who are not living with a partner are much less effective compared to those living with a partner.

In sum, these findings indicate that having a medical card is a strong predictor of needs in a wide range of domains including depression and usage of anti-depressants, lacking in hope, smoking, difficulties in parenting and other relationships, and the experience of neighbourhood problems.

9.13 Influences on Maternal Depression

The results of regression analysis identified three predictors of maternal depression: (i) mother has a medical card; (ii) mother has above average negative affect; and (iii) mother has weak support network. Mothers with a medical card are nearly five times more likely to be depressed compared to mothers without a medical card. Mothers who have a higher-than-average negative affect – as indicated by more frequent experiences of negative

⁹⁸ Fitzgerald, 2007:6

feelings such as distressed, upset, scared, hostile, irritable, ashamed, nervous, jittery and afraid – are slightly more likely (1.2) to be depressed. Finally, mothers with weaker support networks – as indicated by the number of people who are supportive when help is needed - are also slightly but significantly more likely (0.54) to be depressed compared to mothers with stronger support networks.

Further correlation analysis of the factors which influence depression indicates that it is most strongly associated with other mental states of the mother, and a tendency towards negative thoughts, emotions and behaviours which present themselves in the form of negative affect, reduced life satisfaction, hopelessness, and a poor relationship with the child, particularly where the child also has difficulties. The symptoms of depression are further augmented by a weak support network and by financial difficulties.

9.14 Influences on Discipline Practices

The results of the regression analysis revealed that the three predictors of discipline practices are: (i) mother's negative affect (ii) child in the abnormal range of the SDQ and (iii) the parent-child relationship. Negative affect is the strongest predictor of discipline style and nearly twice as strong as the influence of having a child in the abnormal range of the SDQ, or the influence of the mother-child relationship. This is a significant finding because it indicates that the frequency and intensity of disciplining the child is related more to the mother's negative feelings than to the child's specific behaviours, or indeed the mother's relationship with the child. At the same time, the fact of having a child in the abnormal range of the SDQ has an independent influence on the mother's discipline practices and suggests that these children may be more difficult to manage because of problems with behaviour, emotions or hyperactivity. In order to manage these children therefore, mothers tend to increase the frequency and intensity of discipline, often with negative consequences for both mother and child. It is also significant that the quality of relationship between mother and child moderates the discipline style such that mothers who communicate and are more involved with the child are less likely to use excessive discipline.

Further correlation analysis of the factors associated with discipline practices underlines the predominant influence of the mother's mental health as indicated by depression, negative affect, use of sedatives, tranquillisers and anti-depressants, as well as low levels of life satisfaction and hopefulness. The mother's capacity to cope financially is also an influence and reflects how socio-economic disadvantage creates stresses and strains which result in the excessive use of discipline. In other words, excessive discipline is primarily driven by the mother's mental health, with subsidiary influences exercised by her relationship with the child and whether the child is in the abnormal range of the SDQ.

9.15 Needs of Children in Barnardos Services

The survey of children using Barnardos services found that the level of need among those in the Limerick service is considerably higher than in the Thurles service. Notwithstanding this, it is clear from the study that both services are targeting substantial numbers of children in significant need, particularly in the areas of mental health and cognitive development.

More than four in ten children from both services combined are in the abnormal range of the SDQ, particularly in the areas of conduct problems and hyperactivity. The prevalence of these difficulties is more than twice as high in Limerick as in Thurles but the depth of need, as measured in terms of effect sizes, is greater in Thurles (2.43) than in Limerick (2.30). Mothers, particularly those attending the Limerick service, perceive their children's health to be much poorer compared to mothers in Limerick and Ireland. Consistent with this, there is also a very high prevalence of disabilities – 66 per cent in Limerick and 44 per cent in Thurles – which is a multiple of the estimated national average of 18 per cent. The reading ability of children in Limerick is well below the national norm where there are much fewer educational resources in the home such as books, being read to before school age, access to computer and internet, expectations of leaving school. Children in both services also have poorer school attendance rates compared to children in primary school generally.

9.16 Needs of Mothers in Barnardos Services

Mothers using Barnardos services, particularly those in Limerick, have substantial needs in a wide range of domains. They experience much more negative emotions and fewer positive emotions compared to mothers in Limerick or Ireland. Many show signs of depression and lack of hopefulness while their self-rated health is substantially below the norm for Limerick and Ireland. Many are smokers and use sedatives, tranquilisers and anti-depressants. There are vulnerabilities in the parent-child relationship which are indicated by feeling dissatisfied with their performance as parents, and an inability to set appropriate limits for the child. Related to this, possibly as both cause and consequence, these mothers use nearly three times more discipline on their children compared to the norm in Limerick and Ireland. Outside the immediate family context, most mothers have weaker support networks compared to mothers in Limerick and Ireland and there is less trust and reciprocity in dealing with neighbours, possibly because of specific difficulties in the areas where Barnardos services are located. In addition, there are serious neighbourhood problems and many of the local services are rated as poor or very poor.

9.17 Implications

This study has produced an understanding of the prevalence and determinants of needs among children and their mothers. As such, it can offer insights into how services might

respond to those needs. In this final section, we draw out the implications for services in more detail.

9.17.1 Recognising the systemic nature of family difficulties

It is important to emphasise that the factors which influence the needs of children and mothers, whether inside or outside the family, do not operate in isolation from each other because it is their interaction effect which creates the susceptibility to need. Many children and mothers score high on some of the risk factors associated with each type of need but only those who score high on all of them experience a level of need which is measurably greater than the average child or mother. In other words, these factors operate simultaneously rather than sequentially which means that each acts as cause as well as consequence because they are linked bidirectionally rather unidirectionally. This understanding suggests that problems – whether mental health and reading difficulties among children, or depression and excessive use of discipline among mothers - might be seen as part of a negative self-reinforcing cycle while, correspondingly, their solution involves creating a positive self-reinforcing cycle. A key implication of this is that interventions should endeavour to spread their benefits to as many domains as possible in order to create self-sustaining cycles of well being.

In drawing attention to the systemic nature of family life, it is also important to emphasise that while mothers influence the well being of children, and children influence the well being of mothers, it is the characteristics of mothers which are the predominant influence on the well being of both. For example, we know that children's mental health and reading difficulties are influenced by characteristics of the mother, based on the data we have available in this study. We also know that children who have mental health difficulties – particularly in the form of behaviour problems and hyperactivity – contribute directly or indirectly to the mother's depression and excessive use discipline, but these influences are much less than those exercised by the mother's negative mental states. These findings clearly support the notion of the family as a system but also highlight how the flows of influence within the system are predominantly from mother to child rather from child to mother.

Our analysis also confirms that the needs of children and their mothers are shaped not just by the family system but also by the socio-economic context in which the family is situated. This is illustrated by the uneven distribution of family needs between those with and without a medical card. However the relationship between family needs and socio-economic context is not a simple one because, although socio-economic disadvantage makes it more difficult for some families to cope financially, the majority of mothers and children on a medical card do not have needs as we have defined them⁹⁹. This suggests that the influence of socio-

99 Another illustration of this is a study of poor children attending Head Start centres in Seattle, USA which found that two thirds did not have behaviour problems because they were buffered from the effects of poverty through positive and effective parenting whereas the one third who exhibited aggressive behaviours had mothers with histories of abuse or psychiatric illness which rendered them "more vulnerable to the stresses of poverty, a vulnerability that becomes expressed in disrupted parenting

economic context on family needs is bidirectional in that: (i) families with difficulties are more likely to experience socio-economic disadvantage by virtue of those difficulties (a selection effect), while (ii) those living in adverse socio-economic circumstances are more likely to succumb to family difficulties (a causal effect). It is not possible to definitively separate these two effects using the cross-sectional data we have here, although our analysis clearly suggests that having a medical card is more strongly associated with having family difficulties (a selection effect) than with having problems coping financially (a causal effect). The fact that neighbourhood problems are not associated with family problems also suggests a selection effect. In other words, the family system provides an important buffer zone between mother and child on the one hand, and the wider socio-economic environment on the other¹⁰⁰. The practical implication of this is that direct interventions within the family to reduce the problems we have identified - mental health and reading difficulties among children, depression and excessive use of discipline among mothers – are likely to be more effective than interventions to reduce socio-economic disadvantage, although both forms of intervention are likely to be more effective than either taken in isolation¹⁰¹.

The implications of this for services are quite challenging not just because there are limits to the capacity of what one agency can do – and it is unlikely that any one agency can fully address all of the factors simultaneously - but also because there are limits to the effectiveness of programmes in addressing each of the domains of need. In determining the implications for services therefore, it may be necessary to establish priorities as to the form of intervention that is most likely to be effective in reversing these self-reinforcing cycles. In addition to direct therapeutic work with mothers and children, both individually and in groups, which would draw on the acknowledged strengths of Barnardos services, this needs to be supported by measures to improve the socio-economic context of the household and community, drawing on the resources and skills of other agencies which have responsibilities in this area.

9.17.2 Responding to children’s mental health difficulties

Beginning with children whose SDQ scores are in the abnormal range – of which there are over 1,000 in Limerick city according to our estimates - it is clear that these children need to be assessed and treated as soon as possible. Given that the primary influence on the mental health of these children is the mental health of mothers, our findings also point to the need for direct interventions with these mothers. In addition to treatment, our analysis also

behaviour. This disruption involves hostile exchanges with children, inconsistent discipline and a negative reinforcement mechanism which contributes to the development of child conduct problems and poor social competence” (Webster-Stratton and Hammond, 1998:120).

100 This is similar to the bioecological model of Bronfenbrenner (1979; 2001) which sees the child’s development as the outcome of influences within the family, school and local community as well as government policies and societal attitudes.

101 This analysis is consistent with a recent review of the literature on child outcomes generally which observed that socio-economic indicators “have relatively limited utility as guides for designing effective interventions because they tell us relatively little about the causal mechanisms that explain their impacts on child development. Thus, researchers and service providers are focusing increasingly on the importance of within-group variability and individual differences among children and families”(Shonkoff and Phillips, 2000:354).

suggests that prevention and early intervention services should focus on improving the mental health of mothers – including reducing the stress associated with financial difficulties - if the objective is to improve the mental health of children. If possible, this strategy should be supplemented by interventions which focus specifically on parenting skills, particularly the skill of setting appropriate limits on children without using excessive discipline. Interventions in the areas of mental health and parenting are likely to mutually reinforce each other since one of the key predictors of parenting skills is the mental health of the mother.

9.17.3 Responding to children’s reading difficulties

Our analysis indicates that lone parenthood is an important target group in terms of identifying children who may be vulnerable to having reading difficulties. This does not imply that two parent households may not have children with reading difficulties – given that the socio-economic factors associated with lone parenthood also affect some two parent households such as having a medical card, living in local authority accommodation, and having difficulty coping financially – but lone parents are a higher risk group. The main focus of interventions to address reading difficulties should be on the educational environment of the home, and the attitudes and behaviours of mothers towards their child’s education. Children’s ability to read is improved by the presence of books and a computer in the home, and by a mother who reads to the child early in life and ensures that the child attends school regularly. The style of intervention may also be important here, focusing on the pleasure and enjoyment that can come from books and reading to children on the one hand, and the natural propensity of children to flourish when their parents are encouraging and expect them to do well at school. There may also be merit in building stronger links between home and school and finding ways to involve mothers in the school. Interventions might also consider using imaginative schemes and incentives to support and reward mothers and children for reading through book clubs, homework clubs, etc.

9.17.4 Responding to maternal depression

The analysis suggests that the main focus of interventions to address maternal depression should be on the mother and her tendency towards negative thoughts, emotions and behaviours. A growing body of research in positive psychology suggests that this will involve supporting mothers to think and feel differently about their past, their present and their future¹⁰². The analysis also suggests that supports for the mother in terms of improving her parenting skills, particularly the skill of setting appropriate limits on the child, could help create a more positive parent-child relationship. Direct work with the child is also suggested by our analysis, particularly with children who have serious behaviour and hyperactivity problems, since this could help alleviate the burden on the mother while simultaneously setting more consistent and appropriate limits on the child. In addition, advice and assistance to help mothers improve their ability to cope financially would reduce some of the stresses and strains that are associated with depression. Finally, measures to improve the support networks of mothers could also help alleviate the burden of her difficulties.

¹⁰² Seligman, 2002; for further information on cognitive therapy, see www.beckinstitute.org

9.17.5 Responding to excessive use of discipline

Our analysis showed that the mother's discipline style is shaped predominantly by her mental health with subsidiary influences exercised by her relationship with the child, including whether the child is in the abnormal range of the SDQ. This is an important finding from the point of view of services because it suggests that the issue of excessive discipline, possibly fuelled by lack of success in setting appropriate limits on a child who has behaviour problems and hyperactivity, is not due to lack of parenting skills per se but is driven primarily by the mental state of the mother. In other words, interventions to reverse negative thoughts, emotions and behaviours and create more sustained positive experiences are likely, other things being equal, to help the mother become more effective in setting appropriate limits on the child. This suggests, in turn, that parenting programmes for mothers who have particular difficulties in managing their children, should focus predominantly on the needs of the mother; naturally, this does not exclude addressing the specific parenting skill of limit-setting as well.

9.17.6 Monitoring the effectiveness of services

The findings of this report may be helpful in reviewing whether existing services for children and families are consistent with the understanding of need and its determinants which the study has revealed. The findings may also serve to highlight the acknowledged importance of regularly evaluating services to see how much progress is being made, by whom, and which forms of intervention are more effective – and cost effective – than others. In order to answer these questions, an evaluation system is required which continuously monitors the progress of each mother and child using measurement instruments which have been tried and tested and for which there is normative data against which to compare progress. The present study could be a useful beginning in that process since we have used a wide range of instruments, some of which could be part of an ongoing evaluation system.

Clearly, it is always important to measure progress relative to a baseline at the beginning of an intervention. Equally, it is also important to measure progress in terms of the distance which separates service users from the normal experience of other mothers and children in Ireland. Both measures are complementary and help in making a rounded judgement on the effectiveness of a service while also being mindful of the depth of need that may remain even after an effective service has been delivered. We have found, for example, that the depth of need among mothers using Barnardos services in Limerick and Thurles, in most of the key domains, has an effect size of around 1.0 even though the most effective programmes for vulnerable parents tend to achieve effect sizes in the range 0.5 to 0.8. This information is important not just for service evaluations but for service providers so that they can set realistic goals about the outcome of their services.

9.18 Concluding Comment

A significant and encouraging finding of the study is that almost any intervention which cultivated more positive outlook among mothers, both cognitively and emotionally would, in addition to its direct mental health benefits, also improve her parenting and the well-being of her children. In this sense, and if one had to choose one form of intervention over all others, then the focus should be directed at the mental health of mothers through cultivating positive thoughts, emotions and behaviours. This applies to all forms of intervention, whether prevention, early intervention or treatment¹⁰³. At the same time, the fact that the study is based solely on data collected from mothers should not be allowed to occlude consideration of fathers and their well-being, and the role which they can play in promoting positive outcomes for children, as a growing body of research is showing¹⁰⁴. Moreover, while it is generally recognised that the support services for families are inadequate, this inadequacy is even more pronounced for fathers, and especially single fathers¹⁰⁵. The same consideration also applies to the couple relationship which, although not examined in this study, is also known to have a significant influence on the well-being of adults and children¹⁰⁶.

103 Services are sometimes referred to as forms of intervention which vary according to the time at which they intervene in the life of a problem. Some interventions are made before the problem is allowed to emerge (prevention), others occur after the problem has emerged but are made early in order to stop the problem getting worse (early intervention), while yet others take place when the problem is fully developed in order to address the consequences which have evolved (late intervention, sometimes referred to as treatment). These concepts can be illustrated using the example of interventions to promote the well-being of children and their mothers. Prevention could take the form of ensuring that pregnant mothers have good mental health and have healthy lifestyles. Early intervention could involve regular screening of children in terms of developmental milestones, mental health and reading ability while offering support to mothers who may be showing signs of negative affect and depression, or using excessive discipline on the child. Late intervention would involve addressing emotional, behavioural or intellectual difficulties which are displayed when the child goes to school, or serious difficulties in the parent-child relationship, or maternal depression and dependence on sedatives, tranquilisers and anti-depressants.

104 For a review of the evidence on fathers, see Lamb, 2004; see also Carlson, 2006.

105 McKeown, 2001a; 2001b

106 See McLanahan, Donahue and Haskins, 2005; Carlson and McLanahan, 2006; Harold, Pryor, and Reynolds, 2001; McKeown and Sweeney, 2001: Chapter Four.

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