

Understanding the Needs of Children:

A study of needs and their determinants in Limerick and Thurles



Feidhmeannacht na Seirbhíse Sláinte
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in Limerick and Thurles

Executive Summary

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Finally, we would like to thank the mothers who completed our questionnaires. This report is about them and their children and our hope is that it will assist in developing services which meet their needs.

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

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1. Purpose of the Study

The purpose of the 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:

- A representative sample of children living in Limerick city
- Children receiving Barnardos’ services in Limerick city during the reference period of the study
- A sample of children receiving Barnardos’ services in Thurles during the reference period of the study”

The study was commissioned in March 2007. Fieldwork and data collection was carried out in May, followed by data analysis and write-up in June, and submission of the report in July 2007. This report is a summary of the key findings from this survey.

2. 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. 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 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.

3. Questionnaire to Measure the Needs of Children and 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). 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 relationship¹ (using the Parent-Child Relationship Inventory or the PCRI) and the mother's discipline practices (using the conflict tactics scale for parent and child or the CTS-PC²). These instruments have been used in a national study of family well-being in Ireland³. Some have also been used in the evaluation of Springboard projects in Ireland⁴ and in the assessment of the mental health needs of children in Ballymun⁵, other parts of Dublin⁶, and Ireland⁷. 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. Full details of the instruments used in the questionnaire are available in a technical appendix.

4. 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-children⁸. 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

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1 Gerard, 1994

2 Strauss, Hamby, Finkelhor and Runyan, 1995

3 McKeown, Pratschke and Haase, 2003

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

5 See McKeown and Haase, 2006

6 McKeown and Fitzgerald, 2007; McKeown and Fitzgerald, 2007a

7 McKeown and Fitzgerald, 2006b

8 In the north sector, 51 households-with-children were interviewed

four quadrants to represent their known distribution of these households in Limerick city, based on the 2002 Census of Population.

5. Sample of Barnardos' Service Users in Limerick and 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 Barnardos' services 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 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.

6. Data Analysis

The analysis involved preparing frequencies and cross-tabulations and the full results of these are presented in a technical appendix. In addition, we use correlation analysis⁹ and regression analysis¹⁰ 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

9 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.

10 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 of 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.

referred to as 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.

7. Characteristics of Households with Children in Limerick City

The survey shows that households with children in Limerick city 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 consequence¹¹, and is also more heavily concentrated in large urban areas¹², we found that a third of households with children in Limerick city 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 data. The significance of using the medical card is that it is a reliable predictor of socio-economic status and, unlike

many other means-tested benefits, has no stigma attached to it. As a result, 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 way of identifying children and families

We distinguish between households with a medical card and those without in order to examine the effects of socio-economic disadvantage.... entitlement to a medical card is a very effective way of identifying households where there may be significant material deprivation

11 See McLanahan, Donahue and Haskins, 2005

12 See McKeown, Pratschke and Haase, 2003

who have particular needs provides an important policy rationale for using this variable throughout the report¹³.

Consistent with this, our analysis revealed that the most significant variation between households with children in Limerick city is whether they have a medical card. 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 also 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. 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.

8. Needs of Children in Limerick City

We measured the mental health of children using the Strengths and Difficulties Questionnaires (SDQ)¹⁴ and, as table 1 reveals, we 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 Ireland¹⁵ and elsewhere¹⁶.

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.

¹³ The fact that the medical card is widely regarded as an entitlement that is socially acceptable, and therefore non-stigmatising, is a further advantage of using this method for targeting

¹⁴ 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 needs. 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 years), the parent (for children aged 3+), and the teacher (for children aged 3+). Available at www.sdqinfo.com and see Goodman, 1997; Goodman, Meltzer and Bailey, 1998; Goodman and Scott, 1999; Goodman, 1999; and Goodman, Renfrew and Mullick, 2000

¹⁵ 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

¹⁶ Meltzer, Gatward, Goodman, and Ford, 2000; Simpson, Bloom, Cohen, Blumberg and Bourdon, 2005

Table 1 *Percent of Children in Normal, Borderline and Abnormal Ranges of the SDQ in Limerick City*

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

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, the 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 city 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 the number of books, being read to before school age, access to a computer and the internet, and 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 city 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 city (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.

8.1 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 mothers 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.

Having a medical card is the strongest predictor of mental health difficulties....

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.

8.2 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 not read frequently to the child before primary school. Having a mother who is a lone parent is the strongest predictor and children in lone parent households are five times more likely to have reading difficulties compared to children in two-parent families. Similarly, children who are not read to

frequently before primary school are twice as likely to have reading difficulties compared to other children. We carried out further correlation analysis into the variables associated with these two determinants and this revealed the predominant influence of socio-economic circumstances as indicated by having a medical card and living in local authority accommodation. This suggests that children develop reading difficulties because they are not read to before primary school and this is more likely to happen in lone parent households, possibly because the mother has little interest or aptitude for reading to the child.

Having a mother who is a lone parent is the strongest predictorsimilarly children who are not read to frequently before primary school are twice as likely to have reading difficulties compared to other children

9. Needs of Mothers in Limerick City

Mothers in Limerick city 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 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 city, 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 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 housing estates in Limerick city¹⁷.

¹⁷ Fitzgerald, 2007:6

In the area of parenting, the differences between mothers who have and have not got 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 city 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 for 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.

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.

9.1 Influences on maternal depression

The results of regression analysis identified four predictors of maternal depression:

- Taking sedatives, tranquilisers or anti-depressants
- Having a medical card
- Having above-average negative affect
- Being low in hopefulness

The use of sedatives, tranquilisers or anti-depressants is the strongest predictor and these mothers are three times more likely (3.3) to be depressed compared to mothers who do not take sedatives, tranquilisers or anti-depressants. Similarly, mothers with a medical card are three times more likely (3.0) 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 being distressed, upset, scared, hostile, irritable, ashamed, nervous, jittery and afraid, are slightly more likely (1.2) to be depressed. Finally, mothers who lack hope are also slightly more likely (0.95) to be depressed compared to mothers who are hopeful.

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, difficulties coping financially, and a poor relationship with the child. These difficulties are augmented by the consequences of socio-economic disadvantage which make it more difficult for these mothers to cope financially. Having a child who also has mental health difficulties further amplifies these difficulties but is not their main source.

9.2 Influences on discipline practices

The results of the regression analysis revealed that the three predictors of discipline practices are:

- Mother's negative affect
- Child in the abnormal range of the SDQ
- 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 parent-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. Therefore, in order to manage these children, 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.

....the frequency and intensity of disciplining the child is related more to the mother's negative feelings than to the child's specific behaviours...

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.

10. Needs of Children in Barnardos' Services

The survey of children using Barnardos' services found that the level of need among those in the Limerick services 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 services, perceive their children's health to be much poorer compared to mothers in Limerick city 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 the Limerick services 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 a computer and the internet, and expectations of leaving school. Children in both services also have poorer school attendance rates compared to children in primary school generally.

11. 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 city or Ireland. Many show signs of depression and lack of hopefulness while their self-rated health is substantially below the norm for Limerick city 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 city and Ireland. Outside the immediate family context, most mothers have weaker support networks compared to mothers in Limerick city 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.

12. 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.

12.1 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 bi-directionally rather uni-directionally. 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 the 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 of 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.

....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

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 them¹⁸. This suggests that the influence of socio-economic context on family needs is bi-directional 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 other¹⁹. The practical implication of this is that direct interventions within the family to reduce the problems we have identified such as 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 isolation²⁰.

...the family system provides an important buffer zone between mother and child on the one hand, and the wider socio-economic environment on the other.

18 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 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)

19 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.

20 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)



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.

12.2 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 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.

12.3 Responding to children's reading difficulties

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. The analysis also suggests, however, that this may not be easy due to the strong influence of socio-economic circumstances such as being a lone parent, having a medical card, and living in local authority accommodation. Naturally, these circumstances are not incompatible with reading to a child before going to primary school but suggest that there may be no tradition of reading to children in some of these households. However, this could change through the use of imaginative schemes and incentives which support and reward mothers and children for reading.

12.4 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 future²¹. In addition, advice and assistance to help mothers improve their capacity to cope financially would reduce some of the stresses and strains that are associated with depression. This analysis also suggests that supports for the mother in terms of improving her skills in 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.

12.5 Responding to excessive use of discipline

Our analysis shows that the mother's discipline practices are 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 rather than the specific parenting skill of limit setting.

12.6 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

²¹ Seligman, 2002; for further information on cognitive therapy, see www.beckinstitute.org

which forms of intervention are most effective and cost effective. 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.

13. Concluding Comment

A significant and encouraging finding of the study is that almost any intervention which cultivates a 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, 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 treatment²². At the same time, the fact that the

²² 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 others yet 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



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 showing²³. Moreover, while it is generally recognised that support services for families are inadequate, this inadequacy is even more pronounced for fathers, and especially single fathers²⁴. 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 children²⁵.

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, serious difficulties in the parent-child relationship, maternal depression or dependence on sedatives, tranquilisers and anti-depressants.

²³ For a review of the evidence on fathers, see Lamb, 2004

²⁴ McKeown, 2001a; 2001b

²⁵ See McLanahan, Donahue and Haskins, 2005; Harold, Pryor, and Reynolds, 2001; McKeown and Sweeney, 2001: Chapter Four

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