



# **The Well-Being of Parents, Children & Neighbourhoods:**

**A National Study of Families  
in Respond! Housing Estates**

## **Main Report**

**Kieran McKeown Limited**  
Social & Economic Research Consultant





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## Foreword

**from Pat Cogan, ofm., Founder-Director and CEO of Respond!**



I am delighted to introduce this detailed national research on the needs and well-being of parents, children and neighbourhoods in Respond! estates. The context which led us to commission this study was a happy one. In 2007 Respond! celebrated 25 years of housing provision, working with families in seeking to create vibrant, integrated and resourced communities. Ultimately, the goal of Respond! is to empower people to enhance their own lives and

those of their wider community for the benefit of all.

One of the questions which prompted this study is core for any service provider: are we getting it right? In our case, is Respond! making a difference and enhancing people's lives – or are we off-target? Are our efforts in need of re-alignment? Are we missing the obvious? Does living in Respond! housing make a difference and how are residents faring relative to people in Ireland generally? This study provides a baseline from which to evaluate our services, and affords a framework for future comparative and longitudinal studies.

We were very fortunate to have been able to commission Dr. Kieran McKeown to undertake this detailed research on our behalf. Kieran has written very extensively on family, children and parents, and their well-being in an Irish context, including the evaluation of services which support well-being. He brings expertise and erudition to what are very complex and fluid concepts: the dimensions of need and well-being and of what makes for supportive individual and family relationships. These concepts are vital for us all. In thanking Kieran, I also want to thank the entire Research Team who prepared this report. Trutz Haase and Jonathan Pratschke brought their unique expertise in data analysis to the report. I am also very pleased that our own staff in the Research and Development Unit – Cathy Lanigan, Shane Burke, Niamh Murphy, and Lynda Allen – were involved in many aspects of the study, including the design of

questionnaires, the management of the fieldwork, and the interpretation of findings. To all involved in this study and especially the mothers who agreed to be interviewed - my thanks.

While we celebrate the findings in this study - that the vast majority of residents on Respond! estates have levels of well-being in line with the wider population in Ireland - there is a significant minority of residents for whom this is not the case, and significant aspects of well-being (income, health, education, employment) where Respond! residents fare less well than the general population.

In addition to broad-based community development work to which Respond! is committed, this timely study highlights the need to go beyond this to targeted intervention for a significant minority of young people and parents whose needs are not currently being met. The study sharpens our focus and we embrace the opportunity to creatively explore with residents, families and others what solutions will work best; and how appropriate services which take explicit account of the views of our residents, may be accessed, resourced, and assessed.

We charge ourselves, and you the reader, to work collaboratively to forge responsive, inclusive, timely and integrated quality services for the benefit of children, families, neighbourhoods and ultimately of Irish society as a whole. 'For the child there is no tomorrow – only today'. I invite you to read on and see what this study says about the needs and services for residents in Respond! estates and what resonance and learning this may have for us all.

We are indebted to all those who took part in this study - for the encouragement it gives our work to date - and for the renewed impetus it gives us to continue to work collaboratively with individuals, families and communities: strengthening networks and capacity, and ensuring that resources are accessed fairly and equitably so that all of the citizens of the nation are cherished equally.

**Pat Cogan, ofm. June 2008.**

## **Acknowledgements**

This report was commissioned by Respond! in March 2007. Like all such reports, it is the work of many hands.



The initiative for the study emanated from Pat Cogan, ofm, CEO who founded Respond! 25 years ago in 1982 and this study is one of the ways of marking its silver jubilee. In keeping with the mission of Respond!, the study is centrally concerned with the well-being of parents, children and communities and the factors which influence them.

The study would not have been possible without the enormous contribution of Respond!'s Research and Development (R&D) team which comprises Cathy Lanigan (R&D Manager), Shane Burke (Research Officer), Niamh Murphy (Research Officer), and Linda Allen (Administrator / Projects Officer). The team made a huge contribution at every stage of the research process by contributing to the overall conception and design of the study, assisting in the selection of research instruments, drawing the sample and informing residents on each estate that the study was being undertaken, and preparing individual-level and estate-level data which was additional to the survey data.

The survey work for the study was undertaken by QuotaSearch Ireland between May and July 2007. Under the direction of Noeline Murray, the fieldwork was undertaken with great sensitivity and meticulous attention to detail for which we are most grateful.

The study is funded entirely by Respond! and we are particularly grateful to it for supporting such an ambitious research project.

Finally, we would like to thank the mothers who completed our questionnaires. This report is about them, their children, and their neighbourhood and our hope is that it will help to promote the well-being of all families living in Respond! housing estates.

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

**Kieran McKeown, June 2008**

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## **Chapter One**

### **Context and Methodology**

#### **1.1 Introduction**

The context for the study is set by the core objective of Respond! which is to provide housing for people in need. Respond! adopts a holistic approach to housing need, seeing it as part of a broader strategy to address poverty by building low-cost housing estates which are linked to essential services and which promote and sustain the well-being of individuals, families and communities. As such, its aim is to create vibrant self-managed communities rather than simply providing shelter or accommodation.

This study has two main objectives. The first is to determine the level of need and well-being among parents, children and neighbourhoods based on a representative sample of Respond! housing estates. The second is to determine the factors which influence the well-being of parents, children and neighbourhoods in these estates. Both objectives, in turn, are designed to contribute to the overall strategy of Respond! by providing a robust assessment of need which can be used as a baseline against which to set targets and measure progress. In addition, the study aims to assist in the development of strategies which promote different types of well-being by analysing the factors associated with each. In other words, the data and analysis generated through this study is designed to assist Respond! in both reflecting on, and strengthening, the overall vision which has supported its activities over the past 25 years.

In this chapter we describe the context and methodology of the study. The context is set by the objectives and activities of Respond! which are outlined briefly in Section 1.2. The methodology involves describing the instruments used to measure need and well-being (Section 1.3), the procedures used to draw a representative sample of estates and households (Section 1.4), and the methods of data analysis (Section 1.5).

#### **1.2 Context**

The context for the study is set by the core objective of Respond! which is to provide housing for people in need. The organisation was founded as a housing association 25 years ago in 1982 and is informed

by the Christian and Franciscan ethos of its founder and CEO, Pat Cogan, ofm. This vision is clearly articulated in its recent strategy documents as follows: “Respond!’s goal is to provide housing and assist in the building of stable communities for those on low incomes or otherwise in need of housing. We seek to ensure that such communities will foster the growth of the individual resident and that of the whole community. We aim to assist our communities to grow to the stage where sufficient local community leadership exists to enable residents to access the services of and participate fully in the structures of wider society. To that end, we invest in personal and community development activity and family supports in order to build the capacity of residents for such a role. The family should be and is at the centre of the opportunity for a holistic approach in the development of both communities and the individuals within those communities”<sup>1</sup>.

The core activity of Respond! is to build houses and, in the period to June 2007, it has built over 4,000 units, of which some 3,395 housing units are in Respond! management. This is equivalent to building a substantial Irish town like Castlebar, Tullamore or Portlaoise<sup>2</sup>. As such it is a significant contribution to the national housing stock, and a substantial contribution to Ireland’s social housing. However Respond! also manages the rental of these houses and currently manages a larger and more geographically dispersed housing stock than any local authority in Ireland, barring those in the Greater Dublin Area and Cork<sup>3</sup>.

Most of Respond!’s housing, approximately 80%, is built for families and funded by the Department of Environment, Heritage & Local Government (under the Capital Loan Subsidy Scheme). The remaining 20% is for people who are elderly, disabled or homeless or have other special needs, and is also funded by the Department of Environment & Local Government (under the Capital Assistance Scheme, which requires a ‘voluntary contribution’ of 5% of building costs or equivalent ‘value in kind’).

All of those in receipt of Respond! tenancies have previously been on a local authority housing list. The

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1. Respond! 2007a: 3; see also 2007b.

2. See Census of Population, 2006, Volume 3, Household Composition, Family Units and Fertility.

3. For example, it manages a larger housing stock than the local authorities in Limerick, Galway or Waterford; see Census of Population, 2002, Volume 13, Housing.

amount of rent paid by Respond! tenants is based on household income and, in 2007, this varied from a minimum of €12.50 (for those whose income does not exceed €104 per week) to a maximum €78.00 (irrespective of the level of income). Rents are reviewed annually to reflect possible changes in income levels and inflation. In general, Respond! rents are lower than those paid by tenants in local authority houses.

Respond! tenants cannot purchase their houses. There is no provision in legislation for tenant-purchase of housing provided by voluntary housing associations. This has been the long-standing policy of Respond! and is based on Respond!'s commitment to building stable communities and protecting the interests of those who would never be able to buy their own home. In other words, the concern of Respond! is to provide stability of tenure for the good of the whole community, not just those households who can afford a mortgage option. This policy is also informed by the negative effects on low income communities occasioned by the loss of community leaders through the take-up of the £5,000 surrender grant scheme in 1984. In addition, the stance of Respond! is also based on the knowledge that other schemes are available for those on low income who may be in a position to purchase their own home.

In line with its objective of creating vibrant communities, Respond! provides community facilities on its estates. These typically include a community building for meetings, an estate office and facilities for childcare. Many of Respond!'s childcare facilities are staffed by tenants from the estate who have completed its childcare course, and are largely funded by Pobal, through the National Childcare Investment Programme and through the FÁS Community Employment Programme. Pre-tenancy courses and tenant participation courses are also provided by Respond! as well as other adult education courses in areas such as committee skills, book-keeping, conflict resolution, parenting skills, computer usage, arts & crafts.

Respond! has a community development strategy which aims to promote social inclusion by linking the needs of people in each estate to essential services in the areas of childcare, family support, adult

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4. Respond!, 2007a.

education, training, employment initiatives, and environmental maintenance<sup>4</sup>. This strategy is initially led by Respond!'s community development and family support workers whose task, in turn, is to identify, train and support a small number of local residents to become volunteer 'community enablers' so that they can continue to articulate the needs of their estate and other estates in their regional 'cluster' to the different service providers. This process of capacity building occurs over a five-year period, and is informed by the ethos of reducing dependency and empowering communities to be self-sustaining. At the end of this period, Respond! will continue to support community enablers in each estate to take primary responsibility for community development, but the input from Respond! will be significantly reduced.

Respond! contributes to the broader agenda of improving the management of social housing in Ireland by running tenant participation courses for local authority tenants, at the request of a number of local authorities. In 1997, Respond! developed a 3rd-level Certificate and then a Diploma programme, with both academic and professional accreditation, in line with the recommendations of the Housing Managers' Review Group Report in 1996. In time, Respond! further developed this programme to Degree standard and currently offers a Bachelor of Social Studies in Housing & Community Studies (B.S.S) in partnership with University College Dublin. The BSS in Housing & Community Studies is the first degree in housing in Ireland. It is open to mature students (aged 23 years and older), and is a 4-year, part-time, modular programme, comprising a Certificate (for those who successfully complete Year 1), a Diploma (for those who successfully complete Year 2), and a Degree (for those who successfully complete Years 3 and 4). As such, it offers the requisite academic and professional training required to establish a career pathway for housing professionals in Ireland, in line with the need for same identified by the Department of Environment, Heritage & Local Government and the City and County Managers' Association.

Against this background, the present study can be seen as playing a two-fold role in the overall strategy of Respond!. First, it measures the well-being of parents, children and neighbourhoods with a view to identifying need and setting appropriate targets in line with those needs. Second, it identifies the factors associated with each aspect of well-being and, in this way, may help in designing forms of intervention which are evidence-based.

### **1.3 Approach to Measuring Well-Being and Need**

In order to carry out a study of need, it is necessary to begin with a clear definition of need. Parents and 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 a person's well-being including: physical, psychological, relationships, income, lifestyle, etc. In the case of children, well-being is also indicated by their school attendance and performance as well as participation in out-of-school activities, etc. Within the family, the well-being of parents influences the well-being of their children and, as we shall see, vice versa. In addition, since the needs of parents and children are influenced by the quality of their neighbourhood and community, it is also necessary to take these into account in order to provide a comprehensive estimate of need and well-being. It is this understanding, based on existing research on the needs of families and children<sup>5</sup>, which informs our approach to assessing the needs of parents, children and communities in Respond! estates.

The survey data analysed in this report were collected during interviews with mothers. This has the advantage of providing a consistent source of information about the family, about the needs of mothers, their children, and their neighbourhood. 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 undertaken<sup>6</sup>.

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5. 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 bioecological 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.

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

## **Measuring Well-Being**

- Well-being has a universal quality, associated with health, happiness, and fulfilment. Everyone knows and seeks well-being, but it is difficult to define.
- Well-being has many dimensions – physical, mental, social - and is measurable through its positive and negative symptoms.
- In practice, the average experience of well-being in society is the typical standard used for measuring if a person is well.
- In this study, we measured the well-being of mothers in terms of her physical health, disability, emotions, depression, life satisfaction, hopefulness, parenting, financial stress and support networks.
- We measured the well-being of children in terms of their behaviour, hyperactivity, emotions, peer relations, reading ability, school attendance and books at home.
- We measured the well-being of neighbourhoods by the extent of problems on the estate, quality of services, trust and reciprocity between neighbours and community involvement.
- We also measured the demographic characteristics of households such as number and marital status of parents, mother's age, education, employment, income, etc. since these are often seen as the key determinants - or proxies - of well-being.

### **1.4 Questionnaire to Measure Needs of Parents, Children & Neighbourhoods**

The instruments used in this study to measure the well-being of parents, children and neighbourhoods meet the three criteria identified by the National Children's Office in its recent wide-ranging review of appropriate indicators for measuring child well-being<sup>7</sup>. The three criteria are that each indicator should be:

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

Our 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 Ireland<sup>8</sup> and some

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7. Brooks and Hanafin, 2005; Hanafin and Brooks, 2005.

8. McKeown, Pratschke and Haase, 2003



have also been used in the evaluation of Springboard projects in Ireland<sup>9</sup>, and in the assessment of the mental health needs of children in Ballymun<sup>10</sup>, other parts of Dublin<sup>11</sup>, Mayo<sup>12</sup>, and Limerick<sup>13</sup>. As such, they provide useful benchmarks against which to measure well-being in Respond! estates. 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 (QNHS), EU Survey on Income and Living Conditions (EU-SILC), etc. These instruments and the dimensions of need which they measure are summarised in Table 1.1.

**Table 1.1 Instruments used to Measure Need and Well-Being in Respond! Estates**

<b>Dimensions of Need and Well-Being</b>	<b>Scale for Measuring Well-Being</b>
Demographics, etc	Standardised questions from CSO, ESRI, etc
Local Problems	Local Problems Score, adapted from the UK Social Capital Module of the General Household Survey 2000 <sup>14</sup> , and used in Ireland by the Institute of Public Health in Ireland <sup>15</sup> .
Local Services	Local Services Score, adapted from the UK Social Capital Module of the General Household Survey 2000 <sup>16</sup> , and used in Ireland by the Institute of Public Health in Ireland <sup>17</sup> .
Community cohesion	Bespoke questions
Neighbourliness	Measures of Trust and Reciprocity, adapted from the UK Social Capital Module of the General Household Survey 2000 <sup>18</sup> , and used in Ireland by the Institute of Public Health in Ireland <sup>19</sup> .
Neighbourhood Efficacy	Adapted from a scale used by Robert Sampson to measure collective efficacy <sup>20</sup> .

9. See McKeown, Haase and Pratschke, 2001; 2004a; 2004b

10. See McKeown and Haase, 2006.

11. McKeown and Fitzgerald, 2006a; McKeown and Fitzgerald, 2007.

12. McKeown and Fitzgerald, 2006b.

13. McKeown and Haase, 2007.

14. Coulthard, Walker and Morgan, 2002.

15. Balanda and Wilde, 2003.

16. Coulthard, Walker and Morgan, 2002.

17. Balanda and Wilde, 2003.

18. Coulthard, Walker and Morgan, 2002.

19. Balanda and Wilde, 2003.

20. Sampson, 1995.

Dimensions of Need and Well-Being	Scale for Measuring Well-Being
Community Involvement	Adapted from the UK Social Capital Module of the General Household Survey 2000 <sup>21</sup> , and used in Ireland by the Institute of Public Health in Ireland <sup>22</sup> .
Volunteering Support Networks	Question from the Census of Population, 2006 Adapted from other scales, and used in a number of studies in Ireland <sup>23</sup> .
Emotions	Positive and Negative Affect Scales (PANAS) <sup>24</sup> , comprising 20 items and two sub-scales: (i) positive affect (ii) negative affect. Intensity and Time Affect Survey <sup>25</sup> , comprising 8 items and two sub-scales: (i) love (ii) joy.
Satisfaction with Life	Satisfaction with Life Scale <sup>26</sup> , comprising five items.
Depression	The Center for Epidemiologic Studies Depression Scale (CES-D) Scale <sup>27</sup> , comprising 20 items divided into four sub-scales: (i) depressed affect (ii) positive affect (iii) somatic symptoms (iv) interpersonal problems.
Hopefulness	The Hope Scale <sup>28</sup> , comprising 8 items divided equally into two sub-scales: (i) pathways (ii) agency.
Incidence of disability	Questions from the Census of Population, 2006
Number of books in the home	Questions from Educational Research Centre study on reading literacy in disadvantaged primary schools <sup>29</sup> .
Broadband and internet	Quarterly National Household Survey, 2006, Information Society Statistics

21. Coulthard, Walker and Morgan, 2002.

22. Balanda and Wilde, 2003.

23. McKeown, Pratschke and Haase, 2003.

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

25. Reproduced in McDowell, 2006: 214.

26. Diener, Lucas and Oishi, 2002: 70

27. Reproduced in McDowell, 2006: 350-358.

28. Snyder, Rand and Sigmon, 2002: 268-270

29. Eivers, Shiel and Shortt, 2004.

Dimensions of Need and Well-Being	Scale for Measuring Well-Being
Smoking, Drinking and Drugs	Smoking, Drinking and Drugs questions from NACD's Drug Prevalence Survey <sup>30</sup> and National Health and Lifestyle Surveys <sup>31</sup> .
Parent-Child Relationship	Parent-Child Relationship Inventory (PCRI) <sup>32</sup> comprising 20 items and four sub-scales: (i) satisfaction with parenting (ii) involvement with child (iii) communication with child (iv) limit-setting. The original scale has 78 items and six sub-scales.
Strengths and Difficulties	Strengths and Difficulties Questionnaire (SDQ) <sup>33</sup> (version to be completed by parent) comprising 25 items on its core scale which has five sub-scales: (i) conduct problems (ii) emotional symptoms (iii) hyperactivity (iv) peer problems (v) prosocial behaviour.
Child's health	Question from National Health and Lifestyle Surveys <sup>34</sup> .
Incidence of disability	Question from the Census of Population, 2006
Type of school attending	Bespoke question
Educational environment of home	Questions from Educational Research Centre study on reading literacy in disadvantaged primary schools <sup>35</sup> .
Child's reading ability	Question from Educational Research Centre study on reading literacy in disadvantaged primary school <sup>36</sup> .
School attendance	Bespoke question
Relationship with Partner	Ineffective Arguing Inventory <sup>37</sup> , comprising 4 items.

30. National Advisory Committee on Drugs, 2005.

31. See Centre for Health Promotion Studies, 2003.

32. Adapted from Gerard, 1994.

33. Available at [www.sdqinfo.com](http://www.sdqinfo.com)

34. See Centre for Health Promotion Studies, 2003.

35. Eivers, Shiel and Shortt, 2004.

36. Eivers, Shiel and Shortt, 2004.

37. Kurdek, 1994.

## **1.5 Creating a Representative Sample of Mothers on Respond! Estates**

The study is based on a two-stage stratified random sample of households living on Respond! estates. This involved selecting a sample of Respond! estates which meet the criterion of having at least 14 family households on the estate. For the purposes of this study, a family household is defined as comprising a mother with at least one child in the 3-17 age range. This definition was chosen because we decided to focus all interviews on the mother and because the main instrument for assessing the needs of children, the Strengths and Difficulties Questionnaire (SDQ), is valid for children in this age range only. The decision to focus on Respond! estates which have at least 14 family households was made in order to facilitate the identification of neighbourhood-level effects on the well-being of mothers and children.

Once the estates were selected, respondents were chosen at random using the random number function in SPSS and this was also used to select alternative respondents in case of refusals. The survey yielded 499 completed interviews in 34 estates. This is equivalent to 39% of all Respond! family estates (87) and 24% of all family households (2,080). This is a very high sampling ratio and is likely to yield a reliable picture of families on Respond! estates.

The resulting survey data was re-weighted to reflect the true distribution of family households and estates within Respond! This was done in two stages involving: (i) re-weighting the number of respondents in each estate to reflect the total number of family households in each estate (ii) re-weighting the number of respondents in each Respond! region to reflect the total number of family households in each region. The original sample and the re-weighted sample differed only marginally and this reinforces the view that the sample is representative of family households in Respond! estates. All results in the report are based on the re-weighted data and refer to the entire population of family households in Respond! estates.

In addition to the survey data, the Research & Development team in Respond! supplied anonymised data on income and employment and this was merged with the survey data. Similarly, the Research & Development team supplied data on the characteristics of each estate – such as the year in which it was built, the number of family households, estimated community capacity, availability of pre-school and

daycare services, distance to essential services, access to public transport, etc – and this was also merged with the survey data.

## **1.6 Data Analysis**

The analysis involved preparing frequencies and cross-tabulations, the full results of which are presented in the Technical Appendix<sup>38</sup>, mirroring the chapter structure of this Main Report. In addition, we use correlation analysis<sup>39</sup>, regression analysis<sup>40</sup>, and multi-level modelling<sup>41</sup> to test the level of association between the needs of mothers (in the areas of depression, life satisfaction and parenting), children (in the area of mental health), and neighbourhoods (based on an index of need) - the dependent variables - and a range of individual, family, socio-economic and neighbourhood factors (the independent variables). In the Appendix to Chapter One, we provide a more detailed description of both regression analysis and multi-level modelling.

Each method of analysis offers a progressively more detailed and subtle understanding of how the dependent variables are influenced by the unique contribution of individual-level and estate-level characteristics.

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38. Appendix available upon request from the R&D Department in Respond!.

39. Correlation analysis measures the extent to which two variables are associated. The magnitude of the correlation coefficient between the two variables reflects the extent to which their values vary together systematically.

40. Regression analysis is a method of explaining variability in a dependent variable using information about one or more independent variables. The regression coefficient expresses the predicted increase in the dependent variable 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 powerful statistical technique. In logistic regression, the dependent variable is dichotomous and is used, for example, to assess the likelihood of a child being, or not being, in the abnormal range of the SDQ.

41. Multi-level modelling is a more advanced form of multiple regression analysis. The basic principle in a two-level model is that change in a dependent variable is the outcome of individual attributes and neighbourhood characteristics. These influences can be separated into: (i) fixed parameters whose influence can be quantified using the independent variables in the dataset and (ii) variance parameters expressing the variability which cannot be explained using the existing set of independent variables. The influence of fixed parameters on a dependent variable can be separated, in turn, into an intercept (which may be interpreted here as the overall adjusted mean) and a series of slopes (denoting the change in the dependent variable for a unit change in the independent variables). The advantage of multilevel analysis is that it permits the analysis of level 2 (i.e. estate level) variables and provides estimates of their influence on the dependent variable in terms of fixed parameters that express 'contextual effects'. In addition, multi-level modelling assesses how the influence of level 1 (individual-level) variables may vary through interaction with level 2 variables (i.e. how certain influences vary across different contexts). These concepts can be illustrated by drawing on our analysis of life satisfaction in Chapter Four below. This shows that the life satisfaction of mothers is influenced by individual-level characteristics (such as hope, positive affect, etc), by estate-level characteristics (such as the average local problem score) and by the interaction of both levels (such as variability in the way hope influences life satisfaction in different estates). Naturally, these variables do not explain every variation in life satisfaction, which implies that we also have at least two residual variances (for individuals and estates). All our multilevel modelling results were obtained using the MLwiN 1.1 software, developed by the Institute of Education, University of London.

Our analysis reflects an understanding of social reality which sees the individual as embedded in a social context – in this study, individuals live within families and families reside within estates – and sees individual outcomes as shaped not just by individual characteristics but by their social context as well. This understanding recognises the multi-layered nature of social reality and the hierarchy of levels which interact to shape the well-being of individuals. In practice, this means that information about individuals is sensitive to the context in which those individuals are situated and, wherever possible, this needs to be taken into account in the analysis. In this study, our analysis focuses on two levels - the individual and the estate - essentially because this is best practice in studies of this type, and fully exhausts the possibilities of our dataset.

Finally, as with all statistical analysis, it should be pointed out that the existence of a statistical association does not necessarily imply causation, not least because all data are cross-sectional rather than longitudinal. Nevertheless, statistical associations are helpful, when taken in conjunction with findings from other research on the determinants of well-being among mothers, children and neighbourhoods, in suggesting possible interpretations of those associations as well as possible strategies for addressing those needs.

### **1.7 Limitations of the Study**

It is appropriate to draw attention to some limitations to the study. Seven 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 undertaken<sup>42</sup>. 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

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

typically under-estimate 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, although 60% of all households in Respond! estates have a lone parent, usually a mother. 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 shows<sup>43</sup>. 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 fathers<sup>44</sup>. It is important, therefore, 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 considerable<sup>45</sup>, particularly in cases of intense conflict and instability.

Third, the sample size, though large relative to the total number of family households (499, 24%), and estates (34, 39%) within Respond!, is considerably smaller than would be ideal for multi-level modelling. Multi-level modelling normally requires 20-30 level 1 observations (households) and as many as 100 level 2 units (estates), depending on the phenomenon being studied and the strength of the relationships involved, including the strength of contextual effects.

Fourth, there is significant variability in the number of respondents within each estate; half of the estates (17) yielded a sample of 16-23 respondents while the other half yielded samples of 5-15 respondents. This makes it more challenging to identify neighbourhood effects and creates the danger of ‘false negatives’ in the sense that the failure to identify neighbourhood effects may be the result of this

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

44. McKeown, 2001a; 2001b.

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

methodological weakness rather than the absence of these effects *per se*.

Fifth, the overall population of households and estates is relatively homogenous since they are built and managed by one agency, Respond!, and are occupied by tenants on the basis of assessed social need. In addition, as already pointed out, all of the respondents are mothers with at least one child aged 3-17 and therefore constitute a specific sub-group of relatively disadvantaged families. Finding variability in such a homogenous population can be a challenge for statistical analysis.

Sixth, all data were collected at a single point in time (between May and July 2007) and – with the exception of additional data supplied by Respond! on estate-level characteristics - from a single respondent. As a result, it is difficult to distinguish between the respondent's attributions and the true nature of the phenomenon in question. This implies that some caution needs to be exercised in drawing inferences from the study about the broader determinants of well-being among parents, children and neighbourhoods.

Seventh, the sample is drawn entirely from Respond! estates. This means that we will not be able to assess the impact of Respond!'s approach to estate management – which emphasises tenant participation and the development of sustainable communities – relative to the estate management approaches used by other housing agencies such as Local Authorities. This is a significant gap because we are not able to evaluate how different estate management systems contribute to individual and community well-being, since this important question would require comparative data on residents in other estate management systems.

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 in Respond! estates. Nevertheless, it is important to keep the limitations in mind when making inferences to other populations, or drawing out the implications for policy and practice within Respond!.



## **Chapter Two**

### **Characteristics of Family Households**

#### **2.1 Introduction**

This chapter describes some socio-demographic characteristics of Respond! family households, comparing them with households in Ireland as a whole. The household is a space where all, or only some, family members live, but the concepts of household and family do not always overlap, particularly in lone-parent households where the father may live 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 distinct.

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. We also distinguish between one- and two-parent households in order to examine the effects of family type on the different variables. The profile of Respond! family households is quite different from those in Ireland as a whole, having a much higher proportion of Medical Card holders (70% compared to 28% in Ireland<sup>46</sup>) and a much higher proportion of lone parents (60% compared to 21% in Ireland). The tables on which this chapter is based are included in the Appendix<sup>47</sup> to Chapter Two.

#### **2.2 Family Structure**

The term family structure is used to describe whether there are one or two parents in the household. In Respond!, the breakdown between one- and two-parent families is 40% / 60% respectively, compared to 20% / 80% in Ireland. Given that lone parenthood is strongly associated with socio-economic disadvantage – both as cause and consequence<sup>48</sup> – this confirms that Respond! targets its housing at families who need assistance in meeting their housing needs. The composition of one and two-parent households in Respond! is also different. One-parent households in Respond! comprise a much higher proportion of

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46. Nolan, 2007:4

47. Appendix available upon request from the R&D Department in Respond!.

48. See McLanahan, Donahue and Haskins, 2005.

single persons (76% compared to 57% in Ireland) while two-parent households have a much higher proportion of cohabiting couples (25% compared to 14% in Ireland).

### **2.3 Household Size**

The average number of persons in each household in Respond! is 3.7, and each household has an average of 2.2 children. The average age of children is 9.6 years and the average age of the mother is 35 years. In the vast majority of cases (94%) the household lives in a house, but a small proportion (6%), mainly comprised of lone-parent families, live in apartments.

### **2.4 Mother's Education**

The level of education among mothers in Respond! is lower than in Ireland, whether measured in terms of the age completed full-time education or highest qualification achieved. Those in Respond! with a Medical Card have the lowest level of education.

### **2.5 Mother's Employment**

The majority of mothers in Respond! are not economically active (63%) because they are full-time homemakers. In Ireland, the proportion of women with at least one child aged 5 years or more – the most appropriate comparison group in this context – who are not economically active is just over half this (35%), indicating that Respond! mothers are much less likely to be economically active compared to their counterparts in Ireland. Conversely, employment rates are much lower among Respond! mothers than among Irish women generally (35% compared to 62%) and mainly involves part-time work. Within Respond!, mothers on a Medical Card are least likely to be economically active (59%) while, of those in employment, lone parents are most likely to be part-time (81%). These findings point to the relatively weak labour market position of mothers in Respond! – particularly at a time of economic buoyancy and given the availability of childcare services in nearly two-thirds of all Respond! estates – and may be an indicator of the disincentive effects of the tax, social welfare, and rent assessment system on those with weak earning capacity.

## **2.6 Mother's Financial Position**

Financial well-being has both an objective dimension and a subjective dimension. We illustrate the objective dimension by reference to the proportion of households without earned income, and the equivalised per capita income<sup>49</sup> while the subjective dimension is illustrated by the mother's capacity to cope financially.

More than half of all Respond! family households (55%) are without an earned income and therefore totally dependent on social transfers. This is two and a half times higher than comparable households with children (aged 0-14 years) in Ireland where 22% are without an earned income<sup>50</sup>. Those with a Medical Card have a higher dependence on social transfers than those without (64% compared to 35%) and one-parent households have a higher dependency than two-parent households (62% compared to 45%).

The equivalised gross income of all family households in Respond! during 2006/7 was €8,537 or €164 per week. For comparative purposes, it is worth noting that the poverty threshold set by the CSO's 2005 EU Survey of Income and Living Conditions (EU-SILC) – based on 60% of median equivalised income per individual – was €193 per week. This implies that the average Respond! family household is likely to be at or below the poverty threshold, and this likelihood is even greater for households with a Medical Card or a lone parent.

Turning to the subjective dimension of financial well-being, the majority of mothers in Respond! (75%) are not experiencing financial strain, as indicated by 'finding it difficult to manage' or 'in serious difficulties'. However a quarter are experiencing financial strain (25%), significantly higher than in Ireland (14%). 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% to 10%), but also fell for a

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49. The term 'equivalised income' refers to the total income of a household adjusted to take account of the total number of persons in that household. The convention used by the CSO in its Survey of Income and Living Conditions (SILC), and adopted here, is stated as follows: "The national scale attributes a weight of 1 to the first adult and 0.66 to each subsequent adult (aged 14+ living in the household), and 0.33 to each child aged less than 14" (EU-SILC 2005, published by the CSO in November 2006, page 29).

50. Data supplied by Kathryn Carty, CSO on 10 August 2007. Based on 2005 data from the EU Survey on Income and Living Conditions (EU-SILC). Earned income, in this context, is defined as employment income, income from self-employment, other direct income such as investment income and occupational pensions.

range of households experiencing poverty including households with children (from 37% to 12%), older people (from 23% to 12%), unemployed (from 54% to 20%), and the ill / disabled (from 48% to 19%)<sup>51</sup>. In light of this, the level of financial strain among mothers in Respond! is well above that experienced not only by Irish households generally but also by reference to specific groups which are vulnerable to poverty. This suggests that the benefits of Ireland's recent economic success do not seem to have flowed into many Respond! households.

## **2.7 Ownership of Cars**

Nearly seven out of ten mothers (69%) own or have the use of a car. This compares to nearly eight out of ten households in Ireland (79%). Lone parents and those with a Medical Card are much less likely to own or have the use of a car.

## **2.8 Mother's Nationality**

The vast majority of mothers (91%) are Irish, similar to the corresponding proportion recorded in the 2006 Census of Population (89%). Mothers who are not of Irish nationality are most likely to come from the UK (4%) or Africa (2%).

## **2.9 Summary**

This chapter described some socio-demographic characteristics of family households in Respond!, comparing them with households in Ireland. We found that the profile of Respond! family households is quite different from Ireland, having a much higher proportion of Medical Card holders (70% compared to 28% in Ireland) and a much higher proportion of lone parents (60% compared to 21% in Ireland).

The level of education among mothers in Respond! is lower than in Ireland, whether measured in terms of the age at which they completed full-time education or on the basis of the highest qualification achieved. The majority of mothers in Respond! are not economically active (63%) because they are full-time homemakers, whereas the majority of mothers in Ireland (62%) are economically active. Moreover, those

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51. Whelan, Nolan and Maitre, 2005.

who are in employment tend to be working part-time, unlike the pattern among women in Ireland, where full-time employment is the norm. These findings point to the relatively weak labour market position of mothers in Respond! - particularly at a time of economic buoyancy and the widespread availability of childcare services in nearly two thirds of all Respond! estates – and may be an indicator of the disincentive effects of the tax and social welfare system on those with weak earning capacity.

In terms of financial well-being, we found that more than half of all Respond! family households (55%) are without an earned income and therefore totally dependent on social transfers. This is two and a half times higher than comparable households with children (aged 0-14 years) in Ireland, where 22% are lacking earned income<sup>52</sup>.

The equivalised gross income<sup>53</sup> of all family households in Respond! during 2006/7 was €8,537 or €164 per week. Given that the poverty threshold set by the CSO's 2005 EU Survey of Income and Living Conditions (EU-SILC) – based on 60% of median equivalised income per individual – was €193 per week, this suggests that the average Respond! family household is likely to be at or below the poverty threshold.

Turning to the subjective dimension of financial well-being, the majority of mothers in Respond! (75%) are not experiencing financial strain as indicated by 'finding it difficult to manage' or 'in serious difficulties'. However a quarter experience financial strain (25%), significantly higher than in Ireland (14%), and significantly higher than other groups which are particularly vulnerable to poverty<sup>54</sup>. This suggests that the benefits of Ireland's recent economic success have not flowed into many Respond! households.

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52. Data supplied by Kathryn Carty, CSO on 10 August 2007. Based on 2005 data from the EU Survey on Income and Living Conditions (EU-SILC). Earned income, in this context, is defined as employment income, income from self-employment, other direct income such as investment income and occupational pensions.

53. The term "equivalised income" refers to the total income of a household adjusted to take account of the total number of persons in that household. The convention used by the CSO in its Survey of Income and Living Conditions (SILC), and adopted here, is stated as follows: "The national scale attributes a weight of 1 to the first adult and 0.66 to each subsequent adult (aged 14+ living in the household), and 0.33 to each child aged less than 14" (EU-SILC 2005, published by the CSO in November 2006, page 29).

54. Whelan, Nolan and Maitre, 2005.

Throughout our analysis we distinguished between households with a Medical Card and those without, as well as between one- and two-parent households. This revealed that those with a Medical Card and those who are lone parents are in the weakest socio-economic positions, in line with expectations.

The results in this chapter are consistent with the policy and practice of Respond! in allocating housing to those who are most in need. All of the indicators of need used in this chapter – Medical Card, lone parenthood, education, employment status, dependency on social transfers, income and ability to cope financially – confirm that this is an extremely vulnerable group. In the next chapter we explore the dimensions of need in more detail, focusing on various aspects of psychological and relationship well-being.

### **Profile of Families**

- The breakdown of two and one-parent families in Respond! is 60/40 compared to 80/20 in Ireland
- Most residents (70%) have a Medical Card compared to 30% in Ireland
- All are in social housing compared to 3.5% in Ireland
- Education levels are lower than the average Irish adult

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- 60% of mothers are full-time home-makers and 35% are in paid work; in Ireland 35% are full-time home-makers and 62% are in paid work
- 55% of households have no earned income compared to 22% in Ireland
- Average weekly household income, based on rent data, is €164. In 2005, the individual poverty line in Ireland was €193 per week

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- In financial terms, most describe themselves as ‘making ends meet’ (47%) or ‘comfortable’ (29%), but a minority are ‘finding it difficult to manage’ (14%)
- About 70% own or have use of a car
- Over 90% describe their nationality as Irish

**All of this confirms that Respond! is targeting families in need.**

## Chapter Three

### The Well-Being of Mothers

#### 3.1 Introduction

In this chapter we assess the well-being of mothers in Respond!. Our assessment is based on data from a representative sample of 499 mothers in Respond! estates. Data from other surveys in Ireland<sup>55</sup>, Limerick<sup>56</sup> and the US<sup>57</sup> are used for comparative purposes to establish the extent of need among mothers in Respond!. This involves comparing the mean scores from Respond! with the mean scores from other studies. We standardise the difference in mean scores between the two groups and express them as effect sizes<sup>58</sup>. We now report the main findings from our analysis. The full set of results are in the Appendix<sup>59</sup> to Chapter Three.

#### 3.2 Emotional Well-Being

Emotional well-being is measured by each person's experience of positive and negative emotions. In general, positive emotions tend to increase well-being while negative emotions tend to reduce it. The emotional quality of a person's life can be reliably measured by the Positive and Negative Affect Scales (PANAS)<sup>60</sup> and this is used here. We also measure the frequency of positive emotions using the Intensity and Time Affect Survey<sup>61</sup>. The survey revealed that Respond! mothers are more positive and less negative

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55. McKeown, Pratschke and Haase, 2003; Centre for Health Promotion Studies, 2003; National Advisory Council on Drugs, 2005.

56. McKeown and Haase, 2007.

57. See for example, Diener, Smith and Fujita, 1995; Diener, Lucas and Oishi, 2002.

58. 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.

59. Appendix available upon request from the R&D Department in Respond!.

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

61. Reproduced in McDowell, 2006: 214.

than their counterparts in Ireland. Similarly they score higher on the love and joy subscales compared to US studies. However it is noteworthy that these results tend to be at variance with other indicators of well-being which we report in this chapter, particularly depression.

### **3.3 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' because it focuses on how the person assesses his / her life. This assessment is highly personal and is independent of objective standards of performance or achievement<sup>62</sup>. We measured life satisfaction using the Satisfaction with Life Scale<sup>63</sup>. The results show that Respond! mothers have very similar life satisfaction compared to a sample of mothers in Limerick which was representative of all socio-economic groups. However, mothers without a Medical Card and those in two-parent households tend to have somewhat lower levels of life satisfaction. As with emotional well-being, the relatively high level of life satisfaction seems to be at variance with the relatively high levels of depression reported by Respond! mothers in the next section, and may be due to the fact that these mothers have come to accept their lives as they are.

### **3.4 Depression**

We measured depression using the Depression Scale of the Centre for Epidemiologic Studies (CES), usually referred to as CES-D<sup>64</sup>. 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

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62. Carr, 2004: 38-9.

63. 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; 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).

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

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symptoms and other variables”<sup>65</sup>. The scores on the scale range from 0 to 60 while cut-off scores of 16 (in clinical settings) and 20 (in community settings) are used to detect people with depressive symptoms. The overall rate of depressive symptoms among mothers in Respond! is 22% (based on the cut-off score of 20 or over) and 30% (based on the cut-off score of 16 or over). Depressive symptoms do not vary significantly by Medical Card but are much higher in lone-parent households where a third (33%) of mothers show depressive symptoms.

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 sample of 200 mothers in Limerick, representative of all socio-economic groups, where the prevalence of depressive symptoms ranged from 12% (based on the cut-off score of 20 or over) to 17% (based on the cut-off score of 16 or over); the rate for mothers with a Medical Card was 18% (based on the cut-off score of 20 or over) and 25% (based on the cut-off score of 16 or over)<sup>66</sup>. By this standard, therefore, the prevalence of depressive symptoms among Respond! mothers is particularly high. The CES-D was also used in a survey of 244 adults (two thirds of them women) attending the Farranfore Medical Centre in County Kerry, which found that 30% of these showed depressive symptoms (based on the cut-off score of 16 or over)<sup>67</sup>. Internationally, a review of evidence on the prevalence of depression among mothers 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”<sup>68</sup>. In light of these results, it would seem that the rate of depressive symptoms among Respond! mothers is probably higher than would be expected by comparison with the results of population studies which are representative of all socio-economic groups.

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65. McDowell, 2006: 355.

66. McKeown and Haase, 2007.

67. O’Sullivan, 2004.

68. Shonkoff and Phillips, 2000: 251.

### **3.5 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"<sup>69</sup>. In everyday language, people are described as hopeful when they 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 Scale<sup>70</sup> and found that 80% of mothers are hopeful but 20% are lacking in hope. This is similar to the results from the study of mothers in Limerick. Of the two dimensions of hope, Respond! mothers exhibit greater deficits in the area of agency thinking, suggesting a lack of motivation and self-belief to solve their problems which is consistent with the relatively high prevalence of depression. Within the group of Respond! mothers, those in one-parent households are more likely to experience hopelessness, while there is relatively little variation between those with and without a Medical Card.

### **3.6 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 Respond! and the general population in Ireland. However the proportion of Respond! mothers who rate their health at the lower end of the scale - as 'fair' or 'poor' - is significantly higher compared to Ireland (14% compared to 6%). Nearly a fifth (17%) of lone parents rated their health at this end of the scale while there was no difference between those with, and without, Medical Cards.

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69. Snyder, Rand and Sigmon, 2002: 257.

70. Snyder, Rand and Sigmon, 2002: 268-270.

### **3.7 Disabilities**

We assessed the prevalence of any form of disability, using a question from the 2006 Census of Population. This shows that a quarter of mothers (25%) reported having at least one of the disabilities mentioned. This is higher than the rate for females (10%) estimated in the 2006 Census of Population, which is generally regarded as an underestimate. The fact that having a disability is one of the criteria used by Respond!, and other social housing providers, in allocating housing may contribute to the relatively high rates of disability found on its estates. There is no difference in disability rates between mothers in one- and two-parent households but those with a Medical Card (25%) have higher rates than those without (21%). Disabilities interfere with the daily lives of six out of ten mothers, and a higher proportion of lone parents and those on a Medical Card.

### **3.8 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 Respond! mothers (62%) is nearly twice the national average for women in Ireland (33%) reflecting, to some extent, the higher prevalence of smoking among lower socio-economic groups in Ireland and internationally<sup>71</sup>. Smoking rates are much higher among mothers in one-parent households (68%) compared to two-parent households (53%). The use of alcohol is broadly similar between mothers in Respond! (67%) and Ireland (70%). The use of sedatives, tranquilisers or anti-depressants (on prescription) among Respond! mothers (10%) is twice the national average (5%). Usage of these drugs is considerably higher among mothers with a Medical Card (12%) and mothers in one-parent households (14%).

### **3.9 Support Networks**

There is extensive research to show that support networks are a significant influence on the well-being of individuals and their families<sup>72</sup>. In addition, positive support networks are known to improve physical health and mental health and to aid in recovery from illness and adversity<sup>73</sup>. It is generally acknowledged that the relationship between support networks and well-being is 'bi-directional' in the sense that people

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71. Centre for Health Promotion Studies, 2003: 23.

72. For a review, see McKeown, 2000: 11-13.

73. Scovern, 1999 and Sprenkle, Blow and Dickey, 1999, review the evidence.

with higher levels of well-being tend to have stronger support and friendship networks but these networks in turn also contribute to a person's well-being<sup>74</sup>. We measured support networks by asking respondents to rate the supportiveness of the following people, if they needed help: their partner, parents, brothers and sisters, children, relatives, friends, people at work, neighbours, etc. The results indicate that mothers in Respond!, both those with and without a Medical Card as well as those in one- and two-parent households, have stronger support networks than mothers in Ireland.

### **3.10 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 years<sup>75</sup>. We used the Parent-Child Relationship Inventory (PCRI)<sup>76</sup> to measure four sub-dimensions of that relationship: satisfaction, involvement, communication, and limit-setting and independence. The results of the survey reveal that mothers in Respond!, both those with and without a Medical Card as well as those in one- and two-parent households, have a better overall parent-child relationship compared to mothers in Ireland.

### **3.11 Relationship Skills**

We used the Ineffective Arguing Inventory<sup>77</sup> 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 in Respond! are just as effective at resolving arguments compared to a national sample of mothers. 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.

### **3.12 Summary and Conclusion**

In this chapter we assessed the well-being of mothers in Respond!. Our assessment was based on data from a representative sample of 499 mothers in Respond! estates which was then compared with data

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74. Carr, 2004: 20-24; Seligman, 2002: 56.

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

76. Gerard, 1994.

77. Kurdek, 1994.

using the same instruments from other studies in Ireland<sup>78</sup>, Limerick<sup>79</sup> and the US<sup>80</sup>. Differences in mean scores were compared using the effect size statistic<sup>81</sup>.

The results show that Respond! mothers have broadly similar levels of well-being compared to other mothers in Ireland on a wide range of domains including emotional well-being, life satisfaction, support networks, parenting relationships and effectiveness at resolving arguments. At the same time, there are also significant areas of need among Respond! mothers, particularly in the area of depression where nearly a third (30%) show signs of depression which is more pronounced among mothers in one-parent households (33%). This is also reflected in a significant proportion showing signs of hopelessness (20%). 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 and the survey shows that Respond! mothers exhibit greater deficits in the area of 'agency thinking', suggesting a lack of self-belief and motivation to solve their problems which is consistent with the relatively high prevalence of depression. Consistent with this, the proportion of Respond! mothers using sedatives, tranquilisers and anti-depressants (10%) is twice the national average, and highest among mothers in one-parent households (14%). About a quarter of mothers (24%) reported some form of disability, which is significantly higher than the national female prevalence rate. Smoking rates among Respond! mothers are also twice the national average (62% compared to 33%), and are also highest in one-parent households (68%), reflecting the higher prevalence of smoking among lower socio-economic groups in Ireland and internationally<sup>82</sup>. Possibly related to this, self-rated health is below that of mothers in Ireland generally, with lone parents having the lowest self-rated health.

In sum, these findings indicate both strengths and weaknesses in the well-being of Respond! mothers.

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78. McKeown, Pratschke and Haase, 2003; Centre for Health Promotion Studies, 2003; National Advisory Council on Drugs, 2005.

79. McKeown and Haase, 2007.

80. See for example, Diener, Smith and Fujita, 1995; Diener, Lucas and Oishi, 2002.

81. 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.

82. Centre for Health Promotion Studies, 2003: 23.

Those in one-parent households are most likely to display significant areas of need. By contrast, having a Medical Card is not a strong or consistent predictor of need, except in the case of disability. In order to address needs, it is necessary to have a clear understanding of the factors associated with them. For this reason, we explore the factors associated with depressive symptoms, life satisfaction, and parenting in Chapter Four.

## **Chapter Four**

### **Influences on the Well-Being of Mothers**

#### **4.1 Introduction**

In this chapter we estimate the factors which influence three aspects of well-being among mothers in Respond! estates: depression, life satisfaction and parenting. We selected these three dimensions not only because they are key aspects of the well-being of mothers, but also because they are known to influence the well-being of children. Our method of analysis, as described in Chapter One, involves multi-level modelling, which we use to test the level of association between the three dependent variables (depression, life satisfaction, and parenting) and a range of individual, family, socio-economic and neighbourhood characteristics (the independent variables).

Levels of association are expressed in terms of regression coefficients which are unstandardised and presented in the original metric of the variables; they express the net influence of a given variable on the dependent variable, holding all other variables included in the model constant. Each table of results presented below (Tables 4.1, 4.2 and 4.3) comprises three models. Model 1 shows the unexplained variance associated with both individual (level 1) factors and estate (level 2) factors when no explanatory factors are used; this model is referred to as the “null model”. Model 2 shows the influence of individual factors on depression scores (“variance components model”), while Model 3 shows the influence of both individual and estate factors; this model is referred to as the “full multi-level model”. A detailed description of the analyses on which this chapter is based is in the Appendix<sup>83</sup> to Chapter Four.

#### **4.2 Factors Associated with Depressive Symptoms**

The results of the multi-level analysis of depression are summarised in Table 4.1. This shows that 90% of the variance in depression scores is attributable to individuals, with the remaining 10% attributable to estates (level 2)<sup>84</sup>. The final model (Model 3) explains 48.6% of the variance between individual

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83. Appendix available upon request from the R&D Department in Respond!.

84. Estimated from the data in Model 1 where level 1 variance is 105.182 and level 2 variance is 12.234. It is worth noting that the level 2 variance may not be entirely attributable to estate-level factors, but rather to compositional effects, as we will see.

respondents and no less than 86.3% of the variance between estates. This is a highly satisfactory result, in terms of both the individual-level and estate-level results. It is useful to report the findings in terms of risk factors (those which increase the likelihood of depressive symptoms) and protective factors (those which decrease the likelihood of depressive symptoms) since this can help to draw attention to the different domains of intervention where, in the case of risk factors, mitigation and support may be appropriate or, in the case of protective factors, enhancement and strengthening may be appropriate.

**Table 4.1 Multi-Level Model of Depression Among Mothers in Respond! Estates**

Parameter	Model 1	Model 2	Model 3
<b>Individual Level Effects:</b>			
Intercept	11.317 *	10.987 *	10.587 *
Negative Affect		0.622 *	0.601 *
SDQ Children’s Difficulties		0.348 *	0.339 *
Life Satisfaction		-0.305 *	-0.289 *
Hope		-0.177 *	-0.168 *
Disability		2.593 *	2.322 *
Negative Affect x Life Satisfaction interact.			-0.023 *
<b>Neighbourhood Level Effects:</b>			
Housing Units on Estate			0.047 *
Percentage with Primary School Ed.			0.085 *
<b>Variances:</b>			
Variance of level 1 residuals	105.182 *	55.200 *	54.094 *
Variance of level 2 intercept residuals	12.234 *	5.007 *	1.679
<b>Model assessment:</b>			
Deviance statistic	3772.278	3445.645	3413.179
Degrees of freedom	3	8	11
N	499	499	498
% variance explained: level 1		47.52%	48.6%
% variance explained: level 2		59.07%	86.3%

\* Parameter estimates followed by an asterisk are statistically significant at the .05 level.



At individual level, the risk factors for depressive symptoms are negative affect, having a child with difficulties, and having a disability; the protective factors are life satisfaction and hope. A unit increase in negative affect – as indicated by more frequent experiences of negative feelings such as being distressed, upset, scared, hostile, irritable, ashamed, nervous, jittery or afraid – is associated with an increase of 0.601 in depression scores. Having a child who presents with difficulties, such as behavioural, emotional or hyperactivity problems, also increases the risk of depression (0.339), although, as we shall see in Chapter Six below, children are also more likely to present with difficulties if their mothers are depressed (0.143), suggesting a mutually reinforcing negative cycle between mother and child. It is also significant that mothers with a disability or chronic illness are more likely to show symptoms of depression compared to mothers without a disability (2.322). This could arise because of the practical and emotional consequences of living with an impairment, possibly exacerbated by the absence of appropriate social and medical services to assist with the tasks of daily living, but may also be aggravated by the mother's difficulty in coming to terms with and accepting the disability, particularly if it is permanent.

The two protective factors which reduce the likelihood of depression are life satisfaction and hope. Life satisfaction, which essentially refers to the mother's cognitive and affective evaluation of her life, has a counteracting effect on depression, reducing it by 0.289 units for each unit increase in life satisfaction. Similarly, hopefulness reduces depression (-0.17), possibly because those who are hopeful believe they have the will ('agency thinking') and the way ('pathways thinking') to achieve their goals. As a result, mothers with greater hope may be more likely to transform negative cognitions and emotions into practical problem-solving responses, thereby reducing the symptoms of depression.

It is significant that the experience of depressive symptoms is also affected by the interaction of negative affect and life satisfaction. Mothers with high levels of negative affect are more likely to show depressive symptoms if they also have low levels of life satisfaction. For those with particularly high levels of negative affect, combined with low life satisfaction, the depression score is boosted by at least 5 points, whilst it is decreased by more than 4 points amongst the same individuals if life satisfaction is high. By contrast, life satisfaction has a much weaker influence on depressive symptoms when mothers have low negative affect.

In terms of estate-level effects, the results in Table 4.1 indicate that more than half (59.1%) of the variance is attributable to ‘compositional factors’, i.e. systematic differences between estates in values for negative affect, SDQ, life satisfaction, hope and disability<sup>85</sup>. By contrast, more than one quarter (27.2%) is attributable to ‘contextual factors’ across the different estates<sup>86</sup>; given that estate-level effects account for 10% of the variance in depression scores, this implies that contextual or neighbourhood factors explain 2.8% of the total variance in depression scores. Although this is an important and significant finding in itself, it is worth recalling that the neighbourhoods analysed in this study are relatively homogeneous, which has the effect of reducing the level 2 variance (between estates), and decreasing the influence of contextual factors. In a sample that included other kinds of estates in Ireland, we would therefore expect this percentage to rise substantially.

The two key estate-level characteristics associated with depressive symptoms in this study are the size of the estate and the percentage of mothers with a primary education only. Estate size is measured by the number of housing units and, for each unit increase in the size of the estate, depression scores increase by 0.047. Given that the mean size of estates in the sample is relatively small (38 houses) by comparison with many housing estates in the public and private sector, this is an interesting finding. The percentage of mothers with no more than a primary school education also tends to increase depressive symptoms (by 0.085 for each percentage point increase), possibly because it reduces the sense of dynamism and hopefulness in the estate. These results are consistent with findings from some other studies which have endeavoured to estimate the influence of individual and neighbourhood characteristics on mental health<sup>87</sup>.

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85. The compositional effect is estimated by subtracting the level 2 variance in Model 2 (5.007) from the level 2 variance in Model 1 (12.234) and expressing this as a percentage of the latter.

86. The contextual effect is estimated by subtracting the level 2 variance in Model 3 (1.679) from the level 2 variance in Model 2 (5.007) and expressing this as a percentage of the level 2 variance in Model 1 (12.234).

87. In the area of mental health, some studies have identified stronger neighbourhood effects. A recent review of these studies (Fone, Lloyd and Dunstan, 2007) concluded that the influence of area-level deprivation on the mental health of adults was ‘inconsistent’ while the influence of social capital on adult mental health was ‘inconclusive’. However, two recently published studies, based on large data sets in Wales, have found significant neighbourhood-level effects. In one of these studies (Fone, Dunstan, Lloyd, Williams, Watkins and, Palmer, 2007), data on over 10,000 individuals and 325 census enumerations districts in Wales was used to assess the impact of individual and area-level income and social capital on mental health. The results of this study lead the authors to conclude that: ‘we are the first to show that income deprivation and social cohesion measured at small-area level are significantly and independently associated with poor mental health status. ... the effect of deprivation is significantly reduced in areas of high social cohesion and is greater in areas of low social cohesion. ... The large contextual social cohesion effect size in this study suggests that in deprived areas, high levels of community social cohesion based on friendships, visiting and borrowing and exchange of favours with neighbours is potentially of importance in protecting mental health’. In another study (Fone, Lloyd and Dunstan, 2007), based on data for 25,000 individuals and

In considering the practical and service implications of these results, it is important to remember that, although our analysis estimated the separate contribution of each factor to depression, we are not in a position to infer strict causality or to establish its directionality. For example, the problem of maternal depression might be seen as part of a negative self-reinforcing cycle while, correspondingly, its solution involves creating a positive self-reinforcing cycle. Recognising the systemic nature of depression also suggests the desirability of intervening across as many of the relevant domains as possible in order to mitigate the risk factors and strengthen the protective factors.

Beginning with the risk factors, it is clear that while negative affect has a strong influence on depression, it is also the case that negative affect is an enduring personality trait which, although moulded through habits and circumstances, is not easily amenable to change. This knowledge can be of considerable benefit to people with depressive symptoms by virtue of acknowledging this personality trait, which is not ‘wrong’ or a ‘mistake’, and can assist the person in learning to live with this disposition while recognising its dangers and limitations. Interventions which promote this form of self-knowledge could have the effect of relieving the symptoms of depression by helping the person find a constructive way of living with their natural tendencies.

At the same time, we have also seen that depressive symptoms are the practical outcome of burdens associated with having a disability or a child with behaviour and emotional difficulties. Clearly, interventions to support mothers and children in these circumstances would, other things being equal, alleviate the symptoms of depression. Turning to the protective factors, it is clear that measures which strengthen life satisfaction and hopefulness will help to alleviate depression. These two domains have a strong cognitive dimension which essentially entails a perspective on life that is positive, appreciative,

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833 census enumerations districts in Wales, the authors found that economic inactivity, particularly inactivity associated with permanent disability, was associated with reduced mental health and led the authors to speculate that “it is plausible that neighbourhoods with high rates of people with disabilities will have lower levels of social cohesion, due to the difficulties of social engagement resulting from chronic disabling illness, and this effect is likely to be stronger for older age groups”. These results, in turn, are consistent with a Norwegian study of 43,000 individuals in 155 neighbourhoods which found that self-rated health and depression were strongly influenced by neighbourhood-level trust, although the main influences were with the socio-economic characteristics of individuals (Sund, Jorgensen, Jones, Krokstad and Heggdal, 2007).

and problem-solving. There is growing evidence in positive psychology that this perspective can be cultivated by practices which help people to think and feel differently about their past, their present and their future<sup>88</sup>.

### **Explaining the Well-Being of Mothers:**

#### **Depressive Symptoms**

- The influences on depression can be classified into
  - Risk factors
  - Protective factors
- These factors, in turn, can operate at:
  - the individual-level (90%)
  - the neighbourhood-level (10%)
- Individual-Level Risk Factors
  - Having a disability
  - Having a child whose behaviour or emotions cause difficulties
  - Negative affect
- Individual-Level Protective Factors
  - Life satisfaction
  - Hope
- Estate-Level Factors
  - Size of estate
  - Proportion with primary education only

In drawing out the broad implications of our analysis for interventions to reduce depressive symptoms, we acknowledge that further reflection is required in order to identify specific programmes with proven effectiveness in these domains. In addition, the question of which agency or agencies might be involved in delivering these programmes is a separate but equally challenging issue that would need to be addressed.

### **4.3 Factors Associated with Life Satisfaction**

The results of the multi-level analysis of life satisfaction are summarised in Table 4.2. These show that 84% of the variance in life satisfaction scores is attributable to individuals with the remaining 16%

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88. Seligman, 2002; for further information on cognitive therapy, see [www.beckinstitute.org](http://www.beckinstitute.org).

attributable to estates<sup>89</sup>. Given that life satisfaction is a highly personal assessment of one’s life, which is independent of objective standards of performance or achievement, it is not surprising that this dimension of well-being is open to a rather wide range of influences. The final model (Model 3) explains 51.7% of the variance between individual respondents and 79.4% of the variance between estates. This is a highly satisfactory result, in terms of both the individual-level and estate-level results.

At the individual level, the main risk factors which threaten to reduce life satisfaction are depression, being more educated, having difficulty coping financially, and being single. We have already seen in the previous section that depression is influenced by life satisfaction (0.289) and here we see that life satisfaction is influenced by depression (0.156), which underlines the bidirectional nature of this influence. The experience of being more educated – defined as having a higher secondary or third level education – has a negative influence on life satisfaction and is reflected in the fact that the life satisfaction of those with a third level education is 3.826 points lower compared to those with a lower secondary education. This could be due to the fact that those with a third level education may have higher, but unfulfilled, expectations of their life compared to those with less education.

**Table 4.2 Multi-Level Model of Life Satisfaction Among Mothers in Respond! Estates**

Parameter	Model 1	Model 2	Model 3
<i>Individual Level Effects:</i>			
Intercept	24.325 *	24.419 *	24.229 *
Hope		0.211 *	0.196 *
Positive Affect		0.181 *	0.186 *
Depression Score (CES-D)		-0.157 *	-0.156 *
Education (Primary vs. Lower Secondary School)		0.999	1.027

89. Estimated from the data in Model 1 where level 1 variance is 44.856 and level 2 variance is 8.708. It is worth noting that the level 2 variance may not be entirely attributable to estate-level factors, but rather to compositional effects, as we will see.

Parameter	Model 1	Model 2	Model 3
Education (Higher Secondary School vs. Lower Secondary School)		-1.888 *	-1.969 *
Education (Third Level vs. Lower Secondary School)		-3.977 *	-3.826 *
Financial Situation (difficult vs. managing)		-1.940 *	-1.900 *
Financial Situation (good vs. managing)		2.032 *	1.853 *
Support Network		0.704 *	0.664 *
Marital Status (Married vs. Single)		2.112 *	2.285 *
Marital Status (Cohabiting vs. Single)		1.395 *	1.647 *
Marital Status (Separated/Divorced /Widowed. vs. Single)		0.021	0.268
<b>Neighbourhood Level Effects:</b>			
Average Local Problem Score			1.935 *
Average Hope Score			0.258 *
<b>Variances:</b>			
Variance of level 1 residuals	44.856 *	23.358 *	21.674 *
Variance of level 2 slope (Hope)			0.016 *
Covariance between slope and intercept			-0.056
Variance of level 2 intercept residuals	8.708 *	3.814 *	1.798 *
<b>Model assessment:</b>			
Deviance statistic	3357.629	3015.874	2995.657
Degrees of freedom	3	15	19
N	499	499	499
% variance explained: level 1		47.9%	51.7%
% variance explained: level 2		56.2%	79.4%

\* Parameter estimates followed by an asterisk are statistically significant at the .05 level.

Another risk factor for life satisfaction is having difficulty coping financially. The life satisfaction of mothers who have difficulty coping financially is 1.9 points lower than those who describe their financial situation as ‘comfortable’ or ‘well off’. This influence is likely to have an objective dimension associated with the frustration of being unable to meet their needs, as well as a subjective dimension which assesses their situation as unacceptable. The final risk factor is being single, separated, divorced or widowed: the life satisfaction of these mothers is lower than those who are married (2.285 points higher) or cohabiting (1.647 points higher). Again, the influence of being single, separated or widowed on life satisfaction is likely to have an objective dimension (possibly associated with the difficulties of parenting alone) and a subjective dimension (possibly associated with unfulfilled expectations about a partner).

Turning to the individual protective factors, we see in Table 4.2 that life satisfaction is enhanced by hope, positive affect, and a strong support network. Hope is a strong protective factor and an increase of one unit in hopefulness is associated with an average increase of 0.196 units in life satisfaction. The relationship between hope and life satisfaction seems intuitively persuasive, given that hopeful people believe they have the will and the way to achieve what they want in life. Positive affect is also a protective factor – as indicated by more frequent experiences of positive feelings such as being enthusiastic, excited, interested, alert, attentive, active, etc. – with an unstandardised coefficient of 0.186. This factor is likely to enhance life satisfaction by creating a positive emotional appraisal and appreciation of one’s life. Finally, the strength of one’s support network is also a protective factor and a unit increase in support is associated with an increase of 0.664 units of life satisfaction.

In terms of estate-level effects, the results in Table 4.2 indicate that just over half (56.2%) of the level 2 variance is attributable to ‘compositional factors’, because some estates have higher concentrations of risk factors than others<sup>90</sup>. By contrast, almost one quarter of the variance (23.2%) is attributable to ‘contextual factors’ across the different estates<sup>91</sup>. Given that estate-level effects account for 16% of the variance in life satisfaction scores, this implies that contextual or neighbourhood factors explain 3.8%

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90. The compositional effect is estimated by subtracting the level 2 variance in Model 2 (3.814) from the level 2 variance in Model 1 (8.708) and expressing this as a percentage of the latter.

91. The contextual effect is estimated by subtracting the level 2 variance in Model 3 (1.798) from the level 2 variance in Model 2 (3.814) and expressing it as a percentage of the level 2 variance explained in Model 1.

of the total variance in life satisfaction scores. Although this is significant in itself, it is worth recalling once again the relatively homogeneous character of the neighbourhoods studied, which has the effect of reducing the variance between estates and decreasing the estimated influence of contextual factors.

At the estate level, two key factors influence life satisfaction. The first is the local problem score, which rates a range of local problems – litter, rubbish, graffiti, noise, safety, etc – on a five-point scale from a ‘very big problem’ to ‘not a problem’. The results in Table 4.2 indicate that a unit increase in the average local problem score is associated with a decrease of 1.935 units in life satisfaction. This implies that the overall quality of the physical environment in the different estates has a direct effect on the life satisfaction of residents and is compelling evidence of the existence of a significant neighbourhood effect. The second estate-level factor is the average hope score. We have already seen that life satisfaction is heavily influenced by individual-level hope scores (0.196), but this result shows that the hope also has a strong spill-over or contagious effect at the estate-level (0.258). Further inspection of Table 4.2 also reveals that hope has a strong influence on life satisfaction in some estates and a much weaker influence in others. The identification of a significant neighbourhood effect on life satisfaction is an important result, particularly in light of the difficulties experienced by previous studies in finding these neighbourhood effects in Ireland<sup>92</sup>, the US<sup>93</sup>, the UK<sup>94</sup>, and Canada<sup>95</sup>, to name a few.

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92. According to one study, “there is precious little evidence to suggest that the distinctive nature of the environment in which public sector tenants live has any independent influence on their risk of unemployment, poverty or psychological disadvantage” (Nolan and Whelan, 1999:117). However this study is restricted by the fact that the measurement of neighbourhood effects was based on comparing urban and rural locations rather than more micro-level neighbourhoods. A more qualitative study of seven local authority estates found that “the built environment is not the sole, nor even the primary determinant of the quality of life of residents or the of the success of estates” (Fahey, 1999:122).

93. The Movement to Opportunity (MTO) project, which began in five US cities in 1992 (Baltimore, Boston, Chicago, Los Angeles and New York) provides a unique experimental test of neighbourhood effects since it involved assisting low income families to move from poor to more affluent neighbourhoods. Initial studies found that, although there were no improvements in income and other labour market indicators for families as a result of MTO, there were indications that children’s behaviour, health and educational attainment were improving after two years (Goering and Feins, 2003). A follow-up study, 4-7 years after the move, assessed a range of outcomes for 15-25 year olds by comparing three groups: (i) those helped to moved to an affluent neighbourhood (ii) those helped to move to a neighbourhood of their choice and (iii) the control group not helped to move (Kling, Ludwig and Katz, 2005). This study diminished the tentative optimism of earlier studies about MTO by finding no improvement between the groups in terms of educational achievement, health, welfare dependency, or behaviour. However, further analysis found that girls tended to improve but boys tended to disimprove, particularly in terms of property crimes in the more affluent neighbourhoods.

94. A cohort study, based on the British Household Panel Survey, tracked individuals over 10 years and found ‘no evidence of a negative relationship between neighbourhood disadvantage and subsequent income growth; indeed, some evidence of a positive relationship’ (Bolster, Burgess, Johnston, Jones, Popper, and Sarker, 2007; see also Cheshire, 2007).

95. A cohort study tracked children over a period of 15 years who had been randomly allocated to substantially different public housing projects in Toronto (Oreopoulos, 2003). This study found that ‘neighbourhood quality played little role in determining a youth’s adult earnings, educational attainment, or welfare participation but does affect exposure to crime’, leading to the conclusion that ‘policies aimed at improving outcomes among children from low-income backgrounds are more likely to benefit by addressing cases of household distress and family circumstances than by improving residential environment conditions’.



It is clear from our results that life satisfaction is the outcome of a diversity of influences and any interventions to improve life satisfaction must take this into account. As a result, no one intervention is likely to make a decisive impact on its own. Our analysis suggests three broad domains where interventions may be helpful in promoting life satisfaction. The first domain involves strengthening the psychological well-being of mothers by promoting hopefulness and positive affect while also reducing the symptoms of depression. The second domain involves strengthening support networks, particularly for mothers who are single, separated or widowed. The third domain involves addressing local problems in the different estates. All three domains could have an estate-level focus involving group work and community work, similar to Respond!'s community development strategy<sup>96</sup>, possibly supplemented by individual interventions where, for example, the symptoms of depression are particularly severe.

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96. Respond! 2007a: 3; see also 2007b.

## Explaining the Well-Being of Mothers:

### Life Satisfaction

- **Individual-Level Risk Factors**
  - Difficulty coping financially
  - Single
  - Higher levels of education
- **Individual-Level Protective Factors**
  - Hope
  - Positive emotions
  - Support network
  - Married or cohabiting
- **Estate-Level Factors**
  - Local problem score (eg litter, rubbish, graffiti, noise, etc)
  - Average hope score of residents on estate

#### 4.4 Factors Associated with Parenting

The results of our multi-level analysis of parenting, as measured by the Parent-Child Relationship Inventory (PCRI), are summarised in Table 4.3. This shows that nearly nine tenths (86%) of the variance in parenting scores is attributable to individuals (level 1), with just over a tenth (14%) attributable to estates (level 2)<sup>97</sup>. The final model (Model 3) explains 33.9% of the variance between individual respondents and 77.5% of the variance between estates, a satisfactory result, particularly for the estate-level component of the model.

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97. Estimated from the data in Model 1 where level 1 variance is 44.715 and level 2 variance is 7.407. It is worth noting that the level 2 variance may not be entirely attributable to estate-level factors, but rather to compositional effects, as we will see.

**Table 4.3: Multi-Level Model of Parenting Among Mothers in Respond! Estates**

Parameter	Model 1	Model 2	Model 3
<b>Individual Level Effects:</b>			
Intercept	49.888 *	49.160 *	49.135 *
SDQ Children’s Difficulties		-0.366 *	-0.410 *
Positive Affect		0.227 *	0.186 *
Life Satisfaction		0.110 *	0.117 *
Positive Emotions		0.099 *	0.089 *
Number of Persons in Household		-0.478 *	-0.412 *
Child has Disability or Chronic Illness		1.596 *	1.872 *
Age of Child		-0.212 *	-0.187 *
<b>Neighbourhood Level Effects:</b>			
Average Local Problem Score			1.901 *
<b>Variances:</b>			
Variance of level 1 residuals	44.715 *	31.589 *	29.538 *
Variance of level 2 slope (SDQ)			0.015
Covariance – slope (SDQ) and intercept			0.140
Variance of level 2 slope (Life Sat.)			0.024
Covariance – slope (Life Sat.) and intercept			0.069
Covariance – slopes (SDQ and Life Sat.)			-0.024
Variance of level 2 intercept residuals	7.407 *	3.167 *	1.670
<b>Model assessment:</b>			
Deviance statistic	3353.257	3169.041	3142.756
Degrees of freedom	3	10	16
N	499	499	499
% variance explained: level 1		29.35%	33.9%
% variance explained: level 2		57.24%	77.5%

\* Parameter estimates followed by an asterisk are statistically significant at the .05 level.

As in previous sections, we report the findings in terms of the risk and protective factors associated with parenting, bearing in mind that all data are based on the perceptions of the mother. We see that the main risk factors, which have a negative influence on the parent-child relationship include having a child with difficulties (as measured by the SDQ), the number of persons in the household and the age of the child. The main protective factors, which have a positive influence on the parent-child relationship, are positive affect and positive emotions, life satisfaction and whether the child has a disability.

Beginning with the risk factors, it is significant that all of these pertain to characteristics of the child, assuming that the number of persons in the households is a proxy for the number of children in the household. The largest risk factor is whether the child has difficulties, as defined by the SDQ, and these typically involve behaviour and emotional problems as well as hyperactivity. After controlling for the other variables in the model, an increase in the SDQ of one unit is associated with an average decrease of 0.410 in PCRI scores. We have already seen that the child's SDQ scores tend to increase the mother's depression symptoms (0.339) while in Chapter Six below, we will see that the child's SDQ scores are also influenced by the mother's depression symptoms (0.143) and her PCRI scores (0.258). This highlights the systemic nature of the parent-child relationship and the negative reinforcing cycle created by these risk factors. Our analysis also reveals that the number of persons in the household (implicitly the number of children) is also associated with lower PCRI scores (-0.412), possibly because difficulties in the parent-child relationship are rarely confined to one child only. In addition, as children grow older, there is a corresponding reduction of 0.187 in the mother's PCRI scores with each additional year of age. This finding suggests the possibility that difficulties in the parent-child relationship, if not addressed, will tend to increase over time.

Turning to the protective factors, we see in Table 4.3 that positive affect and positive emotions are associated with increased PCRI scores. Positive affect which, as we have seen, refers to the frequency of experiencing positive feelings - such as being enthusiastic, excited, interested, alert, attentive, active, etc - increases PCRI scores by 0.186. Similarly, positive emotions – as indicated by the frequency of experiencing affection, joy, love, happiness, caring, contentment, fondness and pride – has the effect of

increasing PCRI scores by 0.089 units for each unit increase. These two variables – positive affect and positive emotions – cover broadly similar domains, although the question on positive emotions was asked in the context of the mother’s relationship with a partner. Their significance is that a positive emotional outlook on life has a positive spill-over effect on the mother’s relationship with the child.

Life satisfaction is also a protective factor and increases PCRI scores by 0.117, illustrating once again how a positive emotional and cognitive appraisal of one’s life has a spill-over effect on the mother’s relationship with the child. Interestingly, the mother’s relationship with the child is significantly better if the child has a disability or illness (1.872), possibly because the child’s greater vulnerability in these circumstances has the effect of intensifying the mother’s bond with the child.

In terms of estate-level effects, the results in Table 4.3 indicate that just over half (57.2%) of the explained variance is attributable to ‘compositional factors’<sup>98</sup>. This is because of the uneven distribution of risk factors and protective factors between estates. One fifth of the variance (20.2%) is attributable to ‘contextual factors’ across the different estates<sup>99</sup>; given that estate-level effects account for 14% of the variance in parenting scores, this implies that contextual or neighbourhood factors explain 2.9% of the total variance in parenting scores. As before, it is worth recalling that the neighbourhoods analysed in this study are relatively homogeneous, which has the effect of reducing the variance between estates and decreasing the estimated influence of contextual factors.

At the estate level, the extent of problems in the local area – which also had a significant influence on the life satisfaction of mothers in the previous section – is an important predictor of PCRI, with an unstandardised coefficient of 1.901. In addition to this specific neighbourhood effect, it is also noteworthy

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98. The compositional effect is estimated by subtracting the level 2 variance in Model 2 (3.167) from the level 2 variance in Model 1 (7.407) and expressing this as a percentage of the latter.

99. The contextual effect is estimated by subtracting the level 2 variance in Model 3 (1.670) from the level 2 variance in Model 2 (3.167) and expressing it as a percentage of the level 2 variance explained in Model 1.

that some individual-level variables – notably SDQ difficulties and life satisfaction – have different effects on PCRI scores depending on the particular estate. For example, in certain estates, when children have SDQ difficulties, this has a much more negative impact on the parenting relationship than in other estates. This in turn suggests that certain estates are more effective at supporting or ‘buffering’ the parent-child relationship where children have difficulties while others are more likely to reinforce or exacerbate this vulnerability. Similarly, in some estates, life satisfaction tends to give a significant boost to the parenting relationship while in others it is associated with stable PCRI scores. These contextual effects illustrate that the parent-child relationship, although an apparently private matter within the family, is nevertheless permeable to the outside influence of the neighbourhood characteristics. These results are consistent with the results of other studies which have endeavoured to estimate the influence of individual and neighbourhood characteristics on the well-being of children<sup>100</sup>.

The implications of these results from a service perspective suggest that interventions in three broad domains may be helpful in supporting the parent-child relationship within Respond! estates. The first domain involves strengthening the psychological well-being of mothers by promoting a positive emotional and cognitive outlook on life which will have a direct spill over effect on parenting. The second domain involves both direct work with children who have particular difficulties as well as offering parenting support to mothers in these circumstances, particularly those with larger numbers of children and preferably whilst children are at a younger age (in order to sustain this relationship and prevent the deterioration we observe amongst older children). The third domain involves addressing local problems in the different estates and encouraging flexible forms of reciprocal support and assistance that can render the parent-child relationship more robust to external influences. These three domains are not dissimilar to those identified for the purpose of promoting life satisfaction and could involve a range of interventions

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100. A number of studies have specifically examined how neighbourhoods affect the well-being of children. One review of these studies concluded: ‘In summary, although several studies have found evidence of “neighbourhood effects” across a number of development outcomes in both children and adolescents, these effects appear to be modest after taking into account “family effects”’ (Parke and Buriel, 1998: 493). Another US review, also focusing specifically on how neighbourhoods affect children, synthesised the results by observing that “evidence on the impacts of neighbourhood conditions on children’s development is complex and continues to raise more questions than answers. For children residing outside the nation’s inner cities, neighbourhood conditions appear to be far less consequential for children’s development than conditions within the family. Population-based studies are consistent in showing much more variation in achievement, behaviour, and parenting within than across neighbourhoods” (Shonkoff and Phillips, 2000: 336).

comprising individual work, family work and group work. As with other interventions identified in this chapter, we recognise that further work is necessary in terms of identifying the most appropriate programmes to meet the needs identified as well as finding the most appropriate agency to deliver that programme.

### **Explaining the Well-Being of Mothers:**

#### **Parenting**

- **Individual-Level Risk Factors**
  - Having a child whose behaviour or emotions cause difficulties
  - Number of children
  - Older children
  
- **Individual-Level Protective Factors**
  - Positive emotions
  - Life satisfaction
  - Child has a disability or chronic illness
  
- **Estate-Level Factors**
  - Local problem score (e.g., litter, rubbish, graffiti, noise).

#### **4.5 Summary and Conclusion**

In this chapter we analysed the factors which influence three aspects of well-being among mothers in Respond! estates: depression, life satisfaction, and parenting. We used multi-level modelling to test the level of association between these three dimensions of well-being (the dependent variables) and a range of individual, family, socio-economic and neighbourhood characteristics (the independent variables). Levels of association are expressed in terms of regression coefficients which express the net influence of a given variable on the dependent variable, holding all other variables constant.

Beginning with depression, we found that depressive symptoms among mothers in Respond! estates were predominantly associated with the individual characteristics of mothers. These individual characteristics can be divided into risk factors (those which increase the likelihood of depressive symptoms) and protective symptoms (those which decrease the likelihood of depressive symptoms). Our analysis found

that the main risk factors for depressive symptoms are negative affect, having a child with difficulties and having a disability; while the main protective factors are life satisfaction and hope. In terms of estate-level effects, we found that more than half (59%) of the estate-level variance was attributable to ‘compositional factors’. More than one quarter of the estate-level variance (27%) is attributable to ‘contextual factors’ across the different estates, notably the size of the estate and the concentration of mothers with a primary education only, both of which increase the susceptibility to depressive symptoms in a statistically significant way. These results are consistent with findings from some other studies which have endeavoured to estimate the influence of individual and neighbourhood characteristics on mental health.

Turning to life satisfaction, our multi-level analysis revealed that 84% of the variance in life satisfaction scores is attributable to individuals, the remaining 16% relating to estates. At the individual level, the main risk factors which threaten to reduce life satisfaction are depression, being more educated, having difficulty coping financially, and being single. The protective factors are hope, positive affect, a strong support network, and being married or cohabiting. In terms of estate-level effects, we found that more than half (56%) of the variance is attributable to ‘compositional factors’. Just less than one quarter of the estate-level variance (23%) is attributable to ‘contextual factors’ across the different estates, and these comprise the average local problem score (such as the extent of litter, rubbish, graffiti, noise, lack of safety, etc) and the average hope score of residents in the estate. The substantial influence of these contextual factors on life satisfaction is a significant result given the difficulties experienced by previous studies in identifying these neighbourhood effects.

The third dimension of well-being which we examined was parenting, as measured by the Parent-Child Relationship Inventory (PCRI). We found that nearly nine tenths (86%) of the variance in parenting scores was attributable to the individual level, with just over a tenth (14%) attributable to estates. The main individual risk factors to the parent-child relationship are: the child has difficulties, the number of children in the household, and the age of the child. The main protective factors are: positive affect and positive emotions, life satisfaction, and whether the child has a disability. In terms of estate-level effects,



we found that once again more than half (57.2%) of the variance is attributable to ‘compositional factors’, associated with the uneven distribution of risk factors and protective factors between the different estates. One fifth of the estate-level variance (20%) is attributable to ‘contextual factors’, the main one being the extent of problems in the local area, which has a negative impact on the parent-child relationship. The finding that parenting is influenced by neighbourhood factors is significant and consistent with the results of other studies which have endeavoured to estimate the influence of individual and neighbourhood characteristics on the well-being of children.

In considering the practical and service implications of these results, it is important to remember that although our analysis estimated the separate contribution of each factor to three dimensions of well-being, we are not in a position to infer strict causality, not least because our data are cross-sectional rather than longitudinal. In view of this, it is more appropriate in certain cases to treat the factors associated with well-being as operating bi-directionally rather uni-directionally. Recognising the systemic nature of well-being also suggests the desirability of intervening across as many of the relevant domains as possible in order to mitigate the risk factors and strengthen the protective factors.

In the case of depressive symptoms, our analysis highlights the strong influence exercised by negative affect which, although moulded through habits and circumstances, is recognised to be an enduring personality trait and is not easily amenable to change. However, this knowledge can itself be of considerable benefit to people with depressive symptoms by virtue of acknowledging that this personality trait is a natural tendency, which is not ‘wrong’ or a ‘mistake’, and can assist the person in learning to live with this trait while recognising its dangers and limitations. Interventions which promote this form of self-knowledge could have the effect of relieving symptoms of depression by helping the person find constructive ways of living with their natural tendencies. At the same time, we have also seen that depressive symptoms are the practical outcome of challenges associated with having a disability or a child with behaviour and emotional difficulties. Clearly, interventions to support mothers and children in these circumstances would, other things being equal, alleviate the symptoms of depression. Turning to the protective factors, it is clear that measures which strengthen life satisfaction and hopefulness will help to alleviate depression.

These two domains have a strong cognitive dimension which essentially entails a perspective on life that is positive, appreciative, and problem-solving. There is growing evidence in positive psychology that this perspective can be cultivated by practices which help people to think and feel differently about their lives and its past, present and future.

Turning to life satisfaction, our analysis suggests three broad domains where interventions may be helpful. The first domain involves strengthening the psychological well-being of mothers by promoting hopefulness and positive affect while also reducing the symptoms of depression. The second domain involves strengthening support networks, particularly for mothers who are single, separated or widowed. The third domain involves addressing local problems in the different estates. All three domains could have an estate-level focus involving group work and community work, possibly supplemented by individual interventions where, for example, the symptoms of depression are particularly severe.

Interventions that may be helpful in supporting the parent-child relationship within Respond! estates also fall within three broad domains. The first domain involves strengthening the psychological well-being of mothers by promoting a positive emotional and cognitive outlook on life which, in light of our analysis, will have a direct spill-over effect on parenting. The second domain involves both direct work with children who have particular difficulties as well as offering parenting support to mothers in these circumstances, particularly those with larger numbers of children and preferably whilst children are at a younger age. The third domain involves addressing local problems in the different estates and encouraging flexible forms of reciprocal support and assistance that can render the parent-child relationship more robust to external influences.

All of the interventions suggested by our analysis could be carried out through individual work, family work, group work, community work - or combinations of them - depending on the severity of the condition, the resources available, and other circumstances. In deciding on the method of intervention, it would be appropriate to take into account the fact that each dimension of well-being is not solely an individual phenomenon but is also influenced by estate-level characteristics which are both 'compositional', in the

sense that risks and protective factors are not evenly distributed across estates, and ‘contextual’ in the sense that estate-level problems diminish the experience of well-being. This finding suggests that a range of intervention methods might be appropriate, depending on these estate-level characteristics, although equity and efficiency should also be considered as additional grounds in assessing the most appropriate forms of intervention within an estate.

In drawing out the broad implications of our analysis for interventions to promote well-being, we acknowledge that further reflection is required in order to identify specific programmes which have proven effectiveness in the different domains. In addition, the question of which agency or agencies might be involved in delivering these programmes is a separate but equally challenging issue that would need to be addressed.

Finally, it is worth noting that the range of interventions suggested by our analysis, are compatible with the broader strategies of Respond! to promote community development and support families on its estates: “Respond!’s goal is to provide housing and assist in the building of stable communities for those on low incomes or otherwise in need of housing. We seek to ensure that such communities will foster the growth of the individual resident and that of the whole community. We aim to assist our communities to grow to the stage where sufficient local community leadership exists to enable residents to access the services of and participate fully in the structures of wider society. To that end, we invest in personal and community development activity and family supports in order to build the capacity of residents for such a role. The family should be and is at the centre of the opportunity for a holistic approach in the development of both communities and the individuals within those communities”<sup>101</sup>.

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101. Respond! 2007a:3; see also 2007b.

## Well-Being of Mothers

- In terms of emotions, mothers are more positive and less negative than Irish mothers.
- Scores for life satisfaction are in the average range.
- The proportion with depressive symptoms (22-30%) is higher than would be expected in the population.
- Most are hopeful but 22% seem to lack hope, particularly in terms of having the will to solve whatever life difficulties may arise.

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- Most rate their health as good or excellent but 14% rate it as fair or poor, more than twice as high as in Ireland (6%)
- Nearly a quarter (24%) have a disability compared to 10% of women in Ireland.
- Disability is one of the criteria for eligibility for social housing.
- Smoking rates (62%) are twice the national average (33%).
- Taking alcohol (70%) in the past month is the same as the national average.
- Taking sedatives (10%) is twice the national average.

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- Support networks are stronger than average.
- The parent-child relationship is better than average.
- Relationship skills are stronger for those living with a partner than those without.

## Chapter Five

### The Well-Being of Children

#### 5.1 Introduction

This chapter measures the needs of children in Respond! across a range of domains including mental health, disability, reading ability, and school attendance. It is based on a sample of 499 children, comprising slightly more boys (54%) than girls (46%). The largest group of children (50%) are aged seven to twelve, with the remainder divided almost equally between those aged four to six (26%), and thirteen to seventeen (24%). We analyse the results by age and sex, by Medical Card and whether the household has one or two parents. The full set of results is in the Appendix <sup>102</sup> to Chapter Five.

#### 5.2 Strengths and Difficulties

We used the Strengths and Difficulties Questionnaire (SDQ)<sup>103</sup> to assess the mental health needs of children, based on the perceptions of mothers. These perceptions were then classified according to whether the child has ‘no difficulties’, ‘some difficulties’, or ‘serious difficulties’<sup>104</sup>. The use of the SDQ to measure the prevalence of children in need within a community requires that account be taken of the narrow definition of need (based on those with serious difficulties only) and the broad definition of need (based on those with some and serious difficulties combined)<sup>105</sup>. We present data on both definitions to allow the results to be used as flexibly as possible, according to the context.

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102. Appendix available upon request from the R&D Department in Respond!.

103. 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), the parent (for children aged 3+), and the teacher (for children aged 3+). Available at [www.sdqinfo.com](http://www.sdqinfo.com)

104. The terms ‘no difficulties’, ‘some difficulties’, and ‘serious difficulties’ are synonyms for the internationally agreed mental health categories of ‘normal’, ‘borderline’, and ‘abnormal’ respectively which are used for identifying children whose mental health needs meet DSM-IV diagnostic status, sometimes referred to as ‘child psychiatric caseness’; DSM-IV refers to Diagnostic and Statistical Manual of Mental Disorders which sets out the diagnostic criteria developed by the American Psychiatric Association (1994).

105. 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” (Goodman, 1997:585). Given that Respond! qualifies as a low risk population, it follows that a narrower definition of need, comprising serious difficulties only, is the more appropriate definition of need for this study. However, for certain sub-populations within Respond! – such as those with a Medical Card or those in one-parent households – it may be more appropriate to use the broader definition of need, comprising both ‘some’ and ‘serious’ difficulties.

The survey reveals that 14% of children have serious difficulties and a further 9% have some difficulties. The main difficulties involve conduct, hyperactivity and emotional problems. Boys present with slightly more difficulties than girls; similarly, boys are more likely to present hyperactivity and conduct problems while girls are more likely to present emotional problems. Those aged 7-12 present the most difficulties. As a result, older boys are the most vulnerable group with 17% having serious difficulties. The proportion of children with serious difficulties is higher in one-parent households (16%) compared to two-parent households (10%) but there is no significant difference between those with, and without, a Medical Card. Extrapolating these results to the total number of children aged 0-18 in Respond!, we estimate that there are 620 children with serious difficulties and a further 420 with some difficulties; taken together, this suggests that nearly a quarter of children (23%, 1,040) have some level of special need.

The scale of need among children in Respond! – when broadly defined to include ‘some’ and ‘serious’ difficulties - is slightly higher than the results of other studies in Ireland. Most other studies in Ireland have measured the needs of children using the Rutter Scale<sup>106</sup> – which has a high correlation with the SDQ<sup>107</sup> – and these show that about 20% of children living in disadvantaged families and communities show evidence of difficulties which mainly finds expression in behavioural problems<sup>108</sup>. A large study in the UK, based on a representative sample of 10,000 children, found that 10% 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 children<sup>109</sup>.

Given that this study aims to contribute to the development of services for children, it is important not just to assess the prevalence of need but also the depth of need relative to the experience of the ‘average’ child. By depth of need we refer to the journey which a child with some or serious difficulties must travel

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106. 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).

107. Goodman, 1997.

108. 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.

109. Meltzer, Gatward, Goodman, and Ford, 2000.

in order to come within the range of the ‘average’ child. This information is important since it throws light on the type and scale of interventions which may be needed to help and support these children. We do this by comparing the mean scores of children in Respond! with the mean scores of a nationally representative sample of over 10,000 children in Britain<sup>110</sup>, 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<sup>111</sup>: 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 with serious difficulties have an effect size of 2.0 while those with some difficulties have an effect size of 0.9. This indicates a significant scale of need, particularly among those with serious difficulties. 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 improvements with effect sizes in the range of 0.5 to 0.8 and many, such as the High/Scope Perry Pre-School Programme have achieved much lower effect sizes of 0.36<sup>112</sup>. In other words, the scale and depth of need among children with some or serious difficulties is considerable and poses a challenge in terms of finding appropriate interventions as well as setting targets that would be realistic and achievable.

### **5.3 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 83% of mothers rate their children’s health as excellent or very good, similar to the results of other studies<sup>113</sup>. Girls are rated to have slightly poorer health than boys. There are no significant differences between households with a Medical Card or between one and two-parent households.

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110. See Meltzer, Gatward, Goodman, and Ford, 2000; see also [www.sdqinfo.com](http://www.sdqinfo.com)

111. 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.

112. 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).

113. McKeown and Haase, 2007.

## **5.4 Disability**

Mothers assessed whether their child had any form of disability, using a question from the 2006 Census of Population. The survey shows that 25% of children are perceived to have at least one of the disabilities mentioned. This is higher than the prevalence of disabilities (18%) estimated by the National Council for Special Education in 2006 from a range of sources<sup>114</sup>. It is much higher than the rate (5%) estimated in the 2006 Census of Population which is generally regarded as an underestimate. The fact that having a disability is one of the criteria used by Respond! in allocating housing may contribute to the relatively high rates of disability found on its estates. There is a considerably higher prevalence of disabilities among teenage children (33%), in households with a Medical Card (27%), and in households with a lone parent (29%).

## **5.5 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 by a major national study of reading ability where 6,499 children were assessed using the Drumcondra Sentence Reading Test (DSRT) and where parents were also invited to rate their child's reading ability<sup>115</sup>. 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'<sup>116</sup>. The results show that overall reading ability among Respond! children is similar to Ireland. However, the proportion who are likely to have some reading difficulties – denoted by the response 'Not Great' – is higher in Respond! (9%) than in Ireland (6%). Reading difficulties are twice as high among boys (12%) as girls (6%) and are also higher in one-parent households (11%).

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114. McKeown, 2006: 72.

115. Eivers, Shiel and Shortt, 2004.

116. Eivers, Shiel and Shortt, 2004: 81.



## **5.6 Educational Resources and Expectations in the Home**

A substantial amount of research sustains 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 age<sup>117</sup>. Households in Respond! estates tend to have a broadly similar number of books compared to households in Ireland. However the practice of reading to children before primary school age is also more frequent in Respond! among all categories of household. There is less access to the internet in Respond! estates (37%) compared to Ireland (49%), especially in one-parent households (32%). Expectations of when the child will leave school are considerably higher in Respond! than in Ireland as a whole, with six out of ten mothers in Respond! (61%) expecting their child to go to college compared to less than half in Ireland (45%). Expectations tend to diminish with the age of the child and are higher for girls than boys. Households with a Medical Card have somewhat lower expectations as do households with only one parent.

## **5.7 Child's School Attendance**

The school attendance rate among children in Respond! estates, based on the responses of mothers, is slightly higher than among children in Ireland where the data are based on returns from schools rather than the responses of mothers. At primary school, the national school attendance rate is 94% compared to 95% in Respond! while at post-primary school, the national school attendance rate is 92% compared to 95% in Respond!. Similarly, the proportion of children who are absent from school for 20 days or more is considerably lower among children in Respond! compared to Ireland. Absentee rates among post-primary children are higher among boys and in households without a Medical Card, and with one parent. The main reason for being absent from school, according to mothers, is that the child was ill (86%) and this is broadly similar for boys and girls and for those with and without a Medical Card.

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117. Eivers, Shiel and Shortt, 2004: 173.

## Well-Being of Children

- We used the Strengths and Difficulties Questionnaire to measure the mental health of children. We found that most children (77%) have no difficulties but 14% have some difficulties and 9% have serious difficulties. This is slightly higher than most other studies in Ireland.
- Boys are slightly more likely to have difficulties than girls, and those aged 7-12 have the most difficulties (17%). There are differences in how boys and girls express difficulties.
- The depth of need is greatest for those with the most serious difficulties (an effect size of 2.0) and still large for those with some difficulties (an effect size of 0.9).
- 25% of children have at least one disability, higher than the national prevalence of 18%.
- Reading ability and school attendance is similar to other children in Ireland.
- Households have broadly similar educational resources in the home compared to households in Ireland, and mothers have similar educational expectations for their child. Rates tend to be lower for lone parents and those with a Medical Card.

### 5.8 Summary and Conclusion

In this chapter we have found that the prevalence of children with difficulties, as measured by the SDQ, is somewhat higher than in other population-based studies. We found that 14% of children have serious difficulties and a further 9% have some difficulties; this is equivalent to nearly a quarter of children (23%) who present with some difficulties. The main difficulties involve conduct and hyperactivity (particularly among boys) and emotional problems (particularly among girls). Boys present with slightly more difficulties than girls and those aged 7-12 present the most difficulties. The proportion of children with serious difficulties is higher in one-parent households (16%) compared to two-parent households (10%) but there is no significant difference between those with and without a Medical Card.

Extrapolating these results to the total number of children aged 0-18 in Respond!, we estimate that there are 620 children with serious difficulties and a further 420 with some difficulties; taken together, this is equivalent to nearly a quarter of children (23%, 1,040) who have some level of need.

The level of need among children in Respond! is higher than found in other studies in Ireland<sup>118</sup>, the

UK<sup>119</sup> and the US<sup>120</sup>. Further analysis of the depth of need revealed that substantial interventions will be needed to bring children who have some or serious difficulties to the level of well-being experienced by the ‘average’ child, 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 25% of children in Respond! are perceived by their mother to have at least one disability. This is higher than the prevalence of disabilities (18%) estimated by the National Council for Special Education in 2006<sup>121</sup>. There is a considerably higher prevalence of disabilities among teenage children (33%), in households with a Medical Card (27%), and in households with a lone parent (29%).

Children in Respond! have similar reading ability to children in Ireland but a relatively small proportion of children (9%) may have reading difficulties. The number of books in the home is similar to Ireland but access within the home to a computer and the internet is less than in Ireland. However children in Respond! are more likely to be read to before school going age compared to children in Ireland. School attendance rates seem to be slightly higher in Respond! than Ireland although a substantial proportion of post-primary pupils in Respond! (11%) are missing school for 20 days or more; this is equivalent to 490 children.

A significant finding to emerge from the study is that children in need, particularly those with needs in the area of mental health and disability, are more likely to be found in households with one parent. As such, this is a stronger and more consistent predictor of need than having a Medical Card. With this in mind, in the next chapter we undertake a further analysis of the factors which are most strongly associated with the needs of children in Respond!.

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118. 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.

119. Meltzer, Gatward, Goodman, and Ford, 2000.

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

121. McKeown, 2006: 72.

## Chapter Six

### Influences on the Well-Being of Children

#### 6.1 Introduction

In this chapter we estimate the factors which influence the well-being among children in Respond! estates. We focus specifically on the mental health of children since this is a key aspect of well-being, and the one for which we have reliable measurements, based on the Strengths and Difficulties Questionnaires (SDQ)<sup>122</sup>. As we have seen in the previous chapter, the SDQ allows the mental health of children to be classified according to whether the child has ‘no difficulties’, ‘some difficulties’, or serious difficulties’. In this chapter we estimate the risk and protective factors, at both individual and estate level, which influence the mental health of children. Our method of analysis, as described in Chapter One, involves multi-level modelling, which we use to test the level of association between the mental health of children (the dependent variable) and a range of individual, family, socio-economic and neighbourhood characteristics (the independent variables).

Levels of association are expressed in terms of regression coefficients which are unstandardised and presented in the original metric of the variables; they express the net influence of a given variable on the dependent variable, holding all other variables included in the model constant. Each table of results presented in Chapter four (Tables 4.1, 4.2 and 4.3) comprises three models. Model 1 shows the unexplained variance associated with individuals (level 1) and estates (level 2) when no explanatory factors are used; this model is referred to as the “null model”. Model 2 shows the influence of individual factors on depression scores, while Model 3 shows the influence of both individual and estate factors; this latter model is referred to as the “full multi-level model”. A detailed description of the analyses on which this chapter is based is in the Appendix<sup>123</sup> to Chapter Six.

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122. 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), the parent (for children aged 3+), and the teacher (for children aged 3+). Available at [www.sdqinfo.com](http://www.sdqinfo.com).

123. Appendix available upon request from the R&D Department in Respond!.

## **6.2 Factors Associated with Children's Mental Health**

The results of our multi-level analysis are summarised in Table 6.1. This shows that more than eight tenths (83%) of the variance in children's mental health – their SDQ scores – is attributable to individuals (level 1), with just under two tenths (17%) attributable to estates (level 2)<sup>124</sup>. The final model (Model 3) explains 33.7% of the variance between individual respondents and 68.3% of the variance between estates. These percentages are a little lower than those encountered in the analysis of parental well-being in Chapter Four, which is unsurprising given the absence of detailed information on the characteristics of the child, and the use of the mother as proxy in measuring the children's difficulties.

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124. Estimated from the data in Model 1 where level 1 variance is 33.318 and level 2 variance is 6.892.

**Table 6.1: Multi-Level Model of Childrens' Strengths & Difficulties (SDQ) in Respond! Estates**

Parameter	Model 1	Model 2	Model 3
<b>Individual Level Effects:</b>			
Intercept	9.489 *	10.034 *	9.583 *
Mother's Depression		0.153 *	0.143 *
Parent-Child Relationship Index		-0.256 *	-0.258 *
Child has Disability or Chronic Illness		2.686 *	2.650 *
Positive Emotions of Mother (R'ship)		-0.046 *	-0.045 *
Age of Mother		-0.080 *	-0.080 *
Mother Employed		-1.002 *	-1.045 *
Dictionary in Home		-1.052 *	-0.993 *
<b>Neighbourhood Level Effects:</b>			
Percentage with Critical Depression Score			0.041 *
Capacity Rating (Medium vs. Low)			0.313
Capacity Rating (High vs. Low)			2.235 *
<b>Variances:</b>			
Variance of level 1 residuals	33.318 *	22.065 *	22.080 *
Variance of level 2 intercept residuals	6.892 *	3.625 *	2.182 *
<b>Model assessment:</b>			
Deviance statistic	3211.810	3000.611	2990.049
Degrees of freedom	3	10	13
N	499	499	499
% variance explained: level 1		33.77%	33.7%
% variance explained: level 2		47.4%	68.3%

*\* Parameter estimates followed by an asterisk are statistically significant at the .05 level.*

Beginning with individual-level factors, we see that the risk factors for children's health are maternal depression, the parent-child relationship and whether the child has a disability or chronic illness. The protective factors are positive emotions, the age of the mother, whether the mother works, and whether there

is a dictionary in the home, which may be indicative of a cognitively stimulating home environment.

Maternal depression is a significant risk factor for the mental health of children in Respond! and an increase in the mother's depression score of one unit is associated with an average increase of 0.143 in their child's SDQ score. This is consistent with a wide range of international studies<sup>125</sup>. The parent-child relationship can also be seen as a risk factor for the child's mental health since weaker parenting scores are associated with an increase in the children's difficulties, reflected in a large unstandardised coefficient of 0.258. Children who are disabled or chronically ill are significantly more likely to be experienced by their mothers as having difficulties compared to other children, indicated by the unstandardised coefficient of 2.650.

Turning to the protective factors, we see in Table 6.1 that the mother's positive emotions act as a protective influence in relation to the mental health of their children. Positive emotions – as indicated by the frequency of experiencing affection, joy, love, happiness, caring, contentment, fondness and pride – are associated with a reduction in the child's SDQ scores of 0.045 units. We have already seen in Chapter Four that positive emotions improve the parent-child relationship. These findings mean that mothers who experience positive emotions have a direct effect on the child's well-being as well as an indirect effect through the parent-child relationship<sup>126</sup>.

The age of the mother can also be seen as a protective factor since the child's mental health improves directly with the age of the mother, reflected in the unstandardised coefficient of 0.080. There may be some confounding here with the age of the child, in cases where the child's mental health improves with age, but the association may also be due to the fact that, as mothers grow older, they become more

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125. One review of these studies suggested the following profile of children whose mothers are depressed: "Compared with children of nondepressed mothers, those with depressed mothers show greater risk of developing socio-emotional and behaviour problems, which translate into difficulties in school, poor peer relationships, reduced ability for self-control, and aggression. Children of depressed parents are also at heightened risk of serious psychopathology. For example, children of clinically depressed parents are several times more likely to develop major depression than children of parents without such symptoms" (Shonkoff and Phillips, 2000: 251-2).

126. Other research also highlights the beneficial effects of positive emotions on couple relationships. According to John Gottman, a leading researcher on couple relationships, "you must have at least five times as many positive as negative moments together if your marriage is to be stable" (Gottman, 1997:29).

insightful about themselves and how their behaviours and emotions impact on the child. Being employed is also a protective factor for mothers, since their children have fewer mental health difficulties (-1.045) compared to the children of non-working mothers. The benefits of working mothers for the well-being of their children may be mediated through higher family income, or through a greater sense of achievement and fulfilment, both of which have spill-over effects on the child. In view of the sometimes conflicting research evidence on the effects of both working mothers and the related issue of childcare<sup>127</sup>, this is an encouraging result for mothers in Respond! estates. The final protective factor is the presence of a dictionary in the home, which is associated with lower SDQ scores (-0.993). It seems likely that a dictionary may signal the presence of a more cognitively stimulating home environment for the child, possibly also associated with a positive parental attitude towards the child's education.

In terms of estates, the results shown in Table 6.1 indicate that just under half (47.4%) of the variance is attributable to 'compositional factors'<sup>128</sup>. This is because of the uneven distribution of risk and protective factors between estates. One fifth of the variance (20.9%) is attributable to 'contextual factors' across the different estates<sup>129</sup>; given that estate-level effects account for 17.1% of the variance in SDQ scores, this implies that contextual or neighbourhood factors explain 3.6% of the total variance in SDQ scores.

At the estate level, two variables also influence the mental health of children. The first is the percentage of mothers in the estate who have symptoms of depression. Each percentage increase in the aggregate estate-level depression (based on the cut-off score of 16 or over) increases SDQ scores by 0.041. This is a significant result because it suggests that the mental health of children is affected not just by

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127. One of the largest studies on this issue - The NICHD Study of Early Child Care - has been carried out in the US and involved tracking more than 1,000 children from birth through to the start of school. The results show that "good quality child care and exposure to center-based care predict somewhat advanced cognitive-linguistic functioning, but that lots of time spent in any kind of care (irrespective of its quality) and greater exposure to center-based care are related to elevated - but not clinical - levels of externalizing problem behaviour. Clearly, risks and benefits are associated with early child care, at least as routinely experienced in the USA. It is critically important to distinguish distinctive aspects of the child-care experience (i.e., quality, quantity, type) in order to understand its complex effect on child development" (Belsky, 2006).

128. The compositional effect is estimated by subtracting the level 2 variance in Model 2 (3.625) from the level 2 variance in Model 1 (6.892) and expressing this as a percentage of the latter.

129. The contextual effect is estimated by subtracting the level 2 variance in Model 3 (2.182) from the level 2 variance in Model 2 (3.625) and expressing this as a percentage of the level 2 variance in Model 1.



maternal depression within the home, as we have just seen, but also by maternal depression within the neighbourhood. This result underlines how the apparently individual experience of maternal depression has a significant contagion effect on children within families as well as communities. Maternal depression disrupts the normal patterns of parent-child interactions because “depressed mothers are more likely to either withdraw from their children and respond with little emotion or energy, or become intrusive and hostile towards them”<sup>130</sup>. This pattern may also characterise interactions between mothers and children within the broader community. This is a significant result, because it further underlines how the concentration of individual problems within particular estates generates its own neighbourhood-level effects over and above their individual-level effects.

The second estate-level influence on the mental health of children is its community capacity rating. This rating is based on data supplied by Respond! from which we classified the extent of involvement and participation in community activities on each estate into the categories of ‘low’, ‘medium’, and ‘high’. The results in Table 6.1 indicate that estates with a higher community capacity rating tend to have a higher proportion of children with mental health difficulties. For example, the SDQ scores of children in estates with high community capacity are 2.235 units higher – and therefore their mental health is worse – compared to children in estates with low community capacity. This somewhat counter-intuitive result is due to the fact that a number of estates with the highest level of need – based on a composite score reflecting levels of depression, life satisfaction, parenting, and child difficulties, as described in Chapter Seven – are also the estates with the highest community capacity rating.

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130. Shonkoff and Phillips, 2000: 253.

## Influences on Well-Being of Children:

### Mental Health Difficulties

- **Individual-Level Risk Factors**
  - Mother has symptoms of depression
  - Parent-child relationship
  - Child has a disability or chronic illness
  
- **Individual-Level Protective Factors**
  - Mother experiences positive emotions
  - Mother is younger
  - Mother in paid employment
  - Dictionary in the home
  
- **Estate-Level Factors**
  - Percent of mothers on estate who have symptoms of depression
  - Community capacity on the estate

### 6.3 Summary and Conclusion

In this chapter we estimated the factors which influence the mental health of children in Respond! estates, based on the Strengths and Difficulties Questionnaires (SDQ)<sup>131</sup>, and using multi-level modelling. The results shows that more than eight tenths (83%) of the variance in children's mental health – their SDQ scores - is attributable to individuals with just under two tenths (17%) attributable to estates. These individual characteristics can be divided into risk factors (those which increase the likelihood of children's difficulties) and protective factors (those which decrease the likelihood of children's difficulties). Our analysis found that the main risk factors for children's mental health are: maternal depression, the parent-child relationship, and whether the child has a disability or chronic illness. The protective factors are: positive emotions, the age of the mother, whether the mother is employed, and whether there is a dictionary in the home.

131. 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), the parent (for children aged 3+), and the teacher (for children aged 3+). Available at [www.sdqinfo.com](http://www.sdqinfo.com).

In terms of estate-level effects, we found that just under half (47.4%) of the explained variance is attributable to ‘compositional factors’, essentially because of the uneven distribution of risk and protective factors across estates. Roughly one fifth (21%) of variance is attributable to ‘contextual factors’ across the different estates, notably the percentage of mothers in the estate who have symptoms of depression and the community capacity of the estate.

These results highlight the fact that the well-being of children is influenced by the same broad domains as the well-being of mothers. For this reason, interventions which promote the psychological well-being of mothers – by reducing depression and increasing positive emotions – will have direct benefits for the mental health of children, both within their immediate families as well as within their estate. In this context, our analysis also suggests that encouraging and facilitating mothers to become involved in the world of work would have a beneficial effect on the well-being of their children, a significant finding given the exceptionally high level of welfare dependency among mothers in Respond! (55% compared to a national average of 22% for households with children aged 0-14). Interventions which improve the parent-child relationship would also improve the mental health of children and our analysis suggests that, in addition to direct supports for parents where children present with particular difficulties, it may also be advisable to work directly with the children who exhibit more severe behaviour or emotional problems. Children’s mental health also improves in home environments which are cognitively stimulating, as indicated by the presence of a dictionary, and this suggests the possibility of interventions which encourage parents to become more actively involved in their children’s learning and education; estate-level book clubs and homework clubs for both children and parents, for example, could be one way of promoting this as well as building opportunities for social engagement.

Our analysis identified a significant estate-level dimension to the mental health of children and this should be borne in mind in the design of interventions. A particularly encouraging finding is that estates with a high level of need are already those with relatively high community capacity and this should be built upon. Naturally, further work will be needed in order to translate these broad domains of intervention

into actual programmes and to identify the most appropriate agencies and personnel to deliver these programmes. Nevertheless, our analysis provides a solid evidence base from which to start the process of building a strategy for promoting the well-being of children, their parents, and their estates.

## Chapter Seven

### The Well-Being of Neighbourhoods

#### 7.1 Introduction

The analysis in previous chapters illustrates that the well-being of parents and children in Respond! estates is influenced by both individual-level and estate-level characteristics<sup>132</sup>. It is true that well-being is predominantly influenced by individual characteristics, but we have shown that estate-level characteristics also play a significant role in shaping the well-being of parents and their children. Given the homogeneous nature of the sample of estates utilised in this study, we cannot estimate how important these characteristics are for society as a whole, but we have shown that even within Respond! estates, estate-level differences in local problem scores and other attributes can explain 3-4 per cent of the total variation in the dependent variables. In light of this, we will use this chapter to assess the well-being of Respond! estates by focusing on a range of social capital indicators and by constructing a global index of need for the purpose of ranking each estate, based on the four key dimensions of well-being that we have analysed in previous chapters namely: depression, life satisfaction, parenting and children's mental health.

We know that neighbourhoods have objective characteristics such as size, age, and access to services which may influence their well-being. In this study, the average Respond! estate has 38 houses and has been in existence for about 8 years. All but two of the estates studied are adjacent to local authority housing, two out of every three have estate-based pre-school services and the average distance to all essential services was one kilometre. By these standards, therefore, Respond! estates could be described as relatively small, relatively new, and relatively accessible to essential services.

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132. On average, the variance in well-being scores which is attributable to individual-level characteristics is in the region of 80-90%, while the variance attributable to estate-level characteristics is in the region of 10-20%. When compositional effects are taken into account at estate-level, the size of the contextual or neighbourhood effect is in the 3-5% range. In the area of education, where multi-level effects have been studied most extensively, school-level effects tend to account for 8-10% of the variance in individual educational outcomes (Mortimore, 1997). However, as we have seen, studies based on residential neighbourhoods seem to have been less successful at identifying contextual effects over and above individual-level effects (see, for example, Oreopoulos, 2003; Kling, Ludwig and Katz, 2005; Bolster, Burgess, Johnston, Jones, Popper, and Sarker, 2007; Cheshire, 2007).

In addition to these objective characteristics, the well-being of neighbourhoods is also denoted by its ‘social capital’ and a growing body of research has endeavoured to measure this dimension in Ireland<sup>133</sup> and elsewhere<sup>134</sup>. Informed by this research<sup>135</sup>, we used a range of indicators to measure the social capital of neighbourhoods, including the perceived prevalence of local problems, the perceived quality of local services, the extent of trust and reciprocity between neighbours, and the level of involvement in community or voluntary organisations. In addition, as already indicated, we can rank the different estates based on a global index of need. The full results are in the Appendix<sup>136</sup> to Chapter Seven.

## **7.2 Perceptions of Local Problems**

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 the vast majority of mothers (78%) do not have significant local problems on their estate. Conversely, just over a fifth (22%) rate aspects of their neighbourhood as a very big problem or a fairly big problem. The prevalence of local problems on Respond! estates is significantly lower compared to some local authority estates, as indicated by a recent survey in Limerick<sup>137</sup>. The two biggest neighbourhood problems in Respond! estates, as rated by over a third of mothers, are: litter and rubbish (38%) and roaming dogs (36%). No significant variation was found between those with and without a Medical Card or between one- and two-parent households.

## **7.3 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, just under two thirds of mothers (63%) are broadly satisfied with wider local services. Conversely, more than a third (37%) regard all local services as, on

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133. See, for example, Balanda and Wilde, 2003; National Economic and Social Forum 2003; Taskforce on Active Citizenship, 2007.

134. See, for example, Coulthard, Walker and Morgan, 2002.

135. A review of this research, as it pertains to Ireland, was recently completed by the Task Force on Active Citizenship (2007:18), drawing on an earlier report by the National Economic and Social Forum (2003:61), and concluded that: “Ireland is about average or above average for European countries on most indicators of social capital – for example, membership of voluntary or community associations, volunteering, interpersonal trust, trust in various institutions and voter / political engagement. Informal social contact is likely to be higher in Ireland – although the evidence is very limited. ... Within Europe, there are large differences between Southern and Northern Europe with much higher levels of trust in Scandinavia. Ireland and the United Kingdom show medium levels in many comparisons”.

136. Appendix available upon request from the R&D Department in Respond!.

137. McKeown and Haase, 2007; see also Fitzgerald, 2007: 6.

average, 'very poor' or 'poor'. However there is significant variation between services. Schools are given the highest rating of all services. The worst services, defined by the percentage of people rating them as 'very poor' or 'poor', are leisure facilities for teenagers (73%) and children (65%) as well as playgrounds (71%). As with local problems, there is no significant variation between those with and without a Medical Card or between one- and two-parent households.

#### **7.4 Trust**

Trust was measured, as in other studies<sup>138</sup>, by asking 'how many people do you trust in your neighbourhood?'. The response options are: 'most', 'many', 'a few', and 'none'. The results show that seven out of ten mothers in Respond! (72%) do not trust many or most of their neighbours. Conversely, nearly four out of ten (28%) trust most or many of their neighbours. This represents a significantly lower level of trust than reported in a previous study, based on a random sample of 1,000 adults in Ireland, which found that 51% trusted most of their neighbours<sup>139</sup>. It is lower than the level of trust reported in a UK study, based on over 8,000 households, which found that 58% trusted most of their neighbours<sup>140</sup>. The Irish study found that trust was most strongly and directly associated with length of residence in the area and with the age of respondent; in other words, older people tend to be more trusting than younger people and those living in an area for a long time tend to be more trusting than those living there for a short time. The British study also found that age had the strongest association with trust but also found that "people in the more disadvantaged groups ... were also less likely to trust their neighbours or have a reciprocal relationship with them"<sup>141</sup>. These findings suggest that the relatively low level of trust in Respond! estates may be due to the relatively young age of respondents (35.1 years on average), the newness of the estates (8.3 years on average), and the disadvantaged status of most residents.

#### **7.5 Reciprocity**

Reciprocity was measured by asking if mothers had done or received a favour from a neighbour in the

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138. Coulthard, Walker and Morgan, 2002; Balanda and Wilde, 2003.

139. Balanda and Wilde, 2003: 132.

140. Coulthard, Walker and Morgan, 2002: 33.

141. Coulthard, Walker and Morgan, 2002: 31.

past six months, and whether they believe that neighbours look out for each other. This is similar to the questions used in other studies<sup>142</sup>. The results show a relatively high level of reciprocity between neighbours in Respond! estates with around three quarters engaged in giving and receiving favours. This is similar to the level of reciprocity reported in the British study cited in the previous section but lower than that reported in the Irish study. Both of these studies found that reciprocity was influenced by the same set of factors as trust, notably the age of the respondent, length of time on the estate and disadvantaged status.

### **7.6 Volunteering, Community Involvement, and Community Capacity**

We measured volunteering using a question from the 2006 Census of Population. This showed that a fifth (21%) engaged in any volunteer activity over the past four weeks, which is higher than the prevalence of volunteering in Ireland in 2006, at 16%, based on the same question. A recent analysis of volunteering in Ireland, based on a sample of over 1,000 respondents, found that ‘volunteering and active community engagement is highly correlated with level of educational attainment, marital status, length of residence, religiosity and age’<sup>143</sup>. As we have seen in previous sections, these are also the factors associated with trust and reciprocity.

Turning to community involvement within the estate, we asked mothers if they had participated in any of Respond!’s local structures or activities over the past three years. These included residents’ associations, estate management boards, tenant participation committees, other committees and estate events. It is noteworthy that the estates in the survey are divided evenly between those which have some form of community association and those that do not. The results show that nearly eight out of ten (78%) have had no involvement in local structures over the past three years. Conversely, around a fifth (22%) had some involvement. In a recent study, the level of participation in local voluntary organisations by residents from four middle class suburban estates located at Lucan, Ratoath, Mullingar and Leixlip, varied from 31% to 48%<sup>144</sup>.

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142. Coulthard, Walker and Morgan, 2002; Balanda and Wilde, 2003.

143. Healy, 2005.

144. Corcoran, Gray and Peillon, 2007:192.



We constructed an index of community capacity in each estate based on: (i) the existence of local structures or activities (ii) the number of residents involved in these local structures or activities and (iii) the rating by Respond! staff of each estate's potential for community activity. Using these criteria, we classified estates into low, medium and high. The results show that two thirds (22, 65%) of the estates have low community capacity, a fifth (7, 20%) have high capacity, and the remainder (5, 15%) have medium capacity.

### **7.7 Constructing an Index of Need in Respond! Estates**

In order to facilitate the process of identifying estates with significant levels of need, we constructed a global index of need, based on the key dimensions of well-being which we have analysed in this report: depression, life satisfaction, parenting and children's difficulties. We carried out a factor analysis of the individual-level scores for each of these variables and identified a common underlying factor which explains 37.28% of the variance in the four variables combined. The estimated regression factor scores for this single factor were then calculated and aggregated to the estate level.

### **7.8 Summary and Conclusion**

This chapter assessed the well-being of neighbourhoods in Respond! estates. In objective terms, the estates surveyed could be described as relatively small (an average of 38 family households), relatively new (an average of 8 years), and relatively accessible to essential services (an average of one kilometre). We also measured the social capital of estates, drawing on instruments used elsewhere<sup>145</sup>, to assess the perceived prevalence of local problems, the perceived quality of local services, the extent of trust and reciprocity between neighbours, and the level of involvement in community or voluntary organisations.

Beginning with neighbourhood problems, we found that the vast majority of mothers (78%) do not have significant local problems on their estate and the prevalence of local problems would appear to be significantly lower compared to some local authority estates<sup>146</sup>. The two biggest neighbourhood problems are litter and rubbish (38%), and roaming dogs (36%). Similarly, a majority of mothers (63%) are broadly

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145. See notably Coulthard, Walker and Morgan, 2002; Balanda and Wilde, 2003.

146. McKeown and Haase, 2007; see also Fitzgerald, 2007: 6.

satisfied with wider local services. Schools are given the highest rating of all services while the worst services, defined as ‘very poor’ or ‘poor’, are leisure facilities for teenagers (73%) and children (65%) as well as playgrounds (71%).

In the area of trust, the survey found that seven out of ten mothers in Respond! (72%) do not trust most or many of their neighbours. This is a significantly lower level of trust than reported in previous studies, and may be due to the relatively young age of respondents, the newness of the estates, and their relatively disadvantaged status, all of which are known to be associated with lower levels of trust. By contrast, we found a relatively high level of reciprocity between neighbours in Respond! estates with around three quarters engaged in giving and receiving favours.

A significant minority of Respond! residents (22%) have been involved in local structures over the past three years. This is very similar to the proportion of Respond! residents who volunteer (21%). Significantly, the prevalence of volunteering in Ireland, based on 2006 Census of Population, is 16% which is lower than that found in Respond! estates. However the level of participation on local structures would seem to be less than that found in more middle class suburban estates in Ireland. We also rated the community capacity of each estate and found that two thirds (65%) had low capacity, a fifth (20%) had high capacity, and the remainder (15%) had medium capacity.

In terms of social capital, it is difficult to draw definitive conclusions about the well-being of Respond! estates due to the lack of strictly comparable data on other types of housing estates in Ireland, particularly in the social housing sector. When account is taken of the factors associated with social capital – notably age, length of residence, and disadvantaged status – the results suggest that Respond! estates are in line with expectations and not dissimilar to the description of Ireland as being about “average or above average for European countries on most indicators of social capital”<sup>147</sup>.

Finally, we constructed a global index of need - based on a composite factor of depression, life satisfaction,

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147. National Economic and Social Forum 2003: 61.

parenting, and children's mental health – and aggregated individual scores to the level of each estate. This may help Respond! in selecting estates where the type of interventions suggested in earlier chapters may be of greatest benefit in promoting the well-being of parents, children and neighbourhoods.

### **Well-Being of Neighbourhoods**

- Most (78%) do not have significant problems on their estate. The two biggest problems are litter & rubbish (38%) and roaming dogs (36%).
- About two thirds (63%) are broadly satisfied with wider social services. The highest rated service is the school but leisure facilities for children and young people are seen as poor by around 70%.
- Most (72%) do not trust many or most of their neighbours, much higher than other studies in Ireland and UK. Greater trust and reciprocity tends to be associated with being older, living longer in the area, and higher incomes.
- About eight out of ten exchange favours, and look out for neighbours, similar to elsewhere.
- The level of volunteering (21%) is higher than in Ireland (16%) but participation in local structures is lower than would be found in more middle class estates.

## **Chapter Eight**

### **Summary, Conclusions and Implications**

#### **8.1 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.

#### **8.2 Context**

The context for the study is set by the core objective of Respond! which is to provide housing for people in need. Respond! adopts a holistic approach to housing need, seeing it as part of a broader strategy to address poverty by building low-cost housing estates which are linked to essential services and which promote and sustain the well-being of individuals, families and communities. As such, its aim is to create vibrant self-managed communities rather than simply providing shelter or accommodation.

#### **8.3 Approach to Measuring Need**

In order to carry out a study of need, it is necessary to begin with a clear definition of need. People are said to be in need when their well-being is below a threshold that is regarded as either normal or minimal. It is a multi-dimensional concept covering all aspects of a person's well-being and includes physical and psychological well-being, relationships inside and outside the home, neighbourhood quality, community facilities, etc. In the case of children, well-being also includes school attendance and performance as well as participation in out-of-school activities. In addition, since needs are influenced by the socio-economic status of the household and the broader physical environment, it is therefore necessary to measure household income, employment and education as well as neighbourhood perceptions and facilities.

#### **8.4 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 Ireland<sup>148</sup> and some have also been used in the evaluation of Springboard projects in Ireland<sup>149</sup>, and in the assessment of the mental health needs of children in Ballymun<sup>150</sup>, other parts of Dublin<sup>151</sup>, Mayo<sup>152</sup>, and Limerick<sup>153</sup>. As such, they provide useful benchmarks against which to measure the well-being of children and their mothers in Respond! estates. 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.

### **8.5 The Sample**

The study is based on a stratified random sample of Respond! estates which meet the criterion of having at least 14 family households on the estate. The survey yielded 499 completed interviews in 34 estates. This is equivalent to 39% of all estates in Respond! management (87) and 24% of all family households (2,080). This is a very high sampling ratio and is likely to yield a reliable picture of families on Respond! estates. The sample was re-weighted to reflect the true distribution of family households and estates within Respond!. We estimate that the sampling error associated with this sample, at the 95% level of probability, is in the 3-4 range for each statistic generated from this sample. In addition to the survey data, the Research & Development team in Respond! supplied anonymised data on income and employment as well as data on the characteristics of each estate such as year built, number of family households, estimated community capacity, availability of pre-school and daycare services, distance to essential services, access to public transport, etc.

### **8.6 Data Analysis**

The analysis involved preparing frequencies and cross-tabulations, the full results of which are presented

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148. McKeown, Pratschke and Haase, 2003

149. See McKeown, Haase and Pratschke, 2001; 2004a; 2004b

150. See McKeown and Haase, 2006.

151. McKeown and Fitzgerald, 2006a; McKeown and Fitzgerald, 2007.

152. McKeown and Fitzgerald, 2006b.

153. McKeown and Haase, 2007.

in the Technical Appendix<sup>154</sup>, mirroring the chapter structure of this Main Report. In addition, we use correlation analysis<sup>155</sup>, regression analysis<sup>156</sup>, and multi-level modelling<sup>157</sup> to test the level of association between the needs of mothers (in the areas of depression, life satisfaction and parenting), children (in the area of mental health), and neighbourhoods (based on an index of need) - the dependent variables - and a range of individual, family, socio-economic and neighbourhood factors (the independent variables).

## **8.7 Characteristics of Households**

The study shows that Respond! family households are quite different to the average family household in Ireland in having a much higher proportion of Medical Card holders (70% compared to 28% in Ireland)

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154. Appendix available upon request from the R&D Department in Respond!.

155. 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 which the independent variable 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.

156. 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.

157. Multi-level modelling is a more advanced form of multiple regression analysis. The basic principle in a two-level model, such as we use here, is that change in a dependent variable is the outcome of influences at level 1 (individual characteristics) and level 2 (neighbourhood characteristics). These influences, in turn, can be broken into two components: (i) fixed parameters whose influence can be clearly identified and quantified from the independent variables in the dataset and (ii) random or residual variance which cannot be explained by the existing set of independent variables, although the amount of unexplained variance can be quantified. The influence of fixed parameters on a dependent variable can be separated, in turn, into a mean (sometimes referred to as the 'intercept' and denotes the overall tendency for that independent variable) and a variance (sometimes referred to as the slope and denotes the extent of change in the dependent variable for a unit change in the independent variable). These concepts are the core of multiple regression analysis as applied to level 1 variables. The analysis of level 2 variables also involves assessing their influence on the dependent variable in terms of fixed parameters (comprising both a 'compositional effect' arising from the particular cluster of individual characteristics at level 2, and a 'contextual effect' arising from unique level 2 characteristics) as well as unexplained random or residual variance. In addition, multi-level modelling assesses how the influence of level 1 variables may vary through interaction with level 2 variables. These concepts can be illustrated by drawing on our analysis of life satisfaction in Chapter Four. This shows that the life satisfaction of mothers, over and above the level shared by all mothers (the mean or intercept), is shaped by individual level characteristics (such as hope, positive affect, etc), by estate level characteristics (such as the average local problem score), by the interaction of both levels (such as variability in the way hope influences life satisfaction in different estates), and by unknown factors (namely the variance that cannot be explained by the independent variables within the dataset). The strength of this method of analysis lies in simultaneously estimating the unique influence of all level 1 and 2 variables on the dependent variable, as well as the variability of level 1 influences under different level 2 circumstances.

and a much higher proportion of lone parents (60% compared to 21% in Ireland). The level of education among mothers in Respond! is lower than in Ireland, whether measured in terms of the age completed full-time education or highest qualification achieved. The majority of mothers in Respond! are full-time home-makers (63%), unlike the majority of mothers in Ireland (62%) who are in paid employment. Moreover those who are in employment tend to be part-time, unlike the pattern among women in Ireland where full-time employment is the norm. These findings point to the relatively weak labour market position of mothers in Respond! - particularly at a time of economic buoyancy and the widespread availability of childcare services in nearly two thirds of all Respond! estates – and may be an indicator of the disincentive effects of the tax and social welfare system on those with weak earning capacity.

In terms of financial well-being, we found that more than half of all Respond! family households (55%) are without a declared earned income and therefore totally dependent on social transfers. This is two and a half times higher than comparable households with children (aged 0-14 years) in Ireland where 22% are without an earned income<sup>158</sup>. The equivalised gross income<sup>159</sup> of all family households in Respond! during 2006/7 was €8,537 or €164 per week. Given that the poverty threshold set by the CSO's 2005 EU Survey of Income and Living Conditions (EU-SILC) – based on 60% of median equivalised income per individual – was €193 per week, this suggests that the average Respond! family household is likely to be at or below the poverty threshold. This may be tempered, however, by the benefits accruing to Respond! residents such as security of tenure, differential rent based on income including a ceiling on rents, as well as ancillary family and childcare support services on many estates.

Turning to the subjective dimension of financial well-being, the majority of mothers in Respond! (75%) are not experiencing financial strain as indicated by 'finding it difficult to manage' or 'in serious difficulties'. However a quarter experience financial strain (25%), significantly higher than in Ireland (14%), and

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158. Data supplied by Kathryn Carty, CSO on 10 August 2007. Based on 2005 data from the EU Survey on Income and Living Conditions (EU-SILC). Earned income, in this context, is defined as employment income, income from self-employment, other direct income such as investment income and occupational pensions.

159. The term 'equivalised income' refers to the total income of a household adjusted to take account of the total number of persons in that household. The convention used by the CSO in its Survey of Income and Living Conditions (SILC), and adopted here, is stated as follows: "The national scale attributes a weight of 1 to the first adult and 0.66 to each subsequent adult (aged 14+ living in the household), and 0.33 to each child aged less than 14" (EU-SILC 2005, published by the CSO in November 2006, page 29).

significantly higher than other groups which are particularly vulnerable to poverty<sup>160</sup>. This suggests that the benefits of Ireland's recent economic success do not seem to have flowed into many Respond! households.

Throughout our analysis we distinguished between households with a Medical Card and those without, as well as between one and two parents households. This revealed that those with a Medical Card and those who are lone parents are in the weakest socio-economic positions, in line with expectations.

This profile of households is consistent with the policy and practice of Respond! in allocating housing to those who are most in need. All of the indicators of need used in this chapter – Medical Card, lone parenthood, education, employment status, dependency on social transfers, income and ability to cope financially – confirm that this is an extremely vulnerable group.

## **8.8 Well-Being of Mothers**

Mothers in Respond! estates have broadly similar levels of well-being compared to other mothers in Ireland, on a wide range of domains including emotional well-being, life satisfaction, support networks, parenting relationships, and effectiveness at resolving arguments. At the same time, there are also significant areas of need among Respond! mothers, particularly in the area of depression where nearly a third (30%) show signs of depression which is more pronounced among mothers in one-parent households (33%). This is also reflected in a significant proportion showing signs of hopelessness (20%). 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. The survey shows that Respond! mothers exhibit greater deficits in the area of 'agency thinking', suggesting a lack of self-belief and motivation to solve their problems which is consistent with the relatively high prevalence of depression. Consistent with this, the proportion of Respond! mothers using sedatives, tranquilisers and anti-depressants (10%) is twice the national average, and highest among mothers in one-parent households (14%). About a quarter of mothers (24%) reported some form of disability, which is significantly higher than the national female prevalence

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160. Whelan, Nolan and Maitre, 2005



rate. Smoking rates among Respond! mothers are also twice the national average (62% compared to 33%), and are also highest in one-parent households (68%), reflecting the higher prevalence of smoking among lower socio-economic groups in Ireland and internationally<sup>161</sup>. Possibly related to this, self-rated health is below that of mothers in Ireland generally, with lone parents having the lowest self-rated health. These results indicate both strengths and weaknesses in the well-being of Respond! mothers. Those in one-parent households are most likely to display significant areas of need. By contrast, having a Medical Card is not a strong or consistent predictor of need, except in the case of disability.

## **8.9 Influences on the Well-Being of Mothers**

We analysed the factors which influence three aspects of well-being among mothers in Respond! estates: depression, life satisfaction, and parenting. We used multi-level modelling to test the level of association between these three dimensions of well-being (the dependent variables) and a range of individual, family, socio-economic and neighbourhood characteristics (the independent variables).

### **8.9.1 Symptoms of Depression**

Beginning with depression, we found that depressive symptoms among mothers in Respond! estates was predominantly associated with the individual characteristics of mothers, with a tenth (10%) attributable to estate-level characteristics. These individual characteristics can be divided into risk factors (those which increase the likelihood of depressive symptoms) and protective factors (those which decrease the likelihood of depressive symptoms). Our analysis found that the main risk factors for depressive symptoms are negative affect, having a child with difficulties, and having a disability; while the main protective factors are life satisfaction and hope. In terms of estate-level effects, we found that more than half (59%) of the estate-level variance was attributable to ‘compositional factors’. More than one quarter of the estate-level variance (27%) is attributable to ‘contextual factors’ across the different estates, notably the size of the estate and the concentration of mothers with a primary education only, both of which increase the susceptibility to depressive symptoms in a statistically significant way. These results are consistent with findings from some other studies which have endeavoured to estimate the influence of individual and neighbourhood characteristics on mental health.

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161. Centre for Health Promotion Studies, 2003: 23.

### **8.9.2 Life Satisfaction**

Turning to life satisfaction, our multi-level analysis revealed that 84% of the variance in life satisfaction scores is attributable to individuals, the remaining 16% relating to estates. At the individual level, the main risk factors which threaten to reduce life satisfaction are depression, being more educated, having difficulty coping financially, and being single. The protective factors are hope, positive affect, a strong support network, and being married or cohabiting. In terms of estate-level effects, we found that more than half (56%) of the variance is attributable to ‘compositional factors’. Just less than one quarter of the estate-level variance (23%) is attributable to ‘contextual factors’ across the different estates, and these comprise the average local problem score (such as the extent of litter, rubbish, graffiti, noise, lack of safety, etc) and the average hope score of residents in the estate. The substantial influence of these contextual factors on life satisfaction is a significant result given the difficulties experienced by previous studies in finding these neighbourhood effects.

### **8.9.3 Parenting**

The third dimension of well-being which we examined was parenting, as measured by the Parent-Child Relationship Inventory (PCRI). We found that nearly nine tenths (86%) of the variance in parenting scores was attributable to the individual level, with just over a tenth (14%) attributable to estates. The main individual risk factors to the parent-child relationship are: the child has difficulties, the number of children in the households, and the age of the child. The main protective factors are: positive affect and positive emotions, life satisfaction, and whether the child has a disability. In terms of estate-level effects, we found that once again more than half (57.2%) of the variance is attributable to ‘compositional factors’, associated with the uneven distribution of risk factors and protective factors between the different estates. One fifth of the estate-level variance (20%) is attributable to ‘contextual factors’, the main one being the extent of problems in the local area, which has a negative impact on the parent-child relationship. The finding that parenting is influenced by neighbourhood factors is significant and consistent with the results of other studies which have endeavoured to estimate the influence of individual and neighbourhood characteristics on the well-being of children.

## **8.10 The Well-Being of Children**

The prevalence of mental health difficulties among children, as measured by the SDQ, is somewhat higher than in other population-based studies. We found that 14% of children have serious difficulties and a further 9% have some difficulties; this is equivalent to nearly a quarter of children (23%) who present with difficulties. The main difficulties involve conduct and hyperactivity (particularly among boys) and emotional problems (particularly among girls). Boys present with slightly more difficulties than girls and those aged 7-12 present the most difficulties. The proportion of children with serious difficulties is higher in one-parent households (16%) compared to two-parent households (10%) but there is no significant difference between those with and without a Medical Card.

Extrapolating these results to the total number of children aged 0-18 in Respond!, we estimate that there are 620 children who have serious difficulties and a further 420 have some difficulties; taken together, this is equivalent to nearly a quarter of children (23%, 1,040) who have some level of need.

The level of need among children in Respond! is higher than found in other studies in Ireland<sup>162</sup>, the UK<sup>163</sup> and the US<sup>164</sup>. Further analysis of the depth of need revealed that substantial interventions will be needed to bring children who have some or serious difficulties to the level of well-being experienced by the ‘average’ child, 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 25% of children in Respond! are perceived by their mother to have at least one disability. This is higher than the prevalence of disabilities (18%) estimated by the National Council for Special Education in 2006<sup>165</sup>. There is a considerably higher prevalence of disabilities among teenage children (33%), in households with a Medical Card (27%), and in households with a lone parent (29%).

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162. 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.

163. Meltzer, Gatward, Goodman, and Ford, 2000.

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

165. McKeown, 2006: 72.

Children in Respond! have similar reading ability to children in Ireland but a relatively small proportion of children (9%) may have reading difficulties. The number of books in the home is similar to Ireland but access within the home to a computer and the internet is less than in Ireland. However children in Respond! are more likely to be read to before going to school compared to children in Ireland. School attendance rates seem to be slightly higher in Respond! than Ireland although a substantial proportion of post-primary pupils in Respond (11%) are missing school for 20 days or more; this is equivalent to 490 children.

A significant finding to emerge from the study is that children in need, particularly those with needs in the area of mental health and disability, are more likely to be found in households with one parent. As such, this is a stronger and more consistent predictor of need than having a Medical Card. With this in mind, in the next section we undertake a further analysis of the factors which are most strongly associated with the needs of children in Respond!.

### **8.11 Influences on the Well-Being of Children**

We used multi-level modelling to estimate the factors which influence the mental health of children in Respond! estates, based on the Strengths and Difficulties Questionnaire (SDQ)<sup>166</sup>. The results shows that more than eight tenths (83%) of the variance in children's mental health – their SDQ scores - is attributable to individual characteristics with just under two tenths (17%) attributable to estate characteristics. These individual characteristics can be divided into risk factors (those which increase the likelihood of children's difficulties) and protective factors (those which decrease the likelihood of children's difficulties).

In terms of individual-level effects, we found that the main risk factors for children's mental health are: maternal depression, the parent-child relationship, and whether the child has a disability or chronic illness. The protective factors are: positive emotions, the age of the mother, whether the mother works, and whether there is a dictionary in the home. In terms of estate-level effects, we found that just under

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166. 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), the parent (for children aged 3+), and the teacher (for children aged 3+). Available at [www.sdqinfo.com](http://www.sdqinfo.com).

half (47.4%) of the explained variance is attributable to ‘compositional factors’, essentially because of the uneven distribution of risk and protective factors across estates. Roughly one fifth (21%) of variance is attributable to ‘contextual factors’ across the different estates, notably the percentage of mothers in the estate who have symptoms of depression and the community capacity of the estate.

### **8.12 Well-Being of Respond! Estates**

The Respond! estates which we surveyed could be described as relatively small (an average of 38 family households), relatively new (an average of 8 years), and relatively accessible to essential services (an average of one kilometre). We found that the vast majority of mothers (78%) do not have significant local problems on their estate and the prevalence of local problems would appear to be significantly lower compared to some local authority estates<sup>167</sup>. The two biggest neighbourhood problems are litter and rubbish (38%), and roaming dogs (36%). Similarly, a majority of mothers (63%) are broadly satisfied with wider local services. Schools are given the highest rating of all services while the worst services, defined as ‘very poor’ or ‘poor’, are leisure facilities for teenagers (73%) and children (65%) as well as playgrounds (71%).

In the area of trust, the survey found that seven out of ten mothers in Respond! (72%) do not trust most or many of their neighbours. This is a significantly lower level of trust than reported in previous studies, and may be due to the relatively young age of respondents, the newness of the estates, and their relatively disadvantaged status, all of which are known to be associated with lower levels of trust. By contrast, we found a relatively high level of reciprocity between neighbours in Respond! estates with around three quarters engaged in giving and receiving favours.

A minority of Respond! residents (22%) have been involved in local structures over the past three years. This is very similar to the proportion of Respond! residents who volunteer (21%). Significantly, the prevalence of volunteering in Ireland, based on 2006 Census of Population, is 16% which is lower than that found in Respond! estates. However the level of participation on local structures would seem to

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167. McKeown and Haase, 2007; see also Fitzgerald, 2007: 6.

be less than that found in more middle class suburban estates in Ireland. We also rated the community capacity of each estate and found that two thirds (65%) had low capacity, a fifth (20%) had high capacity, and the remainder (15%) had medium capacity.

In terms of social capital, it is difficult to draw definitive conclusions about the well-being of Respond! estates due to the lack of strictly comparable data on other types of housing estates in Ireland, particularly in the social housing sector. When account is taken of the factors associated with social capital – notably age, length of residence, and disadvantaged status – the results suggest that Respond! estates are in line with expectations and not dissimilar to the description of Ireland as being about “average or above average for European countries on most indicators of social capital”<sup>168</sup>.

Finally, we constructed a global index of need for each estate - based on a composite factor of depression, life satisfaction, parenting, and children’s mental health – and aggregated individual scores to the level of each estate. The resulting list of estates, listed by their level of need, may assist Respond! in selecting estates where the type of interventions suggested in the next section may be of greatest benefit in promoting the well-being of parents, children and neighbourhoods.

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168. National Economic and Social Forum 2003: 61.

## General Conclusions

1. Respond! residents have specific needs when compared to the rest of the population, but there is also significant variation in well-being within the population of Respond! residents.
2. Well-being has an external dimension (such as education, employment, income, health, neighbourhood characteristics) as well as an internal dimension (such as mental health, life satisfaction, family relationships). Responding to social exclusion requires addressing both dimensions.
3. The study confirms the systemic nature of family systems and the inter-dependency between parent, child and neighbourhood well-being. Well-being is shaped through cycles which cumulatively influence each other to create either a positive or negative outcome.
4. These findings are consistent with the overall philosophy of Respond! which is to develop individuals and communities and not just housing.
5. In order to turn these findings into actions, it is necessary to: (i) have some knowledge and skill about 'what works' and (ii) dialogue with Respond! residents on how to address the needs identified.

### 8.13 Implications

This study was designed to throw light on the well-being of parents, children and neighbourhoods in Respond! estates. Given Respond!'s commitment to addressing social exclusion, and the fact that its residents are social excluded according to national income-poverty thresholds, the study is also useful in examining the sources of variation in well-being within this socially excluded group of people. As such, the study offers a different perspective to the prevailing paradigm of social exclusion which is based on comparing the differences between 'poor' and 'non poor', 'excluded' and 'included', 'disadvantaged' and 'advantaged'. This paradigm has yielded a wide range of studies which have comprehensively documented that there is a 'social gradient' between these two groups in terms of almost every aspect of well-being including birth weight, life expectancy, health, education, employment, earnings, etc. It is clearly important to map these social gradients from the point of view of equity in society. However the acknowledged differences between these two groups tends to overlook the fact that there are also significant differences within these groups and, in order to understand the dynamics of poverty and social exclusion, it is equally important to understand 'within group' as well as 'between group' variations in well-being.

In this study therefore we try to extend the social exclusion paradigm not only by examining ‘within group’ variations but also by assessing how well-being is shaped by both the ‘external environment’ as well as the ‘internal environment’. The external environment, in this context, is measured by indicators such as income, education, employment, neighbourhood, service usage, etc., while the internal environment is measured by the thoughts, emotions and behaviours that shape the mental health and relationships of individuals and families. We found that while the external environment has an influence on the well-being of Respond! residents, the internal environment had a considerably greater influence<sup>169</sup>. In other words, when we delve more deeply into the quality of life experiences of Respond! residents, we find substantial variation in their ‘internal environment’ despite sharing a broadly similar ‘external environment’. This implies, in turn, that significant variation exists in the capacity and resilience of households to cope with an ‘external environment’ that is defined as ‘poor’.

From the perspective of promoting social inclusion therefore, our analysis suggests that a broader range of interventions is required – over and above those which address the ‘external environment’. It also implies that perspectives which rely too heavily on the external dimension alone – such as the social exclusion paradigm – may tend to underestimate the multi-dimensional nature of well-being and the complex interactions between external and internal environments. In addressing the needs of Respond! residents therefore, it is essential to work with this multi-dimensionality, mindful of the associations which simultaneously link these dimensions as both cause and effect. In light of this, we now draw out some of the main implications of our results.

In this section we highlight some of the ways in which the study could contribute to the development of interventions to support the well-being of individuals, families and communities in Respond! estates. We stop short of making specific recommendations essentially because the development of services requires consideration not just of the processes described in this study but must also consider the available evidence

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169. A similar conclusion emerged from a recent review of the literature on child outcomes 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).



on ‘what works’ to promote different aspects of well-being. In addition, the process of developing services requires an active engagement between service provider and the service user in order to ensure that interventions are properly customised to the specific needs of individuals, households and estates and, by virtue of that, are needs-led rather than service-led, person-centred rather than provider-centred. In other words, the process of service development requires an integration of all these elements and the implications which we propose in this section should be seen as a contribution to that process.

In drawing attention to the implications of the study, it is also important to be mindful of its limitations. The study is based solely on interviews with mothers and the exclusion of fathers is an important limitation – even though 60% are lone parents in female-headed households. At the same time, it is probably not unreasonable to assume that, although there are differences in the perceptions of mothers and fathers, our results are likely to have relevance to all parents and to all family types. It is important, therefore, that this limitation does not 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. For this we refer to parents generally, rather than mothers only, in drawing out the implications of the study.

### **8.13.1 Recognising the systemic nature of family systems**

It is important to emphasise that the factors, whether inside or outside the family, which influence the well-being of parents and children do not operate in isolation from each other because it is their interaction effect which creates the susceptibility to need. In other words, these factors operate simultaneously as well as sequentially, because they have a cross-sectional dimension as well as a longitudinal dimension. This means that each factor acts as cause as well as consequence, essentially because nothing exists independently. This understanding suggests that problems – whether among mothers (such as symptoms of depression, reduced life satisfaction, or stresses in parenting) or children (such as mental health difficulties) - 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, other things being equal, are likely to be the predominant influence on the well-being of both. This suggests, in turn, that interventions to promote the well-being of mothers are likely, other things being equal, to have greater impact on the family system than interventions with children.

Our analysis also confirms that the well-being of mothers and their children is shaped not just by the family system but also by the neighbourhood context in which the family is situated. This is illustrated by the fact that different aspects of well-being are shaped by estate-level characteristics such as the extent of local problems (which influences life satisfaction and parenting), the size of estate (which influences depression), and the estate's community capacity (which influences children's difficulties), as well as the geographical concentration of specific characteristics such as hopefulness (which influences life satisfaction), depression (which influences children's difficulties), and primary education only (which influences depression). This finding is consistent with the ecological theory of family systems which sees the family as a buffer zone protecting children and their parents against adverse contextual influences<sup>170</sup>. The practical implication of this is that while individual and family-based interventions are likely to have the largest overall impact in terms of improving the well-being of mothers and children, there is also a complementary and supportive role for neighbourhood and community-based interventions.

It is significant that these considerations, based on empirical analysis of well-being among a representative sample of 500 mothers in Respond! estates, provide strong evidence in favour of the overall vision which informs the community development and family support strategies of Respond!: "Respond!'s goal is to provide housing and assist in the building of stable communities for those on low incomes or otherwise in need of housing. We seek to ensure that such communities will foster the growth of the individual resident and that of the whole community. We aim to assist our communities to grow to the stage where sufficient

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170. For example, the bioecological model of Bronfenbrenner (1979; 2001) sees child development as the outcome of influences within the family, school and local community as well as government policies and societal attitudes.

local community leadership exists to enable residents to access the services of and participate fully in the structures of wider society. To that end, we invest in personal and community development activity and family supports in order to build the capacity of residents for such a role. The family should be and is at the centre of the opportunity for a holistic approach in the development of both communities and the individuals within those communities”<sup>171</sup>.

In the subsections below, we highlight the key domains where interventions are likely, other things being equal, to foster different aspects of well-being. These interventions could be carried out through individual work, family work, group work, community work - or combinations of them - depending on the severity of the condition, the resources available, and other circumstances. In drawing attention to the broad domains where intervention is desirable, we acknowledge that further reflection is required in order to identify specific programmes which have proven effectiveness in those domains. In addition, the question of which agency or agencies might be involved in delivering these programmes is a separate but equally challenging issue that would need to be addressed.

### **8.13.2 Interventions to improve the mental health of parents**

We have seen that, while the majority of mothers in Respond! estates do not have mental health problems, a significant minority do with nearly a third (30%) showing signs of depression and a fifth showing signs of hopelessness (20%). Consistent with this, the proportion of Respond! mothers using sedatives, tranquilisers and anti-depressants (10%) is twice the national average (5%). Our analysis has shown that mental health has a number of dimensions – denoted by depression, positive and negative affect, life satisfaction, and hope – which mutually influence the well-being of mothers, their parenting capacity and the well-being of their children. We have also shown that the geographical concentration of certain mental health characteristics – notably hope and depression – has an estate-level as well as an individual-level influence. In other words, mental health is not just a private matter affecting individual mothers but has ripple effects, for good and ill, on all family members and the wider estate. This means that interventions

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171. Respond! 2007a:3; see also 2007b.

to improve the mental health of mothers are likely, other things being equal, to have significant multiplier effects on the well-being of families as well as the wider community.

It is well known that the factors which influence mental health have both environmental as well as genetic components. For example, a person's pattern of positive and negative affect, although moulded through habits and circumstances, is recognised to be an enduring personality trait which is not easily amenable to change. However, this knowledge can itself be of considerable benefit to people with depressive symptoms by virtue of acknowledging that this personality trait is a natural tendency, which is not 'wrong' or a 'mistake'. This awareness could assist the person in learning to live with this trait while recognising its dangers and limitations. Interventions which promote this form of self-knowledge could have the effect of relieving symptoms of depression by helping the person find constructive ways of living with their natural tendencies.

It is also recognised that mental health has a learned dimension which is shaped by the perspective which the person adopts towards the self and others. In positive psychology, there is growing evidence that this cognitive dimension can be cultivated to produce a more appreciative, hopeful, and problem-solving approach to life. This is done through practices which help people to think and feel differently about their lives and its past, present and future<sup>172</sup>.

At the same time, we have seen that many aspects of mental health are the practical outcomes of challenges associated with circumstances such as having a child with behaviour and emotional difficulties, having a disability, finding it difficult to cope financially, living in an estate with a high local problem score, or being surrounded by neighbours who lack hope or show symptoms of depression. Clearly, interventions

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172. See, for example, Snyder and Lopez, 2002; see also [www.beckinstitute.org](http://www.beckinstitute.org). For example, feelings about the past can be changed by questioning the ideology that the past determines the present, and by cultivating forgiveness and gratitude towards past events. Feelings about the present can be changed through living mindfully and cultivating one's natural strengths, while positive feelings about the future can be increased through hope and optimism. This is consistent with the 'broaden-and-build theory of positive emotions' (Fredrickson, 2002) which suggests that people with more positive emotions tend to have a greater capacity for building friendships and support networks as well as being more creative at solving problems and challenges in everyday life (Carr, 2004:13-15). In other words, people with more positive emotions are more likely to see the world in terms of expansionary 'win-win' options rather than contractionary 'win-lose' options. This shows the value of cultivating positive emotions because they are known to encourage qualities such as persistence, flexibility and resourcefulness in solving problems and because they broaden the range of options which people perceive to be available (For more information, visit the Positive Psychology Center at [www.positivepsychology.org](http://www.positivepsychology.org) and related links).

to ameliorate these circumstances would, other things being equal, improve the mental health of parents with knock-on benefits for parenting, children, and estates generally.

### **8.13.3 Interventions to meet the needs of children**

Most children in Respond! estates do not have mental health difficulties. However a significant minority do (23%), and this would seem to be somewhat higher than in other population-based studies. The main difficulties involve conduct and hyperactivity (particularly among boys) and emotional problems (particularly among girls), and these are more likely to be found among older children (7-17 years), and in one-parent households. Significantly, it is not just children who are adversely affected by their mental health difficulties; these difficulties also increase the prevalence of depressive symptoms among mothers and weaken the mother's relationship with the child. It follows therefore that interventions to address the mental health needs of children, particularly those with serious difficulties (14%), are likely to have significant beneficial effects for the entire family system.

It is possible that a small number of children may need specialised assessment and intervention. However it is likely that all children would benefit from organised group activities, either within the estate or local community.

Our study produced evidence to suggest that children tend to have more difficulties in home environments that are not cognitively stimulating. This was indicated by the fact that children were more likely to experience difficulties if there was not a dictionary in the home. It is well-known that "there is also a very strong association between the number of books in the pupils' homes and their reading achievement"<sup>173</sup>. These considerations suggest a range of interventions such as encouraging parents to read to their children, providing children with a 'starter pack' of age-appropriate books to stimulate their interest in books and reading, and making parents more aware of the importance of providing cognitive stimulation to the development of children.

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173. Eivers, Shiel and Shortt, 2004:173

#### **8.13.4 Interventions to support families with disabilities**

We have seen that a quarter (25%) of mothers in Respond! estates have a disability or chronic illness, nearly three times higher than the estimated national average for females. We have also seen that a similar proportion of children (25%) are perceived by their mothers to have at least one disability, also higher than the estimated national prevalence of disabilities among children. The scale of need is indicated not just by the prevalence of disabilities but also by the factors associated with it. For example, mothers with a disability are more likely to show symptoms of depression while children with a disability are more likely to have mental health difficulties in the form of behavioural or emotional problems. This suggests that, in addition to the practical difficulties associated with having a disability, there are also mental health consequences. These consequences, in turn, may be exacerbated by the absence of appropriate social and medical services to assist with the tasks of daily living, but may also be aggravated by the difficulty of coming to terms with and accepting the disability, particularly if it is permanent. It is clear that further analysis is required on the extent of disabilities and chronic illness among parents and children in each estate. It is only in light of this needs analysis, that the type and range of interventions can be determined.

#### **8.13.5 Interventions to promote work and manage finances**

We know that families in Respond! estates tend to have low incomes since that is itself a criterion for accessing social housing. In fact our analysis suggests that the average Respond! family household is likely to be at or below the poverty threshold, and this likelihood is even greater for households with a Medical Card and / or lone parent. We also know that more than half of all households (55%) are totally dependent on social welfare, which is two and a half times the national average. Although only a significant minority of mothers in Respond! (25%) are experiencing financial strain, as indicated by ‘finding it difficult to manage’ or ‘in serious difficulties’, this is well above the level experienced not only by Irish households but also by reference to specific groups which are vulnerable to poverty. In other words, it would seem that the benefits of Ireland’s recent economic success have not flowed into many Respond! households.

Our analysis shows that mothers who have difficulties in coping financially tend to have reduced life satisfaction, while those without work are more likely to have children with mental health difficulties. This suggests that earning and managing one's income are not just financial matters but have broader implications for the well-being of mothers and children. In turn, this suggests that interventions which offer advice on budgeting as well as help to find work could have considerable benefits for mothers and children. For mothers, the benefits of work would involve higher family income and, hopefully, a greater sense of achievement and fulfilment, both of which could have spill-over effects on the child. It is worth remembering however that the benefits of maternal employment for children are contingent on the quality of childcare and, for this reason, it is essential to ensure that children are being properly cared for while their mothers are at work.

### **8.13.6 Interventions to support parenting**

The survey revealed that, although there is no generalised need in the area of parent-child relationships within Respond! estates, there may be specific needs among sub-groups of parents, particularly in families where a child has mental health difficulties, where there is a large number of children, or where the children are older. Equally, parents who have mental health difficulties as expressed through reduced life satisfaction and less frequent positive emotions, may find parenting difficult and this vulnerability tends to be greater among those with weaker support networks and among those who are single, separated or widowed. These findings suggest that setting up support groups for parents could have a beneficial effect on parents and on their relationships with children. Support groups could be for the specific purpose of supporting parents but could also be established to organise activities for children or address local problems, while having parent support as a by-product. Whatever the format and range of objectives, it would be important that each support group has the specific objective of cultivating flexible and reciprocal supports that strengthen the parent-child relationship. An encouraging finding in this context is that estates with a high level of mental health and parenting needs are already those with relatively high community capacity and this should be built upon.

### **8.13.7 Interventions to address local problems on the estate**

The finding that estate-level characteristics have a statistically significant influence on various aspects of well-being shows the importance of the physical and social environment. Specifically, we found that well-being is influenced by estate-level characteristics such as the extent of local problems, the geographical concentration of specific characteristics such as hopelessness and depression, as well as the size and community capacity of the estate. We also found that a significant minority of mothers (22%) rate aspects of their estate as a very big problem or a fairly big problem. The biggest problems include: litter and rubbish; roaming dogs; dog dirt; poor state of roads, pavements, boundaries and fences; and not safe to walk alone after dark. Although these problems are located in public spaces, their impact is felt within each family and are associated with reduced life satisfaction among mothers and weaker parent-child relationships. It is clear that interventions to address local problems would have significant benefits for families as well as the estate. Equally, the method of intervention could itself be a way of improving well-being given our finding that community capacity has a beneficial effect on the mental health of children. This suggests that any interventions to address local problems should be done with as much local participation and involvement as possible, a suggestion that is wholly consistent with Respond!'s existing style of intervention.

In drawing attention to the importance of estate-level interventions, the limitations of this form of intervention also need to be recognised since the size of these neighbourhood effects is relatively small – probably no more than 5% - compared to the influence of individual characteristics, although larger effects might be expected from a more diverse sample. Moreover the finding that physical and social environments have a relatively small impact on quality of life is not new. It has been demonstrated in other studies in Ireland<sup>174</sup>, the US<sup>175</sup>, the UK<sup>176</sup>, and Canada<sup>177</sup>, to name a few. All of these have found little evidence to show that neighbourhoods have a substantial impact – over and above individual-level characteristics<sup>178</sup> - on outcomes such as education, employment, income, mental health, etc.

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174. Nolan and Whelan, 1999; Fahey, 1999.

175. Kling, Ludwig and Katz, 2005; Goering and Feins, 2003.

176. Bolster, Burgess, Johnston, Jones, Popper, and Sarker, 2007; see also Cheshire, 2007

177. Oreopoulos, 2003

178. Note the term 'individual-level characteristic', as used here, refers to data about individuals; it does imply that the individual is the cause of, or responsible for, those characteristics. In fact it is recognised that individual-level characteristics are the outcome of structural and cultural influences as well as more unique individual and personality influences.



These findings do not imply that attractive neighbourhoods are unimportant and are not universally valued. However they do imply that if individual-level characteristics are the main factors associated with poverty and disadvantage on the one hand, and mental health and family problems on the other, then any changes to the physical and social environment are likely, other things being equal, to have only marginal effect on these problems. In other words, if the primary causes of social exclusion are not to be found in the physical and social characteristics of neighbourhoods – since the area where one lives is really a consequence rather than a cause of social exclusion - then the primary solutions to social exclusion are not to be found there either. This is an important lesson which does not seem to be well understood, particularly in the context of urban regeneration where there appears to be an assumption – a ‘design determinism’<sup>179</sup> - that physical refurbishment programmes will result in significant improvements in quality of life without a corresponding level of investment in meeting individual and family needs.

### **8.13.8 Monitoring the effectiveness of interventions**

The findings of this report may be helpful in reviewing whether existing strategies to support families and children in Respond! estates are consistent with the understanding of need and its determinants which the study has revealed. In addition, the findings may act as a baseline against which the effectiveness – and cost effectiveness – of interventions may be evaluated over time. As such, the instruments used here to measure the well-being of parents, children and neighbourhoods could form part of an evaluation system which continuously monitors progress, particularly since these instruments have been tried and tested, and normative data exists against which to compare progress.

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 Respond! families from the normal experience of other parents, children and neighbourhoods in Ireland. Both measures are complementary and help in making a rounded judgement on the effectiveness of interventions, while also being mindful of the depth of need that may remain even after an effective service has been delivered. 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.

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179. Fahey, 1999:121

### **Specific Implications**

1. Interventions are required to improve the mental health of a significant minority of mothers. The lessons of Cognitive Behavioural Therapy and positive psychology have much to contribute here.
2. There are differing levels of need among children including: (i) a generalised lack of leisure facilities for most children and (ii) significant difficulties for some children. Group activities would benefit all children but some may require individual assessment and treatment.
3. There is scope for improving the cognitive environment in some homes by encouraging parents to read to children, stimulating interest in books and reading, and raising parental awareness and expectations about education.
4. The level of disability is quite high and generates practical as well as mental health difficulties for parents as well as children.
5. There is evidence that interventions to promote employment and help mothers cope financially would improve the well-being of parents and children.
6. Interventions to improve parenting – possibly through parent support groups – would have beneficial effects on both parents and children.
7. Addressing estate-level problems such as litter & rubbish as well as roaming dogs could generate a wide range of benefits.

### **8.14 Concluding Comment**

A significant and encouraging finding of the study is that almost any intervention which cultivated a more positive outlook among parents, both cognitively and emotionally would, in addition to its direct mental health benefits, also improve parenting, the well-being of children, and the quality of life on the estate. 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 parents through cultivating positive thoughts, emotions and behaviours. This applies to all forms of intervention, whether prevention, early intervention or treatment<sup>180</sup>. At the

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180. 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.

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 showing<sup>181</sup>. 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 fathers<sup>182</sup>. 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 children<sup>183</sup>.

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

182. McKeown, 2001a; 2001b

183. 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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