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Children, Families & Neighbourhoods in the Bray Area

A Study for
Bray Community Consortium

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Final Report
December 2008

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Glossary of Terms

Abbreviations:

CDP	Community Development Programme, funded by the DCRGA
CES-D	Centre for Epidemiologic Studies Depression Scale (scale, see below)
CTS-PC	Parent-Child Conflict tactics Scale (scale, see below)
DCRGA	Department of Community, Rural and Gaeltacht Affairs
EU SILC	European Union Survey of Income and Living Conditions
INCA	Irish National Classification of Addresses
LDG	Local Development Group, constituted under the YPFSF
LDTF	Local Drugs Taskforce
PANAS	Positive and Negative Affect Scale (scale, see below)
PCRI	Parent-Child Relationship Inventory (scale, see below)
RAPID	Revitalising Areas by Planning, Investment and Development
SDQ	Strengths and Difficulties Questionnaire (see below)
YPFSF	Young Peoples Facilities and Services Fund

Concepts and Scales:

Regression Analysis	Regression analysis is a technique used for the modelling and analysis of numerical data consisting of values of a dependent variable (response variable) and of one or more independent variables (explanatory variables). Regression can be used for the modelling of causal relationships.
Multilevel Modelling	Extension of regression analysis to determine whether neighbourhoods have an affect on the experience of people over and above what could be predicted on the basis of their individual characteristics. In other words: are there cumulative affects in certain disadvantaged neighbourhoods due to the clustering of many people who experience considerable levels of need.
Neighbourhood Effects	Effects due to the composition of estates/neighbourhoods.
Positive Affect	Scale: comprising 20 items to determine a person's mind-set
Negative Affect	Scale: comprising 20 items to determine a person's mind-set
Life Satisfaction	Scale, comprising 5 items to measure satisfaction with life
Depression	Scale, comprising 20 items related to depression (CES-D)
Hopefulness	Scale: comprising 8 items related to hope (HOPE)
Parent-Child Relationship	Scale, comprising 20 items on quality of relationship (PCRI)
Parent-Child Conflict	Scale, comprising 18 items on dealing with conflict (CTS-PC)
Strengths and Difficulties	Scale, comprising 25 items to assess child behaviour (SDQ)
Ineffective Arguing	Scale, comprising 4 items to assess partner's relationship
Local Problems Score	Scale, comprising 12 items on quality of neighbourhood (LPS)
Local Services Score	Scale, comprising 13 items on quality of neighbourhood (LSS)

1 Introduction

The context for this study is set by the wider objectives of the seven organisations which have come together as Bray Community Consortium to commission this study on identifying the needs of children, families and neighbourhoods in the Bray area. Of these, Bray Partnership has exercised an overall coordinating function. The individual organisations are as follows:

Bray Partnership

Bray Partnership was established in 1995 and is one of 38 local development companies in Ireland. Its mission is to tackle social exclusion and disadvantage in the Bray area, using a partnership approach. This is achieved by bringing together local community groups, statutory bodies, social partners and elected public representatives to identify local needs and issues and develop effective collaborative responses. Each year, Bray Partnership's programme of activities resources and supports a wide range of projects and initiatives aimed at tackling the disadvantage, poverty and exclusion experienced by individuals and communities in the Bray area. A number of inter-linked support programmes, ranging from education to employment supports, enterprise and community development, give practical application to the Partnership's mission and objectives. The programmes offer a wide range of supports including funding to individuals, groups and communities to address the issues that affect their everyday lives.

Bray Local Drugs Taskforce (LDTF)

Local Drugs Task Forces were established in 1997 by the Government in areas experiencing the worst levels of opiate misuse. Bray was designated as an LDTF area in 2000. The LDTF in Bray was established with representatives from the voluntary, community and statutory sectors in Bray to work in partnership and develop a service development plan for Bray. Following a comprehensive public consultation process this plan was produced in 2001 and included a range of measures in relation to treatment, rehabilitation, education, prevention and curbing local supply. Bray Local Drugs Task Force is responsible for overseeing the implementation of this plan. Bray LDTF is currently undergoing a Strategic Planning process and will contribute to the development of a new National Drugs Strategy post 2008.

Young Peoples Facilities and Services Fund Local Development Group (YPFSF)

The Young Peoples Facilities and Services Fund (YPFSF) is a programme administered by the Department of Community Rural and Gaeltacht Affairs. The YPFSF targets those young people most at risk from substance misuse in areas of disadvantage. By developing youth, sport and other recreational facilities the YPFSF seeks to attract at-risk young people away from the potential dangers of substance misuse into safe, non-threatening and constructive environments.

The Local Development Group (LDG) was established in Bray to develop plans relevant to the needs of the community and to oversee the implementation of these plans. The LDG in Bray is made up of representatives from Bray Local Drugs Task Force, County Wicklow VEC, Bray Town Council, Bray Partnership and Community Representatives.

Bray Travellers Community Development Group

Bray Travellers Community Development Group was founded in 1993. The basis of its work is integration rather than assimilation. Its catchment area stretches from Shankill to Kilcoole. The group employs seven staff members and is funded under the CDP Programme of the Department of Community, Rural and Gaeltacht Affairs.

The group's work is based on the belief that Travellers form part of a distinct culture within Irish society, that their culture and distinctive lifestyle, based on a nomadic tradition, sets them apart from the settled population of Ireland, and believes that Travellers experience isolation and exclusion from many aspects of Irish society because their culture and traditions are little understood. The group strives to address this and advocates for and with Travellers in addressing issues of equal rights, discrimination, educational disadvantage and inadequate health care.

Little Bray Family Resource and Development Centre

Little Bray Family Resource and Development Centre was initiated in 1986 to support women and their respective families in the area with a wide range of services. The project received core funding through the Community Development Programme in 1993. Much has been developed over the past twenty two years through the commitment and participation of local people. Developments have also been initiated through collaboration with state agencies to address the needs and issues of the local area, which includes Fassaroe Estate and the wider Little Bray area.

Little Bray Family Resource and Development Centre has been the key focus of community development activity and development in the area, with a wide range of services and needs addressed. These include Childcare, Education and Training, Environment, Youth, Health and Drugs. The key focus of addressing all these issues has been participation of local people in decision making processes. The central focus of development and participation of local people in making decisions that affect their lives has been fundamental to any positive initiatives and developments over the past twenty two years.

St. Fergal's Resource Centre

St. Fergal's Resource Centre is a community development project which has been providing a broad range of services and programmes for 19 years. The project targets those who experience social exclusion in the community of Ballywaltrim.

Bray RAPID Programme

The RAPID (Revitalising Areas by Planning, Investment and Development) Programme is a focused Government initiative to target the 45 most disadvantaged areas in the country. The Bray Programme aims to ensure that priority attention is given to tackling the spatial concentration of poverty and social exclusion within the designated areas through targeting state resources, available under the National Development Plan. The Programme also calls on Government Departments and State Agencies to bring about better co-ordination and closer integration in the delivery of services. The RAPID estates in Bray are Oldcourt, Ballywaltrim Heights, Deerpark, Ard na Greine, White Oaks, Heatherwood, Cois Sliebhe, Kilbride Grove and Fassaroe.

The RAPID programme in Bray since 2001 has provided funding for estate enhancements, traffic calming measures, employment of staff for local authority estate development, community adult education, childcare and youth work. RAPID has further supported local groups to access funding for the building of community centre's in Little Bray and Ballywaltrim, as well as making applications under the Sports Capital and Dormant Account funds.

1.1 Objectives

This study has two main objectives. The first is to determine the level of need and well-being among children, families and neighbourhoods based on a sample of housing estates in the Bray area. The second is to determine the factors which influence the well-being of children, families and neighbourhoods in these estates. Both objectives are designed to contribute to the overall strategy of the organisations represented by Bray Community Consortium by providing a robust assessment of need which can be used as a baseline against which targets can be set and progress measured. 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 by the study are designed to assist Bray Community Consortium in both reflecting on, and strengthening, the overall vision which has supported its members' activities over the past number of years.

In this chapter we will describe the context and methodology of the study. The broad context is set by the objectives and activities of the member organisations of Bray Community Consortium which were outlined in the introductory section. We will seek to describe the instruments used to measure need and well-being in Section 1.2, the procedures used to draw a sample of estates and households in Section 1.3 and the methods of data analysis employed in Section 1.4.

1.2 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 this concept. People 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 the physical, psychological, relationships, income, lifestyle and so on. 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. 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 families 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, which informs our approach to assessing the needs of families, children and neighbourhoods in the Bray area.

In doing so, this study will frequently refer to three other studies, conducted by the same authors, which together pioneered the measurement of well-being and need of families and children in Ireland. These are the Ceifin study (McKeown, Pratschke and Haase, 2003), the Barnardos study (McKeown and Haase, 2007) and the Respond! study (McKeown, Haase and Pratschke, 2007). The Ceifin study was the first of these research projects, setting out to develop a methodology based on a quota sample of four different family types: married and cohabiting two parent families and two types of one parent families. The Barnardos study used a representative sample spanning the whole of Limerick and was particularly focusing on the needs of children. The Respond! study covered a representative sample across all of the larger housing estates managed by the Respond! housing association across the whole of the country.

Importantly, the Barnardos study, the Respond! study and the present study of families, children and neighbourhoods in the Bray area are all based on the same set of survey instruments. This is of considerable importance, as it will allow us to pool the resulting data and to analyse it together. Taken on their own, each study has a rather limited scope, and the financial constraints of the organisations that funded these studies made it impossible to fully exhaust their potential. In practical terms, this means that either the representativeness of the data is compromised, or there is limited scope to include sufficient control group data to compare the neighbourhoods of particular interest with a representative sample of the population in general. By analysing the data from the three studies together, however, we will

be able to make important comparisons, as well as improving the statistical power when looking at causal relationships.

In common with the Barnardos and Respond! studies, the Bray study also has its own specific focus, as it widens the scope of the households studied beyond those of the previous projects. The Barnardos and Respond! studies were exclusively concerned with the well-being of families with children and, for reasons of cost effectiveness, based exclusively on interviews with mothers. The Bray study, in contrast, also includes households without children, interviews with fathers, and two specific population groups: Travellers and homeless people. The rationale for this derives primarily from the objectives of the organisations represented in Bray Community Consortium, which span all disadvantaged sections of society. The focus of this study is thus on comparing the needs of different population groups as well as specific neighbourhoods.

1.3 Questionnaire Design

The instruments used in this study to measure the well-being of children, families 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. The three criteria are that each indicator should be:

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

Our questionnaire draws together a range of instruments which have been tried and tested internationally. Equally importantly, they have been used in a number of studies of family well-being in Ireland. In addition to the three studies already mentioned, these include the evaluation of Springboard projects in Ireland (McKeown, Haase and Pratschke, 2001; 2004a; 2004b), and the assessment of the mental health needs of children in Ballymun (McKeown and Haase, 2006) and other parts of the Dublin area (McKeown and Fitzgerald, 2006a, 2007) and Mayo (McKeown and Fitzgerald, 2006b). As such, they provide useful benchmarks against which to measure well-being in Bray neighbourhoods. 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) and the EU Survey on Income and Living Conditions (EU-SILC). These instruments and the dimensions of need which they measure are summarised in Table 1.1.

Table 1.1 Instruments used to Measure Well-Being and Need in Three Studies

Barnardos	Respond!	Bray	Dimensions of Need	Scale for Measuring Well-Being
			Section A: Background Information	
√	√	√	Demographics	Standardised questions from CSO, ESRI, etc.
			Section B: Neighbourhood Characteristics and Support Networks	
√	√	√	Local Problems	Local Problems Score, adapted from the UK Social Capital Module of the General Household Survey 2000[1], and used in Ireland by the Institute of Public Health in Ireland[2].
√	√	√	Local Services	Local Services Score, adapted from the UK Social Capital Module of the General Household Survey 2000, and used in Ireland by the Institute of Public Health in Ireland.
√	√	√	Neighbourliness	Measures of Trust and Reciprocity, adapted from the UK Social Capital Module of the General Household Survey 2000, and used in Ireland by the Institute of Public Health in Ireland.
	√		Community Cohesion	Indicators of community cohesion and inclusion
	√	√	Neighbourhood Structures	Adapted from a scale used in Project on Human Development in Chicago Neighbourhoods and available at: http://www.icpsr.umich.edu/PHDCN/sso
	√		Voluntary Involvement	Adapted from the UK Social Capital Module of the General Household Survey 2000, and used in Ireland by the Institute of Public Health in Ireland.
√	√	√	Support Networks	Adapted from other scales, and used in a number of studies in Ireland[3].
			Section C: Personal Characteristics	
√	√	√	Personality Traits	Positive and Negative Affect Scales (PANAS)[4], comprising 20 items and two sub-scales: (i) positive affect (ii) negative affect.
√	√	√	Satisfaction with Life	Satisfaction with Life Scale[5], comprising five items.
√	√	√	Depression	The Center for Epidemiologic Studies Depression Scale (CES-D) Scale[6], comprising 20 items divided equally into four sub-scales: (i) depressed affect (ii) positive affect (iii) somatic symptoms (iv) interpersonal problems.
√	√	√	Hopefulness	The Hope Scale[7], comprising 8 items divided equally into two sub-scales: (i) pathways (ii) agency.

1 Coulthard, Walker and Morgan, 2002
2 Balanda and Wilde, 2003
3 McKeown, Pratschke and Haase, 2003
4 Adapted from Watson, Clark, and Tellegen, 1988.
5 Diener, Lucas and Oishi, 2002:70
6 Reproduced in McDowell, 2006:350-358.
7 Snyder, Rand and Sigmon, 2002:268-270

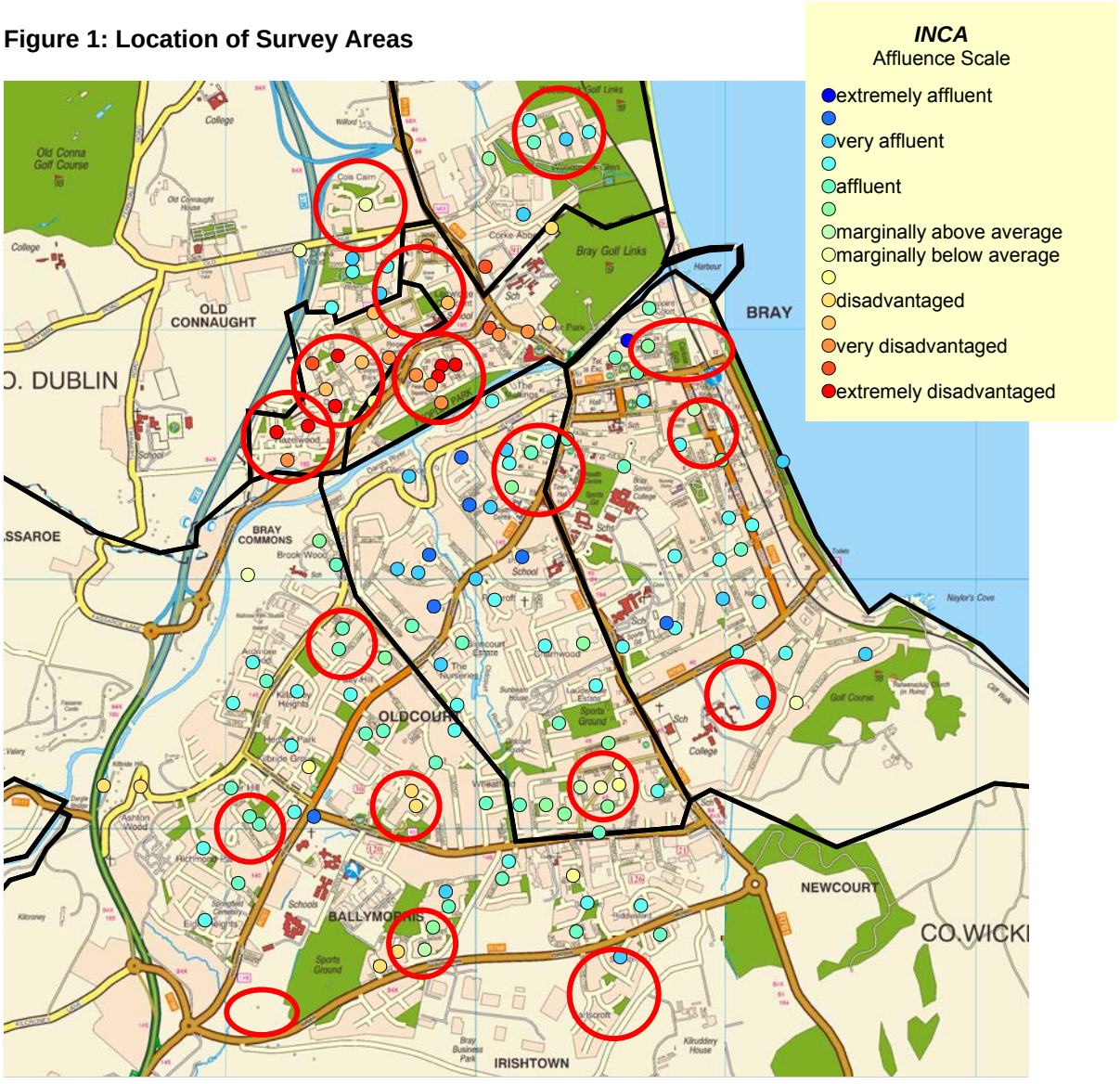
Barnardos	Respond!	Bray	Dimensions of Need	Scale for Measuring Well-Being
			Section D: Parent's / Individual's Health & Lifestyle	
√	√	√	Perceived Health	Question National Health and Lifestyle Surveys[8]
√	√	√	Disability	Questions from the Census of Population, 2006
√	√	√	Home Educational Environment	Questions from Educational Research Centre study on reading literacy in disadvantaged primary schools[9].
√	√	√	Lifestyle	Smoking, Drinking and Drugs questions from NACD's Drug Prevalence Survey[10] and National Health and Lifestyle Surveys[11].
			Section E: Relationship with Child	
√	√	√	Parent-Child Relationship	Parent-Child Relationship Inventory (PCRI)[12] 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.
√		√	Parent-Child Conflict	Parent-Child Conflict Tactics Scale (CTS-PC)[13] comprising 18 items and four sub-scales: (i) non-violent discipline (ii) psychological aggression (iii) minor physical assault (iv) severe physical assault.
			Section F: Needs of Children	
√	√	√	Strengths and Difficulties	Strengths and Difficulties Questionnaire (SDQ)[14], comprising 25 items. Five sub-scales: (i) conduct problems (ii) emotional symptoms (iii) hyperactivity (iv) peer problems (v) prosocial behaviour.
√	√	√	Type of School	Bespoke question
√	√	√	Reading Ability	Question from Educational Research Centre study on reading literacy in disadvantaged primary schools[15].
√	√	√	School Attendance	Bespoke question
√		√	Child Services	Bespoke question
			Section G: Relationship with Partner	
√	√	√	Relationship with Partner	Ineffective Arguing Inventory[16], comprising 4 items and no sub-scales.
√	√		Positive Emotions	Intensity and Time Affect Survey[17], comprising 8 items and two sub-scales: (i) love (ii) joy.

8 See Centre for Health Promotion Studies, 2003.
9 Eivers, Shiel and Shortt, 2004.
10 National Advisory Committee on Drugs, 2005.
11 See Centre for Health Promotion Studies, 2003.
12 Adapted from Gerard, 1994.
13 Straus, Hamby, Finkelhor and Runyan, 1995.
14 Available at www.sdqinfo.com
15 Eivers, Shiel and Shortt, 2004.
16 Kurdek, 1994.
17 Reproduced in McDowell, 2006:214.

1.4 Sample Areas and Survey Population

In line with the requirements outlined in the Terms of Reference by Bray Community Consortium, the estates and streets chosen for inclusion in the Study of Children, Families & Neighbourhoods in the Bray Area are strongly geared towards providing specific insights into the more disadvantaged parts of the Bray town area. At the same time, some more affluent areas were also included, specifically to provide control data and to allow us to obtain reasonable estimates for the area as a whole. In addition to the 17 estates and streets thus selected, two special interest groups that are not associated with any particular geographical area were also included in the survey: Travellers and homeless people.

Figure 1: Location of Survey Areas



Note: INCA (Irish National Classification of Addresses) is a street/neighbourhood level classification system of relative affluence and deprivation based on the Irish deprivation index (Haase & Pratschke 2005) and is jointly developed by GAMMA, Ticketmaster and Trutz Haase.

Once the neighbourhoods were selected, respondents were chosen at random using a random starting point and a fixed sample step so as to fully cover the respective estates. In total, the survey yielded 350 completed interviews in 19 clusters. The estates chosen cover roughly one third of Bray's total population and, within the clusters, roughly one tenth of households were included in the survey. This is a reasonably high sampling ratio and is likely to provide a reliable picture of families in the specific Bray neighbourhoods, as well as yielding robust estimates for Bray as a whole.

1.5 Re-weighting the Sample Data

If our primary aim was to estimate the number of adults and children with certain characteristics in the Bray area, the most accurate way to establish these would be through a survey based on a randomly selected sample. However, as is the case with this study, our primary aim is to investigate the needs of those families and individuals who are at the more disadvantaged end of the social affluence spectrum, and in particular those who are living in certain estates and neighbourhoods. Furthermore, we may want to ask whether the clustering of families or individuals with higher levels of need in particular estates results in additional problems, both for the individual persons or families involved and/or at the estate level.

For this reason, the terms of reference specify 14 specific neighbourhoods which were to be included in the survey, as well as two special interest groups, Travellers and homeless people. This almost exhausted the scope of the study in terms of its overall size. Nevertheless, to gain some comparative data, we added three distinctly affluent estates to these 16 sample clusters, one each in North, Central and South Bray. Thus the total sample comprises 19 neighbourhoods, the greatest possible number of clusters that could be accommodated within a total survey size of 350 interviews.

Estate level results

As the households were randomly selected within each of the clusters, the likelihood of any given household being selected for interview within each estate is the reciprocal value of the sample step utilised during the interview process (Weight1). After applying this weight, the tables effectively provide estate-level data, which is at the core of our interest. It must, however, be noted that the number of interviews in each cluster (19) is at the lower end of the minimum requirements to gain statistically significant insights for each neighbourhood area. Nevertheless, the estate-level results shown in the tables throughout this study can be interpreted as a reasonably accurate picture of conditions prevailing on these estates. The total number of households represented in the estate level data are 3,068 or 30 per cent out of a total of 10,340 households in the total study area.

Estimates for Aggregate Areas and Bray as a whole

Given the requirement to include a large number of specified neighbourhoods in the survey, the re-weighting of the data to gain representative estimates for Bray as a whole is not as straightforward as would have been the case in a single-stage random design for household selection.

Having re-weighted the data to estate level, the second step towards gaining results for Bray as a whole involves re-weighting the data to known household characteristics for the three sub-areas of North, Central and South Bray. To this end, we utilise two distributions which are known from the 2006 Census of Population: firstly, the proportion of household types in each of the areas (local authority rented, privately rented and owner occupied) and, secondly, the number of households in each of the four main family types (two and one parent families and two and one adult households without children). These are two critical dimensions which reflect the different life cycle and affluence characteristics of the Bray population and, by re-weighting the data by these two dimensions, we can gain reasonably robust results for each of the three sub-areas, as well as for Bray as a whole.

1.6 Data Analysis

The analysis involved preparing frequency tables and cross-tabulations, the full results of which are presented in the Technical Appendix. In addition, we use regression analysis and multi-level modelling to explore the relationship between the needs of parents and adults (in the areas of depression, life satisfaction and parenting), children (in the area of mental health), and neighbourhoods (based on an index of need) – these are the dependent variables – and a range of individual, family, socio-economic and neighbourhood factors (the independent variables). In Chapter One of the Technical Appendix, 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 key aspects of well-being and need are influenced by the unique contribution of individual-level and estate-level characteristics. 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 the well-being of 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 or neighbourhood – mirroring the best practice for studies of this type, and fully exhausts the possibilities of the data collected.

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 together with strong theoretical hypotheses and in conjunction with the findings of other research on the determinants of well-being among families, children and neighbourhoods, in suggesting possible interpretations of those associations as well as possible strategies for addressing those needs.

1.7 Presentation of Tables

Throughout the analysis and Technical Appendix (TA), we present results distinguishing between the following:

(i) the 17 estates/neighbourhoods,
(ii) aggregate data for the three sub-areas of North, Central and South Bray
(iii) re-weighted data for Bray and Wicklow Rural
(iv) data for the four family types as outlined above,
(v) data distinguishing between male and female respondents
(vi) data distinguishing between respondents with a Medical Card and those without,
(vii) data for travellers and homeless people, and
(viii) re-weighted data for County Wicklow as a whole.

Please note that the results presented for various group data (points iv, v and vi above) are re-weighted to County Wicklow as a whole!

In addition, we present, where available, comparison data from the Limerick and Respond! studies, as well as from the Ceifin study, which provide the best available estimates for Ireland as a whole. In some instances, the tables also include comparison data from other sources.

1.8 Limitations of the Study

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

The sample size, though large relative to the total number of households in each estate (350 out of 3,068 households, equal to 11%), and estates or 'clusters' (3,068 out of 10,340 households, equal to 30%) within Bray, is considerably smaller than would be ideal for multi-level modelling. Multi-level modelling normally requires 20 to 30 Level 1 observations (households) and as many as 100 Level 2 units (estates/neighbourhoods), depending on the phenomenon being studied and the strength of the relationships involved, including the strength of contextual effects. Overall, the study treads a careful balance between providing estimates for the 17 neighbourhoods and two specific population groups, on the one hand, and providing reasonable estimates for Bray as a whole, on the other. Where estimates appear to be less reliable, we will draw appropriate attention to this.

Secondly, the study of child outcomes is based solely on interviews with one of the parents, mostly the mother. This decision is governed primarily by cost considerations, although it is an internationally accepted approach to needs analysis in relation to children. The disadvantage of only interviewing parents is that the voices of children are not heard directly. It is recognised that the voice of the child is very important. However, the objectives of the study are not seriously undermined by this exclusion, essentially because children typically under-estimate their needs by comparison with their parent's perception, and it is doubtful if any significant needs have been missed without the voice of the child.

Thirdly, the three studies used for comparison throughout this report are all based on interviews with families with children. The Ceifin study included interviews with both mothers and fathers, while the Barnardos and Respond! studies were entirely based on interviews with mothers. When comparing results, this must be born in mind; i.e. they provide a closer reference to the outcomes for two and one parent families, than Bray as a whole.

Finally, we have to draw attention to the fact that this study pays considerably greater attention to the measurement of the internal environment and the way in which it influences a person's well-being than to the external environment. No attempt is made, for example, to assess the objective income situation of families other than the comparatively crude classification of whether a respondent has a medical card or not. We also do not assess whether a household has access to earned income other than from the respondent, nor do we assess job satisfaction and functional control at work, all of which are important dimensions in the external environment that influence individual well-being. Instead, our choice of survey instruments is largely guided by the fact that there exists a considerably larger body of studies on the distribution and effect of these external factors compared to those which attempt to conceptualise and measure the internal factors.

None of these limitations, however, invalidate the results of this study, which offer a robust picture of well-being amongst some of the most excluded population groups and disadvantaged neighbourhoods in the Bray area. 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 Bray.

2 Characteristics of Households

This chapter describes some of the socio-demographic characteristics of Bray households and compares 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.

Family Structure

From the survey data, one can distinguish between seven types of households (TA Table 1.4). In practice, however, such fine distinctions become unmanageable, as the sample size of the survey is too small to report results for so many entities. We have thus reduced the seven family types to four categories as follows:

- two parent households, with children (under 18 years of age)
- one parent households, with children (under 18 years of age)
- respondent aged 55 and over, without children, and
- respondent aged under 55, without children.

The term family structure is used to describe whether there are one or two parents in the household, or whether there are no children and the respondent over 55 years of age. When we talk about families with children only, we will use the term “family households”. Based on the survey, one-parent families account for 25% of family households. This compares to a Census-based share of 28%, and is well above the 21% share prevailing in Ireland as a whole. The composition of one and two-parent family households in Bray, however, differs from the nationally prevailing picture. One-parent households in Bray comprise a much higher proportion of single persons (80% compared to 57% in Ireland) while two-parent households have a marginally lower proportion of cohabiting couples (11% compared to 14% in Ireland).

Overall, Bray has a comparatively strong ‘family’ base, with 54% of households being family households that include children up to 18 years of age. This is above the national average of 50% and contrasts even more strongly with Dublin (47%) and particularly Dublin City (38%). Bray thus reflects the trend for families to increasingly locate in the urban periphery, rather than the major cities.

The proportion of the population aged 55 and over accounts for 21% of Bray’s population and differs just marginally from the proportions pertaining for Dublin (20%) and Ireland as a whole (22%). Thus, although Bray has a significant sector catering for older people, this is not reflected in an overall greater share of older people in the population, but is effectively compensated for by its attractiveness as a location for families.

Household Size

The average number of persons in each household in Bray is 3.1. The numbers for two- and one-parent family households are 4.1 and 2.8 respectively. Family households have an average of 1.7 children. The average age of the oldest child is 9.1 years and the average age of the parents is 39 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.

Housing Status

The proportion of households owning their home is 72%, slightly below the national average of 77%. However, there are huge variations between different population groups and areas. While two parent families (80%) and older households (93%) are both above the average, only 50% of one-parent families own their home and Travellers or homeless people are completely excluded from home ownership!

At the level of housing estates, again huge differentials appear, broadly indicating the relative wealth that characterises the different neighbourhoods. At the upper end are Woodbrook (100%), Killarney Park (84%) and Swanbrook (79%), all of which are considerably above the Bray average for home ownership. The Headlands, Connolly Square and Duncairn stand out in that they are the three areas with the highest proportion of privately rented accommodation, accounting for about one-third of total households each. At the opposite end, local Authority housing is highly concentrated in Guiltspur Heights (89%), Oldcourt (83%), Hazelwood and Ard na Greine (74% each) and Cois Cairn (69%). This contrasts with an overall provision of local authority housing of 13% for Bray as a whole. Furthermore, 68% of Travellers live in local authority housing, whilst all of the homeless people are obviously deprived of any home.

Medical Card

37% of Bray's population avail of a medical card. We are using the presence or absence of a medical card as a proxy for social class or differentiation in financial well-being throughout the study. The proportion of two parent households with medical cards is considerably lower at 15%, indicating their relatively stronger economic position. In contrast, 58% of one-parent families avail of a medical card and 68% of older households without children, indicating the greater economic dependency of these two population groups. An even higher proportion applies to homeless people (77%) whilst 100% of Traveller families have a medical card.

With regard to individual estates, high proportions of households with medical cards are particular prevalent in Hazelwood (84%), Guiltspur Heights (80%), and Greenpark Road (74%).

Respondent's Education

The level of education among the population of Bray is marginally above that for Ireland as a whole. Based on our sample survey, we estimate that 20% of respondents have a primary education only. This is a slight over-estimate as a result of the over-sampling of disadvantaged neighbourhoods and the imperfect re-weighting of the data. The 2006 Census of Population locates 16% of Bray's population in this category, compared to 19% nationally. At the higher end of educational achievement, the survey indicates that 35% of Bray's population have a third-level education. This compares to an identical proportion of 35% for Bray and 31% nationally, based on the 2006 Census of Population.

As can be expected, there is a higher prevalence of low education amongst older people (57%), which is largely a cohort effect; i.e. successive age cohorts have attended school/college for longer periods, a trend particularly pertinent over the past fifteen to twenty years. Low levels of education are also particularly prevalent amongst medical card holders (43%), compared to 9% for those without a medical card, once more showing the strong relationship between education levels and economic dependency. However, by far the highest occurrence of low education is amongst Travellers, 84% of whom have primary education only and homeless people, 65% of whom fall into the same category.

In terms of specific neighbourhoods, low education levels are most pronounced in Hazelwood (53%), Wolfe Tone Square (53%), Ballywaltrim (45%) and Dargle Heights (42%).

Respondent's Employment

The distribution of economic activities in Bray largely reflects those pertaining for Ireland as a whole, with 40% working full-time, 16% working part-time, 4% unemployed and 23% being full-time homemakers. The higher proportions amongst the retired (10%) and those with a long-term limiting illness or disability (6%) may be an artefact of the sampling methodology; i.e. the greater likelihood of meeting such person in their home in a door-to-door survey. The 2006 Census indicates about 4% of households to be retired for both Bray and Ireland as a whole.

Overall, 60% of Bray's households are economically active. This rises to 67% amongst two parent families and even 73% amongst single parents, but is obviously considerably lower amongst older households, the largest proportions of whom are retired. Economic activity rates are also considerably lower amongst medical card holders (38%). However, the latter also contain many retired households. Economic activity is by far the lowest amongst Travellers and homeless people. Only 10% of Travellers are gainfully employed and 16% are unemployed, four times the level prevailing for Bray as a whole. One quarter of homeless people are unemployed (23%) with the remainder (77%) being either long-term ill or having a disability.

With respect to specific estates, labour force participation falls below one third of households in Oldcourt (33%), Greenpark Road (31%), Peter's Road (31%) and Guiltspur Heights (30%).

Respondent's Financial Position

Financial well-being has both an objective and a subjective dimension. We measure the objective dimension by reference to whether a household avails of a medical card, while the subjective dimension is illustrated by the respondent's capacity to cope financially.

The majority of respondents in Bray (86%) are not experiencing financial strain, as indicated by 'finding it difficult to manage' or 'in serious difficulties'. However, 13% are experiencing financial strain, a comparable proportion to that identified in the Ceifin study (15%), though the latter measure applies to family households only.

It is useful to place this result in the context of a recent report which found that the level of financial strain amongst Irish households declined considerably between 1994 and 2001 (from 31% to 10%), but also fell for a 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 people with disabilities (from 48% to 19%). In light of this, the level of financial strain among respondents in Bray appears to be broadly similar to that experienced by Irish households generally but is considerably higher for specific groups which are vulnerable to poverty.

Thus measured, one fifth (20%) of lone parents in Bray are experiencing financial strain, 32% of medical holders, 37% of Travellers and a staggering 82% of homeless people.

With respect to specific estates, the proportion of households experiencing financial strain is highest in Hazelwood (53%), Ard na Greine (47%), Dargle Heights (42%) and Ballywaltrim (39%).

3 The Well-Being of Adults

In this chapter, we assess the well-being of respondents in Bray. Our assessment is based on data from a sample of 350 respondents in Bray estates, but data from other surveys is used for comparative purposes to establish the extent of need among Bray households. The full set of numerical results are presented in Chapter Three of the Technical Appendix.

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) and this is used here. The survey revealed that, overall, Bray respondents are more positive and less negative than their counterparts in Limerick or Respond! housing estates and particularly so when compared to the outcomes of the Ceifin study.

There are, however, some exceptions: Elderly households score slightly worse, as do medical card holders. Well-being is particularly low amongst Travellers and homeless people. With regard to specific areas, Oldcourt and Duncairn appear to be places with lower levels of well-being.

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. We measured Life Satisfaction using the Satisfaction with Life Scale. The results show that, overall, Bray respondents have higher levels of Life Satisfaction compared to mothers in Limerick and Respond! housing estates. However, respondents with a medical card and those in one-parent households tend to have somewhat lower levels of Life Satisfaction. Again, Life Satisfaction is also lower amongst Travellers and, as can be expected, by a large margin the lowest amongst homeless people. As was the case with the previous measures of well-being, Life Satisfaction is significantly lower in Oldcourt and Duncairn.

Depression

We measured depression using the Depression Scale of the Centre for Epidemiologic Studies (CES), usually referred to as CES-D. A recent review of the scale noted that "The CES-D is one of the best-known survey instrument for identifying symptoms of depression. It has been extensively used in large studies and norms are available; it is applicable across age and socio-demographic groups, and it has been used in cross-cultural research. It has often been used in studying the relationships between depressive symptoms and other variables". 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 Bray respondents is 10% (based on the cut-off score of 20) and 16% (based on the cut-off score of 16). Depressive symptoms for Bray respondents as a whole are thus considerably below those obtained in the Limerick and Respond! studies.

Higher rates of depression are observed amongst medical card holders (9%) versus non-medical card holders (2%) and lone-parent households (10%) versus two parent households (2%). Depression is also more prevalent amongst women (5%) than men (4%) and reaches exceptional proportions amongst Travellers (58%) and homeless people (82%). All of these proportions relate to the cut-off score of 20 and County Wicklow as a whole.

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". 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).

Using the Hope Scale, the study found that 86% of respondents are hopeful but 14% are lacking in hope. This mirrors the findings from the depression analysis, in that Bray respondents have greater hope than was the case for mothers in Limerick or Respond! estates.

Among respondents for County Wicklow as a whole, elevated levels of hopelessness are experienced by medical card holders (19%), older households (16%), Travellers (42%) and again particularly homeless people (80%).

Perceived Health

Respondents rated their own health, as well as that of their partners and child(ren), on a five-point scale comprising 'excellent', 'very good', 'good', 'fair', and 'poor. Seventeen per cent of Bray respondents rated their health as either fair or poor, but this is strongly influenced by the poorer health rating amongst older people. When comparing the proportion with poor health amongst family households only, the results for the self-rated health of parents in Bray (5%) is just marginally below that of the population of Ireland (6%) as a whole.

For County Wicklow as a whole, self-rated 'fair or poor' health amongst men (16%) is almost identical to that of women (15%), but significantly higher amongst older households (26%), medical card holders (28%) and Travellers (37%). Homeless people experience the highest level of poor health at 59%. At a spatial level, higher levels of poor health are reported amongst households from Ard na Greine (37%), Peter's Road (26%) and Failte Park (25%).

The interpretation of responses with respect to the respondent's partner and child(ren) is difficult to assess in the absence of comparison data. It could be possible that the lower levels of poor health stated for the partner is a true reflection of reality as, in a door-to-door survey there would be a greater likelihood to meet a person who is staying at home because of poor health or a disability. If that was the reason for the difference observed, the true value for the population as a whole would be somewhere between the rates stated for the respondent and his or her partner and the self-rated observation on its own would over-estimate the true rate.

Long-Term Limiting Illness / Disability

We assessed the prevalence of any form of long-term limiting illness (LLI) / disability, using a question from the 2006 Census of Population. This shows that 17% of Bray respondents reported having at least one of the LLI/disabilities mentioned, as well as 6.5% of their partners. If the true value lies somewhere between these values, this would result in a figure of about 11 to 12 per cent for the Bray adult population, just above the rate of 9% reported in the 2006 Census of Population, which is generally regarded as an underestimate.

Again, there are huge variations between groups and localities throughout County Wicklow. Medical card holders report 21% LLI/disability, older households 18%, Travellers 42% and homeless people 77%. At a spatial level, the only locality with significantly elevated levels is Failte Park (40%), which was specifically included in the survey as it includes a larger estate for older people.

It is equally worth noting the low levels prevailing in Swanbrook (0%), Woodbrook, The Headlands and Wolfe Tone Square (all 5%). The first three of these were specifically included to provide some details about comparatively affluent estates and to complement the general selection of more deprived neighbourhoods. It clearly points to the effective social exclusion that operates throughout the housing market as people with disabilities will seldom be able to afford living in these estates.

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 Bray respondents is 37%, which is considerably below that found amongst women in the Limerick and Respond! studies. For Wicklow as a whole, smoking rates are higher among one-parent households (40%) compared to two-parent households (28%) and higher among medical card holders (42%) than non-medical card holders (24%), largely reflecting the fact that smoking is more prevalent amongst the lower social classes. Seventy-nine per cent of Travellers smoke and 100% of homeless people. The class-related prevalence of smoking can also be observed at estate level, ranging from a low of 10% in Swanbrook to nearly 80% in Ard na Greine, with most of the disadvantaged estates ranging in the in the 50-60% bracket.

The consumption of alcohol in Bray households (64%) is similar to that found in Limerick (65%), Respond! housing estates (67%) and the Ceifin study (70%). Interestingly, drinking alcohol is significantly more prevalent amongst non-medical card holders (74%) than medical card holders (44%) pointing towards the strong social character of drinking and the role of affordability. There is no clear association between either poorer or more affluent estates and higher levels of alcohol consumption, as both combinations occur.

About 4% of Bray respondents use prescribed sedatives, tranquillisers or anti-depressants, which is close to the national average of 5%, but usage of these drugs is considerably higher among Travellers (16%) and homeless people (36%). It also appears to be elevated in certain neighbourhoods, including Cois Cairn (21%), and Oldcourt, Ballywaltrim and Peter's Road (all about 16%).

As is the case in other studies of this type, the responses to taking Cannabis or harder drugs are likely to under-state their true occurrence. About 2% indicate taking cannabis (equal to the level in the Ireland study). The only exception to this are homeless people, 18% of whom indicate taking cannabis and 30% of whom indicate that they are taking either Cocaine, Heroin, Methadone or Ecstasy.

Support Networks

There is extensive research to show that support networks are a significant influence on the well-being of individuals and their families. In addition, strong support networks are known to improve physical health and mental health and to aid in recovery from illness and adversity. It is generally acknowledged that the relationship between support networks and well-being is 'bi-directional', in the sense that people 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. We measured support networks by asking respondents to rate the supportiveness of the following people on a scale of 1 to 10: their partner, parents, brothers and sisters, children, relatives, friends, people at work, neighbours, etc. and took the mean score of the ratings. In other words, the measure is one of the quality of the networks rather than their extensiveness.

The results indicate that the quality of support networks of respondents in Bray is very similar to that indicated by mothers in the Limerick and Respond! studies and marginally higher than in the Ceifin study. There are no significant differences between men and women, nor are

there differences between those on medical cards and those not. The only exception to this is in the case of homeless people who indicate a significantly lower level of support networks.

With regard to specific estates, more affluent estates tend to exhibit slightly higher values, as do older estates. The lowest values are recorded for Cois Cairn, Oldcourt and Dargle Heights.

Relationship Skills

We used the Ineffective Arguing Inventory to measure the skilfulness of respondents in resolving arguments with partners. Each respondent rated his/her effectiveness in resolving arguments with a current partner or, if they have no current partner, with a previous partner. As indicated by its name, the scale measures the ineffectiveness; i.e. a lower value indicates greater effectiveness. The results show that respondents in Bray have significantly better skills in resolving arguments with their partners than indicated in the Limerick, Respond! and Ceifin studies.

Men indicate a significantly higher level of effectiveness than women, but it needs to be borne in mind that this is based on their own perception. Other studies which applied more comprehensive measurements of both partners and each rating their own perception as well as their partner's ability / willingness to resolve conflicts point at greater awareness amongst women. There exists a markedly raised level of ineffective arguing amongst lone parents, which supports findings of previous studies, as well as amongst homeless people, pointing possibly at one of the contributing factors to their current situation.

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. We used the Parent-Child Relationship Inventory (PCRI), which comprises four sub-dimensions of that relationship: satisfaction, involvement, communication and limit-setting. As the parent-child data only applies to households with children, the data is directly comparable to the Limerick, Respond! and Ceifin studies.

The results of the survey reveal that parents in Bray have a slightly better relationship with their children as indicated by the other three studies. This also applies to most groups and localities. Fathers rate their relationship to their child(ren) marginally higher than mothers do, but this could again be influenced by a less critical attitude or by mothers taking on a stronger role in limit setting. Two-parent households report marginally better relationships to their child(ren) than one-parent households. There is no significant difference between medical card holders and non-medical card holders, but a slightly lower level is reported by Travellers.

Possibly somewhat surprisingly, there are no huge variations between localities. This is particularly interesting as, based on a large number of studies were we have applied the PCRI, we have considerable trust in this measure to even capture the slightest differences with considerable accuracy. However, marginally lower values do apply for Oldcourt, Killarney Park and Cois Cairn.

Conflicts with Children

The final measure in this part of the study assesses the extent of conflicts between parents and children. The Parent-Child Conflict Tactics Scale (CTS-PC) is designed to measure the extent of conflict and comprises four sub-scales: non-violent discipline, psychological aggression, minor physical assault and severe physical assault.

Overall, the data for Bray shows a level of conflict with children (17) just marginally below the estimates arrived at in the Limerick (19) and Ceifin study (18); the Respond! study did not include this section.

There are no huge differences between the different groups of population, but conflicts with children are definitely concentrated in certain estates, pointing to the possibility of strong neighbourhood effects in this regard. There are markedly elevated levels of conflict between parents and children in Dargle Heights (47), Duncairn (43), Hazelwood (40) and Cois Cairn (38). At a broader spatial level there are marked differences reaching from a high in North Bray (3), to an average score of 26 in Central Bray, and a low of 9 in South Bray. It thus appears that differences in parent-child conflicts are more characterised by their spatial articulation than by matters of relative affluence, family structure or gender.

4 Influences on the Well-Being of Adults

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

Effects 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 presented in Chapter Four of the Technical Appendix.

4.1 Factors Associated with Depressive Symptoms

The results of the multi-level analysis of depression, using the CES-D scale, are summarised in Table 4.1. This table indicates that 93.4% of the variance in depression scores is attributable to individuals, with the remaining 6.6% attributable to estates (level 2)[18]. The final model (Model 3) explains 53.9% of the variance between individual respondents and no less than 76.2% of the variance between estates. This is a 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.

At the individual level, the risk factors for depressive symptoms are Negative Affect and Long-term Limiting Illness (of the individual themselves). The protective factors, by contrast, are Positive Affect and Life Satisfaction. At the estate level, we must add another risk factor: living in an estate with high average levels of Negative Affect.

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 0.446 in depression scores. This personality attribute is very frequently identified as an important precursor of depression, as it involves a predisposal to experience difficulties and conflicts in a negative manner, as well as experiencing negative cognitive states more often. Where the individual suffers from a long-term and limiting illness or medical condition, he or she experiences, on average, an increase of 4.3 points on the depression scale used here.

18 Estimated from the data in Model 1 where level 1 variance is 72.701 and level 2 variance is 5.120. 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 4.1 Multi-Level Model of Depression

Parameter	Model 1	Model 2	Model 3
Individual Level Effects:			
Intercept	7.691 *	6.293 *	6.283 *
Positive Affect		-0.274 *	-0.334 *
Negative Affect		0.398 *	0.446 *
Life Satisfaction		-0.404 *	-0.425 *
Long-term limiting illness of respondent		4.495 *	4.270 *
Negative Affect x Life Satisfaction (interaction		-0.036 *	-0.038 *
Neighbourhood Level Effects:			
Average Negative Affect			-0.543 *
Variances:			
Variance of level 1 residuals	72.701 *	36.626 *	33.491 *
Variance of level 2 intercept residuals	5.120 *	3.093 *	1.222
Variance of level 2 slope residuals (Life satisfaction)			0.072
Covariance between level 2 intercept residuals and level 2 slope residuals (Life satisfaction)			-0.298
Model assessment:			
Deviance statistic	2251.131	2037.655	2011.555
Degrees of freedom	3	8	11
N	314	314	314
% variance explained: level 1		49.62%	53.93%
% variance explained: level 2		39.59%	76.21%

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

The two protective factors which reduce the likelihood of depression are Life Satisfaction and Positive Affect. Life Satisfaction, which refers to the individual's cognitive and affective evaluation of his or her life, has a counteracting effect, reducing depression scores by 0.43 units for each unit increase in Life Satisfaction. Similarly, Positive Affect – indexed by more frequent experiences of positive feelings such as being enthusiastic, excited, interested, alert, attentive and active – reduces depression (-0.33). It is worth pointing out that Negative and Positive Affect do not represent the poles of a single dimension, but rather two distinct aspects of emotional response which can vary autonomously. For this reason, an individual can be high in both Negative and Positive Affect; in this case, the latter counteracts the risk factor determined by the former, albeit with a slightly weaker effect per unit.

It is significant that the experience of depressive symptoms is also affected by the interaction of Negative Affect and Life Satisfaction (with an unstandardised coefficient of -0.038). Individuals 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 several units, whilst it is decreased by a similar amount amongst the same individuals if Life Satisfaction is high. By contrast, Life Satisfaction has a much weaker influence on depressive symptoms when the respondent is low on Negative Affect. Finally, it is interesting to note that gender has no significant influence, within the present sample, on depression, either in isolation or in interaction with other variables in the model.

Although the number of households with children included in the survey is not sufficient to build a full multilevel model of the influences on depressive symptoms in these families, it is possible to draw some provisional conclusions also in relation to this sub-group of respondents. To this end, we estimated a series of simpler regression models to ascertain whether, for respondents with children, additional (or different) factors influence well-being. In

fact, this analysis identified just one additional factor, whilst the effects of two of the variables identified previously as risk/protective factors are no longer statistically significant. The additional factor is the parent-child relationship (as measured by the PCRI), with an unstandardised coefficient of -0.09, whilst the variables that are now excluded from the analysis (perhaps due to the decreased statistical power of the smaller sample) are Positive Affect and long-term limiting illness.

The remaining variables do not exert a statistically significant influence on the depression score, at least not within the current sample. These variables include the following: family type, gender, residential tenure, education level, occupational situation, medical card holder, financial situation, trust, reciprocity, community involvement, health (of self, partner and child), disability/impairment (of self, partner and child), long-term limiting illness (of partner and child), cigarette consumption, presence of a dictionary, atlas, books, computer or internet connection in the home, number of persons in the home, age, length of residency, hope, Parent-Child Relationship (PCRI), Conflict Tactics Scale (parent-child CTSPC), presence of a partner, Inefficient Arguing scale, Children's Difficulties (SDQ), Support Network, presence of children, immigrant from a developing country, and at the estate level: average years of residency in the estate, percentage of residents with a General Medical Card, percentage of residents with a primary school education only, average Local Problem Index score, average Local Services Scale score, percentage who trust most people in the area, percentage who exceed critical threshold for depression, average Hope score, average Life Satisfaction score.

In terms of estate-level effects, the results in Table 4.1 indicate that 39.6 per cent of the variance is attributable to 'compositional factors', i.e. systematic differences between estates in values for Negative Affect, Positive Affect, Life Satisfaction and long-term illness. More than one third (36.6%) is attributable to 'contextual factors' across the different estates. Given that estate-level effects account for 6.6 per cent of the variance in depression scores, this implies that contextual or neighbourhood factors explain more than 2 per cent of the total variance in depression scores.

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 due to the absence of longitudinal data. Beginning with the risk factors, it is clear that while Negative Affect has a strong influence on depression, this 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 the specific difficulties associated with a long-term illness or limiting medical condition. Clearly, interventions to support residents in these circumstances would, other things being equal, alleviate the symptoms of depression. Turning to the protective factors, measures which strengthen Life Satisfaction will help to alleviate depression, as is the case also with Positive Affect. These domains have a strong cognitive dimension which essentially entails a perspective on life that is positive, active and appreciative. There is growing evidence that this perspective can be cultivated by practices which help people to think and feel differently about their past, their present and their future. It is also becoming increasingly evident that Life Satisfaction incorporates an important contextual dimension that cannot be reduced to the sum of individual cognitions and attributes, which further reinforces the view that intervention strategies can influence outcomes, perhaps over a longer timescale than is often assumed.

4.2 Factors Associated with Life Satisfaction

The results of the multi-level analysis of Life Satisfaction are summarised in Table 4.2. These show that 83.1 per cent of the variance in Life Satisfaction scores is attributable to individuals with the remaining 16.9 per cent attributable to estates. 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 40.4 per cent of the variance between individual respondents and no less than 90.4 per cent of the variance between estates. This is a highly satisfactory result, in terms of the individual-level and, especially, estate-level results. It is interesting to note that the level 2 variance is almost entirely attributable to compositional factors, especially in relation to Positive Affect.

At the individual level, the main risk factors which threaten to reduce Life Satisfaction are depression, child disability or impairment and gender. We have already seen in the previous section that depression is influenced by Life Satisfaction (after controlling for other factors also), and here we see that Life Satisfaction is influenced by depression (-0.25), which underlines the bi-directional nature of this influence. This influence has a complex, multilevel structure which we will discuss below. Where a child has a disability or impairment (such as a learning disability, hearing impairment or a chronic illness or condition), this reduces the respondent's Life Satisfaction score, on average and net of the other influences included in the model, by just over 3 points. Finally, men have lower levels of Life Satisfaction, holding all other influences constant, with an unstandardised coefficient of -1.4.

Table 4.2 Multi-Level Model of Life Satisfaction

Parameter	Model 1	Model 2	Model 3
Individual Level Effects:			
Intercept	26.801 *	27.021 *	27.102 *
Positive Affect		0.130 *	0.151 *
Depression Score (CES-D)		-0.249 *	-0.253 *
Hope		0.201 *	0.181 *
Support Network		0.838 *	0.826 *
Gender		-1.302 *	-1.429 *
Child has a disability or chronic illness/condition		-3.199 *	-3.083 *
Primary school vs. lower secondary education		1.569 *	1.534 *
Higher secondary vs. lower secondary education		0.116	-0.073
Third Level vs. lower secondary education		0.133	-0.079
Neighbourhood Level Effects:			
Variances:			
Variance of level 1 residuals	31.970 *	20.004 *	19.057 *
Variance of level 2 intercept residuals	6.517 *	0.750	0.623
Variance of level 2 slope residuals (Depression)			0.015
Covariance between level 2 intercept residuals and level 2 slope residuals (Depression)			0.053
Model assessment:			
Deviance statistic	2005.490	1840.744	1834.978
Degrees of freedom	3	12	14
N	314	314	314
% variance explained: level 1		37.4%	40.4%
% variance explained: level 2		88.49%	90.4%

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

Turning to the individual protective factors, we see from Table 4.2 that Life Satisfaction is enhanced by Hope, Positive Affect, strong support networks and (low) educational attainments. An increase of one unit in the Hope score is associated with an average increase of 0.18 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 and active – with an unstandardised coefficient of 0.15. This factor is likely to enhance Life Satisfaction by creating a positive emotional appraisal and appreciation of one's life. Support networks are perhaps the most important protective factor, as a unit increase in support is associated with an increase of 0.82 units in terms of Life Satisfaction. Interestingly, the experience of having no more than a primary school education has a positive influence on Life Satisfaction and is reflected in an unstandardised coefficient of 1.53. This could be due to the fact that those with higher levels of education may also have higher, but unfulfilled, expectations of their life compared to those with less education, or may alternatively be due to different response styles and points of reference.

The remaining variables do not exert a statistically significant influence on Life Satisfaction, at least not within the current sample. These variables include the following: family type, residential tenure, occupational situation, general medical card holder, financial situation, trust, reciprocity, involvement, health (of self, partner and child), disability/impairment (of self, partner), long-term limiting illness (of self, partner and child), cigarette consumption, presence of a dictionary, atlas, books, computer or internet connection in the home, number of persons in the home, age, length of residency, Negative Affect, Life Satisfaction, Parent-child Relationship (PCRI), Conflict Tactics Scale (parent-child CTSPC), presence of a partner, Inefficient Arguing scale, Children's Difficulties (SDQ), presence of children, immigrant from a developing country, average years of residency in the estate, percentage of residents with a General Medical Card, percentage of residents with a primary school education only, average Local Problem Index score, average Local Services Scale score, percentage who trust most people in the area, percentage who exceed critical threshold for depression, average Hope score, average Life Satisfaction score, average Negative Affect score.

In terms of estate-level effects, the results in Table 4.2 indicate that no less than 88.5 per cent of the level 2 variance is attributable to 'compositional factors', because some estates have higher concentrations of risk and protective factors than others, above all Positive Affect[19]. As a consequence, very little variance is attributable to 'contextual factors' across the different estates, and no level 2 predictors are statistically significant. This is nevertheless compatible with one contextual effect: the influence of depression varies (slightly) in complex fashion in accordance with the estate context.

It is clear from these results that Life Satisfaction is the outcome of a diversity of influences and any interventions to improve Life Satisfaction must take this into account. 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 residents by promoting hopefulness and Positive Affect while also reducing the symptoms of depression. The second domain, crucially, involves strengthening support networks. Given the key role of Positive and Negative Affect in relation to both depression and Life Satisfaction, it is also of importance to understand how the scores of these two variables are influenced by the social context. One way of achieving this is to estimate distinct multilevel models for these two variables, and thus to develop a second level of analysis of how these crucial, proximal intervening variables mediate between the external social context and the "internal" dynamics of the family system.

[19] The compositional effect is estimated by subtracting the level 2 variance in Model 2 from the level 2 variance in Model 1 and expressing this as a percentage of the latter.

Table 4.3 Multi-Level Model of Negative Affect

Parameter	Model 1	Model 2	Model 3
Individual Level Effects:			
Intercept	20.272 *	20.066 *	20.256 *
Long-term limiting illness		1.918 *	1.832 *
Financial difficulties vs. "making ends meet"		2.218 *	2.770 *
Financially "comfortable"/"well-off" vs. "making ends meet"		-1.627*	-2.076 *
Neighbourhood Level Effects:			
Percentage with primary school education only			-0.042 *
Average life satisfaction score			-0.606 *
Variances:			
Variance of level 1 residuals	28.069 *	25.898 *	25.001 *
Variance of level 2 intercept residuals	9.692 *	10.573 *	2.073
Variance of level 2 slope residuals (Fin. difficulties)			6.498
Variance of level 2 slope residuals (Fin. affluent)			2.030
Covariance between level 2 intercept residuals and level 2 slope residuals (Fin. difficulties)			3.562
Covariance between level 2 intercept residuals and level 2 slope residuals (Fin. affluent)			-1.339
Model assessment:			
Deviance statistic	1972.031	1949.246	1922.690
Degrees of freedom	3	6	13
N	314	314	314
% variance explained: level 1		7.7%	10.9%
% variance explained: level 2		0%	78.6%

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

The results of this analysis are presented in Tables 4.3 and 4.4. In summary, it would appear that Negative Affect resists an exhaustive, individual-level explanation, depending essentially on financial situation (indirectly, therefore, on social status) and long-term limiting illness. Interestingly, Negative Affect has a particularly high percentage of level 2 variance – no less than 25.7% is due to inter-estate differences – which appears to be the result of the mechanisms which lead to the "sorting" of individuals into different residential areas on the basis of their characteristics, and the effects of this segregation. Thus, whilst the roots of this personality attribute in early experience and socialisation within the family of origin is largely opaque to a statistical analysis of this form (with just 10.9% of variance explained at the individual level), its interaction with more general processes of social stratification and segregation appears relatively unequivocal.

Turning now to Positive Affect, this trait is somewhat similar in nature to Negative Affect, being relatively resistant to structural explanation and prediction at the individual level, but nevertheless clearly – and strongly – structured at the aggregate, neighbourhood level. As we suggested before, in relation to Negative Affect, this may result from the way these personality attributes interact with the mechanisms governing social stratification, mobility and spatial segregation. Although we can only explain a relatively small share of the individual-level variance (11.6%), there are four significant factors: age (older respondents tend to have slightly lower levels of Positive Affect), disability/impairment (this produces a considerable drop in scores, equal to -2.69, whether the respondent has a partner (which is associated with considerably higher scores, +2.08, but may be due to the positive influence of this characteristic on the likelihood of relationship success) and financial situation (difficulties are associated with lower scores, whilst being "comfortable" or "well-off" is associated with high Positive Affect, which may also result from a reciprocal conditioning).

Table 4.4 Multi-Level Model of Positive Affect

Parameter	Model 1	Model 2	Model 3
Individual Level Effects:			
Intercept	40.783 *	38.991 *	39.319 *
Age		-0.038 *	-0.042 *
Disability or impairment or chronic condition		-2.743 *	-2.693 *
Partner present		2.311 *	2.080 *
Financial difficulties vs. “making ends meet”		-0.979 *	-1.062 *
Financially “comfortable”/“well-off” vs. “making ends meet”		1.536 *	1.285 *
Neighbourhood Level Effects:			
Percentage with primary education only			0.099 *
Average Hope score for estate			0.533 *
Variances:			
Variance of level 1 residuals	24.759 *	21.890 *	21.886 *
Variance of level 2 intercept residuals	8.697 *	8.153 *	1.251
Model assessment:			
Deviance statistic	1932.883	1895.074	1872.268
Degrees of freedom	3	8	10
N	314	314	314
% variance explained: level 1		11.6%	11.6%
% variance explained: level 2		6.3%	85.6%

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

As before, Positive Affect has a strong aggregate structure, whereby just 74 per cent of the total variance is attributable to individual differences, whilst the remaining 26 per cent results from the clustering of individuals within estates. Using just two variables – percentage with a primary school education (social class composition and demographic structure) and average Hope score for estate – we can explain a very large proportion of the variance of the dependent variable.

4.3 Factors Associated with Parenting

In this section, we will present the results of our multivariate regression analysis of parenting, as measured by the Parent-Child Relationship Inventory (PCRI), which are summarised in Table 4.5. Given the relatively small number of observations (136 cases of households with children), it is not possible to estimate a multilevel model for this dependent variable. It is nevertheless possible to use more robust regression modelling techniques to analyse the most important influences that have a significant impact on parenting.

As in the previous sections, we will 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 respondent. The main risk factors, which have a negative influence on the parent-child relationship, are Children’s Difficulties (measured by the SDQ), parent-child conflict (measured by the Parent-Child Conflict Tactics Scale), financial difficulties and financial affluence (both contrasted with “making ends meet”). It is particularly interesting to find that both financial difficulties (summarised by the responses “in serious difficulties” and “some difficulties”) and financial well-being (“comfortable” and “well-off”) are associated with a drop in PCRI scores. The main protective factors, which have a positive influence on the parent-child relationship, are hope and support networks (the latter with a substantial coefficient but considerable variability).

Table 4.5 Regression Model of Parenting (PCRI)

Parameter	Estimate
Intercept	54.325 *
Hope score of respondent	0.252 *
Support network	0.697
Financial situation: in difficulty vs. making ends meet	-2.198 *
Financial situation: comfortable or well-off vs. making ends meet	-3.181 *
Parent-Child Conflict Tactics Scale	-2.179 *
Children's difficulties	-2.215 *
Model assessment:	
R^2	0.298
N	136

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

Beginning with the risk factors, it is significant that only some of these pertain to characteristics of the child. The largest risk factor is associated with the child's 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 the order of -2.2 in the PCRI score. As we noted above, financial well-being may be identified as a sort of "risk factor", where respondents which describe their situation in terms of being either "comfortable" or "well-off" have lower PCRI scores (-3.18), just as those who identify financial difficulties.

As before with the relationship between depression and Life Satisfaction, the relationship between Children's Difficulties, conflict between parent and child and parenting should be considered as forming a sort of vicious cycle, characterised by close and reciprocal relationships between these three variables. This highlights the systemic nature of the parent-child relationship and the negative reinforcing cycle created by the risk factors. For example, the statistical analysis reveals that CTSPC parent-child conflict score is also associated with lower PCRI scores (-2.18).

Turning to the protective factors, we see from Table 4.3 that greater hopefulness is associated with increased PCRI scores, with an increase of the score of 0.25 units for every unit increase in Hope. Once again, we are in a position to appreciate the positive, protective effect of an active, problem-solving approach that tends to transform difficulties and conflicts into a pro-active and concrete approach, perhaps also involving a more positive and constructive perspective-taking and cognitive adjustment. This is likely to produce positive benefits for the well-being of children, reinforcing the cycle of positive relationships and well-being within the family.

Support networks also represent a protective factor, increasing PCRI scores by 0.697 units for each unit increase, illustrating how the broader social context can provide resources for coping with children and developing a more positive, involved and supportive relationship (this effect is relatively strongly but at the borderline in terms of statistical significance).

The remaining variables do not exert a statistically significant influence on PCRI scores, at least not within the current sample. These variables include the following: family type, gender, residential tenure, education level, occupational situation, general medical card holder, trust, reciprocity, involvement, health (of self, partner and child), disability/impairment (of self, partner and child), long-term limiting illness (of self, partner and child), cigarette consumption, presence of a dictionary, atlas, books, computer or internet connection in the home, number of persons in the home, age, length of residency, Negative Affect, Positive Affect, Life Satisfaction, CES-D Depression Scale, PCRI Parent-child Relationship, presence of a partner, Inefficient Arguing scale, presence of children, immigrant from a developing country,

average years of residency in the estate, percentage of residents with a General Medical Card, percentage of residents with a primary school education only, average Local Problem Index score, average Local Services Scale score, percentage who trust most people in the area, percentage who exceed critical threshold for depression, average Hope score, average Life Satisfaction score, average Negative Affect score.

The final statistical model has an adjusted R square of 0.298, which implies that the explanatory variables included in the model can explain roughly 30 per cent of the variance of the dependent variable (PCRI). This is a little on the low side, but is nevertheless in line with many modelling applications in the social sciences, where outcomes and behaviours typically have strong variability, complex determination and contingency.

The implications of these results from a service perspective suggest that interventions must be guided by a holistic approach to family relationships and the system of interlocking influences between different aspects of the family system. Successful intervention programmes will involve both direct work with children who have particular difficulties as well as support for parents in these circumstances and interventions within the neighbourhood setting to build and stimulate social support networks. Moreover, it is important to address specific, and problematic areas of parenting – such as the use of physical violence and aggression – through active programmes of support and information for parents. The improvement of concrete parenting practices can help to interrupt negative cycles of conflict/aggression that may be triggered initially by children's difficulties or discipline problems. As far as the impact of financial difficulties is concerned, the findings of the research in relation to this factor clearly call for more effective economic support for families in need. It is nevertheless important to study the role of financial situation on parenting via further research, in order to ascertain whether the rather surprising results presented here in relation to financial well-being result from different response styles or whether they reflect substantive differences (perhaps associated with the work-home trade-off in time allocation) in this context.

5 The Well-Being of Children

This chapter measures the needs of children in Bray across a range of domains including mental health, disability, reading ability, and school attendance. It is based on a sample of 150 children, comprising slightly more boys (55%) than girls (45%). The largest group of children (45%) are aged seven to twelve, the second largest are thirteen to seventeen (35%), and the remainder aged four to six (20%). We analyse the results by the same set of categories as the data pertaining to adults in Chapter Three. The full set of results is presented in Chapter Five of the Appendix.

Strength and Difficulties

We used the Strengths and Difficulties Questionnaires (SDQ) to assess the mental health needs of children, based on the perceptions of parents. These perceptions were then classified according to whether the child has 'no difficulties', 'some difficulties', or serious difficulties'. The use of the SDQ to measure the prevalence of children in need within a community requires that account be taken of both 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). We present data on both definitions to allow the results to be used as flexibly as possible, according to the context.

The survey reveals that 8% of children in the Bray area have serious difficulties and a further 8% have some difficulties. This is similar to the levels reported in Rural Wicklow, but lower than in the other two Irish comparative studies (Limerick 9%+8%, and Respond! 14%+9%) and also two percentage points lower than indicated in a study of 10,000 children in Britain. A marginally higher proportion of boys (10%) present with serious difficulties than girls (9%), and a substantially higher proportion of boys present some difficulties. The main difficulties involve conduct, hyperactivity and emotional problems. Girls are marginally more likely to present conduct problems, while boys are more likely to present hyperactivity problems. Emotional problems are roughly equal between boys and girls. These results differ from the more common situation, where boys present more conduct and hyperactivity problems and girls more emotional problems.

With regards to Wicklow as a whole, the proportion of children with serious difficulties is higher in one-parent households (21%) compared to two-parent households (7%) in those with a medical card (17%) against those without (8%). Traveller children present particularly high difficulties (25%). Extrapolating these results to the total number of children aged 0-18 in Bray, we estimate that there could be up to 540 children with serious difficulties and a further 560 with some difficulties. These estimates could be somewhat on the high side, as it is likely that neighbourhoods affect children's difficulties; i.e. children growing up in certain (generally more disadvantaged) estates have a greater tendency to develop difficulties mainly due to peer behaviour. If the latter is the case, than the over-sampling of disadvantaged neighbourhoods would result in slightly exaggerated estimates for the Bray area as a whole. But even on the bases of the current estimates, it is interesting to note that nine estates alone account for about 600 children with difficulties, more than half of the total estimates for Bray.

Most other studies in Ireland have measured the needs of children using the Rutter Scale – which has a high correlation with the SDQ – and these show that about 20% of children living in disadvantaged families and communities show evidence of difficulties, mainly behavioural problems. 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. If broadly compared to the incidence of children's difficulties amongst households with a medical card, it appears that the level of children's needs in Bray is above that for children in general.

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 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 Bray with the mean scores of a nationally representative sample of over 10,000 children in Britain, since there are no corresponding representative studies of children in Ireland using the SDQ. The difference in mean scores is expressed in terms of the effect size, a statistic which allows one to assess if the difference in mean scores – and 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, for example in the region of 0.36. 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.

Perceived Health

Parents rated the health of their children on a five-point scale comprising 'excellent', 'very good', 'good', 'fair', and 'poor'. The results show that 4% of parents rate their children's health as fair or poor, which is a lower proportion than indicated in the Limerick (6%) or Respond! (5%) studies. There are, however, significant differences between households with a medical card (10%) and those without (1%), and Travellers (6%). There are also particularly high results in three of the estates: Cois Cairn (16%), Oldcourt (15%) and Killarney Park (11%).

Disability

Parents assessed whether their child had any form of long-term limiting illness (LLI) or disability, using a question from the 2006 Census of Population. The survey shows that 6% of children are perceived to have at least one of the LLI/disabilities mentioned. This is considerably lower than the prevalence of disabilities (18%) estimated by the National Council for Special Education in 2006 from a range of sources, but higher than the rate estimated in the 2002 Census of Population (2%) which is generally regarded as an underestimate. There is a considerably higher prevalence of disabilities among households with a medical card (14%) than those without (3%), and in households with a lone parent (10%) as against two-parent households (5%) and Traveller's children (14%). With regard to specific estates, Guiltspur Heights indicate 44% of children having an IIL or disability, and Hazelwood and Cois Cairn are both over 20%. In the case of Guiltspur Heights, this may have been a selection criterion for the allocation of local authority housing.

Parent's Perception of Child's Reading Ability

Parent's were asked to rate their child's ability in terms of English reading, based on the precedent of a major national study of reading ability where 6,500 children were assessed using the Drumcondra Sentence Reading Test (DSRT) and where parents were also invited to rate their child's reading ability. 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'.

The results from the present show that overall reading ability among Bray children is slightly above that for Ireland as a whole. Children's reading difficulties based on the surveyed households in Wicklow as a whole are slightly higher among boys (15%) as girls (11%), which is in line with the findings of almost every other study on this subject. Children's reading

difficulties are higher among households with a medical card (16%) as against those without (13%) and are also higher in one-parent households (24%) compared to 11% in two-parent households. Perhaps surprisingly, none of the Travellers interviewed indicate that their child experiences reading difficulties, which probably reflects the better literacy standards of the children compared to their parents.

Educational Resources 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. Households in Bray tend to have a higher-than-average number of books compared to households in Ireland. There is also a higher level of computer ownership in Bray (71%) compared to Limerick (60%) and Respond! estates (55%) and particularly usage of the internet (61%) compared to Ireland (46%) or Dublin (55%, ComReg Eurobarometer, 2006). Computer ownership is highly differentiated according to whether households have a medical card (42%) or not (87%), or one-parent households (51%) as against two-parent households (90%). Only one quarter of Travellers (26%) have access to a computer and one-fifth of homeless people (18%). There are also marked differences between localities, with less than one-third of households owning a computer in Ard na Greine (26%), Connolly Square (31%) and Greenpark Road (32%).

Child's School Attendance

The school attendance rate among children in Bray estates, based on the responses of parents, is slightly higher than among children in Ireland, where the data are based on returns from schools rather than the responses of parents. The results are, however, similar to those indicated from the Limerick and Respond! studies. At primary school, the national school attendance rate is 94% compared to 96% in Bray while at post-primary school, the national school attendance rate is 92% compared to 96% in Bray. Similarly, the proportion of children who are absent from school for 20 days or more is considerably lower among children in Bray compared to Ireland, and also considerably lower than those reported in the Limerick and Respond! studies. Absenteeism rates among post-primary children are higher among girls, which contrasts with findings of most other studies, and in households with a medical card, and with one parent.

School attendance rates at estate level have to be treated with care due to the small numbers upon which the estimates are based. About half of all households participating in this survey have children and these are evenly split between primary and secondary schools. Thus there are, on average, about five students in each type of school per neighbourhood, making estimates at this level unstable. This said, there nevertheless seem to be particularly low attendance rates in Dargle Heights, Hazelwood, Cois Cairne and Killarney Park. This seems to be in alignment with anecdotal evidence that other disadvantaged neighbourhoods in South Bray (e.g. Oldcourt and Ard na Greine) benefit from the proximity of good schools which draw their children from a broad social spectrum.

Educational Expectations

Expectations regarding when child will leave school are considerably higher in Bray than in Ireland as a whole, with seven out of ten parents in Bray (69%) 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 distinctly lower expectations as have households with only one parent.

There are huge variations at estate level with markedly lower expectations prevailing amongst parents living in Dargle Heights, Hazelwood, Guiltspur Heights and Oldcourt.

6 Influences on the Well-Being of Children

In this chapter we estimate the factors which influence the well-being among children in Bray 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). 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. Given the relatively small number of observations (135 cases of households with children with full data on the relevant variables), it is not possible to estimate a multilevel model for this dependent variable. It is nevertheless possible to use more robust regression modelling techniques to analyse the most important influences that have a significant impact on children's well-being.

6.1 Factors Associated with Children's Mental Health

As in the previous sections, we will report the findings in terms of the risk and protective factors associated with children's difficulties, bearing in mind that all data are based on the perceptions of the child's parent. There is just one risk factor, which increases children's difficulties, namely depression (of parent). The main protective factors, which tend to reduce SDQ scores, are PCRI parenting scores and trust relationships within the broader community.

Table 6.1 Regression Model for Children's Strengths and Difficulties (SDQ)

Parameter	Estimate
Intercept	10.525 *
CES-D Depression score of parent	0.194 *
PCRI Parenting score	-0.256 *
Trust	-4.037 *
Model assessment:	
R^2	0.368
N	135

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

Beginning with the risks, it is significant that these are exclusively associated with the well-being of the parent, as measured by their depression score. For each increase of one unit in CES-D depression score, children's difficulties increase by 0.194 units. The potentially negative impact of parental depression on the psychological and emotional well-being of children is well-established in the scientific literature, and it is therefore not surprising to find that once again in the present sample this relationship is present.

As far as protective factors are concerned, these relate both to characteristics of parents as well as children. The first such factor is parenting, an effect which mirrors the relationship between these two variables discussed in relation to the determinants of the PCRI scores. After controlling for the other variables in the model, an increase in the PCRI of one unit is associated with an average decrease of -0.26 in SDQ score. Secondly, the prevalence of trusting relationships in the broader community influences children's well-being, reducing the latter where the respondent reports that they trust many or most people in the immediate neighbourhood (strong unstandardised coefficient of -4.04). This reinforces the view that children and their parents require a supportive and healthy social environment in order to realise their potential; parenting is thus not to be viewed in narrow terms as confined to the family environment alone.

As before, the relationship between parental depression and Children's Difficulties should be considered as forming part of a system of close and reciprocal relationships between the key variables that reflect the various aspects of relational family well-being.

The remaining variables do not exert a statistically significant influence on Children's Difficulties, at least not within the current sample. These variables include the following: family type, gender, residential tenure, education level, occupational situation, general medical card holder, financial situation, reciprocity, involvement, health (of self, partner and child), disability/impairment (of self, partner and child), long-term limiting illness (of self, partner and child), cigarette consumption, presence of a dictionary, atlas, books, computer or internet connection in the home, number of persons in the home, age, length of residency, Negative Affect, Positive Affect, Life Satisfaction, Hope, CTSPC Conflict Tactics Scale (parent-child), presence of a partner, Inefficient Arguing scale, SDQ Children's Difficulties, Support Network, presence of children, immigrant from a developing country, average years of residency in the estate, percentage of residents with a General Medical Card, percentage of residents with a primary school education only, average Local Problem Index score, average Local Services Scale score, percentage who trust most people in the area, percentage who exceed critical threshold for depression, average Hope score, average Life Satisfaction score, average Negative Affect score.

The final statistical model has an adjusted R square of 0.37, which implies that the explanatory variables included in the model can explain more than one third of the variance of the dependent variable (PCRI). This is a little on the low side, but is nevertheless fully in line with many modelling applications in the social sciences, where outcomes and behaviours typically have strong variability, complex determination and contingency.

The implications of these results from a service perspective reinforce the view, expressed earlier, that interventions should be guided by a holistic approach to family relationships, suggesting further that the family system must be contextualised carefully within its broader neighbourhood context. Particularly in relation to children's well-being, it is evident that the community as a whole must provide the (social and cultural) resources, support, role models and positive interactions that are necessary for individual development and well-being. Successful intervention programmes will thus involve a broad approach, which takes preventive measures particularly seriously, involving simultaneously direct work with children who have specific difficulties as well as support for parents in these circumstances and interventions within the neighbourhood setting to build and stimulate their capacities. Relatively simple and concrete forms of support and information for parents can help to improve their relationship with children and deflect difficulties and problems.

6.2 Factors Associated with Children's Language Skills

In this section, we will present the results of our multivariate regression analysis of children's language skills, as measured by their parent's evaluation of their English reading, writing, spelling and verbal expression (Table 6.2). This variable is measured on a continuous scale and can vary between 0 and 12. Given the relatively small number of observations (135 cases of households with children with full data on the relevant variables), it is not possible to estimate a multilevel model for this dependent variable. It is nevertheless possible to use more robust regression modelling techniques to analyse the most important influences that have a significant impact on language skills.

The principal influences on language skills are related to the child's age and difficulties (SDQ), the educational attainments of the respondent, the presence of educational resources within the home (indicated by the availability of a dictionary) and the presence of a computer.

Table 6.2 Regression Model of Children's Language Skills

Parameter	Estimate
Intercept	7.575 *
Age of child	0.210 *
Children's difficulties SDQ	-0.169 *
Dictionary in home	1.678 *
Computer in home	-0.962 *
Primary school versus lower secondary education	-1.908 *
Higher secondary versus lower secondary education	-0.705
Third level versus lower secondary education	-0.115
Model assessment:	
R^2	0.313
N	135

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

This model is a little different to those presented earlier, as it relates to an outcome that is susceptible to a rather broader range of influences, which are not only, or exclusively linked to deprivation. The first influence, and perhaps the most important (and intuitively obvious), is the children's difficulties, as measured by the SDQ: to the extent that the child has behavioural, emotional or psychological difficulties, this tends to interfere with their acquisition of effective language skills. Secondly, the age of the child intervenes positively – as one might also expect – to boost language skills in line with individual development processes. Thirdly, the parent's educational attainments have a powerful effect: where the respondent has no more than a primary education, language skills are considerably lower (when compared with a lower secondary school education), declining by 1.91 units. The coefficients for higher secondary and third level are also negative, but these are not significantly different from zero, and may be interpreted in this way.

Fourthly, where there is a dictionary in the home (indicator of family "cultural capital" as well as educational resources more generally), language skills increase by 1.68 points on the scale used here (which, as we noted above, varies between 0 and 12 with a mean of 4.4 and a standard deviation of 5.32). Finally, and most interestingly, the presence of a computer is associated with poorer language skills (unstandardised coefficient of -0.96), controlling for the other variables in the model. This indicator is not strongly correlated with the dictionary indicator, and the signs of these two variables remain constant regardless of whether they are included individually or together. As the original question explicitly excluded games consoles from the measurement, the most plausible interpretation of this effect is therefore linked with the way in which computers are used by the children in the present sample, and their effect on reading activities and the development of social and verbal skills. This somewhat unexpected effect calls for further research to determine how, and in what circumstances, computer use can influence language competence.

7 The Well-Being of Neighbourhoods

The analysis in previous chapters illustrates that the well-being of individuals, parents and children in Bray estates is predominantly influenced by individual-level characteristics and, to a much smaller extent (typically 2-5 per cent) by estate-level characteristics. In light of this, we will use this chapter to assess the well-being of Bray estates by combining the main indicators of need to form an overall index of need. Following this, we will rank the estates according to their combined level of need. However, engaging in this task, we will develop some community-related indicators which are specific to the estate level and which are additional to the individual-level indicators of social and psychological need considered so far in the report.

We know that neighbourhoods have objective characteristics such as size, age, quality of the environment and access to services which may influence the well-being of people living in them. For example, all of the estates are situated within the Bray town area, and all therefore are within reach of essential services. In addition to these objective characteristics, the well-being of neighbourhoods is also denoted by their 'social capital' and a growing body on research has endeavoured to measure this dimension in Ireland and elsewhere. Informed by this research, 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.

Perceptions of Local Problems

Respondents rated a list of twelve potential neighbourhood problems on a five-point scale comprising the options 'very big problem', 'fairly big problem', 'unsure', 'minor problem', 'not a problem'. The results show that the vast majority of respondents (80%) do not have significant local problems on their estate. Conversely, exactly one fifth (20%) rate aspects of their neighbourhood as at least a fairly big problem. The experience of local problems on Bray estates is significantly lower than in Limerick, but similar to those on the Respond! housing estates studied in a previous project. The two biggest neighbourhood problems in Bray estates are litter and rubbish (35%) and dog dirt (30%). Those with a medical card tend to live in less pleasant environments, as indicated by their mean score of 26 compared to those without a medical card (20); the same is true of one-parent families (29) compared to two-parent families (22). Travellers indicate a significantly higher local problem score of 35, and homeless people (53) again score much higher.

As can be expected, there are considerable variations between estates, the hypothesis at the basis of the Local Problem Score (LPS). The three 'contrast' neighbourhoods of Woodbrook, The Headlands and Swanbrook all have an average LPS between 8 and 13; the only other localities with similarly low scores are Connolly Square and Failte Park. The most troubled neighbourhoods are Oldcourt (52) Hazelwood (42) Duncairn (34) and Dargle Heights (33).

Perceptions of Local Services

The second measure used to rate the quality of neighbourhoods is the Local Services Score (LSS). Respondents 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, more than two-thirds of respondents (71%) are satisfied, in overall terms, with local services. Conversely, nearly one third (29%) regard all local services as, on average, 'very poor' or 'poor'. This compares well with the average responses from Respond! estates (37%) and particularly Limerick (43%).

However there is significant variation between the access to and quality of individual services, as rated by the respondents. As was the case in the Limerick and Respond! studies, schools are consistently given the highest rating of all services, and access to libraries, public transport and shops all receive high ratings (i.e. low LSS scores) for Bray as a whole. The

worst services, defined by the percentage of people rating them as 'very poor' or 'poor', are recreational services (measured by the absence of a swimming pool, 65%), playgrounds (59%) and leisure facilities for young people (52%) and teenagers (50%). In contrast to local problems, there is only a slight variation between those with (33%) and without a medical card (31%), but a more significant one between one- and two-parent households (44% versus 32%). As in the case of the Local Problems Score, 48% of Travellers and 40% of homeless people refer to significant local services problems.

With regard to different localities, the local services score is not as strongly differentiated along variations in social class and relative affluence, but also reflects the geographical proximity of the various estates to the town centre. The neighbourhoods experiencing the greatest problems with local services are Cois Cairn (54%), Ard na Greine (48%), Hazelwood (45%) and Wolfe Tone Square (40%).

Trust

Trust was measured, as in other studies, 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 nearly two-thirds of respondents in Bray (64%) trust many or most of their neighbours. Conversely, one-third (36%) do not trust most or many of their neighbours. This represents a higher level of trust than reported in the Limerick study (55%) and a significantly higher level than reported in the Respond! study (28%). A previous study, based on a random sample of 1,000 adults in Ireland, found that 51% trusted most of their neighbours, which 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. The Irish study found that trust was most strongly and directly associated with length of residence in the area and with the age of the 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 same observations are supported by data from the current study.

There is a certain variation in the level of trust between those with a medical card (60%) and those without (78%). This is in line with the British study which found that people in the more disadvantaged groups were also less likely to trust their neighbours or have a reciprocal relationship with them. At estate level, there are three neighbourhoods where respondents express extremely low levels of trust. These are Cois Cairn (5%), Hazelwood (16%) and Dargle Height (21%), which could be seen as an indicator of acute difficulties or social capital deficits on these estates.

Reciprocity

Reciprocity was measured by asking if respondents have done a favour for a neighbour in the past six months (or received one), and whether they believe that neighbours look out for each other. This is similar to the questions used in other studies. The results show a relatively high level of reciprocity between neighbours in Bray estates, with 84% involved in exchanging favours. This is slightly above the level reported in the Limerick study (80%) and well above the level of reciprocity reported in the Respond! (77%) and British study (74%) cited in the previous section. 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.

Volunteering, Community Involvement, and Community Capacity

We measured volunteering using a question from the 2006 Census of Population. This showed that 10% of Bray respondents had engaged in a voluntary activity over the previous four weeks, which is lower than in Ireland in 2006 (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". As we have seen in previous sections, these are also the factors associated with trust and reciprocity.

7.1 Constructing an 'Ad-hoc' Index of Local Need

In order to facilitate the process of identifying estates with significant levels of need, we constructed an 'ad-hoc' index of need, based on the dimensions of social needs, personal well-being and social capital. When we speak of an 'ad-hoc' index, this is to acknowledge the fact that the present study is insufficient to address in a fully satisfactory manner the construction of a needs index for local areas. Instead, we simply attempt to bring together and summarise some of the rich data that have been collected and analysed throughout this study.

In doing so, we have to refer back to one of the limitations to which we drew attention at the beginning of this study, that is the fact that it is concerned primarily with the measurement of physical and particularly mental well-being and the factors which contribute to this, rather than measuring the more common dimensions of social class differentiation, such as education, income, wealth, or work and work satisfaction. Part of the reason for this emphasis is that many studies have addressed the issue of social stratification, whilst the conceptualisation and measurement of personal well-being is less frequently studied.

A further shortcoming of our aggregate approach is that we will not be able to use any data related to parenting or child outcomes, as only a minority of households in this study are families with children. Nor will we be able to use the data on Travellers and homeless people, as we are strictly concerned with geographical entities, whilst the latter two groups were not sampled in distinct geographical areas, and thus would need to be dealt with separately. In summary, when constructing our index of local need, we include five social indicators, four indicators of personal well-being and four indicators of social capital.

Social Need Indicators:
- proportion of population with a medical card (used as an income proxy)
- proportion of population with primary education only (a proxy for earning potential)
- proportion of lone parent families
- proportion of households indicating financial difficulties
- proportion of older households

Indicators of Personal Well-being:
- proportion of population experiencing depression
- average Negative Affect
- average Life Satisfaction
- average Hope

Social Capital Indicators:
- average local problem score
- proportion of households who trust neighbours
- proportion of households exchanging favours
- average strength of support networks

While the social need indicators are all risk factors, only the first two indicators of well-being also fall into this category, and the other two indicators can best be understood as protective factors. With regard to the social capital indicators, the first is a risk factor, whilst the other three are protective factors.

Throughout the study, we have shown how these factors influence the level of well-being or the extent to which well-being is differentiated across these dimensions. Combining these indicators to form a single measure, however, is not an easy undertaking.

At its simplest, such an approach involves the scoring of the neighbourhoods across these eleven indicators and then adding the scores, arriving at a single score for each neighbourhood. The attractiveness of this approach is that it can be readily understood, and people know what the overall scores represent. However, the shortfall is that it inevitably results in 'double counting', as well as yielding a rather crude measurement scale. The 'double counting' arises from the fact that some dimensions are more easy to measure than others and, as a result of this, a simple additive approach tends to give greatest weight to those dimensions which are easiest to observe.

A more refined approach would involve undertaking a factorial analysis. Factor analysis is based on the belief that there are one or more underlying factors that typically cannot be measured directly but which can be observed indirectly by the way in which they affect a number of more tangible outcomes. For example, we cannot measure the concept of social class directly, but we know that social class has an effect on income, education, wealth, health etc. By undertaking a factor analysis, we can reduce the observations to their essential 'factors' and thus avoid double counting, as well as gaining a deeper understanding of the essence of the observations made.

A factorial analysis would thus be useful in the construction of a needs index for these local areas. However, as we have only 17 neighbourhoods with data, and almost as many variables to consider, it is unfortunately not possible to proceed with such analysis in the context of the present study.

We therefore opt for the sub-optimal, but in this case more robust, approach of simply adding the observations across the eleven variables and 17 neighbourhoods. To this end, we first rank each of the indicators from 1 to 10, with 1 being associated with the lowest level of need (or the highest level of well-being) and the rank 10 indicating greatest need or the lowest level of well-being.

Whilst informative, one has to point out some immediate contradictions in this simplified approach. For example, the proportion of older households is a readily-appreciated social needs indicator as older households are known to be at greater risk of poverty, as well as having greater health needs. At the same time, our analysis showed that there is greater trust in neighbourhoods with an older age profile, as well as greater reciprocity and community involvement. Thus, the proportion of older people is both a risk and a protective factor. Similarly, low levels of education are clearly a major contributing factor to lower earnings and ultimately a greater risk of poverty. Once again, however, people with lower levels of education show greater levels of Life Satisfaction, a finding supported by a number of other studies using the same measurement construct. Thus, while the cumulative index may assist in the broad classification of neighbourhoods within the wider Bray area, when it comes to policy design, one will certainly have to consider the specific risks and needs identified with respect to each of the estates.

Table 7.1 Ranked Neighbourhood Scores

Locality	Medical Card	Low Education	Lone Parents	Financial Difficulties	Proportion Elderly	Local Problem Score	Depression	Negative Affect	Life Satisfaction	Hope	Trust	Reciprocity	Support Networks	Aggregate Score
Swanbrook	1	2	3	2	1	2	4	1	2	1	1	2	1	**1.8**
Woodbrook	1	2	1	2	3	4	2	6	8	6	8	4	3	**3.7**
Failte Park	6	4	1	1	10	3	8	4	3	2	1	3	3	**3.8**
The Headlands	2	2	4	1	2	2	5	5	6	3	8	7	9	**4.2**
Ballywaltrim	7	9	7	8	6	5	2	2	3	3	6	3	8	**5.4**
Killarney Park	3	3	6	2	6	7	6	7	7	4	6	9	6	**5.5**
Connolly Square	4	8	6	6	9	1	9	3	5	7	4	8	6	**5.8**
Wolfe Tone Square	7	10	6	6	9	4	6	5	4	4	4	6	4	**5.9**
Ard na Greine	7	6	9	10	7	3	2	8	5	7	5	5	2	**5.9**
Duncairn	3	2	3	2	7	8	8	10	10	8	5	6	7	**5.9**
Peter's Road	5	6	3	4	9	6	6	8	9	10	2	4	7	**6.0**
Dargle Heights	5	8	6	9	5	8	4	3	3	5	9	4	9	**6.1**
Cois Cairn	4	7	8	6	3	8	9	4	6	3	10	2	10	**6.1**
Guiltspur Heights	10	5	9	8	1	6	10	7	9	8	8	1	5	**6.7**
Greenpark Road	9	8	6	6	10	6	5	10	7	9	3	4	5	**6.8**
Hazelwood	10	10	8	10	5	9	6	2	1	2	10	6	8	**6.8**
Oldcourt	7	4	10	7	6	10	10	9	10	10	9	10	10	**8.5**

Table 7.1 shows the ranking of the 17 estates included in the Bray study from the one exhibiting least needs to the one with the greatest problems and needs. There are probably as may comments to be made about each individual estate as there are observations. We will restrict ourselves here to the most pertinent only:

- As would be expected, the three affluent areas which were specifically included in the sample to provide control data in relation to the predominantly more disadvantaged neighbourhoods which make up the main bulk of this study, are all at the upper end of the table. Swanbrook is by far the most affluent and desirable estate in terms of well-being. Woodbrook has some problems around negative personality traits, whilst The Headlands have some community issues with regard to trust and reciprocity.

- Failte Park would probably not have been expected to receive such a low needs score, as it is obviously the location of many older households with high levels of medical card ownership and appreciable levels of depression. However, this appears to be more than offset by the sense of Life Satisfaction, Hope, Trust and Reciprocity, all driven by the very fact of being an older neighbourhood.

- Ballywaltrim is a prime example of a mature neighbourhood with higher levels of social needs, but an intact neighbourhood structure; protective factors are acting at their best.

- Connolly Square, Killarney Park, Ard na Greine and Wolfe Tone Square are all in the middle field (within the given sample of neighbourhoods), with few extremes in either direction.

- Dargle Heights and Peter's Road are more disadvantaged neighbourhoods, with Dargle Heights scoring higher in terms of social needs and Peter's Road more on the well-being indicators, which may partly be driven by an older population.

- Cois Cairn, Duncairn and Greenpark Road are all disadvantaged neighbourhoods, though the determining factors differ in each instance. Cois Cairn features high on social, well-being and social capital needs, Duncairn features particularly with regard to well-being and possibly the lack of a sense of community. Greenpark Road, in contrast, has high scores on social needs and well-being, but a comparatively intact sense of community.

- Guiltspur Heights and Hazelwood are neighbourhoods with very high levels of need, the former in relation to social and well-being needs, whilst the latter shows clear signs of social disadvantage as well as poor social capital.

- By far the most deprived of all neighbourhoods, however, is Oldcourt, which is 1.7 points higher than the next nearest neighbourhood, and fares the worst on all dimensions of social, well-being and social capital needs.

As pointed out before, we could not include Travellers or homeless people in this comparison as, conceptually, these were not sampled within a single physical environment. From the analysis presented throughout this report, however, it is apparent that these two population groups show even greater signs of need than any of the estates considered.

8 Policy Implications

This study was designed to throw light on the well-being of children, families and neighbourhoods in the Bray area. Given the commitment of Bray Partnership and the other organisations that combined to form the Bray Community Consortium, to addressing social exclusion, the study aimed at identifying the factors that influence well-being and the groups of people and neighbourhoods that experience relatively low levels of well-being. As such, the study adds another dimension to the prevailing studies of social exclusion, which are based on comparing the differences between 'poor' and 'non poor', 'excluded' and 'included', 'disadvantaged' and 'advantaged'.

These studies 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 and this study further reinforces these findings by extending the concept of social exclusion into the actual measurement of physical and psychological well-being. At the same time, the study highlights that there are also significant differences within these groups and, in order to understand the dynamics of poverty and social exclusion, that it is equally important to understand 'within group' as well as 'between group' variations in well-being.

This study therefore tries to extend the analysis of social exclusion by assessing how well-being is shaped by both the 'external environment' and the 'internal environment'. The external environment, in this context, is measured by indicators such as education, employment, housing tenure, neighbourhood quality, 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.

From the perspective of promoting social inclusion, 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 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 Bray 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 Bray 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 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 service user in order to ensure that interventions are properly customised to the specific needs of individuals, households and estates. These interventions should thus be 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 conclusions that 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. In the case of households with children, the study is based solely on interviews with parents. At the same time, it is reasonable to assume that, although there are differences in the perceptions between parents and children, the latter tend to underestimate their own difficulties. Secondly, and possibly of wider importance, is the emphasis on conceptualising and measuring the influences of the internal environment. This is largely because of the ready availability of a large body of work on the effects of the external environment and our interest

in drawing attention to extend the analysis of social exclusion beyond the analysis of material deprivation alone.

8.1 Recognising the systemic nature of family systems

From the onset, it is important to emphasise that the factors, whether inside or outside the family/household, which influence the well-being of adults and children do not operate in isolation from each other, and it is often their interaction which creates need. This means that certain factors can act as cause as well as consequence. This understanding suggests that problems – whether among parents (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, whilst 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 parents influence the well-being of children, and children influence the well-being of parents, it is the characteristics of parents which, other things being equal, are likely to exert the main influence. This suggests, in turn, that interventions to promote the well-being of parents are likely, other things being equal, to have a greater impact on the family system than interventions with children.

Our analysis also confirms that the well-being of adults and children is shaped not just by the family system but also by the individual and collective external context in which the family or individual is situated. This is illustrated by the fact that different aspects of well-being are hugely influenced by people's individual social class background (as approximated by their education levels and presence of a medical card) as well as by estate-level characteristics such as the extent of local problems, the geographical concentration of specific social or well-being characteristics. 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. 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 adults and children, there is also a complementary and supportive role for neighbourhood and community-based interventions.

In the subsections below, we highlight the key domains where interventions are likely, all else 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.

8.2 Possible Interventions

Interventions to improve the mental health of adults

We have seen that although the majority of respondents in Bray do not have mental health problems, a significant minority (10%) show signs of depression and 14% show signs of "hopelessness". Furthermore, 4 per cent of Bray adults use sedatives, tranquillisers and anti-depressants. 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 adults and, where parents, 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 individuals, but has ripple effects, for good and ill, on all family members and the wider estate. This means that interventions to improve the mental health of adults are likely, other things being equal, to have a significant multiplier effects on the well-being of families as well as the wider community.

Interventions to meet the needs of children

Most children in Bray do not have mental health difficulties, although a significant minority is in this situation (16%). The main difficulties involve conduct and hyperactivity as well as emotional problems, 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 parents and weaken the parent's relationship with the child. It follows therefore that interventions to address the mental health needs of children, particularly those with serious difficulties (8%), are likely to have significant beneficial effects for the entire family system.

Interventions to support families with disabilities

Approximately 15% of respondents in Bray have a disability or long-term limiting illness. In addition, 4% of respondents cite an LLI or disability of their partners and 5% of a child. The study does not assess the social and economic needs arising from this, but demonstrates that the prevalence of an LLI/disability has additional implications with regard to the mental well-being of family members. For example, mothers with an LLI/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. It is only in light of this needs analysis that the type and range of interventions can be determined.

Interventions to promote work and manage finances

We know that households in most of the estates included in the analysis tend to have low incomes, since this was a criterion for including the estates in the survey. It is also highlighted by the large proportion of medical card holders in these estates. For Bray as a whole, 2% of respondents are 'in serious financial difficulties' and another 11% are finding it 'difficult to manage', similar to the proportions pertaining for Ireland.

Our analysis shows that respondents who have difficulties in coping financially tend to have reduced Life Satisfaction and are characterised by greater Negative Affect and lower Positive Affect. This suggests that earning and managing one's income are not just financial matters but have broader implications for the well-being of adults and children. In turn, this suggests that interventions which offer advice on budgeting as well as help in finding work could have considerable benefits. For parents, 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.

Interventions to support parenting

The survey revealed that, although there is no generalised need in the area of parent-child relationships within Bray families, 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 children exhibit serious behavioural or emotional problems. Equally, parents who have mental health difficulties, as expressed by 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.

Interventions to address problems on specific estates

The 'ad-hoc' index of need developed as part of this study shows a steep gradient across Bray estates in terms of their social, emotional and community well-being. Although the overall order of need is of little surprise, the data reveal some interesting insights into the key dimensions which contribute to the overall level of need. In some instances, for example, the social composition implies a high level of social need, but this can either be reinforced by low levels of personal well-being and low levels of social capital, or partly be mitigated by strong community structures and support networks. There are examples of all combinations which, together, show that there is no inevitability in all dimensions of disadvantage to co-occur. Indeed, by looking at those estates which show positive signs of well-being and community structures despite high levels of social need, we may learn about the processes and initiatives which reinforce the protective factors against social and economic adversity. The overall estate-level index of need may be used to weight the interventions mentioned in the above sections, as well as other initiatives, in terms of their relative urgency.

Travellers and Homeless People

Literally across every dimension of need considered throughout this report, Travellers and particularly homeless people fare far worse than any other population group or geographical area. This clearly points to the extreme levels of social and economic exclusion experienced by these groups, as well as their considerable shortfall in personal well-being as a consequence. Given the comparatively small size of these groups (about 100 Traveller families and 100 homeless in the Bray area) there is a strong moral obligation, as well as economic possibility, to tackle the social injustice experienced by these groups. The report thus provides a strong argument for the prioritisation of interventions to assist these groups.

8.3 Monitoring the effectiveness of interventions

The findings of this report may be helpful in reviewing whether existing strategies to support families and children in Bray 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 children, families and neighbourhoods could form part of an evaluation system which 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 Bray households from the normal experience of other households 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.

Bibliography

American Psychiatric Association, 1994. DSM: Diagnostic and Statistical Manual of Mental Disorders, VA: Arlington. www.psych.org.

Asay, TP., and Lambert, MJ., 1999. "The Empirical Case for the Common Factors in Therapy: Quantitative Findings", in Hubble, MA., Duncan, BL., and Miller, SD, (Editors), The Heart and Soul of Change: What Works in Therapy, Washington DC: American Psychological Association, pp.33-56.

Balanda, KP., and Wilde, J., 2003. Inequalities in Perceived Health: A Report on the All-Ireland Social Capital and Health Survey, Dublin: The Institute of Public Health in Ireland.

Ballymun Youth Action Project, 2004. Benzodiazepines – Whose Little Helper? The role of benzodiazepine in the development of substance abuse problems in Ballymun, Dublin: National Advisory Committee on Drugs.

Barnett, WS., 1996. Lives in the balance: Age 27 benefit-cost analysis of the High / Scope Perry Preschool Program, Ypsilanti, MI: High / Scope Press.

Barton, Y., and Fitzgerald, M., 1986. "A Study of Behavioural Deviance in 10 and 11 Year Old Irish Girls in an Urban Area", Irish journal of Medical Science, March, pp.80-82.

Beck, A., Ward, C., Mendelson, M., Mock, J., and Erbaugh, J., 1961. "An Inventory for Measuring Depression", Archives for General Psychiatry, Volume 4, pp.561-571.

Beck, J., Beck, A. and Jolly, J., 2002. Beck Youth Inventories of Emotional and Social Impairment. San Antonio, TX: The Psychological Corporation.

Belsky, J. 2006. "Early Child Care And Early Child Development: Major Findings Of The NICHD Study Of Early Child Care", European Journal Of Developmental Psychology, 3.

Bem, S., 1974. "The measurement of psychological androgyny", Journal of Consulting and Clinical Psychology, 42 (2), pp. 155-62.

Bolster, A., Burgess, S., Johnston, R., Jones, K., Popper, C., and Sarker, R., 2006. "Neighbourhoods, households and income dynamics: a semi-parametric investigation of neighbourhood effects", Journal of Economic Geography, Vol 7, pp.1-38.

Bray, J.H. and Jouriles, E.N., 1995. "Treatment of Marital Conflict and Prevention of Divorce", Journal of Marital and Family Therapy, October, Volume 21(4), pp. 461-473.

Bronfenbrenner, U., 1979. The Ecology of Human Development: Experiments by Nature and Design, Cambridge MA: Harvard University Press.

Bronfenbrenner, U., 2001. "The Bioecological Theory of Human Development", in Smelser, NJ., and Baltes, PB., (Editors), International Encyclopaedia of the Social and Behavioural Sciences, Volume 10, pp.6963-6970, New York: Elsevier.

Brooks, AM., and Hanafin, S., 2005. Measuring Child Well-Being: An Inventory of Key Indicators, Domains and Indicator Selection Criteria to Support the Development of a National Set of Child Well-Being Indicators, Dublin: The National Children's Office. Available at www.nco.ie.

Carlson, M., 2006. "Family Structure, Father Involvement, and Adolescent Behavioural Outcomes", Journal of Marriage and Family, 68, September, pp.137-154.

Carlson, M., and McLanahan, SS., 2006. "Strengthening Unmarried Families: Could Enhancing Couple Relationships Also Improve Parenting", Social Service Review, June, pp.297-321.

Carr, A., 2004. Positive Psychology: The science of happiness and human strengths, Hove and New York: Brunner-Routledge.

Centre for Health Promotion Studies, 2003. The National Health and Lifestyle Surveys: Survey of Lifestyle, Attitudes and Nutrition (SÁN) & The Irish Health Behaviour in School-Aged Children Survey (HBSC), Galway: Centre for Health Promotion Studies.

Cheshire, P., 2007. Segregated Neighbourhoods and Mixed Communities: A Critical Analysis, York: Joseph Rowntree Foundation. Available at www.jrf.org.uk

Cohen, J., 1988. Statistical Power Analysis for the Behavioural Sciences, Second Edition, New Jersey: Erlbaum.

Department of Health and Children, 1999. Children First: National Guidelines for the Protection and Welfare of Children, Dublin: The Stationery Office.

Department of Health and Children, 2002. Our Duty to Care: The Principles of Good Practice for the Protection of Children and Young People, April, Reprinted in October 2002 and May 2004, Dublin: Department of Health and Children.

Derogatis, L., 1992. Symptom Checklist - SCL 90-R: Administration, scoring, and procedures manual. Towson, MD: Clinical Psychometric Research. (Originally published in 1977).

Diener, E., Smith, H., and Fujita, F., 1995. "The Personality Structure of Affect", Journal of Personality and Social Psychology, 50,, pp.130-141.

Diener, E., Lucas, RE., and Oishi, S., 2002. "Subjective Well-Being: The Science of Happiness and Life Satisfaction", in Snyder, CR., and Lopez, S., (Editors), Handbook of Positive Psychology, pp.63-73, New York: Oxford University Press.

Fahey, T., 1999. Social Housing in Ireland: A Study of Success, Failure and Lessons Learned, Dublin: Oak Tree Press.

Fahey, T., Russell, H., and Whelan, CT., 2007. Best of Times? The Social Impact of the Celtic Tiger, Dublin: Institute of Public Administration.

Fitzgerald, J., 2007. Addressing Issues of Social Exclusion in Moyross and other disadvantaged areas of Limerick City: Report to the Cabinet Committee on Social Inclusion, April, Dublin: Institute of Public Administration.

Fitzgerald, M., and Jeffers, A., 1994. "Psychosocial Factors Associated with Psychological Problems in Irish Children and their Mothers, The Economic and Social Review, Volume 25, Number 4, pp.285-301.

Fone, D., Dunstan, F., Lloyd, K., Williams, G., Watkins, J., and Palmer, S., 2007. "Does social cohesion modify the association between area income deprivation and mental health? A multilevel analysis", International Journal of Epidemiology, February, 36(2):338-345.

Fone, D., Lloyd, K., and Dunstan, F., 2007. "Measuring the neighbourhood using UK benefits data: A multilevel analysis of mental health status", May, BMC Public Health, 7:69.

Gerard, AB., 1994. Parent-Child Relationship Inventory (PCRI): Manual, Los Angeles: Western Psychological Services.

Goering, J., and Feins JD., (Editors), 2003. Choosing a Better Life: Evaluating the Move to Opportunity Experiment, Washington, DC: The Urban Institute Press.

Goodman, R., 1997. "The Strengths and Difficulties Questionnaire: A Research Note", Journal of Child Psychology and Psychiatry, Volume 38, Number 5, pp. 581-586.

Goodman, R., Meltzer, H., and Bailey, V., 1998. "The Strengths and Difficulties Questionnaire: A Pilot Study on the Validity of the Self-Report Version", European Child and Adolescent Psychiatry, Volume 7, pp. 125-130.

Goodman, R., and Scott, S., 1999. "Comparing the Strengths and Difficulties Questionnaire and the Child Behaviour Checklist: Is Small Beautiful?", Journal of Abnormal Child Psychology, Volume 27, Number 1, pp. 17-24.

Goodman, R., 1999. "The Extended Version of the Strengths and Difficulties Questionnaires a Guide to Psychiatric Caseness and Consequent Burden", Journal of Child Psychology and Psychiatry, Volume 40, Number 5, pp. 791-799.

Goodman, R., Renfrew, D., and Mullick, M., 2000. "Predicting type of psychiatric disorder from Strengths and Difficulties Questionnaire (SDQ) in child mental health clinics in London and Dhaka", European Child Adolescent Psychology, Volume 9, pp. 129-134.

Gottman, J., 1997. Why Marriages Succeed or Fail... And How You Can Make Yours Last, New York: A Fireside Book.

Graham, C., Hammond, RA., and Peyton young, H., 2007. "Obesity and the Influence of Others" The Washington Post, 21 August. Available at: http://www.brookings.edu/views/op-ed/graham20070821young.htm

Haase, T., & J. Pratschke, J., 2005. Deprivation and its Spatial Articulation in the Republic of Ireland – New measures of deprivation based on the 1991, 1996 and 2002 Census of Population. Dublin: Pobal. Available at www.pobal.ie.

Halford, W.K. and Markman, H.J., (Editors), 1996. The Clinical Handbook of Marital and Couples Interventions, London: John Wiley and Sons.

Hall, D. M. B. and Elliman, D., 2003. Health for All Children, 4th Edition, Oxford: Oxford University Press.

Hanafin, S., and Brooks, AM., 2005. Report on the Development of a National Set of Child Well-Being Indicators in Ireland, Dublin: The National Children's Office. Available at www.nco.ie.

Harker, L., and Keltner, D., 2001. "Expressions of positive emotion in women's college yearbook pictures and their relationship to personality and life outcomes across adulthood", Journal of Personality and Social Psychology, volume 80, pp.112-124.

Harold, G., Pryor, J., and Reynolds, 2001. Not in front of the children? How conflict between parents affects children, London: One Plus One Marriage and Partnership Research.

Haase, T., and Pratschke, J., 2005. Deprivation and its Spatial Articulation in the Republic of Ireland: New Measures of Deprivation based on the Census of Population, 1991, 1996, 2001, June, Dublin: Area Development Management Limited.

Healy, T., 2005. "The Level and Distribution of Social Capital in Ireland", 24th November, Journal of the Statistical and Social Inquiry Society of Ireland, Volume XXXV, pp.58-88.

Hetherington and Kelly, 2002. For Better or For Worse: Divorce Reconsidered, New York and London: Norton and Company.

Home Office Citizenship Survey, 2004. 2003 Home Office Citizenship Survey: People, Families and Communities, December, London: Home Office Research, Development and Statistics Directorate. Available at:

Huebner, E., 1994. "Preliminary development and validation of a multi-dimensional life satisfaction scale for children". Psychological Assessment, 6, pp. 149-158.

Huebner, E., 2001. Manual for the Multidimensional Students' Life Satisfaction Scale. SC: University of South Carolina (unpublished paper provided by the author).

Kiecolt-Glaser, J.K. and Newton, T.L., 2001. "Marriage and Health: His and Hers", Psychological Bulletin, 127, pp.472-503.

Kling, R., Ludwig, J., and Katz, L., 2005. "Neighbourhood effects on crime for females and male youth: evidence from a randomised housing voucher experiment", Quarterly Journal of Economics, Volume 20, Number 1, pp.87-130.

Kurdek, L., 1994. "Conflict resolution styles in gay, lesbian, heterosexual nonparent, and heterosexual parent couples". Journal of Marriage and the Family, 56, pp. 705-722.

Lamb, ME., (Editor), 2004. The Role of the Father in Child Development, Fourth Edition, New Jersey: John Wiley and Sons.

Lamborn, S., Mounts, N., Steinberg, L., and Dornbusch, S., 1991. "Patterns of competence and adjustment among adolescents from authoritative, authoritarian, indulgent and neglectful families". Child Development, 62: 1049-1065.

Layzer, J., Goodson, B., Bernstein, L., and Price, C., 2001. National Evaluation of Family Support Programs: Volume A: The Meta-Analysis, April, Cambridge MA: ABT Associates Inc.

Lynch, K., Fitzgerald, M., and Kinsella, A., 1987. "The prevalence of Child Psychiatric Disorder in 10 and 11 Year Old Boys in an Urban School", Irish Journal of Psychiatry, Autumn, pp.20-24.

Lundbeck Mental Health Barometer, 2007. Mind Yourself, July, www.lundbeck.ie

McCarthy, PW., and O'Boyle, CA., 1986. "Prevalence of behavioural maladjustment in a social cross-section of Irish urban school children", Irish Medical Journal, Vol 79, No 5, pp.125-129.

McCartney, K., and Dearing, E., 2002. "Evaluating Effect Sizes in the Policy Arena", The Evaluation Exchange Newsletter, Spring, Harvard Family Research Project.

McDowell, I., 2006. Measuring Health: A Guide to Rating Scales and Questionnaires, New York: Oxford University Press, pp.350-358.

McKeown, K., 2000. Supporting Families: A Guide to What Works in Family Support Services for Vulnerable Families, October, Dublin: Stationery Office. Available at www.doh.ie

McKeown, K., 2001a. Fathers and Families: Research and Reflection on Key Questions, November, Dublin: Stationery Office. Available at www.doh.ie

McKeown, K., 2001b. "Families and Single Fathers in Ireland", Administration: Journal of the Institute of Public Administration, Volume 49, No 1, Spring, pp. 3-24.

McKeown, K., Haase, T., and Pratschke, J., 2001. Springboard: Promoting Family Well-Being through Family Support Services, December, Dublin: Stationery Office. Available at www.doh.ie

McKeown, K., and Sweeney, J., 2001. Family Well-being and Family Policy: Review of Research on Benefits and Costs, June, Dublin: Stationery Office. Available at www.doh.ie

McKeown, K., Lehane, P., Rock, R., Haase, T., and Pratschke, J., 2002. Unhappy Marriages: Does Counselling Help?, December, Report to ACCORD, Maynooth, Co. Kildare: ACCORD. Available at www.welfare.ie and www.accord.ie

McKeown, K. and Kidd, P., 2001. Men and Domestic Violence: What Research Tells Us, March, Dublin: Department of Health and Children. Available at www.doh.ie

McKeown, K., Pratschke, J., and Haase, T., 2003. Family Well-Being: What Makes a Difference?, November, Jointly published by Department of Social & Family Affairs, Family Support Agency and The Céifin Centre in Shannon, Co. Clare. Available www.welfare.ie and www.ceifin.ie

McKeown, K., Haase, T., and Pratschke, J., 2004a. Making Life Better for Families: Do Family Support Services Help?, Evaluation of Springboard Project in Loughlinstown, Dublin, Dublin: East Coast Area Health Board.

McKeown, K., Haase, T., and Pratschke, J., 2004b. Making Life Better for Families: Do Family Support Services Help?, Evaluation of Springboard Project in Darndale, Dublin, Dublin: Northern Area Health Board.

McKeown, K., Haase, T., and Pratschke, J., 2004c. Distressed Relationships: Does Counselling Help?, May, Report to MRCS: Marriage and Relationship counselling Services, Dublin: MRCS. Available at www.welfare.ie

McKeown, K., 2006. "Estimated Number of Children with Special Education Needs", in National Council for Special Education, Implementation Report: Plan for the Phased Implementation of the EPSEN Act 2004, October, Kells Co Meath: National Council for Special Education, Chapter Three, pp.59-76.

McKeown, K., and Fitzgerald, G., 2006a. The Impact of Drugs on Families. Report prepared for Ballyfermot STAR. September. 58 pages.

McKeown, K., and Fitzgerald, G., 2006b. Experiences and Attitudes of Early School Leavers. Report prepared for EQUAL Youth Project in Ballymun and Mayo. September. 69 pages. Available at http://www.equal-youth.ie/publications/

McKeown, K., and Fitzgerald, G., 2007. Strengthening the Well-Being of Young People: Evaluation of a Community-based Mental Health Project in Dublin. Report prepared for Mounttown Neighbourhood Youth and Family Project. April. 118 pages.

McKeown, K., and Haase, T., 2007. Understanding the Needs of Children: A Study of Needs and Their Determinants in Limerick and Thurles, A Report for Barnardos, September, Unpublished, Dublin: Barnardos.

McLanahan, S., Donahue, E., and Haskins, R., (Editors), 2005. Marriage and Child Wellbeing, Volume 15, Number 2, Washington and New York: Brookings Institution Press and the Woodrow Wilson School of Public and International Affairs, Princeton University.

Martin, M., Carr, A., Carroll, L., and Byrne, S., 2005. The Clonmel Project: Mental Health Service Needs of Children and Adolescents in the South East of Ireland: A Preliminary Screening Study, Clonmel: Health Services Executive, Psychology Department.

Mathai, J., and Anderson, P., 2004. "Comparing psychiatric diagnoses generated by the Strengths and Difficulties Questionnaire with diagnoses made by clinicians", Australian and New Zealand Journal of Psychiatry, Volume 38, Number 8, pp.639-643.

Meltzer, H., Gatward, R., Goodman, R., and Ford, F., 2000. Mental health of children and adolescents in Great Britain. London: The Stationery Office.

Miller, R., and Lefcourt, H., 1982. "The assessment of social intimacy". Journal of Personality Assessment, 46, 5, 514-518.

Mohan, D., Fitzgerald, M., and Collins, C., 1998. "The relationship between maternal depression (antenatal and pre-school stage) and childhood behavioural problems", Irish Journal of Psychological Medicine, Vol. 15, No. 1, pp.10-13.

Moos, R., Cronkite, R., Billings, A. & Finney, J., 1986. Health and Daily Living Form Manual. Palo Alto, California: Veterans Administration and Stanford University Medical Centers.

Mortimore, P., 1997. "Can Effective Schools Compensate for Society?", in Halsey, A., Lauder, H., Brown, P., and Stuart-Wells, A., (Editors), Education, Culture, Economy and Society, Oxford: Oxford University Press.

Murch, M., and Keehan, G., 2003. The Voice of the Child in Private Family Law Proceedings: Findings from a Reconnaissance of Anglo-Irish Child-Related Divorce Legislation, Bristol: Jordan Publishing Limited.

Myers, D., and Diener, E., 1996. "The pursuit of happiness", Scientific American, Number 274, May, pp.54-56.

Najman, J.M., Behrens, B.C., Andersen, M., Bor, W, O'Callaghan, M. and Williams, GM., 1997. "Impact of Family Type and Family Quality on Child Behaviour Problems: A Longitudinal Study", Journal of the American Academy of Child and Adolescent Psychiatry, Volume 36(10), pp. 1357-1365.

National Advisory Council on Drugs, 2005. Drug Use in Ireland and Northern Ireland: First Results from the 2002/2003 Drug Prevalence Survey, Bulletin 1 & 2, Dublin: National Advisory Council on Drugs.

Nelson, Westhues and MacLeod, 2003. "A Meta-Analysis of Longitudinal Research on Preschool Prevention Programs for Children", Prevention and Treatment, Volume 6, Article 31, December.

Nolan, B., 2007. (Editor), The Provision and Use of Health Services, Health Inequalities, and Health and Social Gain, Dublin: Economic and Social Research Institute.

Nolan, B., and Whelan, CT., 1999. Loading the Dice? A Study of Cumulative Disadvantage, Dublin: Oak Tree Press.

O'Connor, J., Ruddle, H., and O'Gallagher, M., 1988. Cherished Equally? Educational and Behavioural Adjustment of Children: A Study of Schools in the Mid-West Region, University of Limerick: Social Research Centre.

O'Brien, E., 2006. Analysis of Attendance Data at Primary and Post-Primary Levels for 2004/2005, Report prepared by MORI Ireland on behalf of the National Educational Welfare Board, July, Dublin: National Educational Welfare Board. Available at http://www.newb.ie

O'Rourke, M., and Fitzgerald, M., 1985. "An Epidemiological Study of Behavioural Deviance, Hyperactivity and Physical Abnormalities in a Dublin Primary School Population", Irish Journal of Psychiatry, Spring, pp.10-16.

O'Sullivan, C., 2004. "The Psychosocial Determinants of Depression: A Lifespan Perspective", Journal of Nervous and Mental Disease, 192(9): 585-594, September.

One Plus One, 1999. "Focus on … Marital Quality and Parenting" in Bulletin Plus: The News Magazine of One Plus One Marriage and Partnership Research, November, Volume 3, Number 4.

Oreopoulos, P., 2003. "The Long-Run Consequences of Living in a Poor Neigbbourhood", Quarterly Journal of Economics, Volume 118, Number 4, pp.1533-75.

Parke, RD., and Buriel, R., 1998. "Socialisation in the Family: Ethnic and Ecological Perspectives", in Damon, N., and Eisenberg, N., (Editors), Handbook of Child Psychology, Volume 3: Social, Emotional and Personality Development, Fifth Edition, New York: John Wiley and Sons, pp.464-532.

Porteus, MA., 1991. "A Study of Behavioural and Emotional Problems in Irish Primary School Children", The Irish journal of Psychology, Vol 13, No. 3, pp.304-315.

Pratschke, J., 2002. "The Statistical Measurement of Neighbourhood Effects", in Haase, T., and McKeown, K., Developing Disadvantaged Areas Through Area-Based Initiatives: Reflections on over a Decade of Local Development Strategies, Appendix 3, April, Dublin: Area Development Management Limited, pp.42-50.

Bray, 2007a. Community Development Strategy: The Next Phase, Waterford & Dublin: Bray Housing Association.

Bray, 2007b. Estate Management Strategy 2007-2012, Waterford & Dublin: Bray Housing Association.

Rutter, M., 1967. "A Children's Behavioural Questionnaire for Completion by Teachers: Preliminary Findings", Journal of Child Psychology and Psychiatry, Volume 8.

Ryff, C., 2001. Scales of Psychological Well-Being. Wisconsin: University of Wisconsin Unpublished paper provided by the author.

Ryff, C., and Keyes, L., 1995. 'The structure of psychological well-being revisited'. Journal of Personality and Social Psychology, 69: 719-727.

Sampson, RJ., Morenoff, JD., and Gannon-Rowley, T., 2002. "Assessing 'Neighbourhood Effects': Social Processes and New Directions in Research", Annual Review of Sociology, volume 28, pp.466-467.

Schweinhart, LJ., and Weikhart, DP., 1997. "The High / Scope Preschool curriculum comparison study through age 23", Early Childhood Research Quarterly, Volume 12, pp.117-143.

Schweinhart, LJ., 2004. "The High / Scope Preschool Study Through Age 40", Ypsilanti, MI: High / Scope Press. Available at www.highscope.org.

Scovern, A.W., 1999. "From Placebo to Alliance: the Role of Common Factors in Medicine". In M.A. Hubble, B.L. Duncan and S.D. Miller, (Editors), The Heart and Soul of Change: What Works in Therapy, Washington: American Psychological Association, pp. 259-295.

Seligman, M., 2002. Authentic Happiness: Using the New Positive Psychology to Realise your Potential for Lasting Fulfilment, New York: The Free Press.

Shonkoff, JP., and Phillips, DA., (Editors), 2000. From Neurons to Neighbourhoods: The Science of Early Childhood Development, Washington DC: National Academy Press.

Simpson, GA., Bloom, B., Cohen, RA., Blumberg, S., Bourdon, KH., 2005. U.S. children with emotional and behavioral difficulties: data from the 2001, 2002, and 2003 National Health Interview Surveys. Advance data from vital and health statistics; Number 360, June. Hyattsville, MD: US Department of Health and Human Services, CDC, National Center for Health Statistics; 2005. Available at http://www.cdc.gov/nchs/data/ad/ad360.pdf.

Smedje, H., Broman, JE., Hetta, J., and von Knorring, AL., 1999. "Psychometric Properties of the Strengths and Difficulties Questionnaire", European Child and Adolescent Psychiatry, Volume 8, pp. 63-70.

Sprenkle, D.H., Blow, A.J. and Dickey, M.H., 1999. "Common Factors and Other Non-technique Variables in Marriage and Family Therapy". In M.A. Hubble, B.L. Duncan and S.D. Miller, (Editors), The Heart and Soul of Change: What Works in Therapy, Washington: American Psychological Association, pp. 329-359.

Stack, S., and Eshleman, J.R., 1998. "Marital Status and Happiness: A 17-Nation Study", Journal of Marriage and the Family, Volume 60, May, pp. 527-536.

Stone, D., Fitzgerald, M., and Kinsella, T., 1990. "A Study of Behavioural Deviance and Social Difficulties in 11 and 12 Year Old Dublin School Children", Irish Journal of Psychiatry, Spring, pp.12-14.

Straus, M., Hamby, S, Finkelhor, D., and Runyan, D., 1995. Identification of Child Abuse with the Parent-Child Conflict Tactics Scales (CTSPC): Development and Psychometric data for a National sample of American parents. Durham, NH: Family Research Laboratory, University of New Hampshire.

Sund, ER., Jørgensen, SH., Jones, A., Krokstad, S., Heggdal, M., 2007. "The influence of social capital on self-rated health and depression – The Nord-Trøndelag health study (HUNT)", Norsk Epidemiologi, 17(1)59-69.

Taskforce on Active Citizenship, 2007. Statistical Evidence on Active Citizenship in Ireland: Background Working Paper, March, Dublin: Taskforce on Active Citizenship. Available at www.activecitizen.ie

Vogt, WP., 1999. Dictionary of Statistics and Methodology: A Nontechnical Guide for the Social Sciences, Second Edition, London: Sage Publications.

Watson, D., Clark, L., and Tellegen, A., 1988. "Development and Validation of Brief Measures of Positive and Negative Affect: The PANAS Scales", Journal of Personality and Social Psychology, 54(6), 1063-1070.

Waite, LJ., 1995. "Does Marriage Matter?", Demography, Volume 32(4) November, pp. 483-507.

Whelan, CT., Nolan, B., and Maitre, B., 2005. Trends in Welfare for Vulnerable Groups, Ireland 1994-2001, Policy Research Series, Number 56, August, Dublin: The Economic and Social Research Institute.