FINAL REPORT

HOW ARE OUR KIDS?

Experiences and Needs of Children and Families in Limerick Regeneration Areas

PREPARED BY

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1. INTRODUCTION

This is the report of the findings of the study, ***How are our kids?*** The research explores the needs and experiences of children and families in Limerick City, with a particular focus on families in the communities which have been targeted for assistance under the Limerick Regeneration Initiative. These are the most deprived local areas of the city. The research was commissioned by the Limerick City Children's Services Committee. The data collection was undertaken in 2010 and it provides a snapshot of conditions at this point in time. This introductory chapter outlines the background to the research, the aims and objectives, and the priorities and focus of the study.

1.1 Background

The overall context of the research is the regeneration of Limerick City's most disadvantaged estates. As documented in the Limerick Regeneration Masterplans (2008), the "*tipping point*" for the intervention of government (the Fitzgerald Report to the Cabinet Sub-committee on Social Inclusion, and the subsequent setting up of Limerick Regeneration Agencies) was the petrol bomb attack on children (by young people) within the Moyross estate. This report highlighted the extent to which the problems of the estates had deteriorated, the extent of social disorder on the estates, and the need to tackle the serious and complex problems in a comprehensive way. The plan involved putting new structures in place to drive the regeneration process, additional funding (including public and private investment) and a planned and strategic approach to regeneration. Significant progress has been made since the Regeneration Agencies were set up in June 2007, including the publication and agreement of Masterplans on the physical, economic and social aspects of regeneration. However, the severity of the economic recession, including large job losses in Limerick and the Mid-West Region, and the deterioration in the public finances have created more difficult conditions for, and affected progress with, the regeneration of the estates.

The Regeneration Masterplans identify three pillars – economic, social and physical regeneration. The social aspect is acknowledged to be the most important, and the most difficult aspect of the regeneration programme. It will also require the longest timeframe to show an impact. Within the social regeneration pillar, the needs of "*Children, Youth and Family Support*" are addressed together with "*Education*", "*Health*" and "*Neighbourhoods and People*". There are strong inter-connections between these strands. As well as sectoral areas of intervention in the plan (housing, education, health etc.), the strategy focuses on the need to improve the coordination and integration of services to communities, and for structures to promote inter-agency cooperation in service delivery.

The Limerick City Children's Services Committee is a city-wide initiative established in 2007. It was one of four such pilot initiatives in the country at that time. It consists of senior representatives of the key statutory agencies with a remit for the delivery of services to children and families including: the

HSE, An Garda Síochána, the Probation Services, the Department of Education and Skills, the National Education Welfare Board, Limerick City Council, Limerick City VEC, the PAUL Partnership and Limerick Regeneration Agencies. It is the structure responsible for progressing strategic planning and policy, and for promoting the integration and coordination of services for children in Limerick City. The Limerick City Children's Services Committee has a key role to play in support of the Regeneration Programme, namely to "*prioritise the development, delivery and integration of services for children and families in communities targeted under the Regeneration Programme*".

A comprehensive programme of research is being undertaken "*to inform the planning and action of the CSC*". The research includes this study of children and families which comprises two strands:

- An integrated baseline analysis of the experiences and needs of children (up to 18 years) and families in the city, especially those residing in regeneration areas (Strand 1);
- A series of public consultations (focus groups) with parents / carers and service providers across the city (Strand 2).

1.2 Aims and Objectives of the Research

The overall aim of this research is to contribute evidence-based research to inform the work of Limerick City CSC and its constituent agencies. The specific objectives, as outlined in the Terms of Reference, are twofold. The first objective is "*to establish a baseline profile of children in Limerick City, with a particular focus on children residing in the regeneration communities, which will enable further examinations of the quality of life of an equivalent cohort of children in subsequent years*". The methodology to be applied here is a quantitative research strategy centred on a household survey to be undertaken in the Regeneration Areas of the city and two other non-regeneration communities. The second objective is to undertake public consultations or focus groups with parent and service providers in order "*to assess the relevance, quality, efficiency and impact of existing service provision for children in Limerick and assist in interpreting key findings"* from the household survey. As well as information or data gathering, further objectives of the focus group interviews, as specified in the Terms of Reference, were: to *"raise awareness of the research and generate community understanding of the purpose and scope of the research programme, whilst also generating a sense of ownership and active participation in the research*"; to "*contribute to the development of themes to be examined in the household survey"*; and to *"assist in the interpretation of findings from the household survey".*

Due to issues in the scheduling of the various components of the research, and the relatively short time available in total for the fieldwork, the objective of using the focus group outputs to inform

research themes for the household survey was not realisable. Accordingly, the objectives for the focus groups were reshaped such that they focus on the issues of ownership and participation, and on getting the service providers' perspective.

1.3 Focus and Priorities

The focus and priorities of the research were agreed in consultation with the Limerick City CSC.

The overall priority was to gather relevant data on needs and experiences of children and families, and map the baseline position with particular attention to the situation in Regeneration Areas. The research was designed as a cross-sectional study, with potential for follow-up (say in 5 years) using repeat cross-section design (i.e. going back to the same areas). It involved an aspect of "control" based on selection of "control areas" and this adds a comparative perspective across different types of community in Limerick City.

Considerable attention was given to the purpose of a mixed methods approach, namely use of both quantitative and qualitative research methods, and which method should have priority. As this is a baseline exercise (which requires "measurement"), priority was given to the quantitative component. The qualitative part of the research involving parents adds richness to the findings and informs interpretation of the survey findings. The qualitative component involving service providers is an additional source of data gathering (i.e. a further perspective) and also assists in interpretation of the quantitative research findings.

The implementation of the research involved no extensive literature or policy review. Review of national policies in favour of children and families is the subject of an additional piece of research commissioned by the Limerick City CSC. However, the research instruments were developed with reference to national policy frameworks – for instance, policy to identify good outcomes for children and young people (*The Agenda for Children's Services: A Policy Handbook*, Office of the Minister for Children, Department of Health and Children, 2007) and other key policy documents. Similarly, key sources of literature were reviewed to inform the development of the research instruments, particularly the questionnaire surveys. This included research on children and families in Ireland, the UK and other advanced countries. The purpose here was to use, as much as possible, validated / tested questions, and to focus on those that are used extensively in international research in this field. This approach allows for an additional comparative perspective to the research.

1.4 Report Structure

The detailed findings are provided in this, the main report, of the research. The report is structured as follows:

- Chapter 2 describes the research methodology.
- Chapter 3 provides a description of the study areas (neighbourhoods) drawing on secondary data sources as well as findings from the household survey related to characteristics of the sample.
- Chapter 4 sets out the detailed findings of the household survey which comprised the quantitative strand of the research. This comprises findings from the survey of (i) parents / carers and (ii) children.
- Chapter 5 provides the findings of the qualitative investigations (focus groups) with parents and with service providers.
- Chapter 6 presents the conclusions of the study.

Other material is available in a separate volume of annexes to the report, including the questionnaires and interview schedules, information sheets and consent forms (research ethics).

2. METHODOLOGY

This section details the methodology used in the development and implementation of the research. It provides a description of (i) the research strategy and research design, including details of the research methods and study sites for the primary research, and (ii) details of the implementation of the research strategy. It provides a description of the methodology related to both the quantitative component (the baseline analysis of the needs of families in different types of community in the city); and the qualitative component (the assessment of the relevance, quality and efficiency of existing service provision based on consultations with parents and service providers in the target communities and the city).

2.1 Research Strategy and Research Design

The research strategy and research design were informed in the first instance by the specification provided by the Limerick City CSC. The approach, as specified in the Terms of Reference, was multi-strategy, involving quantitative and qualitative research methods.

In terms of balance between the two types of method, the research team proposed placing stronger emphasis on the quantitative aspect of the research. The primary reasons for this were as follows: (i) a baseline assessment of needs implies quantification of the current situation; (ii) international and national studies in this field are mainly quantitative and therefore application of the same approach (and measures) allows a comparative perspective. A quantitative strategy was also deemed appropriate: (iii) to provide broad coverage of the target population (i.e., to generate data representative of the population under investigation), and (iv) to achieve sufficiently large numbers of respondents in order to explore variations related to the key issues (e.g., indicators of need) in the target population. The quantitative strategy is centred on a household survey involving a parent interview and a child interview, with households selected using a probability sampling approach.

The qualitative strand was deemed important in building a detailed understanding of the context and issues, especially in the regeneration areas of the city, from the perspective both of parents and service providers to children and families. A secondary objective was to promote awareness of the study in the target population, to establish a sense of ownership and to encourage the participation of households from the target communities in the survey. The qualitative data collection involved focus groups with parents, mainly from the regeneration areas of the city, and with service providers to children and families in the regeneration areas and in city-wide services.

The research involves a cross-sectional design (i.e., a snap-shot at a single point in time). Cross-sectional design was considered most appropriate in that the research gives priority to: (i) exploring causal connections between factors associated with outcomes for children and families; and (ii) producing findings that can be generalised to a broader population than that on which the research is

based. The units of analysis are: (i) the household, (ii) the parent / carer, (iii) the child and (iv) the type of place.

The Terms of Reference, provided by the Limerick City CSC, referred to the research as part of a wider programme of longitudinal research related to children and families in Limerick City. By establishing the baseline position of children and families in regeneration areas at this point in time, research undertaken in the future could provide an assessment of how certain aspects of the lives of children and families, and outcomes for them, have changed over time. However, this research was not designed as longitudinal research (i.e., it did not involving recruiting participants to take part in several phases of research now and in future years). Rather, the design of the study and the area-based approach, allows for repeat cross-section design (to assess needs and experiences of families and children in the same neighbourhoods at different points in time). This approach was considered appropriate for the broader programme of research of the Limerick City CSC as it is expected that the social geography of the city and suburbs will change with regeneration.

The research design also involved the application of "control" in the research, using control areas. Inclusion of the regeneration areas and two non-regeneration areas of the city was identified as a requirement in the Terms of Reference. The non-regeneration communities were to be selected in consultation with the Limerick City CSC. The purpose of including non-regeneration communities was to have a comparative base for the research from the outset, and to include "control groups" in the research design. In practice, the study sites selected were broadly representative of the different types of neighbourhood in Limerick City. In terms of relative affluence / disadvantage, they comprised: (i) the northside and southside regeneration areas of the city which are the most disadvantaged areas of the city; (ii) one control area which is in the second tier of disadvantaged communities in the city (i.e., the next level up); and (iii) a second control area which is broadly average for the city. In this way a "gradient" of neighbourhood types from most disadvantaged, through disadvantaged and up to average was built into the design of the research. This allows not just for examination of differences in the current situation and outcomes for children and families across these types of areas but will permit an assessment of the extent to which the most disadvantaged areas converge towards the average over time.

Several difficulties were identified at the outset in building a disadvantaged "control" area into the research design – i.e. an area with household characteristics matched to those of children and families in the regeneration areas. In particular, the high level of mobility of families between estates within the city, and the dispersal of population from the regeneration areas as the demolition programme got underway, mean that a significant number of those living in any candidate control area are likely to have originated within the regeneration areas, and may still have extensive interaction with family and friends living there. This could include accessing services available within the regeneration estates,

even if the family no longer permanently resides there. In these circumstances, the control factor is weakened.

2.2 Data Collection Methods

Three main methods of primary data collection methods were used, as follows:

i. Consultations with the key stakeholders in the study using the structure of the Research Sub-group of the Limerick City CSC and a regular programme of meetings especially during the development phase of the research. This process was part of the detailed scoping of the study and had the objectives: (i) to collect background information on policies in favour of children and families, and contextual information on the neighbourhoods (e.g., housing units occupied in the regeneration areas); (ii) to inform the final selection of the study sites; and (iii) to facilitate the detailed development of the research instruments.

ii. A household social survey based on two highly structured questionnaires: (i) for the parent / carer; and (ii) for a child within the age group seven year to 17 years. These were structured around the seven outcomes for children set out in national policy (*The Agenda for Children's Services: A Policy Handbook*, Office of the Minister for Children and Department of Health and Children, 2007) which are described in detail below.

iii. Focus group interviews for two types of participants: (i) for parents / carers and (ii) for providers of services to children and families. These are also described in detail below. The interview schedules for the parent / carer focus groups were structured on the seven outcomes for children and families; the interview schedule for providers drew on the five characteristics of services to children (Office of the Minster for Children and Department of Health and Children, 2007).

In addition, to the primary data collection, data were compiled from the census of population (CSO 2006, Small Area Population Statistics) in order to inform the final selection of research sites.

2.3 Sampling Strategy and Development of the Survey Instruments

This section describes the implementation of the research design for both the quantitative and qualitative components of the research. It describes the choice of study areas, and the selection of households for the survey of parents and children, as well as the recruitment of participants for the focus groups. In addition the process used to develop the various data collection instruments (questionnaires and focus group schedules) is outlined.

2.3.1 Research ethics

Ethical approval for the research was granted by the Research Ethics Committee of Mary Immaculate College, University of Limerick (MIREC). The application to MIREC was submitted in two phases:

(i) first, for the focus groups which commenced before the survey; and (ii) subsequently, for the household survey.

2.3.2 Definition of the study site(s) and study population

As outlined above, the broad identification of the research sites was specified by the Limerick City CSC: namely, the northside (Moyross and St. Mary's Park) and southside (Southill and Ballinacurra Weston) regeneration areas, and two non-regeneration areas. A condition specified by the Limerick City CSC was that all areas selected must be within the boundaries of Limerick City (and not extend to the suburbs). The selection of the "control" areas was undertaken in consultation with the Limerick City CSC, based on three criteria:

i. Indicators of relative affluence / disadvantage at Electoral District level, including the relative deprivation score (Haase Index), the rate of lone parent families, and the male unemployment rate.
ii. Age structure and the presence of families with children, with particular attention to areas with both a relatively high absolute number of children and a relatively high percentage of households with children.
iii. Natural boundaries of neighbourhoods. While the Research Team sought to select areas with an identity as neighbourhoods, it was also considered desirable not to select a disadvantaged control area directly adjacent to the regeneration areas as there is typically strong interaction of families between such areas (e.g. Ballynanty / Moyross) and "spillover" from one into the other in accessing services such as schools, health centres, and community centres.

The "control" areas eventually selected, in consultation with the Limerick City CSC, were as follows:

i. **Disadvantaged (Control) Area**: A large area on the southside of the city covering Garryowen, Kennedy Park, and estates within the Limerick City Boundary in the Old Cork Road area.
ii. **Average (Control) Area**: A large area to the north of the city centre covering most of the Corbally area within the Limerick City boundary and the new estates in Rhebogue.

Further details of the composition of all areas included in the research are provided in Chapter 3.

2.3.3 Sampling strategy for the quantitative and qualitative research

The four study sites fall within the boundaries of 11 Electoral Districts (ED) in Limerick City. In preparing the household survey component, the first task was to identify the boundaries of the neighbourhoods / study sites (i.e. specific streets / estates etc.) with reference to ED boundaries. This was in order to identify the size of the population in each of the areas in terms of (estimated) number of households and households with any children under 18 years. This informed the decision on the

size of sample required for the study. The sample size in this research was considered with reference to two criteria: (i) the need to be representative of the overall study population (households with children) and (ii) the need to be able to carry out statistical modelling and tests in line with the study objectives, including tests for significant differences in indicator and outcome variables across the four study areas. Taking into account these criteria (representativeness and statistical power) and resource considerations, a target of 400 respondents (i.e., valid useable questionnaires) from across the four areas was set, with an approximately equal number of respondents to be drawn from each area (i.e., approximately 100 cases from each).

Implementation of the household survey is based on a probability sampling approach involving four independent samples of the target population. In the two regeneration areas, sampling was undertaken using an (incomplete) sampling frame of households with families combined with on-the-ground systematic sampling. The use of the latter was in order to address the problem of lack of completeness in the sampling frame. In the control areas, following detailed investigations of possible sources that could be used to construct a sampling frame, it was found not possible to do so (see below). Consequently, sampling in both of the control areas was based entirely on a systematic approach.

In relation to the qualitative strategy, the number of focus groups planned and implemented was influenced by: (i) timescale and resources available for the research; (ii) timing in terms of practical considerations influenced by the fact that much of the research was undertaken over the summer holiday months; (iii) greater priority overall given to successful completion of the household survey component; (iv) greater priority given to engaging with parents in the regeneration areas (rather than all areas); and (v) the Research Team's understanding of the purposes of the focus groups (to gather data but also to promote awareness and ownership of the research). In using focus groups as a method of data gathering, an important aspect was to draw on the group interaction (i.e., how the participants engage with the topics and influence each other in the discussion). Based on previous experience, it was expected that there would be difficulties in recruiting parent participants for focus groups, especially in obtaining a cross-section of parents broadly typical of the population in the target areas, a large number of "no shows", and sensitivities in discussing some issues.

Purposive sampling was conducted in recruiting participants into the parent and provider focus groups, and in planning the total number of focus groups to be undertaken. Additional focus groups continued to be planned and conducted for as long as the Research Team identified gaps in the information generated from the discussion and in types of participants (e.g., the education sector was identified as a gap in the provider focus groups, and additional focus groups involving representatives of that sector were organised). The focus groups continued until the Research Team was satisfied that: (i) they had captured the diversity of views sought, and (ii) had reached saturation in terms of the views articulated (i.e., no new information was emerging from additional focus groups).

Parent focus groups were planned and participants recruited through schools (Home School Community Liaison personnel), crèches, and the parish (church), while focus groups with service providers were planned and recruited through the Youth Fora and Youth Services / Garda Youth Diversion Projects (Northside, Moyross and St. Mary's Park, Ballinacurra Weston, Southside / Southill) and, in the case of education providers, through OSCAILT, the network of DEIS (*Delivery Equality of Opportunity in Schools*) Schools in Limerick.

2.3.4 The sampling frame for the household survey

The construction of a sampling frame required considerable work to ensure that it was as complete as possible from the sources available. The sources used for mapping the total number of households by area comprised: (i) the most recent Electoral Registers available to the Research Team (Limerick City, February 2007) which were used in the first instance to identify numbers of households by street / estate in all areas; (ii) maps from the Regeneration Agencies showing housing currently occupied in the northside and southside regeneration areas; and (iii) selective visits to some parts of areas to identify any new housing developments in the study areas since 2007 (Corbally / Rhebogue). This enabled the broad mapping of the four research sites, street-by-street / by estate (to establish numbers of houses and numbering sequence).

Following detailed investigation, it was established that no comprehensive lists of households with children under 18 years old could be obtained from public sources (e.g. schools, Department of Education and Skills) for the four study areas. However, while not totally accurate, relevant sources of information to establish which households (addresses) had children could be obtained for regeneration areas. Sources included: (i) with permission from Limerick City Council, a database of households renting from the Council; (ii) data sources of the Regeneration Agencies mapping the characteristics of households in the regeneration areas (not a complete mapping of all households in the areas however); (iii) information available to the Research Team from previous survey work in the Northside Regeneration areas, particularly Moyross. Using these sources a large number of households with children was identified for the two regeneration areas. This enabled a more focused sampling strategy in these areas than was possible for the two control areas. Nevertheless, because of the incompleteness of the sampling frame (and use only of an incomplete list would result in sampling error), the use of the sampling frame had to be supplemented by using a (random) systematic sampling approach on the ground (e.g. selecting every fifth house etc.). This resulted in households which were not identified as households with children being included in the sample actually selected.

In order for the sample households to be broadly representative of the parts of the community that make up the study areas, each study area was broken down into sub-areas (small estates within a larger area, groups of streets adjacent to each other etc.). For each sub-area the population of households with children was estimated based on the data sources listed above (for the regeneration

areas) and the most recent census data (at the level of Enumeration Areas). The sample for the area as a whole was then drawn proportionally across the sub-areas (for instance, if 40% of the total number of households / households with children were estimated to be in one sub-area, 40% of the sample population was drawn from that sub-area).

2.3.5 Development of the research instruments: Questionnaires

The design of the research instruments was informed by: (i) the review of national policy documents on outcomes for children and families and lists of appropriate indicators[1]; (ii) national and international studies addressed to establishing current conditions and well-being of children and families, particularly from Ireland and the UK; (iii) previous studies undertaken by members of the Research Team in similar community studies in recent years (which provided tested questions / instruments for measurement of factors related to contextual conditions of the neighbourhood, social capital, self-assessed health status, service utilisation and quality assessment); (iv) reviews of the use and robustness of alternative research instruments to assess, for instance, adult physical and mental health, child and infant health and well-being, and (v) input in terms of advice and feedback from the Limerick City CSC Research Sub-group.

Sources of particular relevance which informed the design of the survey instruments (for both parents and children) included: (i) questionnaires used in primary research on social capital in communities in Limerick city (Humphreys, 2005) and the health status of older people (Humphreys and deBurca 2009); (ii) the ESRI-led *Growing Up in Ireland* study currently underway (parent and child questionnaires); (iii) the national evaluation of *On Track*, National Centre for Social Research and Policy Research Bureau, UK (2006) (parent and child questionnaires); and (iv) the *Millennium Cohort Study* UK and associated studies.[2] Questions used in the Irish Census of Population (e.g. diagnosed health problems, questions addressed to various aspects of socio-economic status such as level of educational attainment, principle economic status, and occupation) were also incorporated into the questionnaire. In relation to parent / carer self-assessed health, the decision was taken to use SF-12 (Ware, Kosinski et al 1993, 2000) as it was considered the most appropriate generic instrument. Arguments in favour of its use included: its extensive use internationally; the capability of measuring both physical and mental health; and the availability of population norms against which the findings of this research could be compared.

In relation to child health, following a review of potential instruments which could be used to assess child strengths and difficulties, it was decided to use the "Strengths and Difficulties Questionnaire"

[1] E.g. Brooks and Hanafin (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: National Children's Office.
[2] See ESDS Longitudinal which provides a databank on the eight main studies most heavily used in the UK including a number of studies of children, families and young people. http://www.esds.ac.uk/longitudinal

(SDQ) (Goodman, 1997).[3] This is a brief behavioural screening questionnaire appropriate to children in the broad age range 3-16 year olds. It exists in several versions (for parents, teachers, children). It is structured on 25 questions (items) used to construct five scales (one positive or related to strengths and four negative or related to difficulties) and a composite "total difficulties" score, the latter based on 20 items. The decision to use the SDQ instrument was based on its widespread use, its suitability for application to a wide range of children, the existence of a version for parents suitable for self-administration or interviewer administration, and the availability of population norms to allow comparison of the findings of this research with other studies.

The questionnaires were highly structured, containing "closed" questions only. They were designed for administration based on face-to-face interviews with respondents. The content and structure of the Parent / Carer questionnaire and the Child Questionnaire with reference to outcomes for families and children are outlined in Figure 2.1 (Parent / Carer) and Figure 2.2 (Child).

[3] For further information on the Strengths and Difficulties Questionnaire see www.sdqinfo.org

Figure 2.1: Content and Structure of the Parent / Carer Questionnaire and Outcomes for Children and Families and Service Provision	
Questionnaire Structure and Key Issues Addressed	**Outcomes for Children and Families**
A: Introduction and Household Composition Gender, household size, household structure (couple, adults, children, relationships)	Economically secure
B. The Neighbourhood, Safety, Community Integration Years residents in the neighbourhood / at current address, car ownership, quality rating of the neighbourhood, extent of neighbourhood problems (litter, anti-social behaviour, stigma); safe play / meeting areas; knowing and trusting neighbours; availability of support in parenting.	Secure in the immediate and wider physical environment; Safe from accidental and intentional harm (neighbourhood context); Part of positive networks of family, friends neighbours and community
C. Child Health *Addressed to one sample child – namely "the child whose birthday comes next*": Age, assessment of child's health status, birth weight, any diagnosed physical or mental health problems / learning or behavioural difficulties; for children 36 months or less, indicators of child's health record (immunisation) and development progress (weight gain, hearing etc.), incidents of accidents and injury requiring A&E or hospital admission, incidents of child trauma, strengths and difficulties assessment (SDQ); regularity of physical activity.	Healthy both physically and mentally (Child); Safe from accidental and intentional harm (family context)
D. Child's Education & Active Learning *Addressed to sample child* Whether at school; type of school attended; childcare arrangements; participation in out-of-school activities (sport, cultural, clubs etc.); whether assessed with special needs and support received; parent / school interaction; absence from school; school exclusion; homework from school; parent assessment of child's educational attainment in sums (maths) and reading (English); satisfaction ratings with school, teachers and extent to which child is reaching his/her potential; expected progress of the child in education.	Supported in active learning; Safe from accidental and intentional harm (school); Included and participating in society (out-of-school activities)
E. Relationship with Child and Parenting *Addressed to the sample child* Regularity of various family-based activities; extent to which parent is coping; relationship with the child (5 indicators); monitoring the activities of the child; types and regularity of use of various forms of discipline; problems and pressures faced by the family (illness, addiction, indebtedness)	Safe from accidental and intentional harm; Part of positive networks of family and friends, neighbours and community; Economically secure
F. Parent / Carer Health Diagnosed health problems of the parent / carer; self-assessed health (8 scales and 2 summary components – physical and mental health); regularity of physical activity	Healthy both physically and mentally
G. Service Use and Quality Assessment Use of a range of health, social care and education services over the last 12 months; quality assessment of those services; quality rating of a range of local / locally accessible services for children / families; quality rating of other local services (adult education, police, shops, etc.)	**Service outcomes**: Ensuring quality services Opening access to services
H. Demographic and Socio-Economic Profile Nationality, age, marital status, home tenure, education level, principle economic status, occupation, sources of household income and self-assessment of extent of adequacy of income (relative difficulty in making ends meet)	Economically secure

Figure 2.2: Content and Structure of the Child Questionnaire and Outcomes for Children and Families and Service Provision	
Questionnaire Structure and Key Issues Addressed	**Outcomes for Children and Families**
A: Introduction and Household Composition Gender, age, nationality, whether have pets	
B. School and Learning Whether in school, class, extent to which child likes school; whether child likes teacher(s); child assessment of competency in maths / sums; English / reading; sports / PE; homework; child assessment of expected progress in school; assessment of extent to which child feels safe, can report problems / difficulties and has friends at school (6 indicators); whether any incidents of bad behaviour (kicking / hurting, threatening) and / or exclusion by peers, and location of such incidents (school, neighbourhood, other).	Supported in active learning; Secure in the immediate and wider physical environment (school, neighbourhood); **Services Outcomes**: Ensuring quality services Opening access to services
C. The Neighbourhood Child assessment of issues in the neighbourhood context: clean, safe, friendly, places to play, peers, like living there etc.	Secure in the immediate and wider physical environment (neighbourhood); Safe from accidental and intentional harm (neighbourhood context); Part of positive networks of family, friends, neighbours and community
D. About You and Your Friends Child self-assessment on certain behaviours (anger) and how they relate to friends (popular); whether child has received awards for school work / other activities; whether child likes reading; whether best friends have received awards; have engaged in positive (helpful) and negative behaviours (smoking, stealing etc.); child assessment on the extent to which certain behaviours are wrong (smoking, stealing, fighting, taking alcohol, drugs etc.).	Part of positive networks of family, friends, neighbours and community (friends)
E. About You and Your Family Whether the child engages in leisure activities with parent(s); communication (talk, praise) with parents; discipline from parents (3 indicators); whether child regularly sees people in the extended family network (categories); whether child could talk to persons in a wider network (categories) when worried / something wrong	Part of positive networks of family and friends, neighbours and community;
F. After / Out of School Activities Number and types of activities in which child participates (sport, clubs, jobs such as babysitting / help at home); whether in a sports club; extent of regular physical activity; involvement in any civic activities	Part of positive networks of family, friends and community; Included and participating in society

On the specific research instruments to measure parent / carer health (SF-12 v.2) and child strengths and difficulties (SDQ), further information on the structure, meaning and methods of scoring of the instruments is provided below.

SF-12 (version 2) measures eight dimensions (scales) of health (based on 12 questions or items). Details are provided in Figure 2.3 below. For each dimension, item scores are coded, summed and transformed onto a scale from 0 (lowest well-being/worst health) to 100 (highest well-being/best health).

Figure 2.3: SF-12 v 2: Items, Dimensions (Scales) and Summary Measures				
Quest. No.	**Code**	**Item (Question)**	**Dimension /Scales (No. of Items)**	**Summary Measure**
1	GH01	In general, would you say your health is Excellent, Very Good, Good, Fair, Poor	General Health (1)	Physical Health Summary Component GH01, PF02, PF04, RP02, RP03, BP02 (6 items)
2		Whether health limits you, and how much:	Physical Functioning (2)	
2a	PF02	Moderate activities such as moving a table ….		
2b	PF04	Climbing several flights of stairs		
3		During the past 4 weeks, how much time have you had any of the following problems ... because of physical health	Role Physical (2)	
3a	RP02	Accomplish less that you would like		
3b	RP03	Were limited in the kind of work or other activities		
5	BP02	During the past 4 weeks, how much did pain interfere with your normal work ….	Bodily Pain (1)	
4		During the past 4 weeks, how much time have you had any of the following problems .... because of any emotional problems	Role Emotional (2)	Mental Health Summary Component RE02, RE03, MH03, MH04, VT02, SF02 (6 items)
4a	RE02	Accomplish less that you would like		
4b	RE03	Didn't do work or other activities as carefully as usual		
6		How much time during the last 4 weeks	Mental Health (2)	
6a	MH03	Have you felt calm and peaceful		
6c	MH04	Have you felt downhearted and depressed?		
6b	VT02	Did you have a lot of energy?	Vitality (1)	
7	SF02	During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives)	Social Functioning (1)	

Two standardised summary scores, involving norm-based scoring using general US population statistics, are calculated from the eight SF-12 scales – namely, the Physical Component Summary (PCS) and Mental Component Summary (MCS). The scores range from 0 (worst health) to 100 (best health), with a score of 50, average.

The questions (items), structure and scales in the Child Strengths and Difficulties Questionnaire are outlined in Figure 2.4.

Figure 2.4: Strengths and Difficulties Questionnaire (SDQ): Items (Questions), Structure and Scales			
Quest. No.	**Item**	**Scale (No. of items)**	**Composite Scale**
3	somatic symptoms (complains sickness)	Emotional symptoms (5)	Total Difficulties Score
8	many worries		Sum of all scales except
13	often unhappy		Pro-social scale
16	nervous in new situations		
24	many fears, easily scared		
5	often tempers	Conduct problems (5)	
7	generally obedient		
12	often fights or bullies		
18	often lies or cheats		
22	steals from home, school ..		
2	restless, overactive	Hyperactivity (5)	
10	constantly fidgety		
15	easily distracted		
21	thinks before acting		
25	good attention span		
6	solitary, tends to play alone	Peer Problems (5)	
11	has good friend		
14	generally liked by other children		
19	picked on or bullied		
23	better with adults than with children		
1	considerate of other's feelings	Pro-social (5)	
4	shares readily		
9	helpful if someone is hurt		
17	kind to younger children		
20	often volunteers to help others		

For each of the five scales, the scores can range from 0 (best) to 10 (worst). The total difficulties score is generated by summing the scores of four scales (all scales except the Pro-social scale which measures strengths). The resultant score can range from 0 (least difficulties) to 40 (extreme difficulties). In further interpreting the scores, actual scores can be classified into bands representing (i) normal, (ii) borderline or (iii) abnormal ranges. Normative SDQ data are available for different populations and thus findings of this research can be compared with other populations.

2.3.6 Development of the research instruments: Interview schedules

The preparation of the interview schedule (for use in the Focus Groups) was informed, in the first instance, by the review of the key policy documents, addressing outcomes for children and families and especially the five characteristics of services for children (Office of the Minister for Children, Department of Health and Children, 2007). It was also informed by the process of review and feedback from the Limerick City CSC Research Sub-group. The issues addressed and structure of the

interview schedules for parents / carers and providers, with reference to outcomes identified by national policy in this area, are shown in Figure 2.5 and Figure 2.6 respectively.

Figure 2.5: Structure of and Issues Addressed in the Interview Schedule for Parents / Carers, and Reference to Outcomes for Children and Families and Service Outcomes

Structure and Key Issues Addressed	Outcomes for Children and Families
A: Neighbourhood, Facilities and Safety and Sense of Community Recreation and play areas (safe, supervision), age-groups best / worst served, community spirit / people looking out for each other	Secure in the immediate and wider physical environment; Safe from accidental and intentional harm (neighbourhood context); Part of positive networks of family, friends neighbours and community
B. Networks of Support from Family and Friends Friends (positive and negative influences), extended family relationships, family-based activities	Part of positive networks of family, friends neighbours and community
C. Education and Active Learning Whether happy with the quality of local schools and other services (standard of education offered, environment for positive relationships, parent school interaction); learning support; crèches / pre-school provision and quality; other learning activities / opportunities available in and out of school and in the community	Supported in active learning; Safe from accidental and intentional harm (school); Included and participating in society (out-of-school activities) **Services Outcomes**: Ensuring quality services Opening access to services
D. Services for Children and Families What's available, what's good and how to improve them?: childcare provision and quality; health and social services (child development clinics, social workers, psychological assessment and other specialist services such as speech therapy, mental health services, family support. Other services such as Gardai and services provided by local authorities. Gaps in services and areas for improvement	**Services Outcomes**: Ensuring quality services Opening access to services
F. Parent / Carer Health Diagnosed health problems of the parent / carer; self-assessed health (8 scales and 2 summary components – physical and mental health); regularity of physical activity	Healthy both physically and mentally
G. Service Use and Quality Assessment Use of a range of health, social care and education services over the last 12 months; quality assessment of those services; quality rating of a range of local / locally accessible services for children / families; quality rating of other local services (adult education, police, shops, etc.)	**Service outcomes**: Ensuring quality services Opening access to services Delivering integrated services

In the design of the interview schedule for parents / carers, there were some adaptations (minor variations) to address the questions more specifically to parents of very young versus parents of older children, and to the context of the neighbourhood.

Figure 2.6: Structure of and Issues Addressed in the Interview Schedule for Providers of Services to Children and Families	
Structure and Key Issues Addressed	**Outcomes for Children and Families and Service Outcomes**
A: Needs and Strengths of Children and Families - The Neighbourhood Positive and negative aspects of the neighbourhood environment (facilities, safety, sense of community); which groups of children are best and worst served by current provision (age groups and level of need, based on Hardiker model of need levels)	Secure in the immediate and wider physical environment (neighbourhood); Safe from accidental and intentional harm (neighbourhood context); Part of positive networks of family, friends, neighbours and community Opening access to services
B. Education and Support for Active Learning and Opportunities for Social Inclusion The environment and support for active learning: pre-schools, schools, learning support, other forms of educational provision, support for parent education; absence, exclusion, engagement in school; Opportunities for getting involved in activities in and outside community	Supported in active learning; Included and participating in society; Opening access to services;
C. Services and How to Improve Them: Striving to Achieve Five Essential Characteristics Understanding of positive outcomes for children and families; (1) To what extent services are connecting with families and community strengths, and what could be improved? How to judge success here	Connecting with families and community strengths
(2) To what extent ensuring quality services for children and families and what could be improved? How outcomes are defined, whether making best use of resources? Responsive to needs? Inclusive?	Ensuring quality services
(3) To what extent opening up access to services and what could be improved? (Use Hardiker model for reference): Targeted and universal services, information, outreach, local access, referral systems in place?	Opening access to services
(4) To what extent delivering integrated services and what could be improved here? Meaning of integration, feasible to deliver whole child / whole system approach, structures working? Barriers, constraints?	Delivering integrated services
(5) To what extent engaged in planning, monitoring and evaluating services and what improvements are needed here? Information systems adequate, views on new developments, whether engaged in planning, balance between activities and reporting, user involvement?	Planning, monitoring and evaluating services

2.3.7 Piloting the questionnaires and interview schedules

The survey instruments for parent/ carers and children were each developed in three main drafts. The first and second drafts were refined following review by members of the Research Team, further review of the existing literature and detailed review / feedback from the CSC Research Sub-group. The second and third (final) drafts were also informed by piloting of the questionnaires with parent / carers and children.

The piloting of the questionnaire was undertaken with parents / carers (seven in total, six female and one male) from different socio-economic backgrounds who were parenting children in different age categories (infants, children under 12 years and teenagers). Pilot interviews were undertaken in communities in suburbs of Limerick and in towns outside of Limerick (all outside of the study area).

The purpose of the piloting was to test the questions in terms of understanding (clear / unambiguous), appropriateness of pre-coded categories / "closed" question responses, possible omissions, the sensitivity of questions and the likelihood of respondents refusing to answer or taking offence, the flow of questions, the length of time needed to execute the interview, and any tendency to lose interest in the course of the interview (Bryman, 2004).

No additional questions were included in the questionnaire as a result of the piloting. The wording was refined in the case of some questions to improve clarity, some additional response options were included in "closed" questions (e.g., use of scales rather than "yes" or "no" answers) and allowance was made for multiple responses to certain questions. As expected, the piloting highlighted that there could be some sensitivities with certain questions (e.g. the question on the SDQ module related to whether the child steals – which was particularly sensitive with parents / carers in disadvantaged communities – and questions on family problems such as addiction, family members in prison etc.). No parent / carer objected to any of the questions included in the child questionnaire including those addressed to "bullying" and "wrong doing". The length of the interviews varied (from 30 minutes to more than 60 minutes for the parent / carer and from 15 minutes to over 30 minutes for the child interviews). The variation in the length of time needed arose from the tendency of some respondents to include commentary to explain their answers and / or to qualify them, or to ask for further information on how the findings of the research would be used. While the time needed for each interview in the pilot survey was quite long, interviewees generally did not show loss of interest. Some commented on the detail required (extensive) in the questionnaire responses. It was also found to be quite challenging for the interviewer to maintain rapport with the respondent and the flow of the interview. Overall, the piloting confirmed the relevance of the issues covered in the survey to the target populations (parent / carer and children). It also confirmed that the pre-final drafts were at the limit in terms of their length and the time required to answer.

The two sets of interview schedules (parent / carer and service providers) were also developed in three drafts: the first draft was developed from the review of the literature / policy documents and the second and third (final) drafts were developed following a process of review by the CSC Research Sub-group. The interview schedules were not piloted. In practice, because of variations in the types of participants (parents from different neighbourhoods, parents of infants v. children v. teenagers, frontline v. other service providers, and mix of participants etc.), actual size of focus groups (small v. larger number of participants) and time period allocated to the focus group discussions, it was anticipated by the Research Team that the final (structured interview schedules) would need to be implemented in a flexible way.

2.4 Implementation of the Research Strategy: Fieldwork

As outlined above, data collection involved both a household survey and focus groups. In order to raise the profile and awareness of the research, the Limerick City Children's Services Committee branded the study with the title "**How are our kids?**" and a logo, and undertook to inform all providers of services to children and families in Limerick City that the research had been commissioned, and to ask for their cooperation with the Research Team. All documentation related to recruiting participants for the research (e.g. letters to potential participants and information sheets for both strands) was reviewed by the CSC Research Sub-group and revised as appropriate following feedback. All documentation was approved by the Mary Immaculate College Research Ethics Committee. This documentation comprised:

- **Household Survey**: a letter to inform and recruit eligible parents / carers; separate information sheets and consent forms for parents / carers and children;
- **Focus Groups**: a letter to recruit participant parents, separate information sheets and consent forms for parent / carers and service providers.

Details on the approach to implementation of each strand of the research and the response rates obtained from the fieldwork are outlined in the next sub-section.

2.4.1 Household survey

Four additional external interviewers were recruited to assist the principal researcher with the interviewing / administration of the questionnaires to parents / carers and children. The external interviewers undertook a half-day training session with the principal researcher, related to administration of the questionnaires and procedures for implementation of the survey.

In order to recruit participants to the survey, a letter together with information sheets (parent / carer and child) and consent form(s) (provided in the additional volume) were delivered by the interviewer to households selected for participation in the survey. The interviewer, at this stage, sought to speak to a household member rather than drop letters in a letter box, in order to establish eligibility of the household to participate (i.e., it had to be a household with children aged up to 17 years) and to explain to whom the questionnaires are addressed (i.e., the parent / care respondent would "need to be involved in the care of the child / children" and the children should be "seven years or older in order to be able to answer the questions"). Up to two children per household where a parent / carer completed the questionnaire survey could participant in the child survey. The interviewer went on to explain that the potential respondent should take time to read the documentation and that s/he would call back to establish whether or not the household would participate. Interviewers did not conduct the survey without giving potential participants time to consider whether or not they wanted to participate in the research. In a small number of cases (actual numbers not recorded), some agreed "on the spot".

In these cases, prior to conducting the interview, the interviewer explained the details presented in the letter and information sheet and obtained consent.

The letters were delivered in batches, focused on sub-areas within each of the study areas, to facilitate quick follow-up. The household survey component was administered via face-to-face interviews undertaken in the homes of parents / carers who agreed to participate in the study. Most interviews were conducted by one interviewer in a one-to-one relationship with the respondent. Exceptions to this were in the early stages of the research where two interviewers were present in some cases (one interviewing, one observing) as part of the training and induction of interviewers. All child interviews were undertaken with the parent present. This was a requirement of the survey and was identified as such in the information sheet and explained to parents / carers. Ideally, the interviews were undertaken with the parent / carer with nobody else present. This was not possible however in all cases. Signed and witnessed consent forms were obtained from participants. Child consent forms required the child's signature and the parent's / carer's signature. In some cases (relatively few), participants agreed to participate in the survey; and completed, but did not sign their name on, the consent form as they did not want their identity to be recorded on any of the documentation. In some cases, participants indicated that they had literacy problems and did not sign the consent form. Generally, across all areas, some (potential) participants were concerned about anonymity and confidentiality, and asked for further explanation of the methods used by the Research Team to ensure confidentiality and anonymity.

The approach to selection of potential participants involved over-sampling (i.e. selecting four times the number of respondents sought in the study areas or 400 in order to achieve a target of at least 100 participants per study area). This strategy was in order to address the likelihood of non-response (refusal to participate), non-eligibility (no children aged under 18 years living in the household), un-occupied housing, and non-contactable potential participants in the sample.

Interviewers were required to call at least three times to those households selected to participate in the survey. After three failed attempts, potential participants were reported as non-contactable. All households on the original sample lists (400 in each area) were approached and additional households added as replacements where necessary (for in-eligible, non-contactable, un-occupied, refusal households). In many cases, interviewers called more than three times in order to establish contact and obtain a response (yes / no or not eligible). Ideally, on establishing contact interviewers sought to fix appointments to call back to conduct the interview(s) if the eligible household member agreed to do so. This worked better in some areas than others. Completion of the fieldwork typically involved numerous call backs in order to achieve the target number of responses.

It was anticipated that the number of child interviews obtained would be lower than the number of parent / carer interviews, since not all households with children would have children in the age group

eligible to complete the questionnaire (seven years or over). However, achievement of child interviews proved more difficult than expected, and the number of child interviews achieved was significantly lower than the number of parent / carer interviews achieved. The reasons for a lower response from children were many and varied by area. When children were not present in the household at the time of the parent / carer interview, it proved to be difficult to engage them later (despite several call backs for child interviews in cases where the parent / carer agreed the child would participate). In the early stages of the research (in the regeneration areas) over the first period of school holidays, many children were at summer camp or engaged in activities during the day, some children did not want to do the survey, some were "out" or "playing" outside the house and would not come in to do the survey etc. At the mid- and later stages of the research (in the Control Areas) when children returned to school, they were not present during the day, and many children were engaged in after-school activities (sport, music) and were not available in the early evening; in other cases, they were busy doing homework or were too tired after a busy day.

The fieldwork for the household survey was undertaken from late June 2010 to early October 2011. The time sequence of the fieldwork by area is as follows (Figure 2.7):

Figure 2.7: Household Survey Field Work: Time period of fieldwork and area	
Time Period	**Study Area**
Late June – Late July	Northside Regeneration Area (Moyross and St. Mary's Park)
Late July – Late August	Southside Regeneration Area (Southill and Ballinacurra Weston)
Late August – Mid-September	Disadvantaged Control Area (Garryowen, Kennedy Park, Old Cork Road Area)
Mid-September – Mid October	Average Control Area (Corbally, Rhebogue).

The total number of valid parent / carer interviews obtained was 418, exceeding the target set of 400. The numbers of households approached, of useable parent / carer interviews by study area (and broad sub-area within each area), of non-eligible households and refusals, and the response rates achieved are presented in Table 2.1. In order to achieve the target number, it proved necessary to call on 1,869 households (many of them on several occasions). The response rate[4] achieved overall was 70 per cent. While a lower than expected number of interviews was achieved in the Southside Regeneration Area, the highest response rate was achieved here (79.6%) followed by the Northside Regeneration Area (77.8%). The response rate was lowest in the Average Control Area (61.8%).

The response rate in the regeneration areas may be slightly inflated in that potential respondents here seemed to be more reluctant to refuse to participate and either did not open the door or were not home

[4] Response rate (%) is calculated as follows: Total number of interviews obtained / (Total number of households contacted – Non-contactable households and Non-eligible)*100

when the interviewer was asked to call back. Refusal rates (numbers saying no relative to households contacted, excluding non-eligible and non-contactable households) were highest in the control areas (38.2% in the Average Control and 35.4% in the Disadvantaged Control Area). The higher rate of non-contactable households in the sample selected in the regeneration areas (highest in the Southside Regeneration Area at 63.5% of all households in the sample followed by 53.1% in the Northside Regeneration Area) is explained by higher rates of unoccupied and boarded up housing here compared with other areas and a tendency "not to open the door" to callers (as well as not being home). Higher rates of ineligible households relative to all households in the sample from the Disadvantaged Control (24%) and Average Control (24.5%) areas are explained by the lack of any sources of information on the actual location (addresses) of households with families for these areas. While the sub-areas in the research sites focused on those with the highest concentrations of families based on secondary sources of data, it was still necessary to find them by applying the sampling strategy (systematic sampling and replacement).

Table 2.1: Household survey by broad area and sub-areas: Number of households approached and details of response rates

Area	No.HH in Sample (including replace-ments)	No. HH Non-contactable / not occupied/ boarded	No. HH Not Eligible (no children)	Total No. Contacted and Eligible	No. Refused	Parent / Carer Interviews Obtained	Response Rate, %
Northside Regeneration	**424**	**225**	**46**	**153**	**34**	**119**	**77.8**
Moyross	270	135	36	99	19	80	80.8
St. Mary's Park	154	90	10	54	15	39	72.2
Southside Regeneration	**425**	**270**	**42**	**113**	**23**	**90**	**79.6**
Southill	340	211	34	95	19	76	80.0
Ballinacurra Weston	85	59	8	18	4	14	77.8
Disadvantaged Control	**479**	**203**	**115**	**161**	**57**	**104**	**64.6**
Garryowen	274	116	78	80	24	56	70.0
Kennedy Park	127	47	24	56	30	26	46.4
Old Cork Road	78	40	13	25	3	22	88.0
Average Control	**541**	**239**	**132**	**170**	**65**	**105**	**61.8**
Corbally	331	128	98	105	34	71	67.6
Rhebogue	210	111	34	65	31	34	52.3
All Areas	**1869**	**937**	**335**	**597**	**179**	**418**	**70.0**

Focusing on the child interviews, 128 useable questionnaires were achieved across all areas - the highest number in the Northside Regeneration Area (42), followed by the Disadvantaged Control Area (39), and the Average Area (24), with the lowest number in the Southside Regeneration Area (23). The number of child interviews related to 119 of the 418 households (parents / carers) that participated in the survey, indicating that in some households, two children participated in the survey.

The rate of child interviews relative to the number of households with any children in the age group seven years and over (the criterion set for participation in the child interview) was 39.3 per cent. See Table 2.2 for details.

Table 2.2: Child Interviews - Response rate relative to all households with children 7 years and over

Area	Child Interviews, No.	Corresponding Number of Households, No.	All Respondent HH with children 7 years and over, No.	% of child interviews (households) relative to all households with children 7 years and over
N'side Regeneration	42	37	91	40.7
S'side Regeneration	23	22	69	31.9
Disadvantaged Control	39	37	76	48.7
Average Control	24	23	67	34.3
Total	**128**	**119**	**303**	**39.3**

2.4.2 Focus groups

In the recruitment of participants to the focus groups, letters and information sheets addressed to potential parent / carer participants were provided in advance to the contact person who offered to assist with the process. These organisers were drawn from schools (Home School Community Liaison), crèches and Garda Diversion Project / Youth Work services and other community / voluntary organisations. The venue and time for the focus groups were established in advance with the organiser and this information was provided to potential participants. The profile and number of participants to be invited was agreed with the organiser and the expected attendance confirmed with the organiser one day in advance of the focus group. In two of the parent / carer focus groups, the organiser (Home School Community Liaison in each case) attended the focus group session. Venues for the focus group discussions were: schools (parent rooms), community centres, youth services facilities, and another site.

Focus group discussions were held in the Northside Regeneration Area (Moyross and St. Mary's Park) and the Southside (Southill) Regeneration Areas, and in a northside venue that brought together participants from the Average Control Area and the Northside Regeneration Area (St. Mary's Park). Not all participants were current residents of the study sites (but all were using services such as schools, crèches and youth services in the study sites). The priority in the research was to engage with parents / carers in the regeneration areas. There were no focus group discussions in the Disadvantaged Control Area. The timing of the research over the summer months (most of it after schools had closed for the summer) presented difficulties in reaching parents. Schools were an important point of contact and access. Community organisations did not have the capacity or resources to assist with

organisation of focus groups over the summer months (for instance, they run various activities such as summer camps and, generally, it is a busy period for them).

All focus group sessions were led by two members of the Research Team – one moderator and one mainly taking notes. A topic / issue guide (on one page) was provided to all participants while the moderator worked from the more detailed interview schedule (with more specific questions and probes). The session started with a general introduction of the team members, an overview of research, statement of "ground rules" (e.g., no names to be used in the discussion), outline of the structure and duration of the discussion, and an explanation of the research ethics and ethical procedures to be followed (including a requirement to complete consent forms). There were no introductions of the participants. Some of the focus groups proved quite difficult to manage in terms of orderly discussion (for instance, at some points many participants talked at the same time, or engaged in separate conversations). A great deal of facilitation / moderation was required in some discussions, to encourage people to discuss the issue and to draw them into discussion. Nonetheless, the quality of the discussion was generally good with rich data gathered.

With the exception of two sessions, all parent / carer focus group discussions were tape recorded, with permission given by all participants. Overall, eight parent / carer focus group discussions were held involving 32 participants, mainly female participants. Details of focus group organisation, with location and attendance (including male / female breakdown) is provided below in Table 2.3.

Table 2.3: Parent /Carer Focus Groups: Organisations, Numbers Invited and Attendance

Place and Location	Month	Number invited	Number attending	Male	Female	Taped	Comment
Parent Focus Groups							
Moyross, Community Centre	June	10	5	1	4	Yes	
Moyross, School	June	12	7	0	7	Yes	
Moyross, School	June	10	5	1	4	Yes	
St. Mary's Park, School	June	10	2	0	2	Yes	Joined by HSCL
St. Mary's Parish, Youth Services	June	14	1	0	1	No	No shows despite many attempts
Southill - other location	August	unspecified	3	1	2	No	Second attempt to host focus group; informal
Southill: School	November	8	2	0	2	Yes	Several no shows
Corbally / Rhebogue / St. Mary's Park: School	September	14	7	0	7	Yes	Joined in discussion by HSCL
Total			**32**	**3**	**29**		

The focus groups with service providers were organised with the assistance of the structure and the coordinators of the Northside, St. Mary's Park, Southill, and Ballinacurra Weston Youth Fora (services to children and families) and the PLUS network of DEIS (Delivering Equality of

Opportunity in Schools) schools in Limerick City (education providers in particular). In advance of organising the focus groups, a member of the Research Team attended a Youth Forum meeting to present the research and ask for cooperation in terms of participation in the focus groups. One meeting of each Youth Forum was dedicated as a focus group discussion.

The same organisational procedures and research process (facilitated by two members of the research team, taped discussion etc.), as described above, were followed in the focus group discussions with service providers. Details are provided in Table 2.4

Table 2.4: Service Providers' Focus Group Discussions: Organisation and Attendance

Place	Month	Number attending	Male	Female	Tape
Northside: Moyross	June	6	3	3	Yes
Northside: Moyross	June	3	1	2	Yes
Northside: St. Mary's Parish	June	4	1	3	Yes
Southside: Southill	July	10	5	5	Yes
Rosbrien / Ballinacurra Weston	October	9	2	5	Yes
Educational Providers: city wide	September	8	1	7	Yes
Educational Providers: Northside Regeneration	September	2	0	2	Yes
Total		**42**	**13**	**27**	

Again, the discussions yielded relevant and rich data. The focus groups with educational providers were added later, as findings emerging from earlier discussions in the focus groups, and experience of implementation of the household survey, indicated that it was important to include the "education voice" in the research.

2.5 Data Analysis

The approach to data analysis is presented in relation to (i) the quantitative component, covering the analysis of primary data from the household survey, and (ii) the qualitative strategy or the focus groups.

2.5.1 Analysis of survey data

The survey data, comprising 418 parent / carer questionnaires and 128 child questionnaires, were analysed using SPSS, now known as PASW (version 18). The analysis focused on two types of datasets:

i. The two complete sets of cases of individual parents / carers and children with different characteristics (e.g. gender, education etc.) across all four study areas;

ii. A set of datasets for each of the four study areas, with different contextual characteristics of place and different structural characteristics (linked to the composition of the population).

Both are important datasets. The former provides a basis for examining outcomes for children and families (and parents) based on characteristics of people (e.g. gender, marital status, family structure, household size, education level etc.), and the latter allows for comparative analysis based on different types and characteristics of place (the neighbourhoods / study areas). Linked to the study design – in particular, the use of control areas as a comparative context for the most disadvantaged regeneration areas of the city – the spatial or area-based analysis is particularly important.

The variables included in the parent / carer questionnaire enable an analysis of child outcomes (mainly with reference to the sample child selected) linked to characteristics of place, parent health profile, various aspects of family life, parenting styles, socio-economic characteristics, etc. The findings of the child questionnaires add a further dimension (the child's perspective) to the analysis, and an element of independent verification of the findings of the parent / carer analysis. The relatively small number of child interviews achieved places some limitations on the level and types of analysis that could be undertaken with a degree of confidence in the findings (i.e., there is not a sufficient number of cases to undertake more complex analysis).

Uni-variate data analysis (frequencies, descriptive data) and, later, bi-variate analysis were undertaken as part of the data "cleaning" exercise (checking that data were correctly entered onto the computer and correctly coded). This analysis required considerable time, and typically involved checking the individual questionnaires where discrepancies were found.

Following first stage analysis, data for specific variables (questions) which sought to measure elements of an overall problem (the extent of neighbourhood problems, the extent of child trauma experienced, the extent of family problems in the household) were transformed to create summary variables. These summary variables combine questions such that they can be used to measure conditions which are identified as possibly affecting good outcomes for children and families. This data transformation created a series of new variables (the sum or average of respondents' scores on all the items within the relevant group of questions).

In relation to the health module (SF-12 v.2) in the parent / carer questionnaire, the methodology set out by the developers (Ware, Kosinsk *et al* 1993, 2000; Ware and Kosinski 2001) was applied to the dataset to calculate norm-referenced scores for each of the eight dimensions of health status and the two summary components: the physical health and mental health summary scores. The eight scales

and the items included in the Physical and Mental Health Component Scores are shown above (Figure 2.3).[5] There were no missing data in this module (SF-12).

Similarly, with the Strengths and Difficulties module (SDQ) addressed to the sample child in the parent / carer questionnaire, the methodology defined by the developer (Goodman, 1997) was applied in transforming the data to calculate the five scales of child difficulties / strengths and the composite scale (based on four of the five scales) to measure total child difficulties (score). This required reverse coding of certain items (25) which comprise the five scales. The approach suggested by the developers to the treatment of missing data was applied here – i.e., if at least three items on each scale (5 items) are completed, the missing scores can be pro-rated (an average of the three completed scores). As well as using the new continuous variables (5 scales and the total difficulties score) in the analysis, the scores were also classified to transform them into "normal", "borderline" and "abnormal" bands (ordinal variables) based on the specification of the developers (Goodman, 1997).

Bi-variate analysis of the data (cross-tabs and comparison of means) was conducted. This focused on identifying patterns of association, based mainly on an area-based analysis (comparison across the four study areas). This process, in turn, identified the main factors to be tested in a more complex multivariate model. Data analysis techniques involved linear multiple regression analysis using the child Total Difficulties Scale as the outcome (dependent) variable.

2.5.2 Analysis of the focus group discussions

For all taped focus groups (except two parent / carer interviews or group discussions), full transcripts of the discussions were prepared. Notes were used for the two interviews /discussions which were not taped. "Back-up" notes were prepared of the discussions at all the focus groups.

The data generated from the transcripts and the notes were subject to detailed analysis. The data in the transcripts were organised thematically (e.g., neighbourhood environment and community, family and friends, education and active learning, service provision etc.), based on the structure of the interview schedules. The analysis of the qualitative data involved "pulling the data apart" to identify sub-themes, based on the words of participants, within these broad themes. Using this method of analysis, core categories, which describe "the majority of variation that occurs most frequently in the data", were identified – again using the precise words of the participants. Illustrative quotes, especially related to core categories were identified in the transcripts. Effectively, the specification of core

[5] The methodology applied to the calculation of the eight dimensions of health status (scales) involved: (i) item recoding for specific questions which required reverse coding; (ii) computation of a raw score for each scale (the sum of responses on all items included in the scale); (iii) transformation of the raw scale score to a 0-100 scale using the formula provided by the developers (to convert the lowest and highest possible scores to 0 and 100 respectively). The summary physical health and mental health scores were then calculated involving three steps: (a) standardizing the eight scales using means and standard deviations from the 1998 US general population (creating a z-score for each scale); (b) aggregating the scales to create the physical health and mental health summary scores using weights (factor score coefficients) from the 1990 general US population and (c) standardising the aggregate PCS and MCS scores using a linear T-score transformation with a mean of 50 and standard deviation of 10 in the general 1998 US general population.

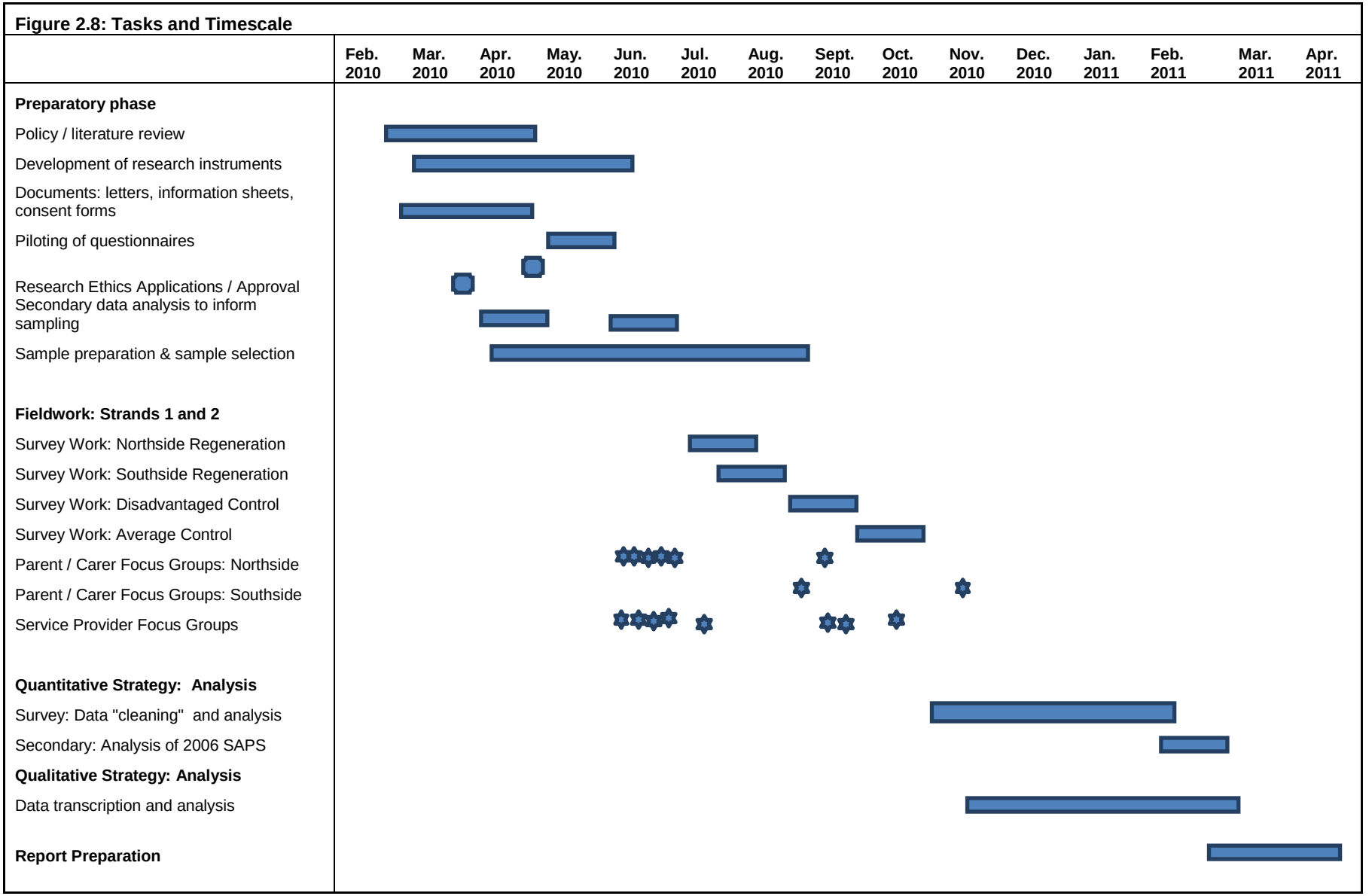
categories involves identifying those views that are constantly repeated across the dataset. Grouping of core categories identifies overall theoretical propositions which explain or build up an understanding of "what is going on". This method of analysis is slow and requires constant cross-comparison of data (from the large body of transcript data). Analysis of the qualitative data was facilitated by using the computer software NVivo.

2.5.3 Timescale for implementation of the study and review

The time scale for implementation of the study according to the key tasks undertaken is shown in Figure 2.8.

Over the time period of study from the preparatory through implementation and analysis phases, regular meetings of the Research Team and the Limerick CSC Research Sub-group were held. The purpose of these meetings was to obtain views and feedback at key stages, in particular when the research instruments and study sites were being agreed, and to report progress, and, later, the preliminary findings of the research.

Figure 2.8: Tasks and Timescale



2.6 Summary: Methodology

This chapter presented the methodology used in the research, namely: the research strategy and research design, the development and implementation of data collection methods, and the methods of data analysis. The methodology was informed by the requirements of the Limerick City Children's Services Committee which commissioned the research.

The research involves both quantitative and qualitative research methods, and a mixed methods approach. As a baseline exercise, focused on measurement of needs, there is more emphasis on the former. The qualitative methods generate additional data in order to build up an understanding of conditions, needs and experiences, and inform the interpretation of the quantitative findings.

2.6.1 Research design

The research is cross-section in design, meaning it provides a snap-shot of the situation at a single point in time, 2010. It is anticipated that research will be undertaken in subsequent years by the Limerick City Children's Services Committee to establish whether, and the extent to which, the study areas have changed over time (i.e., stayed the same, improved, deteriorated). The research design involves an element of "control". It establishes variations or differences between families in the most disadvantaged communities (the two regeneration areas) and relatively more advantaged communities in the city (a Disadvantaged Control and an Average Control Area) at the baseline stage in 2010. A "gradient" from the most disadvantaged, to disadvantaged and up to an average area is built into the design of the research. By going back to the same areas in subsequent years, this design enables an assessment of the extent to which outcomes for children and families in the most disadvantaged areas converge towards the average over time. The study areas were selected as types of areas, with concentrations of family-based households with children, broadly representative of the types of areas or neighbourhoods in Limerick City as a whole.

2.6.2 Quantitative strategy: A social survey of households

Focusing on the quantitative strategy, the primary research is addressed to two types of participants in households with children under 18 years, namely: (i) parents / carers of children and (ii) children aged seven years and older. Both types of participants are drawn from the same households (i.e., all child participants are drawn from households where parents / carers completed the survey). The research instruments comprise highly structured questionnaires (closed questions involving ticking responses) covering a wide range of topics designed to investigate the position with reference to outcomes for children and families specified in national policy. The parent / carer questionnaire includes modules for self-assessment of health status of the parent / carer (SF-12 Version 2) and assessment of child strengths and difficulties (SDQ). The latter focuses on one sample child in the household. The

questionnaires were designed for administration based on face-to-face interviews in the homes of those who agreed to participate.

2.6.3 Samples and sampling strategy

The survey is based on four independent samples (one sample from each study area) and uses a probability (or random) sampling approach. It was not possible to construct a sampling frame (i.e., a complete list of family-based households with children under 18 years) across all study areas. In all areas, samples were randomly selected based on a systematic sampling approach (e.g., selecting every fifth, sixth, or seventh house). The sample in each area was stratified by sub-areas (estates, streets) based on estimates of the proportion of households with children in the sub-areas, relative to the study area as a whole.

2.6.4 Social survey: Fieldwork implementation

While the fieldwork presented many challenges, an overall response rate of 70 per cent was obtained and 418 valid parent / carer questionnaires. This exceeded the target of 400 set (100 for each of the four study areas). Response rates were highest in the most disadvantaged areas (Regeneration Areas). Achievement of child interviews proved to be more difficult than expected. The number of useable child interviews was 128 across all areas. The reason for achievement of lower than expected targets here generally related to the non-availability of children in the home at the time of the parent / carer interview.

2.6.5 Qualitative strategy: Focus groups

The qualitative component of the research involved focus groups with two sets of participants: (i) parents / carers in the study areas; and (ii) service providers to children and families in the city. Priority was given to engaging with parents / carers in the Regeneration Areas, and also to service providers working in the most disadvantaged areas of the city. The purpose of the focus groups with parents / carers was (i) to gather relevant data, and (ii) to promote awareness of, and a sense of ownership of, the research. Interview schedules were developed for both sets of focus groups. Service providers such as schools, crèches, youth services and community organisations assisted with recruitment of parent / carer participants and practical aspects of organisation (e.g., securing a venue). Overall, eight focus groups involving 32 participants were held. Focus groups with service providers were organised mainly through the structures of the Youth Fora, now operating in various areas of the city. Overall, seven service provider focus group discussions were held involving 42 participants.

2.6.6 Data Analysis

The quantitative data were analysed using SPSS (now known as PASW). Analysis of survey data involved, *inter alia*, bi-variate analysis with a strong focus on an area-based comparison. The purpose was to establish the key patterns of variation across the study areas. Multivariate statistical techniques

(linear multiple regression) were also undertaken using the child "total difficulties" scale as the dependent or outcome variable.

With the exception of two focus groups which were not tape recorded, transcripts of focus group discussions were prepared. Based on these transcripts and notes, detailed analysis of the data was undertaken.

The qualitative data analysis was structured as a thematic analysis. A coding frame was developed based on sub-categories identified in the process of data analysis, and using the precise words of participants. Using this method of analysis and constant comparison across the dataset, core categories were identified. Illustrative quotes were identified to correspond with the core categories. NVivo software was used to facilitate the analysis.

2.6.7 Progress reporting

Over the time period of preparation and implementation of the study, regular meetings of the Research Team and the Limerick City CSC Research Sub-group were held. The purpose was to obtain views and feedback at key stages and to report progress and preliminary findings.

3. NEIGHBOURHOOD CONTEXT: PROFILE OF THE STUDY AREAS AND SAMPLE

This section describes key characteristics of the four study areas in the broader context of Limerick City and suburbs. The data are drawn from the household survey findings and observations from the fieldwork, as well as from secondary sources, in particular the 2006 census of population which provides data at Electoral District (ED) level that are used to present a socio-economic and demographic profile of the four areas. As stated in the methodology chapter (Chapter 2), the 2006 census data are now out-dated. Since 2006, there has been further change in the social geography of the city with extensive residential mobility in parts of the city linked to the regeneration programme. This is "not a new departure", however, but rather reflects continuity of an earlier trend: loss of population from the regeneration areas has been established for some time.

The four study areas span eleven (11) EDs – all now within the boundary of Limerick City.[6] The ED boundaries do not correspond precisely with the study area boundaries.[7] Linked to the time period for which secondary data are available and lack of match of census area and study area boundaries, the analysis presented is not definitive.

The purpose of this chapter is to profile the study areas and the study population – the latter by presenting key characteristics of the sample included in the household survey. This combined analysis also enables some assessment of the extent to which the sample achieved is representative of the study population.

3.1 Overview: Population and Socio-Spatial Analysis of Limerick City

Drawing on most recent census data available (2006), Limerick City has a population of 59,141 (CSO, 2006) and the City and Environs[8] a population of 90,757 (McCafferty and O'Keeffe, 2009). The population of Limerick City has declined over the period from 2002-2006 (-1.9%). Over the last ten years, the population of Limerick City has grown slightly (+1.1%) and remained, more or less static over the fifteen period, 1991-2006. This is in contrast to the trend in population growth in the County (+ 21.1%), the Mid-West region (+16.2%) and the State (+20.3%) over the period 1996-2006. Population growth across the City (38 EDs) and the suburban EDs (5) was unevenly distributed. Over the period, 1996-2006, population increased by 46 per cent in the five suburban EDs. Population growth was particularly high in the suburban EDs of Limerick South Rural (which includes Bawnmore, +107.3%) and Ballycummin (including Raheen, Gouldavoher, Dooradoyle, +96.7%). The

[6] Until recently Limerick City comprised 37 Electoral Districts (EDs) while the wider metropolitan area (including the suburbs) includes a further six sub-urban EDs – of which five are in Limerick County and one is in County Clare. Since March 2008, there has been a limited extension of the city boundary definition between the City and Limerick County to include Limerick North Rural (formerly in County Limerick) within the boundaries of the city (now 38 EDs).

[7] The only precise match is the ED of St. John's A which coincides with the residential estate of St. Mary's Park in the Northside Regeneration Area.

[8] The City and Environs comprises the 38 EDs in the administrative area of Limerick City and the suburbs of the City – i.e. within 5 EDs in Limerick County and Clare County that contain a significant part of the environs of the city, as defined for census purposes.

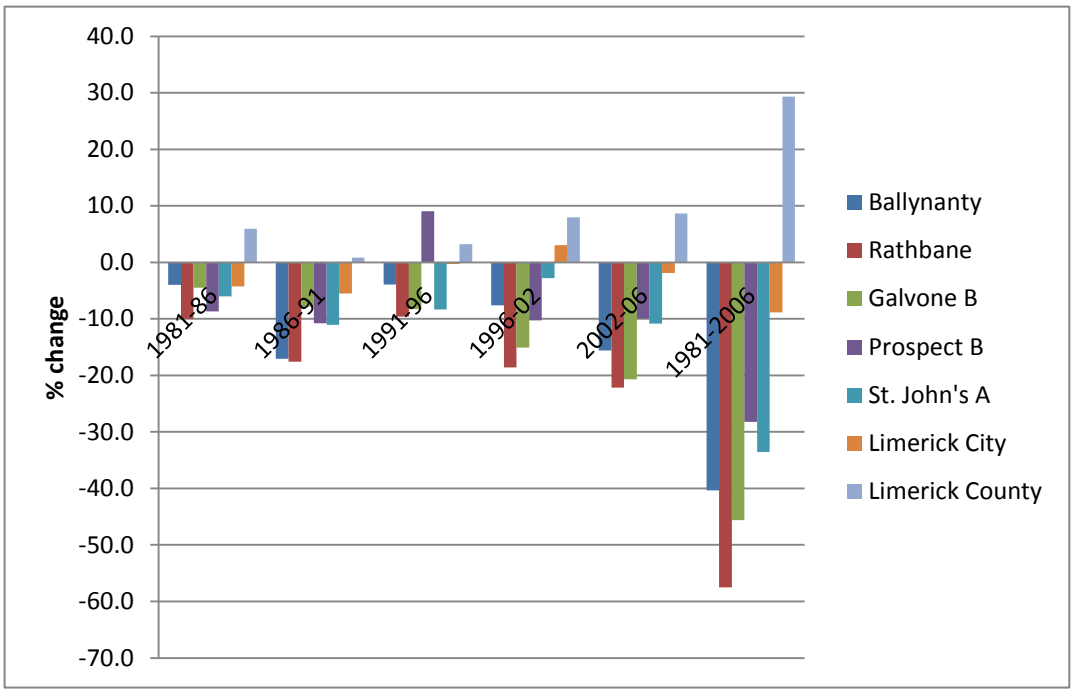
population of Limerick North Rural (7,251 in 2006), which was transferred into Limerick City with the limited boundary extension in 2008, has remained static over the fifteen year period (1991-2006).

The areas of Limerick City experiencing high population growth over the period 1991-2006 are the parts of the inner city undergoing redevelopment – particularly around the docks area (Shannon A, including Harvey's Quay and Howley's Quay, +404.3%), (Dock A, including Steamboat Quay, +299.6%) and in the Rhebogue area (Abbey D +145.2%) where there was considerable new housing construction in recent years. These areas contrast sharply with the areas of greatest population decline, which are the most deprived neighbourhoods on the southside (ED of Galvone B in Southill, -42.7%; Rathbane ED, which includes part of Ballinacurra Weston, -33.2%,) and on the northside of the city (Ballynanty ED, including most of Moyross, -25.1%). All of these deprived areas are included in this study (Southside and Northside Regeneration Areas) while Rhebogue (ED of Abbey B) is included as part of the Average Control Area.

Population change in the disadvantaged local authority estates with reference to the situation in the city and county for various periods from 1981 to 2006 and for the whole period 1981-2006 is shown in Figure 3.1 below. The trend in the city (population decline) was at variance with the county pattern (reflecting population growth in the suburbs and the towns in County Limerick). This graph particularly shows the collapse of population in the large local authority housing estates in the city (especially Southill and Moyross), which is testament to the relative failure of social housing policy in Limerick City.

The age structure of the population has an influence on the demand for different types of services (e.g., younger populations require access to child care and schools, while for older populations proximity to day care centres and post offices is more important). The overall trend in Limerick City has been towards a maturation of the population, linked to decline in birth rates from the 1980s and improved life expectancy. However, there are marked variations in age structure across different areas of the city. The youth dependency ratio (population less than 15 years per hundred population aged 15 to 64 years) is highest in the following areas (in order): O'Malley Park, Weston, Kileely, Moyross and the area of Garryowen centred on Fairview Crescent. These are also areas of population decline and spatial deprivation and, with the exception of Kileely, are all included in the study sites. The coincidence of high percentages of children and low or negative population growth in these areas is explained in part by family structure – in particular, the high rates of lone parent families in these areas (McCafferty and O'Keeffe, 2009).

Figure 3.1: Population Change (%) Limerick City and County, and Selected EDs (1981-2006)



Source: Census of Ireland 1981, 1986, 1991, 1996, 2002 and 2006.
Note: EDs closest to boundaries of estates - Galvone B (O'Malley & Keyes Park); Rathbane (Carew & Kincora Park) , Prospect B (Ballinacurra Weston), Ballynanty (Ballynanty-Moyross), St. John's A (St. Mary's Park).

Based on 2006 data, youth dependency is particularly low in the city centre EDs where, as identified above, there has been strong population growth. The age structure in parts of the re-developed city in 2006 shows concentrations in the main family forming age groups (20-40 years), as reflected in a high vitality ratio (percentage of the population aged 20-40 years relative to that 60 years and older). However, this demographic potential only translates into a growing child population if the young adult population choose to stay and form families there, rather than move, as is often the case, to suburban locations. Other parts of the city with high vitality rates include Rhebogue and parts of Garryowen. There is evidence that young people with children (typically single parents with a profile of disadvantage) have moved into re-developed city centre locations as they leave regeneration areas, thus changing the profile of areas of the city centre. Generally, there is a high level of cross-mobility between regeneration areas and inner city locations, with the young population, including some children, coming and going between the inner city and areas in regeneration estates often as part of a "chaotic" living pattern.

Focusing specifically on households with families, average household size in Limerick City and suburbs is 2.69 persons. This is broadly in line with the State average, 2.81 persons (CSO, 2006). The overall trend is towards small household size in the city centre moving towards larger household size in the urban periphery. An exception to this pattern is St. Mary's Park in the city centre (average household size 2.87 persons). With a mix of household types in this area, including many households

with no children, the implication is that households with children in St. Mary's Park are likely to experience overcrowding. Other areas with higher average household size include Moyross and Southill. The areas which show the highest proportion of large families (containing six or more persons) are St. Mary's Park, Thomondgate, Kileely, Moyross/Ballynanty on the northside, and Ballyclough, O'Malley Park and Ballincurra Weston, on the southside.

It should be noted that a substantial proportion of households in the city (36% in 2006) are non-family-based households.[9]. Non-family based households include persons living alone and in student accommodation. Corbally, Rhebogue and areas in the suburbs including Rossbrien and Ballyclough are amongst the areas with the lowest proportion of non-family based private households (i.e., these are areas with concentrations of family-based households). The Corbally area and Rhebogue are included as study sites (Average Control area).

Adult families (eldest child resident at home aged 20 years or more) are more prevalent in areas with large numbers of families and also in areas which are longer-established (i.e., housing built for 20 years or more). Areas with high proportions of adult families are: Thomondgate and Ballinacurra Weston (highest at 38%); King's Island (St. Mary's Park, Lee Estate, Assumpta Park), Caherdavin, North Circular Road, Garryowen and Janesboro. Rhebogue, much of it relatively newly-built, is one of the areas with the lowest proportion of adult families.

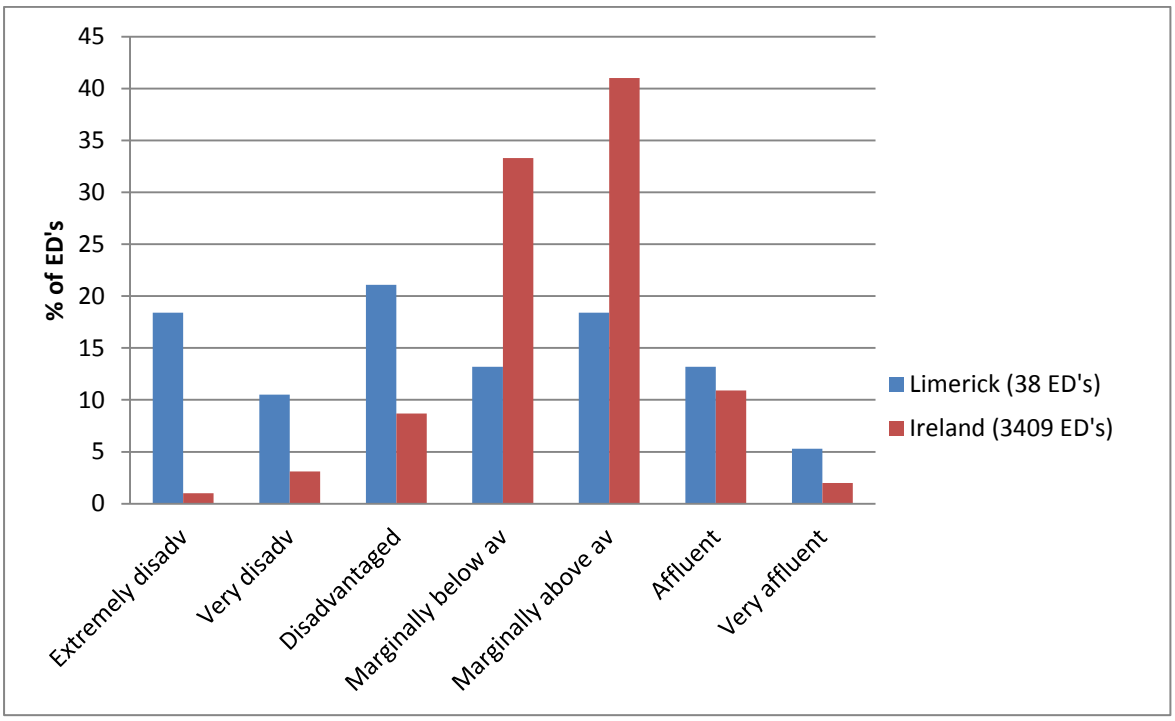
In terms of family composition, Limerick City has the highest proportion of lone parent families of any local authority area in the State, with over one in four households (27%) headed by a lone parent (CSO, 2006). There is a clear spatial association between lone parent families and local authority housing, with the estates of Moyross / Ballynanty, St. Mary's Park and Southill all having lone parent rates in excess of 45 per cent (CSO, 2006). Rates are also high in Kileely, Garryowen, Janesboro and Rathbane. However, when change in lone parent rates is examined, there is some evidence of dispersal of lone parent families in Limerick. While the overall number of lone parent families increased by 21 per cent between 2002-2006, the greatest increases were not necessarily in the most deprived areas (where they were already very high) but in some of the areas experiencing new development including Rhebogue, the Dublin Road, and part of the quayside area in the inner city as well as Castletroy and Raheen / Dooradoyle in the suburbs. Rates fell in other parts of the city centre as well as in O'Malley Park and Weston. These changes appear to be linked to housing policy, in particular, the movement of lone parent families into private rented accommodation through Rent Supplement / Rental Assistance Scheme (RAS) (McCafferty and O'Keeffe, 2009).

Spatial inequality in Limerick City has been highlighted in many recent reports (McCafferty 2005; McCafferty and O'Keeffe 2009; Haase and Pratschke 2008). Using the composite measure of

9 This is 6% above the state average in 2006.

affluence / deprivation compiled at ED level for the country as a whole and published by Pobal[10], the degree of spatial inequality in Limerick and change in inequality over time are presented below (Figure 3.2). Based on the Index of Relative Affluence / Deprivation 2006, over 50 per cent of the city's EDs are classified as "disadvantaged" to "extremely disadvantaged" with over 18 per cent in the worst category of "extremely disadvantaged" compared with only one per cent in the latter category at national level. Just over 30 per cent of EDs are in the middle or average range of "marginally above" or "marginally below" average, compared with almost 75 per cent of EDs at national level. At the other end of the spectrum, 19 per cent of EDs are classified as "affluent" or "very affluent" which is above the national level of 13 per cent in these categories. This distribution is indicative of greater inequality in the spatial distribution of affluence / poverty in Limerick City compared with the wider national context.

Figure 3.2: Relative Deprivation Index 2006: Classification of EDs in Limerick City and Ireland



Since 1991, Limerick City has ranked as the second most disadvantaged local authority area in the State. Over the ten year period (1996-2006), the spatial pattern of change has been one of widespread disimprovement across the entire urban area. Only three EDs improved relative to the national norm. There has also been a deterioration in terms of the number of EDs in the "extremely disadvantaged" category (two in 1996, four in 2002 and seven in 2006). The most significant disimprovements were in the Old Clare Street area, St. Mary's Park, Ballinacurra Weston, O'Malley Park and the area

[10] www.pobal.ie

immediately south of the city centre. These include significant parts of the regeneration areas as well as areas where young lone parents have moved into private rented accommodation with support from Rent Supplement / the Rental Assistance Scheme.

The EDs containing the local authority estates of Moyross / Ballynanty, Kileely, St. Mary's Park, on the northside, and Southill and Ballincurra Weston, on the southside, have been consistently (for the fifteen year census period for which the composite deprivation indicator is available) identified as extremely disadvantaged. Over the years of high economic growth (particularly from 1996 onwards), they deteriorated further. These extremely disadvantaged areas have particular characteristics in terms of children and families including generally high rates of family-based private households, relatively high rates of larger families and a higher average household size, high youth dependency rates, and very strong concentrations of (female-headed) lone parent households.

3.2 The Study Areas: Selection and Description

3.2.1 Selection of study areas

Combined with the regeneration areas, it was specified by the CSC Research sub-group that the mix of study sites, including control areas, should be broadly representative of the types of areas in the City with family-based households that contained children under 18 years of age. In developing the research design, the Research Team identified areas within the city administrative boundaries which could meet criteria for inclusion as "control areas" in the study – a Disadvantaged Area and an Average Area. As the possibilities for "control areas" were considered based on analysis of census data at small area level (2006), there were found to be few options.

In regard to the disadvantaged control area, the analysis showed that several areas of disadvantage exist outside the regeneration areas, including parts of the city centre and Garryowen. The current profile of the city centre in terms of relative disadvantage, and children and families, could not be established from 2006 data with a high degree of accuracy, due to the high level of turnover of population in the area over recent years. Furthermore, the population of young families in the city centre is not easy to find, as it is scattered into new in-fill housing and apartment blocks. Likewise it was clear that basing the Disadvantaged Control area on Garryowen would also be problematical since the area had matured demographically to the extent that high proportions of households in many parts do not include families with children. The Disadvantaged Control area eventually selected (see below) is overall less disadvantaged that the regeneration areas, though there are pockets of extreme deprivation, coinciding with some concentrations of family-based households with children, within it. In terms of the Average Control Area, the Corbally / Rhebogue area emerged from the analysis as the only area within the city boundaries with sufficient concentrations of families and children (within parts of it) and with an average social class / socio-economic profile.

The four study sites are described below in terms of location, demographic and key socio-economic characteristics with particular reference to families and children.

3.2.2 The study sites

The study sites comprise four broad areas as follows:

1. **Northside Regeneration Area**: comprising Moyross Estate and St. Mary's Park;
2. **Southside Regeneration Area**: comprising Southill and the parts of Ballinacurra Weston defined as included in the regeneration programme;
3. **Disadvantaged Control Area**: Garryowen, Kennedy Park and the Old Cork Road Area (in the last case, those areas within the Limerick City boundary);
4. **Average Control Area**: Most of Corbally within the Limerick City boundary and the "new" estates in Rhebogue.

The profile of the four study areas, the corresponding EDs, and best estimates of the number of households are shown in Appendix I.

Estimates for the total number of households (not all of which are eligible households with children under 18 years) at the time of the study and by study area, are as follows:

- Northside Regeneration Area: some 1,240 households (840 Moyross and 400 St. Mary's Park);
- Southside Regeneration Area: some 1,030 households (800 in the Southill estates and 230 in Ballinacurra Weston);
- Disadvantaged Control Area: some 1,740 households (1,170 Garryowen, 400 Kennedy Park and 170 Old Cork Road Area);
- Average Area: some 1,655 households (1,225 Corbally and 430 Rhebogue).

Focusing on the **Northside Regeneration Area**, Moyross, originally comprising approximately 1,100 housing units (and now approximately 825-840 households) is one of the most disadvantaged neighbourhoods in the city. It is physically bounded in that the estate was constructed as a cul-de-sac – i.e. with one way in and no through road into the adjacent estates of Caherdavin. Moyross can be categoried into three broad areas. The first of these is the oldest part of Moyross, comprising Dalgaish Park, Cosgrove Park, Cliona Park and College Avenue, which is located closest to Ballynanty and to the church, school, health centre, crèche and community centre. This part is regarded as the most "settled" and least disadvantaged part of Moyross. The second component is the area north of the railway line, formerly known as Glenagross Park. This is a relatively more disadvantaged part of Moyross comprising: Castle Park, Sarsfield Gardens, White Cross Gardens, Hartigan Villas and Ballygrennan Close (which includes the RESPOND! Housing Association development of some 30 housing units). Compared with the first sub-area, there are large numbers of unoccupied houses in

parts of this area, including houses expected to be demolished under the regeneration programme (80 housing units). The third sub-area comprises the parts formerly within the County Limerick ED of Limerick North Rural, namely Craeval Park, Pineview Gardens and Delmege Park. This area is also extremely disadvantaged, and there are relatively large numbers of unoccupied houses or demolished housing (approx. 200 units) relative to the numbers originally constructed. The Watch House Cross retail development, library, offices and other services is the nearest to a town centre in Moyross and is located at the entrance to the estate. The main community-based services in Moyross are located in the community centre, there are youth facilities and services in "The Bays", adult education in the Glenagross area together with secure housing for vulnerable families in Ballygrennan, and more recently, activities centred on the presence of "the monks" in Delmege Park.

St. Mary's Park is the second community in the Northside Regeneration Area. It is close to the city centre and is also physically bounded (constructed on an island). The ED corresponding to St. Mary's Park (ED of St. John's A) is the most disadvantaged ED in the State, based on the composite indicator of relative affluence / deprivation. St. Mary's Park was built as terraced housing in the 1930s, which is regarded now as of poor quality, with a small number of new in-fill housing units constructed in recent years. The area is within walking distance of the city centre and traditionally had "six shops" on the estate (now one). Many of the shopping outlets in Nicholas Street, Mary Street and Patrick Street nearest to, and traditionally used by, St. Mary's Park residents are now closed. A youth / community centre on the river provides accommodation for a crèche. Adult education services are available in St. Mary's and youth services in Nicholas Street.

The **Southside Regeneration Area** comprises Southill and Ballincurra Weston. The housing in Ballinacurra Weston is mostly older stock (1940s and 1950s) compared with Southill (late 1960s / early 1970s). Southill comprises four parks, O'Malley Park (which is the largest with 600 housing units originally constructed), Keyes Park, Kincora Park and John Carew Park. A large number of houses in O'Malley Park and Keyes Park have been demolished, are unoccupied or "burnt out" such that the physical environment of parts of these estates is now poor. Kincora Park has a relatively older population structure with larger numbers (and proportions) of households having older (adult) children or classified as "empty nest" households. Anecdotally, there is a pattern of transfer of families from O'Malley Park into John Carew Park. A halting site is located adjacent to John Carew Park. Community-based services in Southill are centred on Southill House and Southill Area Centre (O'Malley Park) where the health centre and church are also located. The Fulflex complex houses recreational activities for children and young people.

The second community in the Southside Regeneration area, Ballincurra Weston, is "tightly draw" to comprise a relatively small number of households overall (220-250). At the time of the study, only two housing units in Clarina Park (a more recently constructed estate of 64 housing units) were

occupied with most of the housing here having been demolished. Ballinacurra Weston, while close to the city centre and with schools and amenities nearby, lacks a village core. Our Lady of Lourdes Action Centre and until recently, the Community Development Programme office in Clarina Park, provide the focal point for community-based services (young people, older people). The LEDP complex in Roxboro comprising shops, work places, a canteen, hotel / leisure centre, education and community services, and a crèche, and with more shops and a pub close by, is the nearest to a village core for the Southside Regeneration Areas.

The **Disadvantaged Control Area** comprises Garryowen, Kennedy Park and the Old Cork Road Area, and is a large and relatively mixed area. Garryowen has pockets of deprivation (such as Fairview Crescent, parts of Pike Avenue and St. Lawrence) and pockets of middle class households (such as the new small estates of Churchfields and Ballysimon Crescent). It is a traditional working class area in the city. A large proportion of households in parts of Garryowen now are families with older children and "empty nest" households (e.g. the Kilalee area, Claughan and Singland, the Well Field). Other parts, such as Fairgreen Road and parts of St. Patrick's Road, formerly with older residents, are "turning", with housing vacated by older residents being bought or rented by young families. The population of Kennedy Park has also matured, with an older age structure (i.e. smaller proportion of families with children / young children) than in the past, and less disadvantage than the adjacent local authority estates. In terms of services, these areas are located close to shops / retail outlets in the city centre and more recent developments, for instance, on the Childer's Road. The Old Cork Road Area, located adjacent to Southill and separated from Southill by a roadway, could be categorised as a "lower middle class / middle class" area. As the upwardly mobile population left Southill from the mid-1980s (assisted in part with the Surrender Grant), some bought housing in this area. More recently, some housing units are occupied as private rental accommodation by a more disadvantaged population (including lone parents formerly from regeneration areas) compared with homeowners in this area. In recent years, new small housing estates have been constructed here as in-fill housing. The Clonlong Halting Site is located between the Old Cork Road Area and Southill.

The **Average Control Area** comprises: most of the parts of Corbally within the City administrative boundary and Rhebogue. The residential estates of Westbury and Shannon Banks (in County Clare) are excluded from the study area. The part of Corbally known as The Irish Estates (with relatively low concentrations of families with non-adult children), within the Limerick City boundary, was also excluded. The main areas with families are the relatively affluent (above average) estates on the Mill Road (such as Silver Brook and Spring Grove with concentrations of households with young children), newer estates such as Carrabullawn and Carriglea off Park Road, and the areas of Abbey Vale and Abbey Lock close to the canal. Other parts of Corbally which have matured, such as College Park, Janemount Park, Rosendale Gardens and Park Gardens, now have smaller numbers of households with non-adult children. The area of Rhebogue comprises the estates located off the main

road across from the Parkway Shopping Centre and behind the new retail developments (Aldi etc.). These areas comprise the estates of Rhebogue Meadows and Angler's Walk (recent developments but the longest constructed in this area) and the more recently constructed estates of Drumroe and Drominbeg. While Corbally and Rhebogue have shops, schools and amenities in the area, they each lack a village core. Corbally is divided by a busy road – a main route out from the city to the suburbs and into County Clare.

All study areas are well-serviced in terms of access to primary and secondary schools. However, some schools in, and with catchment populations from, the regeneration areas have declined markedly in enrolments in recent years. Some now have small numbers of pupils (and good physical facilities) and have a profile of extreme deprivation. On the other hand, enrolment in some schools in the suburbs and county towns has increased markedly, and some now have very large school populations. As such, a characteristic of the school population in the city is its mobility, reflecting, in turn, the exercise of parental choice.

3.3 Profile of the Sample

Drawing on the findings of the survey, selected characteristics of the demographic and socio-economic profile of respondents are presented below. This is presented as an area-based analysis.

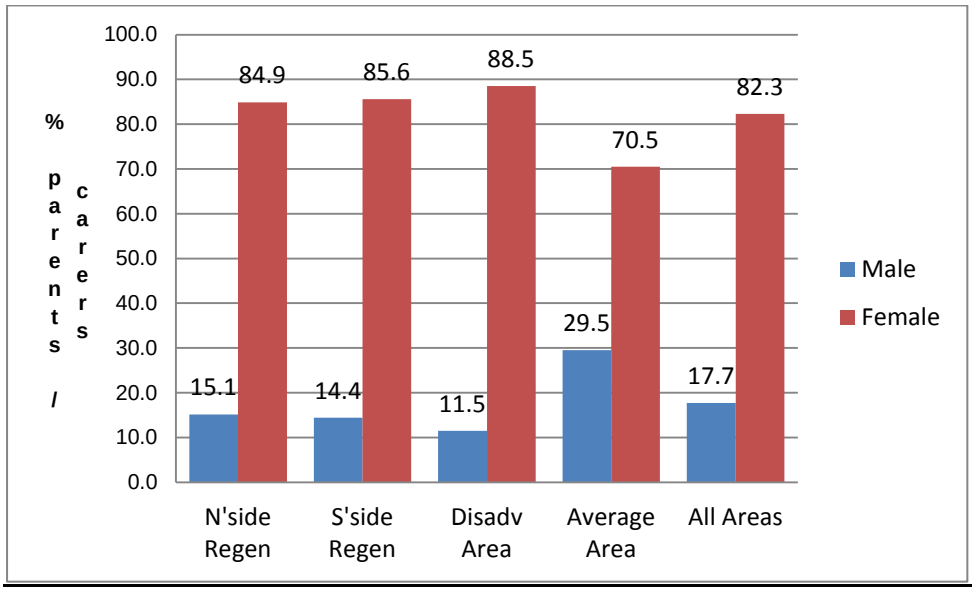
3.3.1 Gender, relationship to child(ren), age, and household size

The profiles of the sample of parents / carers and the two categories of child respondents (the sample child selected in the parent / carer survey, and respondents in the child survey itself) are described below.

The gender balance of parent / carer respondents overall is 82 per cent female and 18 per cent male respondents (Figure 3.3). The area with the largest proportion of male respondents is the Average Control Area (30% males). In terms of relationship to the child / children in the household, the vast majority of respondents across all areas are the parent (95%), followed by grandparent (3% across all areas) and the step-parent (1.2% across all areas). The remainder (1.1%) are a foster parent, an aunt / uncle or unrelated guardian.

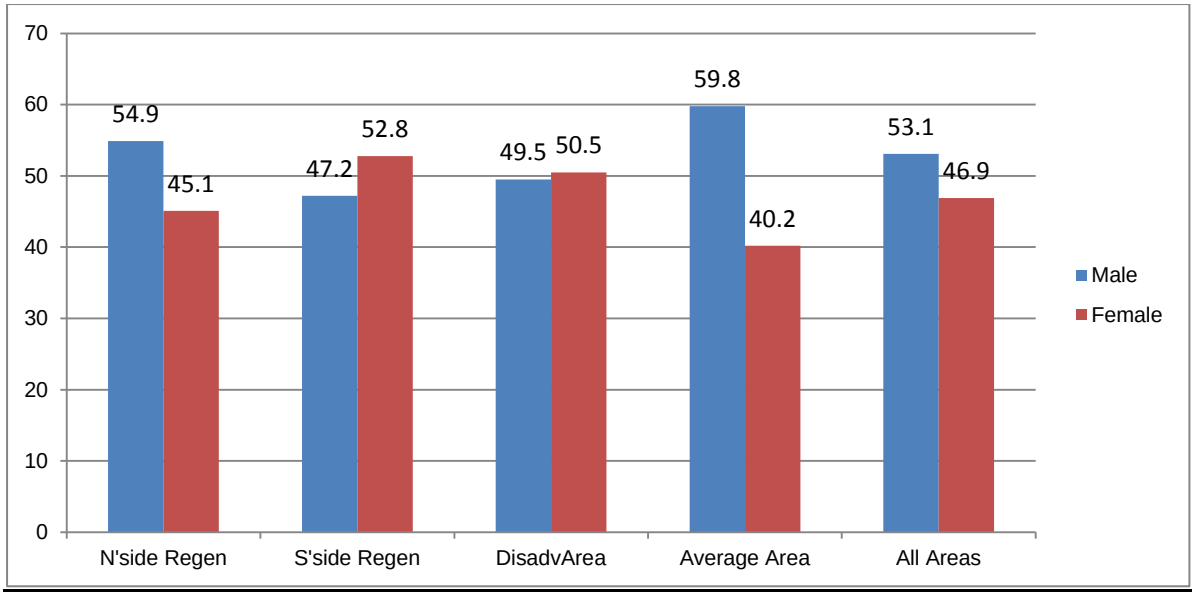
Focusing on the sample child in the parent / carer questionnaire survey (selected as the child whose birthday comes next), the gender breakdown is relatively equally balanced between male (53%) and female (47%) respondents – See Figure 3.4.

Figure 3.3: Gender of respondent parent / carer by study area (%)



N All =418; N Northside=119; N Southside=90; N Disadvantaged=104; N Average=105
Statistical Tests: Chi Sq=13.98 (df=3), p=0.18, n.s.

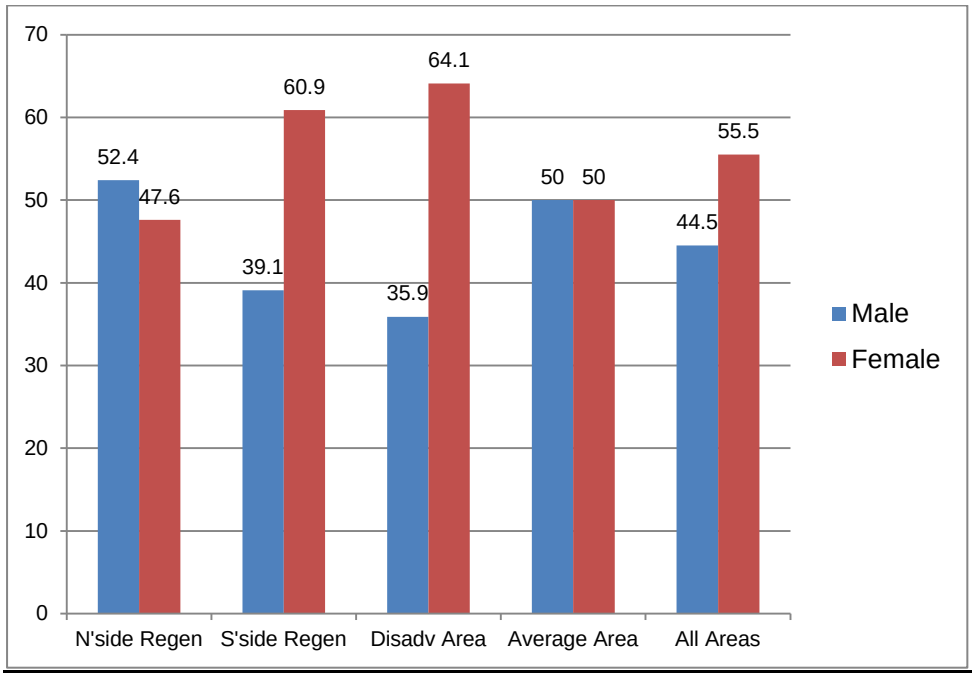
Figure 3.4: Gender of the sample child (in parent / carer survey) by area (%)



N All=407; N Northside=113; N Southside=89; N Disadvantaged=103; N Average=102
Statistical Tests: n.s.

There is also a good gender balance in the sample for the child questionnaire survey: 44.5% of the children interviewed were male and 55.5% were female. However there is more of an imbalance in the Southside Regeneration Area and the Disadvantaged Control Area, in both of which there is a clear majority of female respondents.

Figure 3.5: Gender of child respondent (child survey) by area (%)



N All=128; Northside N=42; Southside N=23; Disadvantaged N=39; Average N=24; Statistical Tests: n.s.

The age profile of the parent / carer respondents by area is shown in Table 3.1. The largest proportion of respondents (43%) is in the age category 35 to 44 years and the next largest in the age grouping 25 to 34 years (33%). Parents / carers in the regeneration areas have a younger age profile compared with those in the Disadvantaged and Average Control Areas. The variation here is statistically significant ($p<0.001$) but the differences are modest[11]. Approximately, half of the parents / carers are aged 34 years or younger in the Northside (50%) and Southside (48%) Regeneration Areas compared with some 30 per cent in these categories in the Disadvantaged Control (30%) and Average Control (27%) Areas.

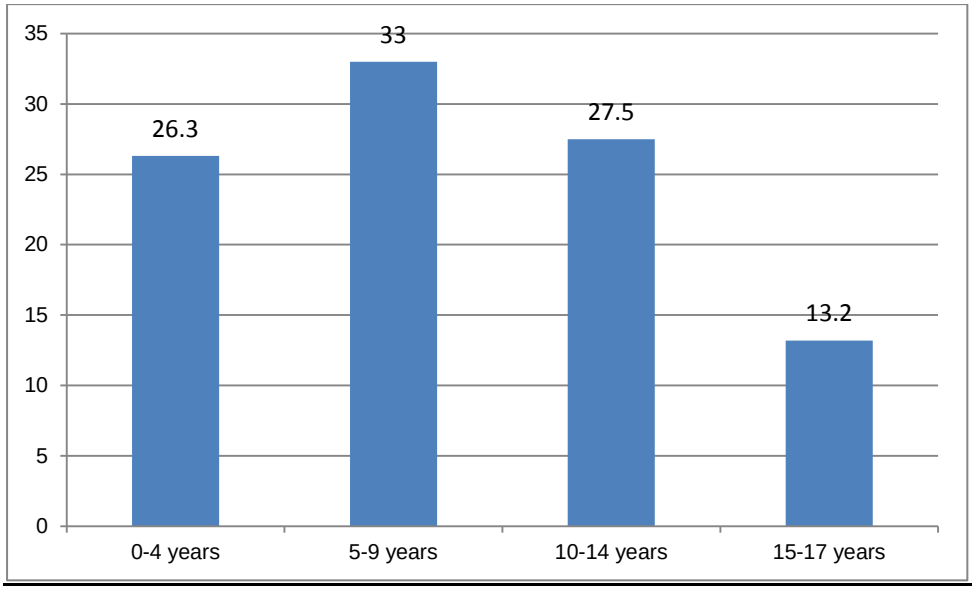
[11] The statistical significance of findings is reported extensively throughout this and the next chapter. In these instances we are testing to see whether the measured differences between categories (normally areas, but occasionally gender or other categories) in the prevalence of an attribute could be due merely to chance arising from the fact that our samples (of parents / carers and of children) are randomly drawn. Since the samples represent only part of the population there exists the possibility in all cases that differences apparent in the samples do not obtain in the background population. The p values reported in the Tables and Figures measure the probability that the observed differences are due merely to chance and do not reflect real differences in the population as a whole. A difference is said to be statistically significant if it is highly unlikely to have arisen by chance, i.e., if the p value is below some critical level. We use .05 as the critical value throughout. This means that a pattern of differences between areas (for example) will be said to be statistically significant if there is less than a 5 in 100 chance of it arising by virtue of the particular random sample that we have drawn.

Table 3.1: Age profile of parent / carer by area										
Age Categories	**N'side Regeneration Area**		**S'side Regeneration Area**		**Disadvantaged Control Area**		**Average Control Area**		**All Areas**	
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
18-24 years	9	7.6	8	8.9	6	5.8	1	1.0	24	5.7
25-34 years	50	42.0	35	38.9	25	24.0	27	25.7	137	32.8
35-44 years	31	26.1	32	35.5	54	51.9	61	58.0	178	42.6
45-54 years	25	21.0	12	13.3	17	16.3	15	14.3	69	16.5
55+	4	3.4	3	3.3	2	1.9	1	1.0	10	2.4
Total	**119**	**100**	**90**	**100**	**104**	**100**	**105**	**100**	**418**	**100**

Statistical Tests: Chi Sq=35.46 (df=12); p<0.001; Cramer's V = 0.17

Focusing on the sample child in the parent / carer survey, the breakdown by age group (for all areas) is shown in Figure 3.6. There is a "good mix" of children across the age range from infant to teenage children, with an approximately equal proportion in the age groups 0-4 years (26%) and 10-14 years (28%). The largest proportion is in the age group 5-9 years (33%) and the smallest in the late teenage age group, 15-17 years (13%).

Figure 3.6: Age of sample child (in parent / carer questionnaire): Age grouping (%)



N All = 418

In terms of variation in the age of the sample child by area, children in the Average Area have the lowest mean age (7.1 years), and those in the Northside Regeneration Area the highest mean age (9.3 years), compared with sample children across all areas (8.4 years) – See Table 3.2. The values of the standard deviation (SD) generally indicate similar degrees of variation in children's ages within each area though the differences between areas are statistically significant (p<0.001).

Table 3.2: Age of sample child by area: descriptive statistics						
	N'side Regeneration Area	**S'side Regeneration Area**	**Disadvantaged Area**	**Average Area**	**All Areas**	**Statistical tests**
	Mean **SD** N	Mean **SD** N	Mean **SD** N	Mean **SD** N	Mean **SD** N	
Age	9.34 **4.90** N=119	8.8 **4.90** N=90	8.23 **4.93** N=104	7.08 **4.40** N=105	8.38 **4.85** N=418	F=4.4 p<0.001

These findings indicate a difference between the control areas and the regeneration areas in the age profiles of parents / carers and children. In the control areas (both the disadvantaged and average areas) parents tend to be slightly older and have younger children on average, while in the regeneration areas parents, on average, are younger but have older children. In other words the data show that parents in the regeneration areas start having their children at a younger age.

In terms of the survey of child respondents[12], the mean age across all areas was 10.8 years. The average age of respondents was highest in the Southside Regeneration Area (11.4 years), followed by the Northside Regeneration Area (11.1 years) and the Disadvantaged Control Area (10.4 years), with the lowest mean age in the Average Control Area (10.3 years).

Across all areas, average household size is 4.21 persons, and the average number of children 17 years and younger per household is 2.24. Differences between the areas on these attributes are not statistically significant.

3.3.2 Length of residence and mobility

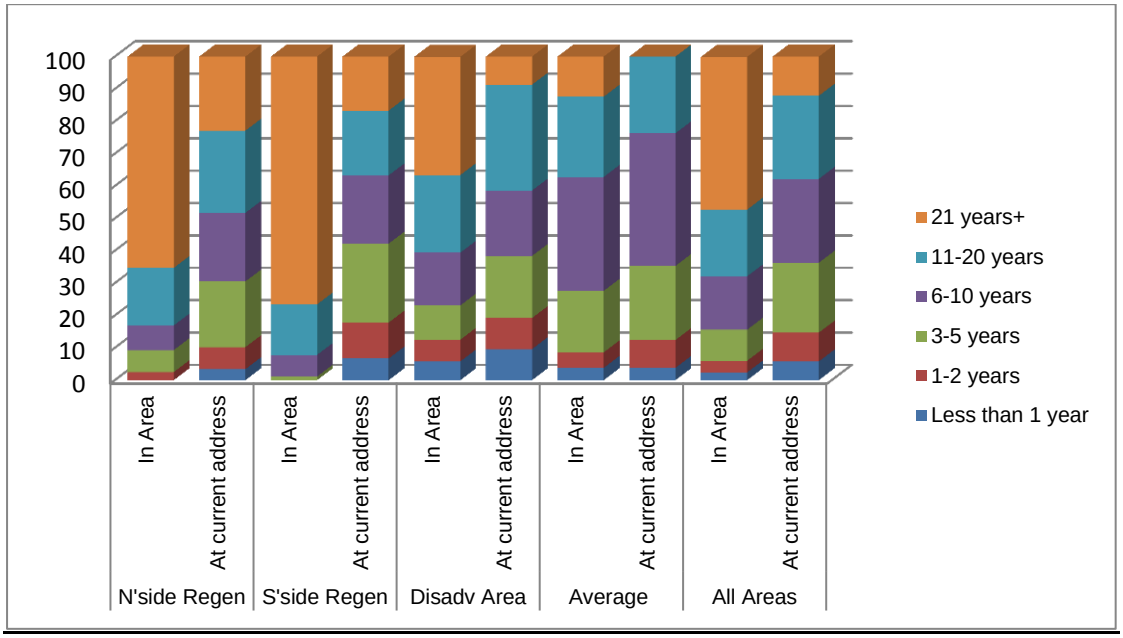
In terms of years resident in the area, higher proportions of families in regeneration areas are resident for longer periods compared with the control areas. For instance, 92 per cent of families in the Southside Regeneration Areas and 83 per cent in the Northside Regeneration Areas have been resident there for 11 years or more, compared with 61 per cent in the Disadvantaged Control and 37 per cent in the Average Control Areas (Figure 3.7). Approximately one-quarter of families are resident in the control areas for five years or less; but over this period of time there has been virtually no inward mobility to the Southside Regeneration Area. There is a clear association between place and length of residence and variation here is statistically significant ($p<0.001$).

A second indicator of mobility was used in the survey (i.e. length of time the respondent has been resident at the current address). Based on this indicator, it can be established that there is a higher level of mobility within certain areas. For instance, in the Southside Regeneration Area, while 77 per cent have been resident in the area for 21 years or more, only 17 per cent have been resident at the same address for that period (meaning that a large proportion has moved house within the Southside

[12] Children from age 7 years and upwards were eligible to participate in the child survey

Regeneration area). In the regeneration areas, where there has been virtually no inward mobility, 18 per cent in the Southside and 10 per cent in the Northside Regeneration Area have moved address within the area in the last two years. While the highest mobility in terms of change of address is in the Disadvantaged Control Area (19% within the last two years), a significant proportion of this change is in-movement to the area (13% are resident in the neighbourhood for two years or less).

Figure 3.7: Residential mobility: Years resident in the neighbourhood and at current address



Years Living in the Area: N All=417, Northside N=118; Southside N=90; Disadvantaged N=104; Average N=105
Years At Current Address: N All=417, Northside N=118; Southside N=90; Disadvantaged N=104; Average N=105
Statistical Tests: Years living in the Area: Chi Sq = 125. (df=15), p<0.001, Cramer's V=0.32
Years at current address: Chi Sq=45.50 (df=15), p<0.001; Cramer's V=0.20

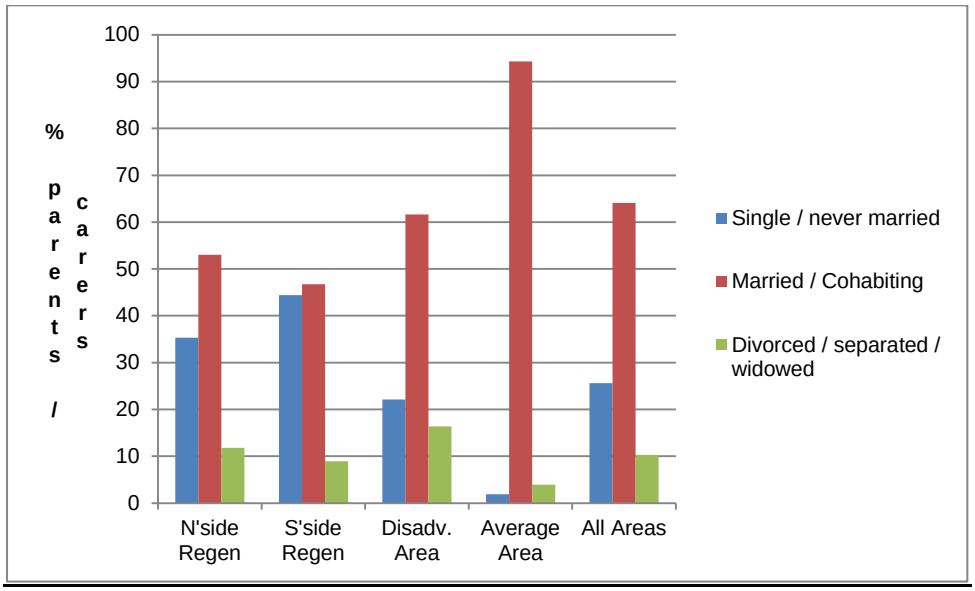
3.3.3 Family structure and marital status

Some 64 per cent of respondents across all areas are "living with someone as a couple". There are strong variations in family structure between the areas (p<0.001, Cramer's V=0.38). The proportion of parents / carers living with someone as a couple varies from a low of 46 per cent in the Southside Regeneration Area, through 53 per cent in the Northside Regeneration, 62 per cent in the Disadvantaged Control Area, to a high of 94 per cent (living as a couple) in the Average Control Area. This implies that some 54 per cent in the Southside Regeneration Area and 47 per cent in the Northside Regeneration Area, compared with just six per cent in the Average Control Area, are parenting alone.

Across all areas, some 26 per cent are "single / never married" and 64 per cent married or co-habiting with a partner. This ranges from a high of 44 per cent "single / never married" in the Southside Regeneration Area, through 35 per cent in the Northside Regeneration Area, 22 per cent in the

Disadvantaged Control Area, and less than two per cent "single / never married" in the Average Control Area. In the latter area, the vast majority (94%) are married or co-habiting – see Figure 3.8.

Figure 3.8: Marital status of parent / carer by area



N All = 418; Statistical Tests: Chi sq=104.53 (df=12), p<0.001; Cramer's V=0.29

3.3.4 Key socio-economic characteristics

In terms of level of educational attainment of the parents / carers, there is a clear pattern of variation between the areas (p<0.001; Cramer's V=0.33). Across all areas, some 51 per cent have not attained beyond a lower secondary education while some eight per cent have a third level degree or post-graduate qualification. In the regeneration areas, some 70 per cent in the Northside and 68 per cent on the Southside have not attained beyond lower secondary education, compared with 49 per cent in the Disadvantaged Control and just 16 per cent in the Average Control Area. At the other end of educational spectrum, some 29 per cent in the Average Control Area, zero per cent in the Southside Regeneration Area, less than one per cent in the Northside Regeneration Area and three per cent in the Disadvantaged Control Area have a third level degree or post-graduate qualification as their highest level of educational qualification – see Table 3.3.

The highest rates of home ownership are in the Average Control Area, where the vast majority are home owners (90% owned with / without a mortgage) followed by the Disadvantaged Control Area (64% owned with/ without a mortgage). This compares with less than one-third owning their homes in the Northside (25%) and Southside (32%) Regeneration Areas. In the regeneration areas, the highest proportions rent their homes from the local authority (70% in the Northside and 62% in the Southside Regeneration Areas); but just over one-fifth rent from the local authority in the Disadvantaged Control Area (21%). A relatively small proportion overall is in private rental accommodation (7%

across all areas). Rates of private rental accommodation are highest in the Disadvantaged Control Area (14%) followed by the Average Control Area (9%) – See Table 3.4.

Table 3.3: Highest level of educational qualification of parent / carer by area										
Educational qualification level	**N'side Regeneration Area**		**S'side Regeneration Area**		**Disadvantaged Area**		**Average Area**		**All Areas**	
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
No formal / incomplete primary / primary	35	29.4	24	26.7	16	15.4	1	1.0	76	18.2
Lower secondary – JC or equivalent	48	40.3	37	41.1	35	33.7	16	15.2	136	32.5
Upper secondary – LC or equivalent	28	23.5	20	22.2	37	35.6	34	32.4	119	28.5
Technical / vocational	2	1.7	1	1.1	2	1.9	3	2.9	8	1.9
Third level cert / diploma	5	4.2	8	8.9	11	10.6	21	20.0	45	10.8
Third level degree / post graduate	1	0.8	0	0	3	2.9	30	28.6	34	8.1
Total	**119**	**100**	**90**	**100**	**104**	**100**	**105**	**100**	**418**	**100**

Statistical tests: Chi Sq 134.78 (df=15), p<0.001, Cramer's V=0.33

Table 3.4: Home tenure of respondent by area										
Tenure	**N'side Regeneration Area**		**S'side Regeneration Area**		**Disadvantaged Area**		**Average Area**		**All Areas**	
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Owned – no mortgage	19	16.5	21	23.3	15	14.4	9	8.6	64	15.5
Owned – with mortgage	6	5.2	6	6.7	50	48.1	86	81.9	148	35.7
Being purchased from LA	4	3.5	2	2.2	1	1	0	0	7	1.7
Rented from LA	80	69.6	56	62.2	22	21.2	1	1	159	38.4
Rented from private landlord	3	2.6	2	2.2	14	13.5	9	8.6	28	6.8
Rented from voluntary body	3	2.6	0	0	0	0	0	0	3	0.7
Living with relatives	0	0	3	3.3	2	1.9	0	0	5	1.2
Total	**115**	**100**	**90**	**100**	**104**	**100**	**105**	**100**	**414**	**100**

Statistical tests: Chi sq=245.81 (df=18), p<0.001; Cramer's V=0.44

Across all areas, some 36 per cent of parents / carers are working in employment or self-employment while 32 per cent are unemployed. The proportion in employment / self-employment is highest in the Average Control Area (51%) and relatively lower in the Regeneration Areas (23% in the Northside and 26% in the Southside). Some 26 per cent are looking after home / family with the proportion in

this category highest in the Northside Regeneration Area (35%) and lowest in the Average Control Area (18%) – See Table 3.5. Of those parents / carers in employment or self-employment, some 56 per cent are in full-time and 44 per cent in part-time employment. The proportion in full-time employment is highest in the Average Control Area (72%) while the proportion in part-time employment is highest in the Southside Regeneration Area (77%). Differences between the areas on principal economic status and structure of employment (full-time / part-time) are statistically significant.

Table 3.5: Principal economic status of respondent (parent / carer) by area

Categories	N'side Regeneration Area		S'side Regeneration Area		Disadvantaged Area		Average Area		All Areas	
	No.	%	No.	%	No.	%	No.	%	No.	%
Working as employee (incl. CE/ apprenticeship)	26	21.8	21	23.3	38	36.9	44	41.9	129	30.9
Working in self-employment / own business	2	1.7	2	2.2	8	7.8	10	9.5	22	5.3
Unemployed	41	34.5	43	47.8	25	24.3	26	24.8	135	32.1
Student / On state training scheme	3	2.5	1	1.1	0	0	4	3.8	8	1.9
Looking after home / family	42	35.3	20	22.2	27	26.2	19	18.1	10.8	25.9
Can't work due to permanent sickness / disability	5	4.2	3	3.3	5	4.9	2	1.9	15	3.6
Total	**119**	**100**	**90**	**100**	**103**	**100**	**105**	**100**	**417**	**100**

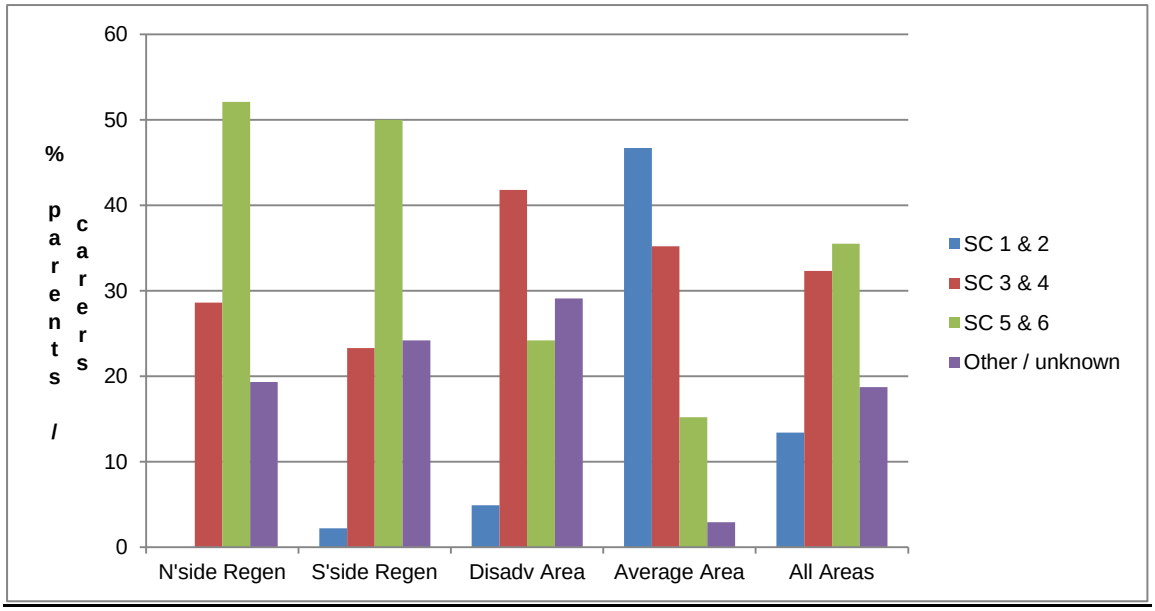
Statistical tests: Chi Sq=43.05 (df=15), p<0.001, Cramer's V=0.19

Analysis of the social class structure by area is based on occupational groupings of parents / carers. As expected, there are strong patterns of variation between the areas. Across all areas, some 13 per cent are in social classes 1 and 2 (professional and managerial or technical), 36 per cent in social classes 5 and 6 (semi-skilled and unskilled), 32 per cent in the intermediate social classes 3 and 4 (non-manual and skilled manual) and 19 per cent in all other or unknown social class. The Average Control Area has the largest proportion in social classes 1 and 2 (56%) and the smallest proportion compared with other areas in social classes 5 and 6 (15%). At the other end of the spectrum, the Northside Regeneration Area has no parents / carers in social classes 1 and 2 while the Southside Regeneration Area has two per cent in these social classes. The Disadvantaged Control Area has five per in the top two social classes and 24 per cent in social classes 5 and 6 (Figure 3.9).

These variations in social class profile are associated with differences between areas in occupations. The most common occupations in the regeneration areas are low level services including cleaning, catering assistance, social care / community services (in some cases involving Community Employment schemes) and some factory work. Much of this employment is part-time. In the

Disadvantaged Control Area, there is a mix of occupations including services such as cleaning, factory work, retail services at "shop floor" and middle management levels, administration in the public and private sectors, personal services (hairdressing), catering and social care. In the Average Area, in the more affluent parts, occupations include teaching, public service employment at managerial level, health professions (e.g. nursing), professional and technical occupations in sectors such as information technology, accountancy and law. Male occupations also include construction and related occupations at all levels (engineering and professional services, skilled occupations including carpentry, as well as unskilled labouring).

Figure 3.9: Social class (based on occupational groupings) by area



N All = 418
Statistical tests: Chi Sq=201.36, (df=18), p<0.001, Cramer's V=0.40

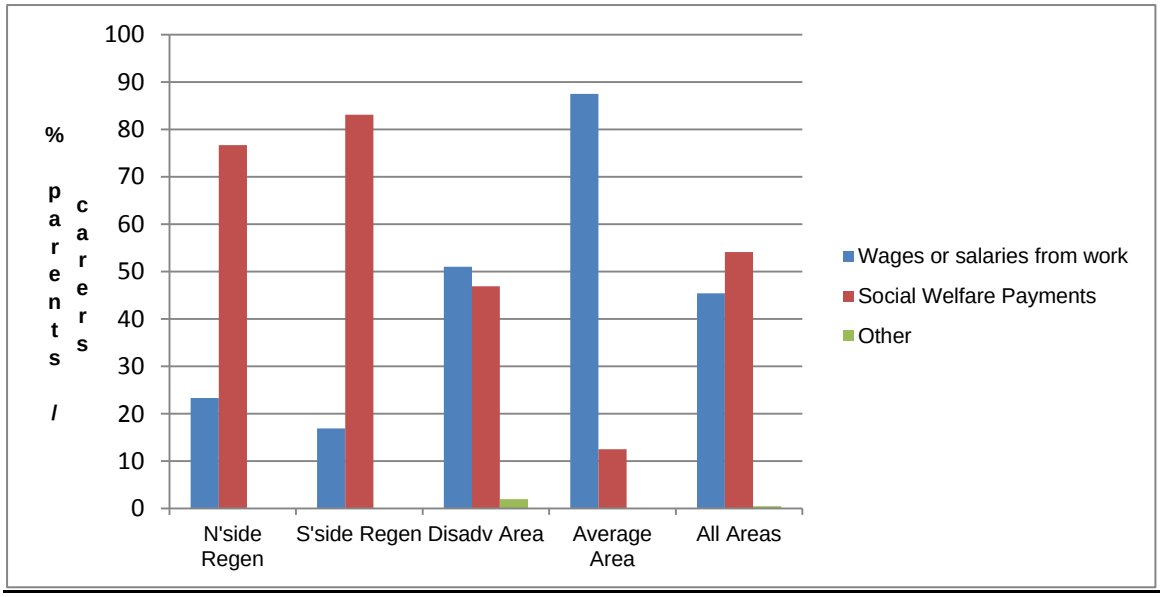
3.3.5 Income

Both the sources of household income and the parents' / carers' assessment of the adequacy of household income were explored in the household survey.

Almost all households receive child benefit (97%), some two-thirds receive income from social welfare payments and over half (54%) receive income from wages or salaries. In terms of differences between the areas, 88 per cent of households in the Average Control Area receive income from wages or salaries compared with 33 per in the Northside Regeneration Area and 34 per cent in the Southside Regeneration Area. In the regeneration areas, the largest proportion of households receives income from social welfare payments (82% in the Northside and 90% in the Southside Regeneration Area) compared with less than one-third (31%) of households receiving any income from this source (social welfare) in the Average Control Area.

There are also strong variations by area in the largest source of income into households. In the Average Control, wages and salaries are the largest source of income in some 88 per cent of households, whereas just 23 per cent and 17 per cent identifying wages / salaries as the largest source of income in the Northside and Southside Regeneration Areas respectively (Figure 3.10). In the regeneration areas, social welfare payments are the largest source of income in the large majority of households (77% in the Northside and 83% in the Southside Regeneration Areas). In the Disadvantaged Control Area, approximately half of households identify wages / salaries (51%) and social welfare payments (47%) as the largest sources of household income.

Figure 3.10: Largest source of household income by area



N All=401; N Northside=116; N Southside=83; N=Disadvantaged=98; N Average=100
Statistical tests: Chi Sq=132.96 (df=6), p<0.001, Cramer's V=0.41

Strong and statistically significant (p<0.001) variations between areas are evident also in relation to parents' / carers' assessment of the adequacy of income (expressed as the degree of difficulty in "making ends meet"). Across all areas, reflecting the difficult current economic climate, 36 per cent of respondents have "great difficulty in making ends meet", a further 42 per cent have "some difficulty", while 20 per cent state that it is "very easy" (2%) or "fairly easy" (18%) to "make ends meet". Household income is less adequate to material needs in the regeneration areas compared with other areas – 50 per cent in the Northside and 56 per cent in Southside Regeneration Areas, compared with 12 per cent in the Average Control Area, state that they have great difficulties in "making ends meet" – See Table 3.6.

Table 3.6: Perception of adequacy of income by area – difficulty in making ends meet										
Extent of difficulty	**N'side Regeneration Area**		**S'side Regeneration Area**		**Disadvantaged Area**		**Average Area**		**All Areas**	
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
With great difficulty	59	49.6	50	55.6	30	28.8	12	11.5	151	36.2
With some difficulty	49	41.2	32	35.6	52	50.0	43	41.3	176	42.2
Fairly easily	10	8.4	5	5.6	20	19.2	41	39.4	76	18.2
Very easily	0	0	2	2.2	0	0	5	4.8	7	1.7
Depends	1	0.8	1	1.1	2	1.9	3	2.9	7	1.7
Total	**119**	**100**	**90**	**100**	**104**	**100**	**104**	**100**	**417**	**100**

Statistical tests: Chi Sq=88.20 (df=12), p<0.001, Cramer's V=0.27

3.4 Summary: Neighbourhood Context: Profile of Study Areas and the Sample

This chapter locates the study areas in the physical and social geography of Limerick City. It identifies the broad typology of the study areas, and key demographic and socio-economic characteristics of households in these areas. This analysis draws on secondary sources of data, namely the most recently available census data (2006), as well as findings from the household survey. The child profile is presented drawing on the analysis of findings of the parent / carer survey (for the sample child selected in that survey instrument) and the child survey itself.

3.4.1 Limerick City: Profile

The population of Limerick City has declined over the last census period (2002-2006) and has grown only slightly over the last ten years. This is in contrast to the trend in population growth in the County, the Mid-West region, and the State as whole. The main population growth in Limerick urban area (including the suburbs) has been concentrated in parts of the suburbs (outside the City boundary), the redeveloped inner city, and Rhebogue.

There has been sharp population decline in the most deprived areas centred on the large local authority estates on the Northside (Moyross / Ballynanty) and the Southside (Southill and Ballinacurra Weston) of the city. Rates of population decline here are well in excess of what would be expected from normal demographic change; rather this trend is explained by an exodus of population from these areas, some of it linked to movement of population under the regeneration programme. This has resulted, in part, in a wider dispersal of disadvantage into other areas of the city, suburbs and county towns. However, a highly disadvantaged residual population remains in the large local authority estates of the city. Population decline and concentrated deprivation in regeneration areas (and pockets of other areas) coincide with high rates of youth dependency. This is explained, in part, by the dominant family structure in these areas, namely, lone parent families.

In terms of the location of households with families, various parts of the city have concentrations of non-family-based households (e.g., areas with a strong presence of students, and people living alone

including young professionals and older people). Areas with larger household sizes and / or concentrations of family-based households with children include St. Mary's Park, Southill and Moyross (disadvantaged areas), Corbally (including affluent parts), and Rhebogue.

Limerick City has the highest proportion of lone parent families of any local authority area in the state – with 27 per cent of all households headed by a lone parent (CSO 2006). Lone parent rates are particularly high in the large local authority housing estates of the city (over 45%). In recent years, there has been a dispersal of lone parent families in Limerick linked to housing policy, in particular the effect of the Rent Supplement / Rental Assistance Scheme (RAS) in facilitating the movement of lone parent families (and others) into private rented accommodation in both the city centre and suburbs.

Limerick City is characterised by a high degree of inequality in the distribution of affluence / deprivation across the local areas of the city as compared with the national context. A key feature of Limerick urban area is the extent of concentrated disadvantage in parts of the city (namely, the local authority estates) as reflected in the proportion of Electoral Divisions (EDs) classified as "extremely disadvantaged" and "very disadvantaged" (Haase and Pratschke, 2008). The trend over the last ten years in the spatial pattern of affluence / deprivation shows a widespread disimprovement in the whole urban area; those areas classified as "extremely disadvantaged" and "very disadvantaged" have remained in that position, and they have been joined by other areas that have disimproved relative to the national average.

3.4.2 The four study areas

The four study sites are:

1. the **Northside Regeneration Area**, covering Moyross Estate and St. Mary's Park;
2. the **Southside Regeneration Area**, covering the Southill estates of Keyes Park, Kincora Park, John Carew Park and O'Malley Park, and the parts of Ballinacurra Weston included in the Southside Regeneration plan;
3. **Disadvantaged Control Area**: a large area comprising Garryowen, Kennedy Park and the Old Cork Road area. Parts of these areas have concentrations of families that are disadvantaged, and also family-based households which are "empty nest" and with adult children. Overall, the area has a better socio-economic profile than the regeneration areas (which are the most disadvantaged areas in the city);
4. **Average Control Area**: a large area comprising most of Corbally within the city administrative boundary, and the housing estates in Rhebogue. While it has an average profile, there is a degree of heterogeneity within it – i.e. some parts are affluent / very affluent, some are intermediate, and others are lower middle class areas.

The selection of the two control areas was informed by the analysis of secondary data to identify areas within the City that had: (i) the required socio-economic profiles (one area of socio-economic disadvantage and one with an average socio-economic profile); and (ii) concentration of households with families including children under 17 years.

3.4.3 Profile of the Sample: Demographic characteristics

Key characteristics of the sample of parents / carers and children included in the household survey are outlined below.

3.4.3.1 Gender, age and length of residence in the neighbourhood

Parent / carers in the household survey are mainly female (82%) and mothers. The area with the largest proportion of male respondents (fathers) is the Average Area (30%). There is a roughly equal gender breakdown (53% boys and 47% girls) of sample children in the parent / carer questionnaire survey, and a relatively even representation across all age groups from infant through to older teenagers. Similarly, the child survey (with a smaller number of respondents drawn from households where a parent / carer completed the survey) shows a good balance of males (45%) and females (55%).

On average parents / carers in the Average Control Area are slightly older, and their children slightly younger compared with the samples in the regeneration areas. However, these differences are relatively small. Overall, the four independent samples are considered to be relatively homogeneous (i.e. they are not very different from each other) in terms of the demographic characteristics of gender and, to a lesser extent, age of the parent / carer.

In terms of length of residence of families in the areas and at their current address, there is a strong pattern of longer residence in the regeneration areas compared, in particular, to the Average Control Area. While there is virtually no in-mobility to the regeneration areas in the last two years, the evidence is that there has been significant re-location and mobility of families within the areas (based on those reporting change of address in recent years).

3.4.3.2 Family structure and socio-economic characteristics

The main and strongest variations in the sample (and population) relate to family structure, marital status and key socio-economic characteristics. Families in the regeneration areas clearly have a profile of greater deprivation, and show characteristics associated with poorer outcomes for children, including a high rate of lone parenthood. Approximately half of the parent / carers in the regeneration areas (just under half on the Northside and just over half on the Southside) are parenting alone compared with 6 per cent parenting alone in the Average Control Area. The vast majority of parents / carers in the Average Control Area are married or cohabiting (94%).

In the regeneration areas, levels of educational attainment of parents / carers are very low – 70 percent on the Northside and 68 percent on the Southside have not proceeded beyond lower secondary education while zero (Northside) or less than 1 per cent (Southside) have a third level degree or post-graduate qualification. This contrasts with parents / carers in the Average Area especially (just 12% have not attained beyond lower secondary education while 29% have a third level degree or postgraduate qualification).

The proportion of parents / carers in employment is highest at 51 per cent in the Average Control Area and lowest in the regeneration areas (23% Northside and 26% Southside). Analysis of social class structure (based on occupational groupings) by area shows the expected variations – with the largest proportions in the regeneration areas belonging to the lower social classes (semi-skilled and unskilled occupations) and the largest proportion in the Average Area belonging to the higher social classes (professional / managerial and technical). None of the sampled parents / carers in the Northside Regeneration Area are in the professional or managerial and technical social classes.

Social Welfare payments are the largest source of household income in the regeneration areas while wages / salaries are, by far, the largest source of income in the Average Control Area. In the Disadvantaged Control Area, approximately equal proportions (half and half) identify wages / salaries and social welfare payments as the largest source of household income. Reflecting the current economic climate, more than three-quarters of all households state that they have great (36%) or some difficulties (42%) in "making ends meet". Households in regeneration areas have greater difficulties in this respect, with some 50 per in the Northside and 56 per cent on the Southside having "great difficulties" in making ends meets compared with 12 per cent in this category in the Average Control Area.

3.4.4 Representativeness of the Sample

Based on the combination of secondary (census) data and the data gathered in the parent / carer and child surveys, the sample is considered to be a good representation of the study population in each of the four study areas. It is also considered broadly typical of types of communities and family-based households with children in Limerick City.

4. MAIN FINDINGS OF THE HOUSEHOLD SURVEY

This chapter describes the main findings from the household survey. The findings are presented under the following headings: (i) the neighbourhood, safety and community integration; (ii) child health and well-being; (iii) child's education and active learning; (iv) respondent's relationship with the child and parenting; (v) parent / carer health; and (vi) service utilisation and quality assessment. Following from this, and in order to draw the findings together, an analysis of the factors explaining variations in outcomes for children using the total child difficulties scale as the dependent (outcome) variable is presented.

4.1 Neighbourhood, Safety and Community Integration

This section provides an account of the contextual conditions of the study neighbourhoods including issues related to the quality of community life and social capital (trusting and knowing neighbours and support networks). These findings address child outcomes related to safety, security in the wider physical environment of the neighbourhood and being "part of positive networks of family, friends and community".

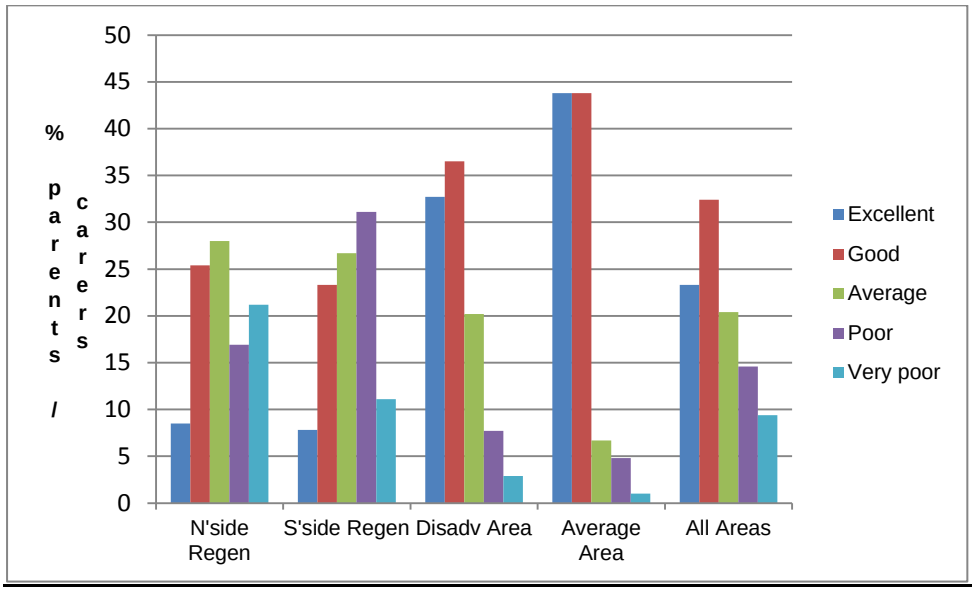
4.1.1 The neighbourhood context

In rating the quality of the neighbourhood as a place to bring up a family, over half the total sample (55%) rate their neighbourhood as excellent or good, and one-quarter rate it as poor or very poor. Here, we find the gradient between the different types of area: by far the best rating amongst parents / carers is in the Average Control Area, where some 87 per cent rate their neighbourhood as excellent or good, followed by the Disadvantaged Control Area (70% rate it excellent or good), the Northside Regeneration Area (34% rate it excellent or good) and lastly the Southside Regeneration Area (31% rate it excellent or good). In the Southside Regeneration Area, the largest proportion rates the quality of the neighbourhood as poor or very poor (42%). A substantial proportion of parents / carers in the Northside Regeneration Area (38%) also rate the neighbourhood as poor or very poor – See Figure 4.1.

Considering the child's perspective, drawing on the findings of the child survey, the majority of children across all areas (81%) state that is true that they "like where they are living". This is true to the greatest extent in the Average Control Area (96%) closely followed by the Disadvantaged Control Area (95%). Relatively lower proportions of children (but still quite high considering the parent / carer ratings) in the regeneration areas agree that they "like where they are living" (70% in the Southside and 67% in the Northside). However, when asked whether it is true that they would like to move, almost half of the children surveyed in the regeneration areas would like "to move from this place and live somewhere else" compared with 8 per cent in the Average Control Area and 15 per

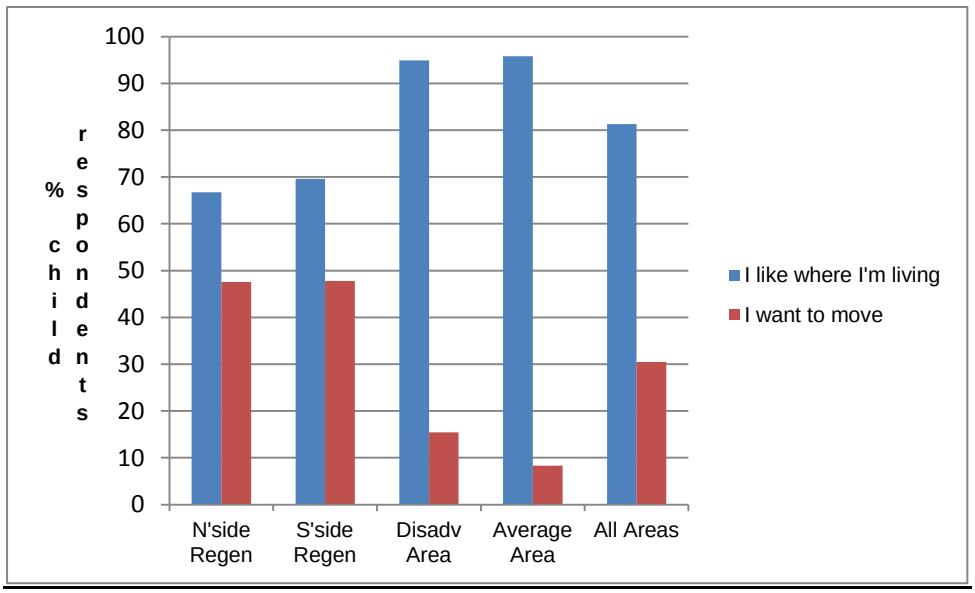
cent in the Disadvantaged Control Area. Differences between the areas on these indicators are statistically significant (Figure 4.2).

Figure 4.1: Rating of the neighbourhood as a place to bring up a family



N All =417; N Northside=118; N Southside=90; N Disadvantaged Area=104; N Average Area=105
Statistical Tests: Chi Sq-125.10 (df=12): Cramer's V=0.319, p<0.001

Figure 4.2: Child perceptions of the neighbourhood as a place to live, by area

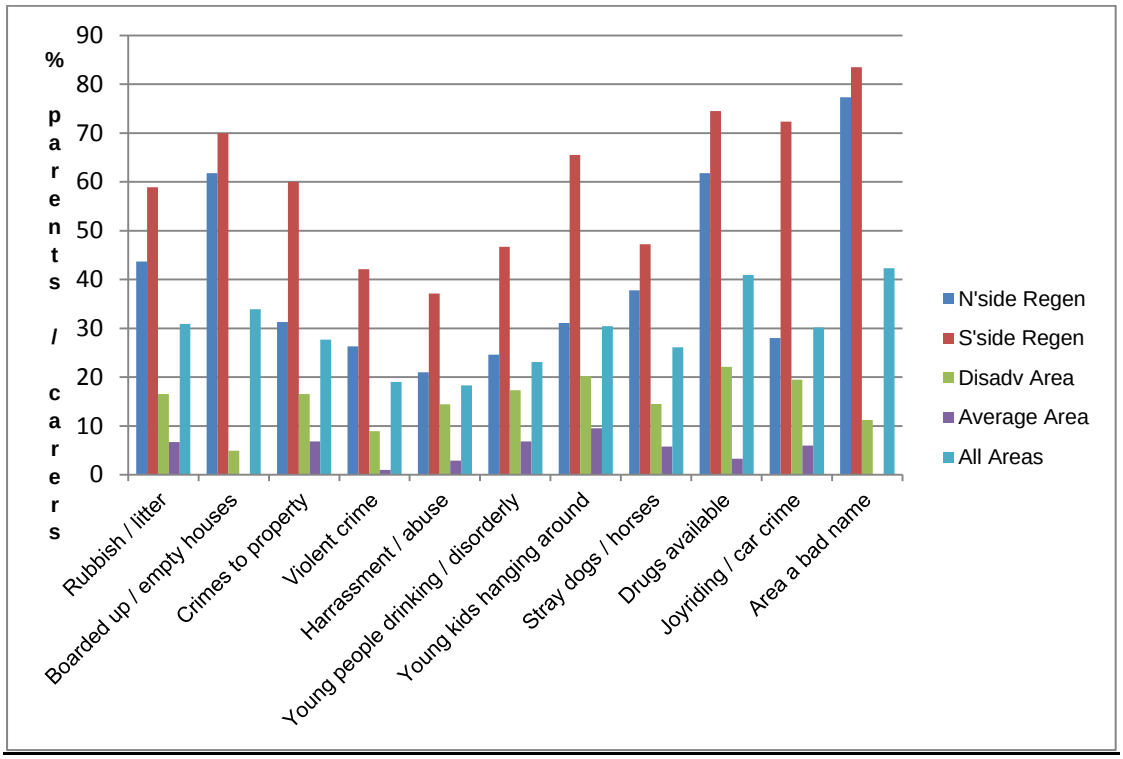


N All =128
Statistical Tests: I like where I'm living Chi Sq=16.03 (df=3), Phi=0.34, p<0.001
I want to move: Chi Sq=18.84 (df=3), Phi=0.38; p<0.001

The extent to which certain issues are problems in the neighbourhood was explored with parents / carers. The proportion of parents / carers indicating issues are "a very big" or "a big" problem is

illustrated in Figure 4.3. The extent to which residents (parents / carers) report that specific issues are a "big / very big" problem is greatest the Southside Regeneration Area. Based on parent / carer reports in the Average Control Area, the specific issues examined are much less serious problems. While it is not without problems, the proportion of parents / carers in the Average Area indicating that any one of the issues explored is "a big / very big" problem is less than 10 per cent. This contrasts greatly with the reports from parents in the regeneration areas.

Figure 4.3: Neighbourhood problems: Issues identified as a big/very big problem



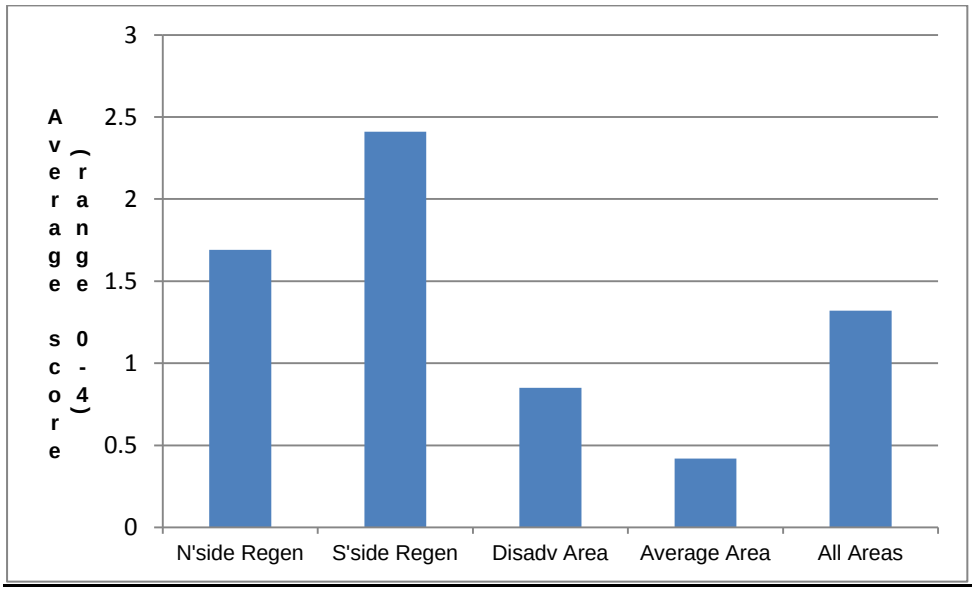
Area stigma (i.e. the area "having a bad name") is identified as a big / very big problem by 77 per cent of parents / carers in the Northside Regeneration Area and 83 per cent of parents / carers in the Southside Regeneration Area. While stigma tends to be attributed to external factors or agents, residents themselves identify serious problems within the neighbourhoods. These include problems with the physical environment (62% in the Northside and 70% in the Southside Regeneration Areas indicating that boarded up / empty / derelict properties are a big / very big problem); violent crime (26% in the Northside and 42% in the Southside Regeneration Areas indicating it is a big / very big problem), availability of drugs including open drug dealing (62% in the Northside and 75% in the Southside Regeneration Areas) and various forms of anti-social behaviour such as young people drinking and disorderly, "kids hanging around" etc.

Differences between the areas on the problem issues are all statistically significant. The greatest variations (strength of association between area and the issue as a problem) are, in order: boarded up /

empty / derelict properties, poor external image/ stigma, availability of drugs, joyriding / car crime, rubbish / litter, crimes to property, violent crime, kids hanging round, stray dogs / horses, harassment / abuse, and young people drinking and disorderly. Within pockets of the Disadvantaged Control Area, parents / carers report to a greater extent that certain issues are big / very big problems (detailed data by sub-area not shown). For the Disadvantaged Control Area as a whole, the most serious problems are: availability of drugs (22% state it is a big / very big problem) young people / kids hanging round (20%), joyriding / car crime (20%) and young kids / drinking and disorderly (17%).

Figure 4.4 brings this analysis together to illustrate the extent of concentration of problems by area (i.e., the extent to which areas have multiple neighbourhood problems), based on an average score for all types of problems. This average score, theoretically, can range from 0 (all respondents in the area considers all the issues covered to be "not a problem") to 4 (all respondents consider all the issues to be a "very big problem"). Based on parent / carer reports, the Southside Regeneration Area, followed by the Northside Regeneration Area has the highest concentration of problems, while the Average Control Area has the lowest concentration of neighbourhood problems.

Figure 4.4: Summary Score: Concentration of neighbourhood problems by area

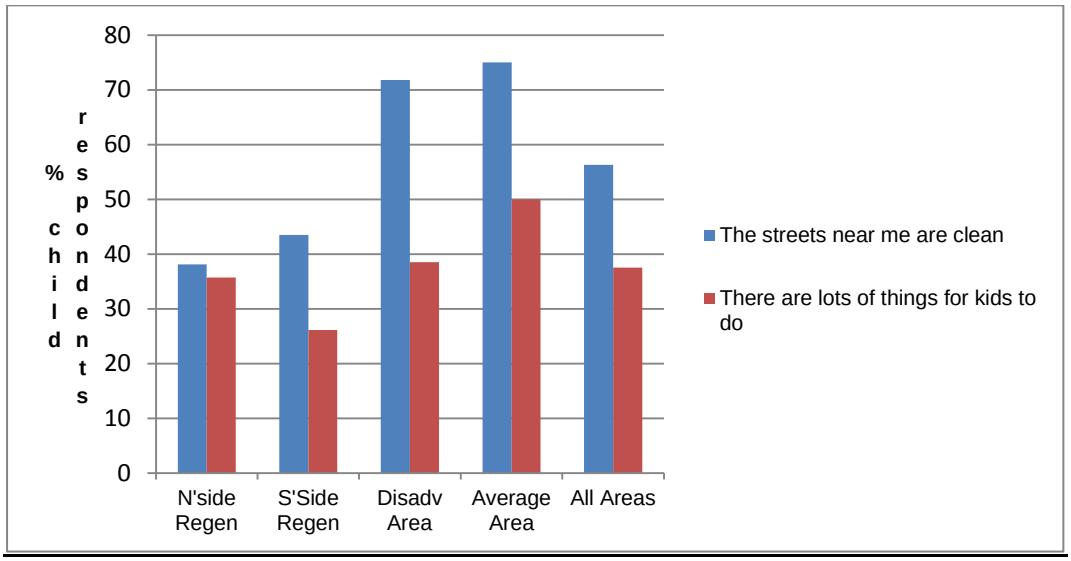


N=418
Statistical Tests: F= 112.39; p<0.001

If the child's perspective is considered in relation to the physical environment of the neighbourhood, some 56 per cent overall agree that "the streets near me are clean and look good". Children in the control areas agree with this statement (75% in the Average Area, and 72% in the Disadvantaged Area) to a greater extent than those in the regeneration areas (44% in the Southside and 38% in the Northside). Children in the Average Control Area agree to the greatest extent that there are "lots of

things for kids to do where I live" while the proportion agreeing with this statement is lowest in the Southside Regeneration Area (26%) – See Figure 4.5.

Figure 4.5: Child perceptions of the neighbourhood environment by area



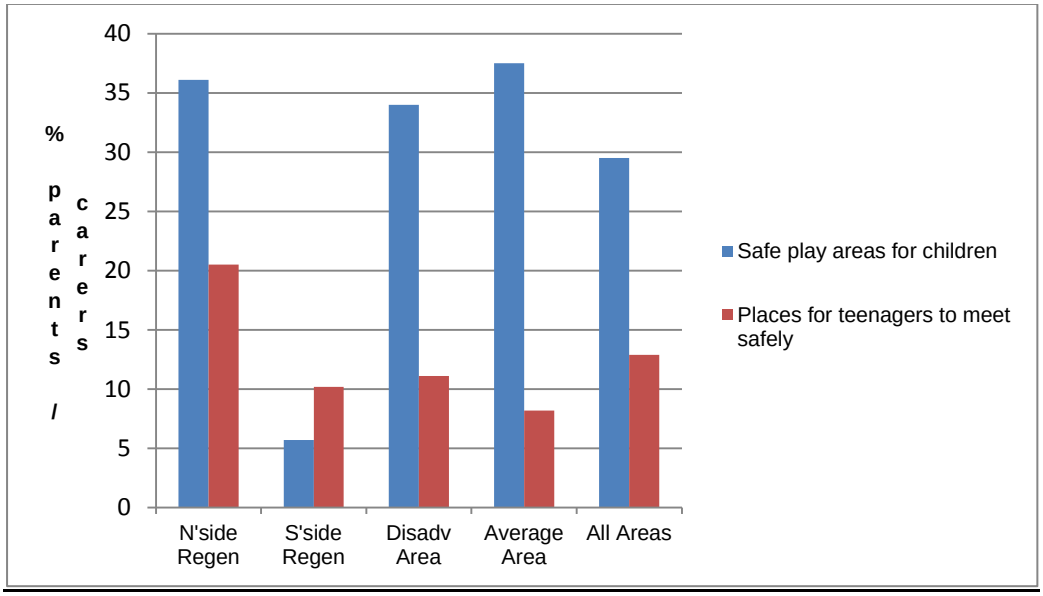
N All=128; Statistical Tests: Clean streets Chi Sq=14.41 (df=3); Phi=0.34; p<0.001; Things for kids to do: not significant

Across all areas, less than one-third of parents / carers consider that there are "safe places" for young children to play in their neighbourhoods (Figure 4.6). Rates are relatively uniform on this indicator between the Average Control Area (38%), Northside Regeneration Area (36%), and the Disadvantaged Control Area (34%). The situation is less favourable, however, in the Southside Regeneration Area, where less than 6 per cent of parents / carers consider that there are safe play areas for young children. Focusing on teenagers, only 13 per cent of parents / carers across all areas consider that there are safe places for teenagers to meet in the neighbourhood. Based on parent / carer reports, teenagers are best catered for in the Northside Regeneration Area (21% consider that there are places for teenagers to meet safely here) while the situation is least favourable in the Average Control Area (8%). The relatively better position of the Northside Regeneration Area could reflect a developed infrastructure of provision for children and teenagers on the Northside including the Youth Cafe, playground, outdoor and indoor facilities in Moyross, the Northside Learning Hub and the re-opened Shelbourne Park. On the Southside, there is a youth space available in the "Fulflex" complex.

Child perceptions of safety in the neighbourhood are next considered based on a number of indicators. Drawing on findings from the child survey, high proportions of children across all areas consider it true that "there are lots of mean kids living around here". The proportion is highest in the Northside (62%), with little difference between the Disadvantaged Control (49%) and the Southside Regeneration Area (48%); the lowest rate is in the Average Control Area (21%) – see Figure 4.7. All children surveyed in the Average Control Area agree that they "feel safe when I go outside", but this falls to 65 per cent in the Southside Regeneration Area. Across areas, the largest proportion saying it

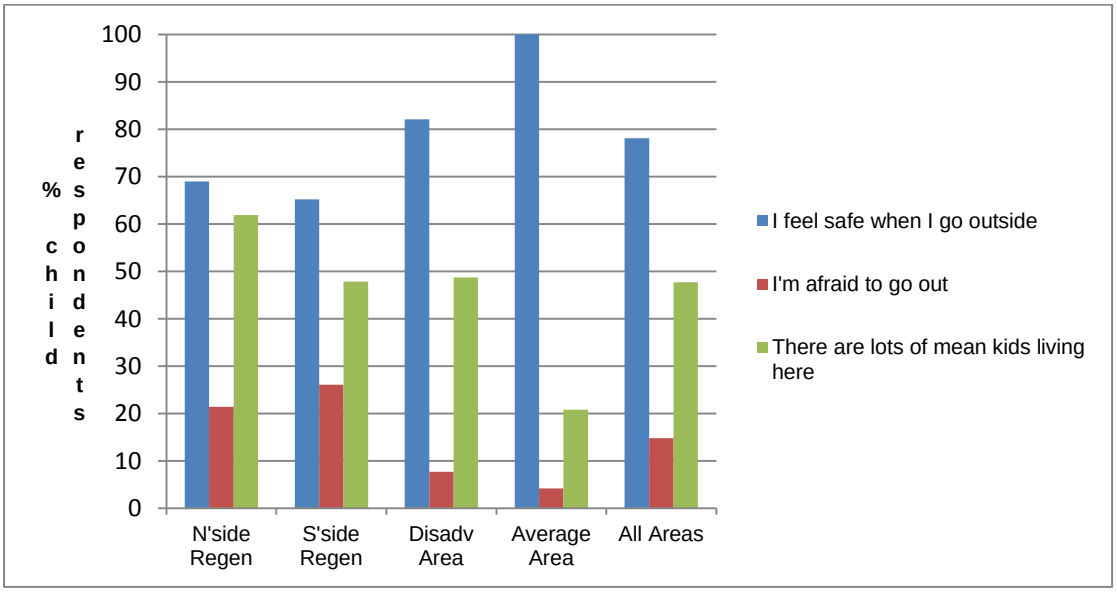
is true that they are "afraid to go out" is in the Southside Regeneration Area (26%), followed by the Northside Regeneration Area (22%). The smallest proportion of children stating this is true is in the Average Control Area (4%).

Figure 4.6: Whether safe places for children to play and teenagers to meet (% yes)



N Safe places for children=414; N Safe places for teenagers = 396
Statistical Tests: Children Chi Sq=30.74 (df=3); Phi=0.272; p<0.001
Teenagers: Chi Sq=8.534 (df=3); Phi=0.147; p<0.05

Figure 4.7: Child perceptions of neighbourhood safety by area: Various indicators



N All =128
Statistical Tests: Feel safe: Chi Sq=11.34 (df=3), Phi=0.30; p<0.05 (p=0.01); Afraid to go out: Chi Sq=7.48 (df=3); Phi=0.28; p=0.06 (almost significant); Lots of mean kids: Chi Sq=10.36 (df=3), Phi=0.28; p<0.05 (p=0.02)

4.1.2 Transport

The main form of transport used and access to a car were explored in the survey. These issues are important on a number of grounds: car ownership and access to a car can be indicators of economic security; walking, as a form of physical exercise, can positively contribute to healthy lifestyles; and use of public transport, rather than use of the car, is better in terms of environmental effects.

Almost all households in the Average Control Area (98%) compared with approximately 60 per cent in the regeneration areas and 74 per cent in the Disadvantaged Control Area have access to a car. While the car is the main form of transport used in the Average Control Area (96%), just over half of parents / carers in the regeneration areas, and approximately 70 per cent in the Disadvantaged Control Area, use the car as the main form of transport. Most of the remainder in the regeneration areas either walk (20% in the Northside and 16% in the Southside) or use public transport (24% in the Northside and 29% in the Southside) as their main form of transport. Differences between the areas on these indicators are statistically significant.

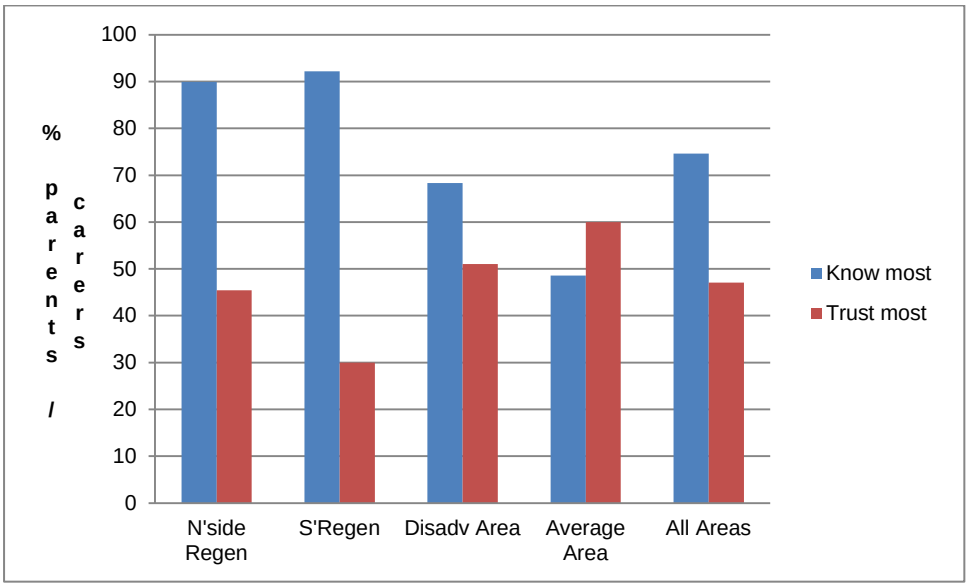
4.1.3 The neighbourhood and social capital

Neighbourhood social capital was explored in terms of the extent to which parents / carers know and trust people living in the neighbourhood and the extent to which they "look out for each other".

There is a gradient between regeneration and non-regeneration areas in the extent to which parents / carers know their neighbours – in the Southside and Northside Regeneration Areas 90 per cent and 92 per cent respectively know most of their neighbours. This falls to 68 per cent in the Disadvantaged Control Area and 49 per cent in the Average Area (Figure 4.8). The reverse is the case, however, in terms of the extent to which parents / carers *trust* people in the neighbourhood. In the Southside Regeneration Area, some 46 per cent trust "only a couple of people" (37%) or "nobody" (9%); 33 per cent in the Northside Regeneration Area trust "only a couple of people" (25%) or "nobody" (8%) and 32 per cent in the Disadvantaged Control Area trust "only a couple of people" (22%) or "nobody" (10%). This contrasts with the Average Control Area where 18 per cent trust "only a couple of people" (14%) or "nobody" (4%).

The "gap" or percentage difference between "knowing most" and "trusting most" people in the neighbourhood is an important indicator of community social capital and cohesion. In common among the disadvantaged areas (i.e., the Disadvantaged Control Area as well as the regeneration areas), the population of parents / carers knows their neighbours to a greater extent than they trust them. The reverse is true in the Average Area (i.e. they trust more than they know).

Figure 4.8: Community social capital: knowing most and trusting most by area



N=418
Statistical Tests: Know neighbours: Chi-sq.=76.639 (df=9); Cramer's V= 0.247, p<0.001
Trust neighbours: Chi-sq.=24.011 (df=9); Cramer's V= 0.138, p<0.01 (p=0.004)

In terms of the extent to which parents / carers consider that "people look out for each other", the situation is most positive in the Average Control Area, followed by the Disadvantaged Control Area, then the Northside Regeneration Area, and least positive in the Southside Regeneration Area. In the Southside Regeneration Area, the largest proportion compared with other areas (38%) either disagree (15%) or strongly disagree (24%) with the statement that "people look out for each other" – See Table 4.1.

Table 4.1: Extent to which parents / carers agree people look out for each other, by area

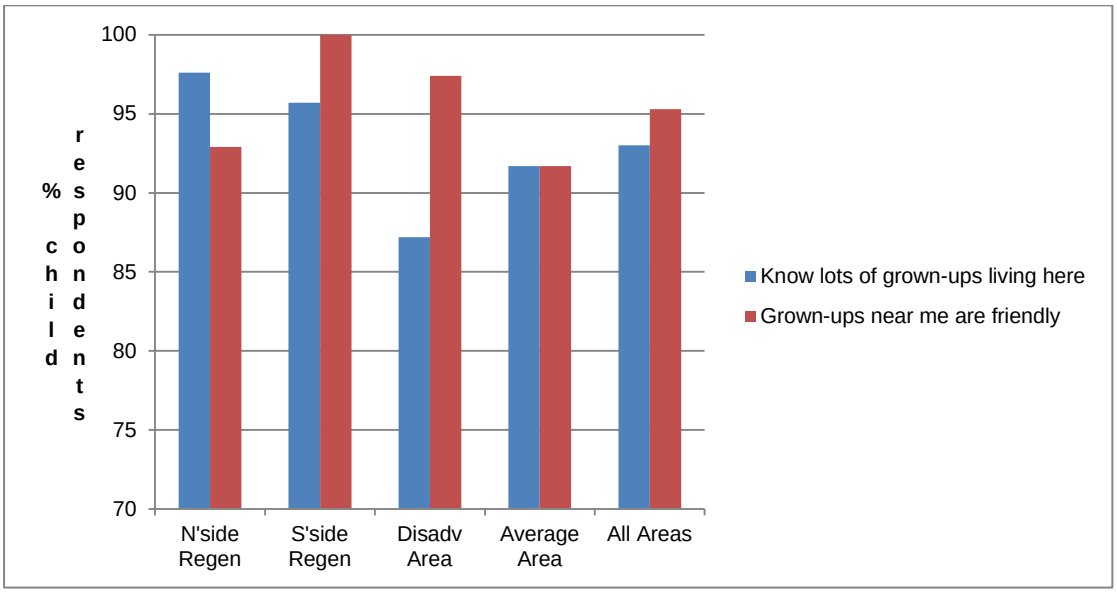
This is an area where local people look out for each other	**N'side Regeneration Area**		**S'side Regeneration Area**		**Disadvantaged Area**		**Average Area**		**All Areas**	
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Strongly agree	53	46.5	29	32.6	46	46.5	55	56.7	183	45.9
Agree	33	28.9	26	29.2	35	35.4	29	29.9	123	30.8
Disagree	13	11.4	13	14.6	8	8.1	10	10.3	44	11.0
Strongly disagree	15	13.2	21	23.6	10	10.1	3	3.1	49	12.3
Total	114	100	89	100	99	100	97	100	399	100

Statistical Tests: Chi-sq.=25.088 (df=9); Cramer's V= 0.145, p<0.01 (p=0.003)

With regard to children's knowledge and perceptions of adult neighbours, the vast majority of children across all areas "know lots of the grown-ups living near me" and consider the "grown-ups living near me are friendly". The proportion of children who know adult neighbours is highest in the Northside Regeneration Area (98%) and lowest in the Disadvantaged Control Area (87%). All children in the Southside Regeneration Area have positive perceptions of grown-ups living near them being "friendly" (Figure 4.9). These findings indicate that while there are problems in the neighbourhoods, in terms of anti-social behaviour involving children / teenagers and safety issues, and

while children are aware of these problems (mean kids, afraid to go out etc.), there are also positive aspects in the relationships between children and adult neighbours.

Figure 4.9: Community Social Capital: Child perceptions of adult neighbours



N=128. Statistical Tests: not significant

4.1.4 Social capital: child peer networks

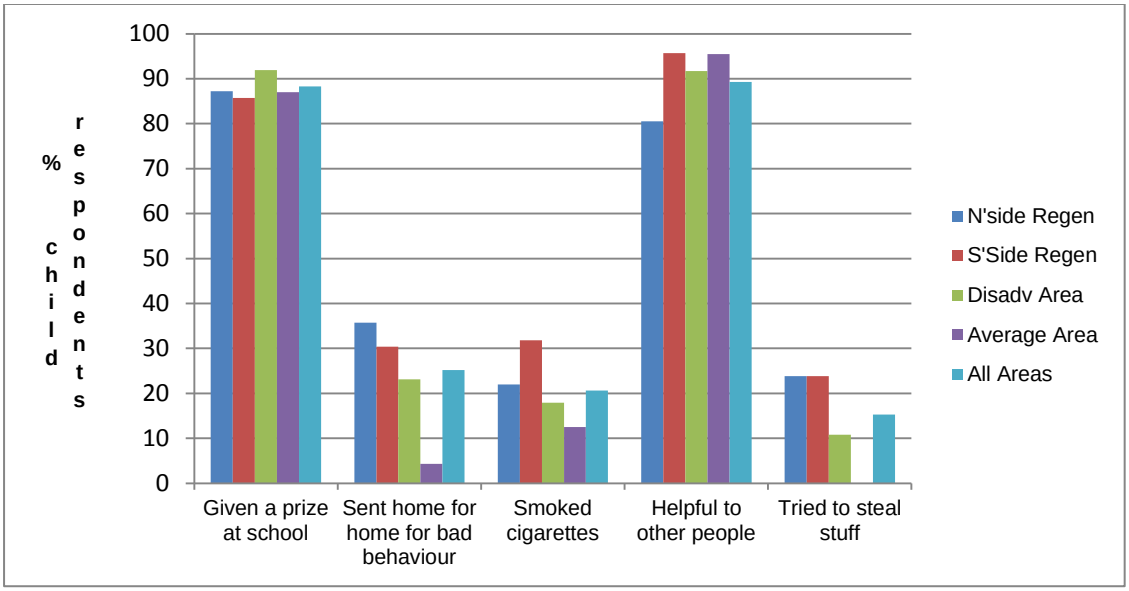
Certain aspects of positive and negative behaviours by the child respondent, and attitudes towards certain behaviours (smoking, stealing, taking drugs), were explored with children in the child survey, with their parents present at the interview.

Across all areas, high proportions of children report being given a prize at school (88% across all areas), a prize for art, sport, music (76%) and being helpful to other people (95%). There were no statistically significant differences between the areas on these indicators. Similar findings obtain for the child's peer networks, i.e., his or her best friends. High proportions of children across all areas report positive behaviours amongst their best friends; in particular, high proportions have been given prize(s) at school (88%) and have been helpful to other people (89%). There are no differences between the areas on these indicators.

In terms of negative behaviours, larger proportions of children in the regeneration areas report that their best friends have been sent home from school for bad behaviour (36% Northside Regeneration and 30% Southside Regeneration) compared with the control areas, particularly the Average Control Area (4%) where the incidence of this is much lower (Figure 4.10). Larger proportions in the regeneration areas similarly report that their best friends have "tried to steal stuff" – 24 per cent in both the Northside and Southside Regeneration Areas compared with 11 per cent in the

Disadvantaged Control Area and 0 per cent in the Average Area. Differences between the areas on these negative behaviours in peer networks are statistically significant.

Figure 4.10: Children's peer networks: Best friends getting awards and engaging in negative behaviours



N All Range 120 to 127 cases. Don't knows excluded
Statistical Tests: Prize at school=not significant; Smoked cigarettes=not significant; Helpful to other people=not significant
Sent home for bad behaviour: Chi Sq 8.20(df=3), p<0.05 (p=0.04), Phi=0.25; Tried to steal stuff: Chi Sq 8.42(df=3), p<0.05 (p=0.04), Phi = 0.21

With older children (12 years and older), other types of negative behaviours in peer networks were explored, including getting into trouble with the guards (22% across all areas reported yes), drinking alcohol (29% across all areas reported yes), and taking drugs (11% across all areas reported yes). The total number of cases who answered these questions is small (45 children). There were no statistically significant differences between the areas on these indicators.

Children were asked for their views on the extent to which certain behaviours "are wrong for someone your age". All children were asked about smoking cigarettes, stealing from a shop or from a person, and starting a fight. Almost all children across all areas (99%) consider stealing and starting a fight are "very wrong" or "a bit wrong". It is only in relation to smoking cigarettes that there are statistically significant differences between the areas (Chi Sq=18.52 (df=6), p<0.05, Cramer's V=0.27). While 100 per cent of children in the Average Control Area consider smoking cigarettes as very wrong, 83 per cent in the Northside Regeneration Area, 74 per cent in the Southside Regeneration Area and 85 per cent in the Disadvantaged Control Area do so. On other issues explored with older children, the number of cases, as indicated above, is small (45). However, the vast majority across all areas (94%) agree that it is very wrong "to do damage to a property" and all agree that it is very wrong "to take drugs". In terms of drinking alcohol, three cases (7%) consider this not wrong, and eight cases (17%) consider it a bit wrong. While there are differences between the areas on this

indicator (Chi Sq=13.13 (df=6), $p<0.05$), the pattern is not consistent. In the Southside Regeneration Area and the Average Control Area, some children (3 in total) consider drinking alcohol "not wrong".

Generally, the findings here indicate that children are part of positive peer networks across all areas. Some negative behaviours amongst peers show stronger prevalence in the regeneration areas. However, children show an awareness of how they are perceived, and have an awareness of age-inappropriate (smoking, drinking) and bad behaviours.

4.1.5 Social capital: social networks and parenting support

In terms of social networks for support with parenting, almost all parents / carers across all areas confirm that they have "someone to ask for advice with parenting" (97%) and "someone to ask for practical help" with parenting (97%), if needed (for instance, if the parent was ill and needed someone to look after the child/children). There are no differences between the areas on these indicators of the availability of support.

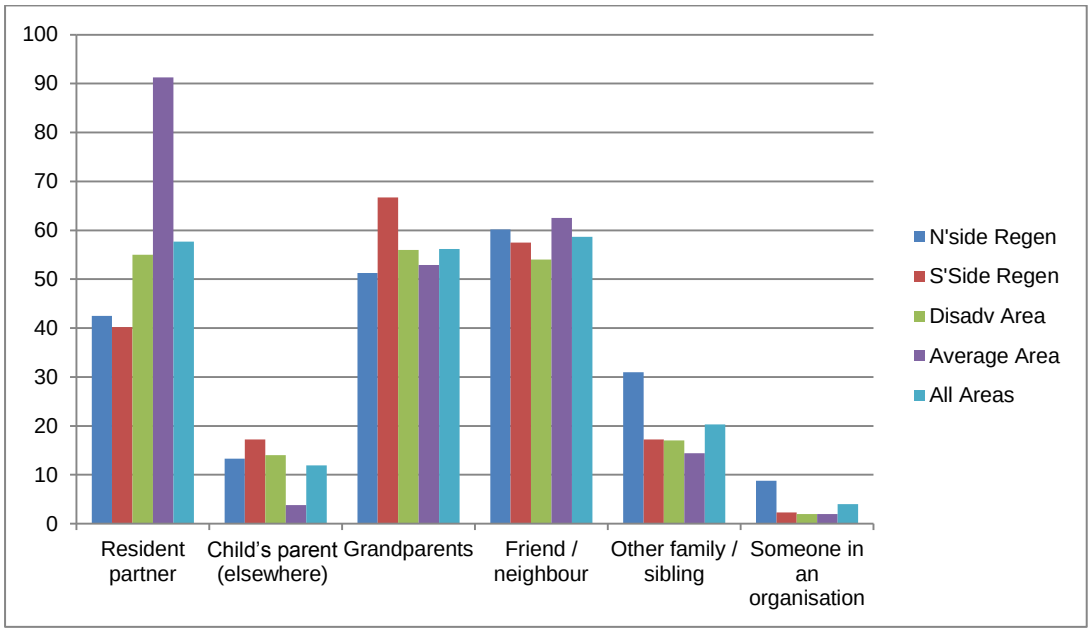
However, there are differences between the areas in terms of *who* the parent / carer would ask for support. Reflecting variations in family structure, "the partner that I live with" is much more important as a source of advice in the Average Control (91%) compared with the regeneration areas (43% Northside and 40% Southside)[13]. In contrast, the proportion getting advice from the "child's parent who lives elsewhere" is larger in all the disadvantaged areas (Northside, 13%, Southside, 17%, Disadvantaged Control, 14%) than the Average Control Area (4%) (Figure 4.11). However, considering the proportion of parents / carers who are parenting alone in the regeneration areas (54% in the Southside and 47% in the Northside), there is relatively little support coming from former partners. Support from "someone in an organisation" such as a teacher or support worker is less important overall. The highest rates of support from the latter source in terms of advice on parenting are in the Northside Regeneration Area (9%).

In terms of practical support with parenting, the pattern is similar to that reported with reference to sources of advice on parenting (Figure 4.12). In the Average Control Area, a slightly lower proportion indicates that the "partner who lives with them" provides practical support (86%) compared with advice on parenting (91%). This is most likely because the partner may not be there when needed (e.g., working).

In all areas, grandparents, and friends and neighbours, are important sources of support with parenting, both in terms of advice (grandparents, 56% across all areas and friends and neighbours, 59%) and practical support (grandparents, 58% and friends and neighbours, 59%).

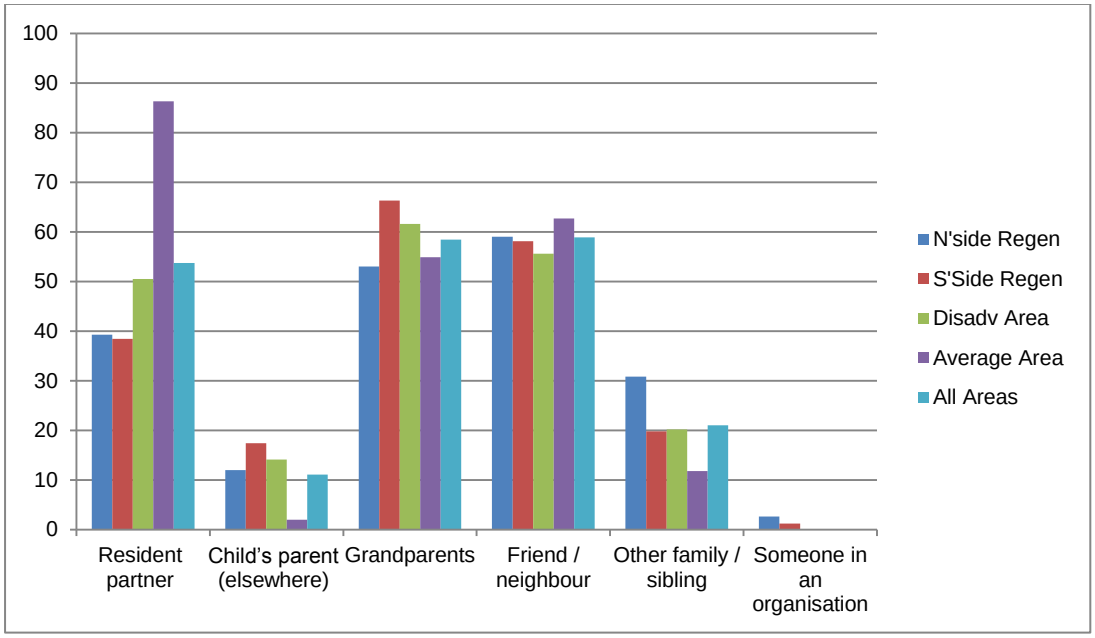
[13] Note that "the partner that I live with" may not necessarily be the biological parent of the child.

Figure 4.11: Who helps with advice on parenting



N All=404; N Northside=113; N Southside=87; N Disadvantaged=100; N Average=104
Statistical Tests: Advice, Partner that I live with: Chi Sq = 70.13 (df=3); Phi V 0.42; p<0.001
Child's parent living elsewhere: Chi Sq = 9.439 (df=3); Phi 0.153; p<0.05 (p=0.024);
Grandparents: not significant; friend / neighbour: not significant'
Other family / siblings: Chi Sq = 11.35 (df=3); Phi V 0.172; p<0.01 (p=0.008);
Someone in an organisation: Chi Sq = 9.88 (df=3); Phi V = 0.16; p<0.05 (p=0.02)

Figure 4.12: Who helps with practical support with parenting



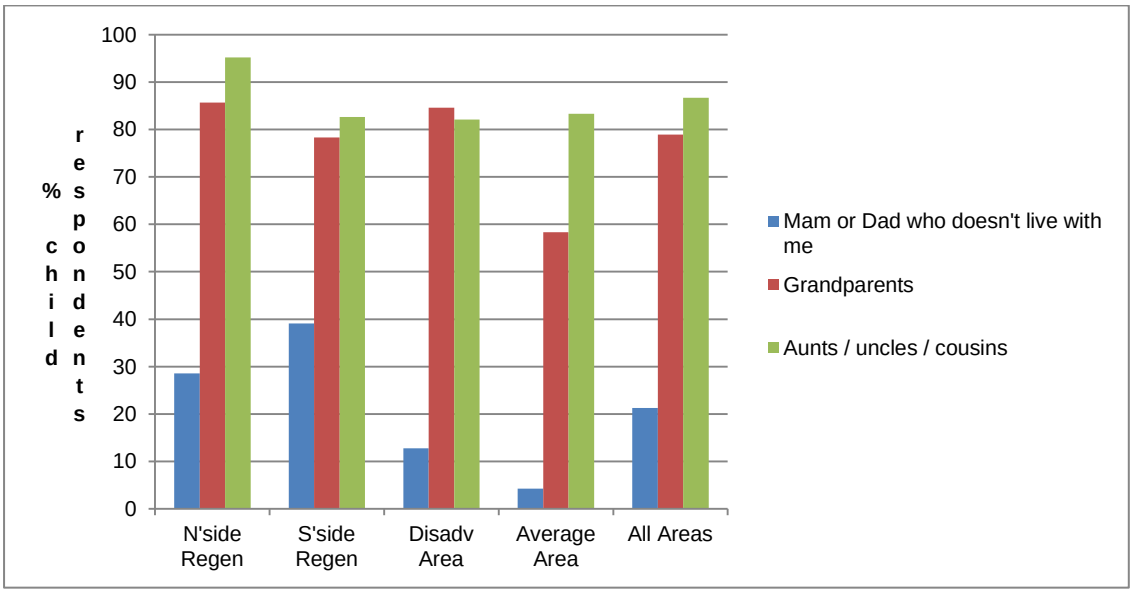
N All=404; N Northside=113; N Southside=87; N Disadvantaged=100; N Average=104
Practical Help: Partner that I live with: Chi Sq = 61.80 (df=3); Phi= 0.279; p<0.001;
Child's parents living elsewhere: Chi Sq =12.84 (df=3); Phi = 0.18; p<0.01
Grandparents: not significant; Friend / neighbour: not significant;
Other family / sibling: Chi Sq = 12.07 (df=3); Phi= 0.172; p<0.01 (p=0.008);
Someone in an organisation: not significant

4.1.6 Child's extended family networks and other sources of support

The child survey explored the extent to which the child has extended family networks, in terms of people they see regularly and in whom they can confide or draw support in times of need.

The findings show that children across all areas have regular contact with members of their wider family particularly aunts / uncles / cousins (87% across all areas) and grandparents (79% across all areas). Reflecting higher rates of separated parents, larger proportions of children in the regeneration areas regularly see "a mam or dad who doesn't live with me" (39% Southside and 29% Northside compared with one child only (4%) in this category in the Average Control Area). In all the disadvantaged areas, children regularly see their grandparents to a greater extent (86% Northside, 78% Southside, 85% Disadvantaged Control) compared with children in the Average Control Area (58%) – Figure 4.13.

Figure 4.13: Child and regular contact with people in the extended family by area



N All=127 (Mam or Dad who doesn't live with me) and 128
Statistical Tests: Aunts / uncles / cousins=not significant; Mam or Dad Chi Sq=11.32(df=3), p<0.05 (p=0.01), Phi=0.30; Grandparents Chi Sq=8.04(df=3), p=0.05, Phi=0.25

Child perceptions of their wider support networks provide insights to the quality of relationships with extended family and others. Across all areas, the vast majority of children (98%) stated that "if something was wrong" or they "were worried" they could tell someone "besides their mam or dad" about it. (Two children, Northside Regeneration and Disadvantaged Control Area, could not identify someone to tell).

In exploring to whom they would talk if worried or troubled, the pattern of wider support networks is varied. The following sources of support are identified by approximately similar proportions of children: grandparents (46%), aunts, uncles and cousins (44%), friends (44%) and siblings (44%). The parent not living with the child (14%) and a youth worker of Home-School Community Liaison

(HSCL) worker (2%) are cited by some children but in much smaller proportions (a youth / HSCL worker only in the Northside Regeneration Area). There are no statistically significant differences between the areas on these indicators. The detailed findings are show in Appendix II.

Findings from the child survey, which point to the greater importance of extended family and friends as compared to "the parent who does not live with the child" in the family home are consistent with findings of the parents / carers survey.

4.1.7 Social capital: child involvement in civic activities

Engagement in civic activities is used as an indicator of positive social capital. It is also a measure of participation in society. Engagement in civic behaviour was explored with children in the child survey. The proportion of children engaged in "helping other people without getting any money for it" (volunteering) was high across all areas (86%). This is an important indicator of civic behaviour as it is an "unstructured" voluntary act. Rates of "helping collect money for people or a group that needs it" were also high (72% across all areas). Such activities tended to be undertaken within schools (e.g. collecting for Haiti or Bóthar). A lower proportion of children across all areas engaged in helping in the community such as "clean up" and parades (53%). There were no statistically significant differences between the areas on any of these indicators.

4.2 Child Health

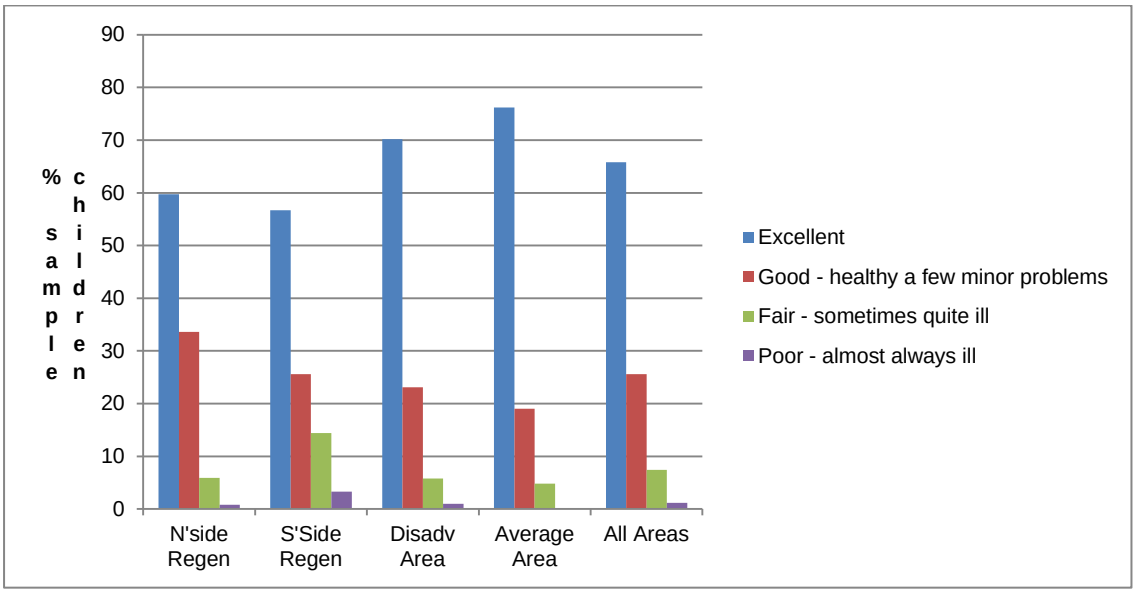
Various aspects of child health were explored in the parent / carer survey with reference to one (selected) sample child. The findings provide indicators of well-being and outcomes for children living in Limerick City and the different types of areas included in this study.

4.2.1 Child health status, peri-natal outcomes and diagnosed illnesses

Parents / carers were asked to assess the health of the sample child. Subjective assessment of health is regarded as a good indicator of overall health and is used extensively in censuses and surveys internationally.

The majority of parents across all areas assess the sample child's health as excellent (66%) or good (26%). It is in the Average Control Area that the highest proportion of parents / carers rate the child's health as excellent or good (76% excellent and 19% good), followed by the Disadvantaged Control Area (70% excellent and 23% good), and the Northside Regeneration Area (60% excellent and 34% good), while in the Southside Regeneration Area, the smallest proportion of parents / carers, compared with other areas, rate the child's health as excellent or good (57% excellent and 26% good) (Figure 4.14). Some 18 percent of parents / carers in the Southside Regeneration Area rate the child's health as fair (14%) or poor (3%). No parent / carer in the Average Control area rates child health as poor. Variations between the areas are statistically significant.

Figure 4.14: Parent / carer's assessment of sample child's health

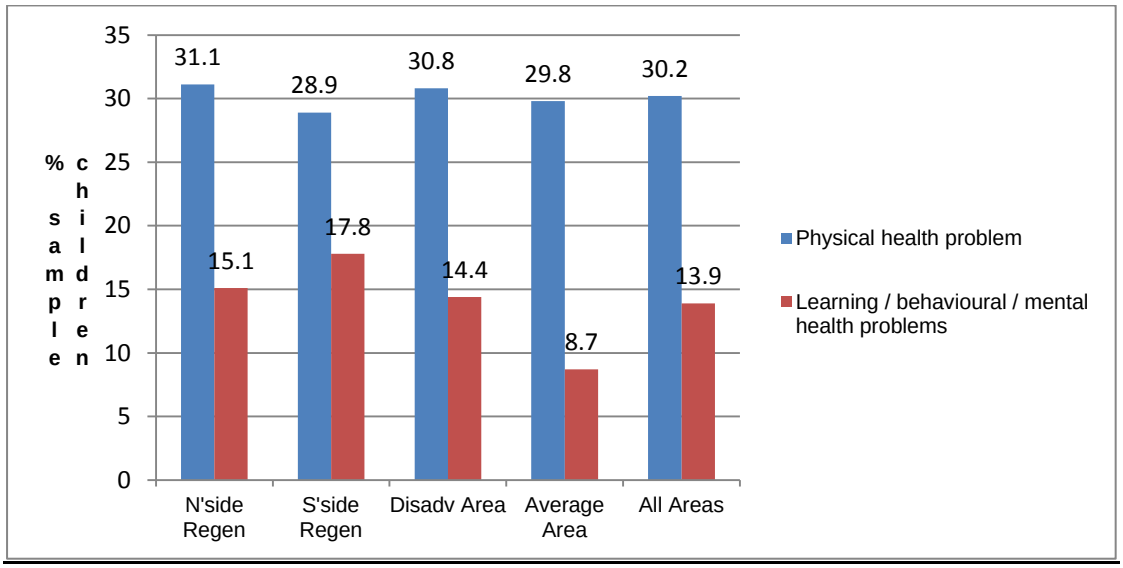


N All=418; Statistical tests: Chi sq=21.471 (df=9), Cramer's V=0.131, p<0.05 (p=0.011)

Indicators typically used to assess health inequalities from birth were explored with parents / carers in the survey (based on recall and self-reporting). These indicators include, birth weight and the rates of premature birth (as well as incidence of multiple births). There were no statistically significant differences between the areas on any of these indicators. Average birth weight across all areas is 3.34 kilos, 98 per cent of births across all areas were single births, and 19 per cent of children were born either a bit early at 33-36 weeks gestation (16%) or very early at 32 weeks gestation or earlier (3%). The rate of low birth weight babies was 8 per cent across all areas, which is slightly higher than the rate for Limerick (6%) and the national rate (5.6%) in 2010 (*National Peri-natal Reporting System*, ESRI, cited in Department of Health and Children and Office of the Minister for Children and Youth Affairs, 2010). The rate of low birth weight babies was highest in the Northside Regeneration Area (11.5%), followed by the Disadvantaged Control Area (7.1%), the Average Area (6.8%) and lowest in the Southside Regeneration Area (5.7%).

In terms of diagnosed physical health problems (i.e. an on-going or long-standing physical health problem diagnosed by a doctor or other professional), 30 per cent of children across all areas are reported to have a physical health problem (Figure 4.15). There are small variations across the areas (lowest in the Southside Regeneration Area at 29% and highest in the Northside Regeneration Area at 31%) and no statistically significant differences between the areas on diagnosed physical health problems in the sample child. Some 14 per cent of children (based on the sample child) across all areas have been diagnosed by a doctor or other professional as having learning difficulties and / or behavioural problems or mental health problems. Rates are highest in the Southside Regeneration Area (18%), followed by the Northside Regeneration Area (15%), and the Disadvantaged Control Area (14%), and are lowest in the Average Control Area (9%).

Figure 4.15: Whether sample child diagnosed types of health problems



N All=417; N Northside=119, N Southside=90, N Disadvantaged=104; N Average=104
Statistical Tests: not significant

Of those children diagnosed by a professional with a physical health problem (126 cases), by far the most common illness is asthma (which affects 63% of children diagnosed with a health problem, or 18% of all sample children). The next most common illnesses in order of importance are: a speech difficulty (17 children or 14% of those children diagnosed with a physical health problem); other illnesses (17 children, 14%); and skin problems such as eczema (15 children or 12% of those children diagnosed with a physical health problem). There are no statistically significant differences between the areas on any of these specific illness indicators.

Poorer health rating of children by parents / carers in the regeneration areas compared with other areas would seem to be inconsistent with the finding of no differences between the areas in terms of diagnosed physical health problems. A possible explanation is that parents in the Average Control Area, in particular, are more likely to seek a diagnosis (linked to better education, more confidence in dealing with professionals and better health literacy). This may be the case even though parents / carers in the regeneration areas, because of their socio-economic profile and means, are much more likely to have medical cards.

Of those children diagnosed by a professional with learning difficulties, behavioural problems or mental health problems (58 children in all), the most common diagnosis is dyslexia or dyspraxia (20 children or 35% of those diagnosed with any learning, behavioural or mental health problems) and other difficulties (20 children / 35%) closely followed by ADHD (17 children or 29% of children diagnosed with any learning, behavioural or mental health problem). The next most common diagnosis was aggressive behaviour / conduct disorder, and anxiety or withdrawn behaviour (both reported for 5 children or 9% of those children with diagnosed learning / behavioural or mental health

problems). The overall numbers diagnosed are small, and there are no statistically significant differences between the areas on any of these diagnosed learning / behavioural / mental health problems. However, in the case of ADHD, differences between the areas are almost significant (p=0.055 which is just above the cut-off value of 0.05). Diagnosis of this condition only arises in the Northside Regeneration Area (4 children or 22% of children in the Northside Regeneration Area with diagnosed learning, behavioural or mental health problems), Southside Regeneration (8 children, 50% of children in the Southside Regeneration Area with diagnosed learning, behavioural and mental health problems) and Disadvantaged Control Area (5 cases or 33% of children in the Disadvantaged Control Area with diagnosed learning, behavioural or mental health problems) and no cases in the Average Control Area. Based on discussions with parents during the fieldwork, diagnosis of ADHD seems to be more common in the regeneration areas, in that parents frequently mentioned that a child (other than the sample child) is diagnosed with this condition. It should be noted that diagnosis with this condition (ADHD) attracts an allowance which is significant in families where incomes are very low. While there is a perception (identified from informal discussions with parents / carers in the course of the fieldwork, and also in the focus groups) that the availability of this allowance acts as a financial incentive to parents to seek an ADHD diagnosis, it was beyond the scope of this study to investigate whether this is in fact the case.

Of the sample children diagnosed with a physical health problem, or learning, behaviour difficulties or mental health problems (154 in total), some 43 per cent are medicated for a physical health problem and 7 per cent for learning, behavioural difficulties or a mental health problem. 50 per cent (77 children) are not on medication for their health conditions. There are no statistically significant differences between the areas on these indicators.

Of those children with a physical and/or mental health problem, half (50%) across all areas are either affected severely (7%) or to some extent (44%) by their health condition (Table 4.2). Children in the Southside Regeneration Area are affected to the greatest extent (15% severely and 64% to some extent) compared with other areas. Variation between the neighbourhoods here is statistically significant.

Table 4.2: Extent to which sample child is affected by physical and / or mental health problems										
Categories	**N'side Regeneration Area**		**S'side Regeneration Area**		**Disadvantaged Area**		**Average Area**		**All Areas**	
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Yes, severely	2	4.3	5	13.9	2	5.4	2	5.7	11	7.1
Yes, to some extent	14	30.4	23	63.9	14	37.8	16	45.7	67	43.5
No, not really / not at all	30	65.2	8	22.2	21	56.8	17	48.6	76	49.4
Total	**46**	**100**	**36**	**100**	**37**	**100**	**35**	**100**	**154**	**100**

Statistical Tests: Chi Sq=16.741(df=6), Cramer' V=0.233; p<0.05 (p=0.010)

4.2.2 Early years development: children less than thirty-six months

In relation to young children (less than 36 months old), indicators of child development were explored with parents / carers – including immunisation, weight gain, hearing and other developmental checks. There are no statistically significant differences between the areas on any of these indicators. Early child physical development is consistently positive in terms of outcomes across all areas. Rates of child development indicators for all areas are shown in Table 4.3 below. The reported high rates of immunisation take up are in line with national trends (e.g. 93% at 24 months, as reported in *Health in Ireland: Key Trends 2010*. Department of Health and Children, 2011).

Table 4.3: All Areas - Child development in children < 36 months: development checks done & results		
Indicators	**No.**	**%**
Up to date with immunisations	58	96.7
Child weighed in development clinic / by Public Health Nurse	60	100
Weigh in line with expected for age	58	96.7
Child's hearing checked	52	87.9
Where hearing checked, found to be ok	52	100
Other developmental checks done	52	86.7
Checks not done yet (not due)	6	10.0
Results of other development checks show development as expected	49	94.2
Some / all delayed development	3	5.8

Note: N All = 60; don't knows excluded

4.2.3 Accidents and injuries

Incidence of accident and injury can be interpreted as an indicator of child safety (from accidental harm). The rate of attendance of the sample child at A&E, or admission to hospital because of accidents or injury, is 55 per cent across all areas. Rates of attendance at A&E or hospital are very similar across all areas (56% Northside Regeneration, 57% Southside Regeneration Area, 48% Disadvantaged Control Area, 59% Average Control Area). There are no statistically significant differences in these rates between the areas. With regard to the number of accidents and injuries in the sample child requiring hospital treatment, the mean number was higher in the Northside (2.36 average number of accidents and injuries) and the Southside (2.45) Regeneration Areas compared with the

Disadvantaged Control Area (2.10) and Average Control Areas (1.84) but the differences here are not statistically significant.

Rates of accidents / injury requiring attendance at A&E or hospital admission, as expected, vary by age group and increase with age (Table 4.4). The rates indicated in the table are higher than those cited in *State of the Nation's Children* (Department of Health and Children and Office of the Minister for Children and Youth Affairs, 2011) but the rates cited in the latter relate to hospital discharges.[14] In line with expectations (DoHC and OMCYA, 2011), rates were found to be slightly higher amongst males (58%) compared with females (52%), but differences by gender were not statistically significant.

Table 4.4: Incidence of accidents & injury requiring attendance at A&E or in-hospital admission by age group

	Yes, required hospital attention		Cases N
	No.	%	
Under 1 year	2	15.4	13
1-4 years	42	43.3	97
5-9 years	78	56.9	137
10-14 years	71	61.7	115
15-17 years	34	64.2	53
All age groups (0-17 years)	**227**	**54.7**	**415**

4.2.4 Experience of emotional trauma in the child

Specific experiences of emotional trauma in the sample child (bereavement, separation from parents, moving house, moving country etc.) were explored with parents / carers. The findings by area are shown below (Figure 4.16).

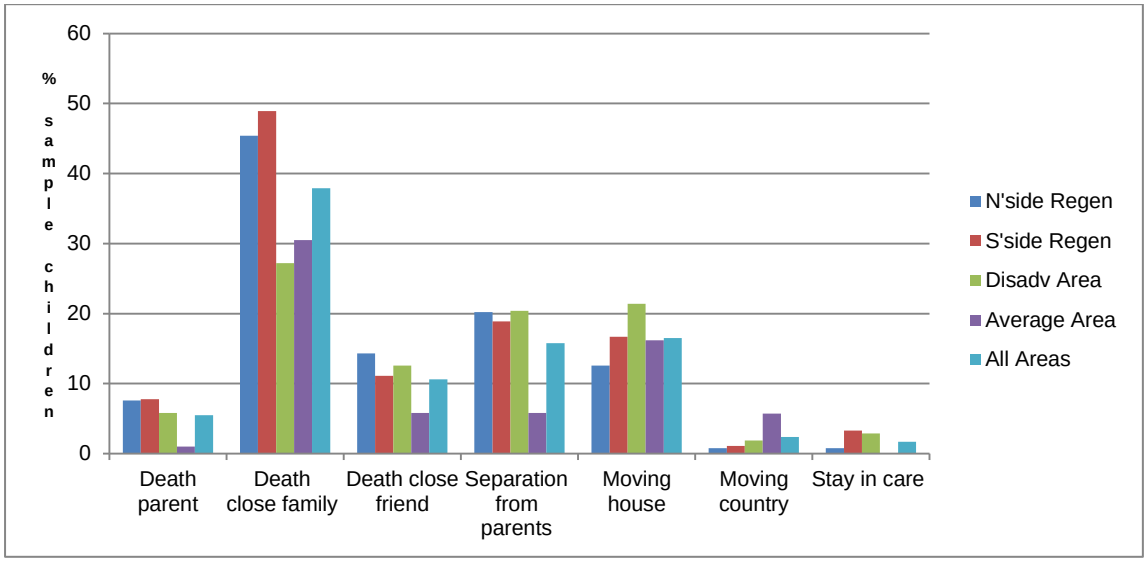
There are statistically significant differences between the areas in the incidence of trauma related to the death of a close family member, where the higher rates occur in the Northside (45%) and Southside (49%) Regeneration Areas compared with the Disadvantaged Control (27%) and Average Control Areas (31%). Based on discussions with parents / carers in the course of the fieldwork, there are other differences here. In the control areas, the child's experience of bereavement tends to involve the death of a grandparent, while in the regeneration areas family bereavement involves younger family members such as siblings and uncles to a greater extent.

Rates of separation from parents are higher in the disadvantaged areas including the regeneration areas (20% Northside, 19% Southside) and Disadvantaged Control Area (20%) compared with the Average Area (6%). The between-area variation here is statistically significant. In view of the high rates of lone parenthood in the regeneration areas (approximately 50%), the extent to which parents / carers in these areas identify separation from parents as a traumatic event in a child's life is low. In

[14] Statistics in the State of the Nation's Children (2011) are drawn from Hospital In-Patient Enquiry (HIPE), Department of Health and Children

comparison, all cases of child separation from parents (e.g. through divorce) in the Average Control Area are identified by parents as a traumatic event in the child's life. Based on comments and discussions with parents / carers during the fieldwork, lone parenthood is normalised in the regeneration areas, and some parents would simply state that the child "doesn't remember him" (father) or it "doesn't affect him/her at all".

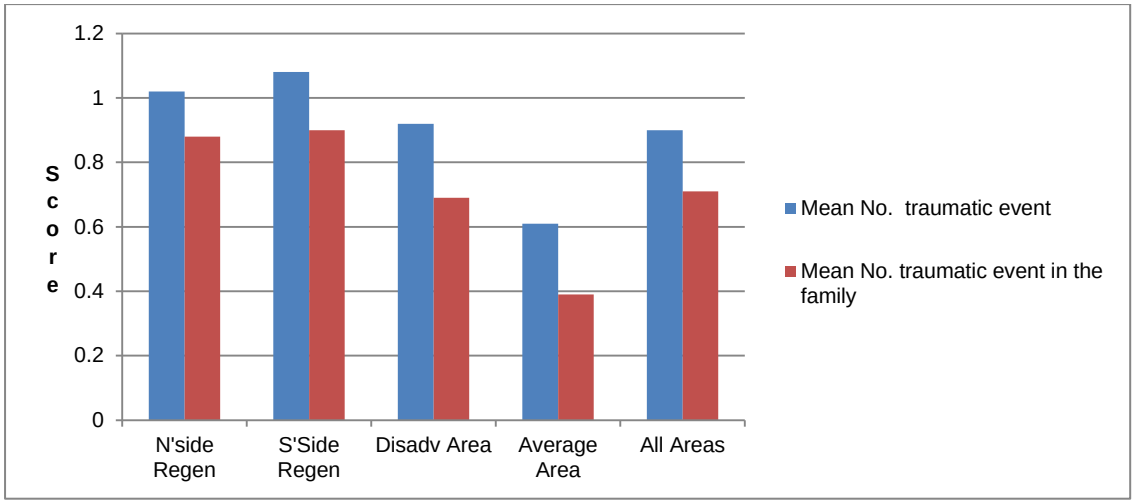
Figure 4.16: Emotional traumas experienced by the sample child, by area (% yes)



N All=417; N Northside=119; N Southside=90; N Disadvantage=103; N Average=105
Statistical Tests: Death of parent: not significant; Death of close friend: not significant; Moving house / area: not significant; Moving Country: not significant; Stay in care: not significant
Death close family: Chi Sq=14.93 (df=3), Phi=0.19; p<0.001; Separation from parents: Chi Sq=15.31 (df=3); Phi=0.19; p<0.001.

The data on traumatic events in the sample child's life can be aggregated to measure the extent to which children experience multiple traumas. The findings (Figure 4.17) show that the mean number of traumatic events per sample child (across all seven traumatic events included in the questionnaire) is greatest in regeneration areas. If family-related traumatic events only are selected (five traumatic events), differences between the areas are even greater. Variations between the areas on both of these indicators are statistically significant.

Figure 4.17: Scores for emotional trauma experienced by the sample child (all events and within family events)



N All=417. All events (7): scoring no=0; yes=1; possible range 0 (no trauma) to 7 (all traumatic events)
Family-related trauma: (i) death of a parent; (ii) death of close family member; (iii) death of close friend; (iv) separation from parents; (v) stay in foster care.
Possible Range 0 (no trauma) to 5 (all events)
Statistical tests: All events F=4.44; p<0.001; Family-related trauma: F=8.03; p<0.001

4.2.5 Strengths and difficulties in the child

As outlined in the Methodology Chapter, the Strengths and Difficulties Questionnaire (SDQ) was used to profile the (sample) children in terms of strengths and difficulties based on five scales: (i) Emotional symptoms, (ii) conduct problems, (iii) hyperactivity, (iv) peer problems and (v) pro-social behaviour. The first four scales measure difficulties while the fifth scale (pro-social behaviour) measures child strengths. An overall scale (based on the first four scales) to measure total difficulties (i.e. the total difficulties score) can also be derived. Findings in relation to the scales are typically reported in terms of averages in the population (mean and median). Applying the methodology of the developers (Goodman, 1997), scores on the different scales and the overall total difficulties score can be "banded" by normality ranges, namely: abnormal, borderline, and normal for a child population. Scores on each of the five scales and the total difficulties score, based on averages (means), are reported in Appendix II (additional tables). The findings indicate that there are statistically significant differences between the four study areas on four of the five scales: emotional symptoms, conduct problems, hyperactivity and peer problems. The findings follow the gradient of the Southside Regeneration Area having the greatest child difficulties, followed by the Northside Regeneration Area, and the Disadvantaged Control Area, with the Average Area showing the lowest level of child difficulties. Differences between the areas are greatest in relation to conduct problems, followed by peer problems. While the gradient also applies in the pro-social scale, differences between the areas on this scale are small and are not statistically significant.

This gradient between the study areas also applies to the findings in terms of the child's total difficulties (score): the most severe child difficulties occur in the Southside Regeneration Area,

followed by the Northside Regeneration Area, the Disadvantaged Control Area and the Average Control Area with the last area having a profile of lowest average child difficulties scores.

Differences by gender (between boys and girls) are also statistically significant. Higher mean scores for girls in terms of emotional symptoms (3.50 for girls compared with 2.64 for boys) indicate that girls have greater difficulties on this scale ($F=8.134$, $p<0.01$). Higher means scores for boys on the hyperactivity scale (4.13 for boys compared with 3.40 for girls) indicate that boys have greater difficulties on this scale ($F=4.780$, $p<0.05$). In terms of comparison of the findings of this research with the *Growing Up in Ireland* study (ESRI 2010), the mean scores by gender on all four scales which measure difficulties are higher in aggregate across all four areas in this study (referred to below as All Areas) compared with an Irish population of nine-year olds.

The mean score on pro-social behaviour is approximately the same for boys (in the two studies) and is lower for girls (indicating a lower score on strengths) in this study (All Areas) compared with nine-year olds in the *Growing Up in Ireland* study (ESRI 2010).

The findings in relation to each of the scales with reference to "normality" bands are presented below. Taking into account that "normal population" frequency distributions have certain proportions of children in all scale categories (normal, borderline, abnormal), the findings can be contextualised by comparison with an American population of children aged 4-17 years[15] and with the findings of the ESRI-led *Growing Up in Ireland* (2010) study (cohort of nine year olds).[16] Comparison with the US reference population is shown for each scale in turn.

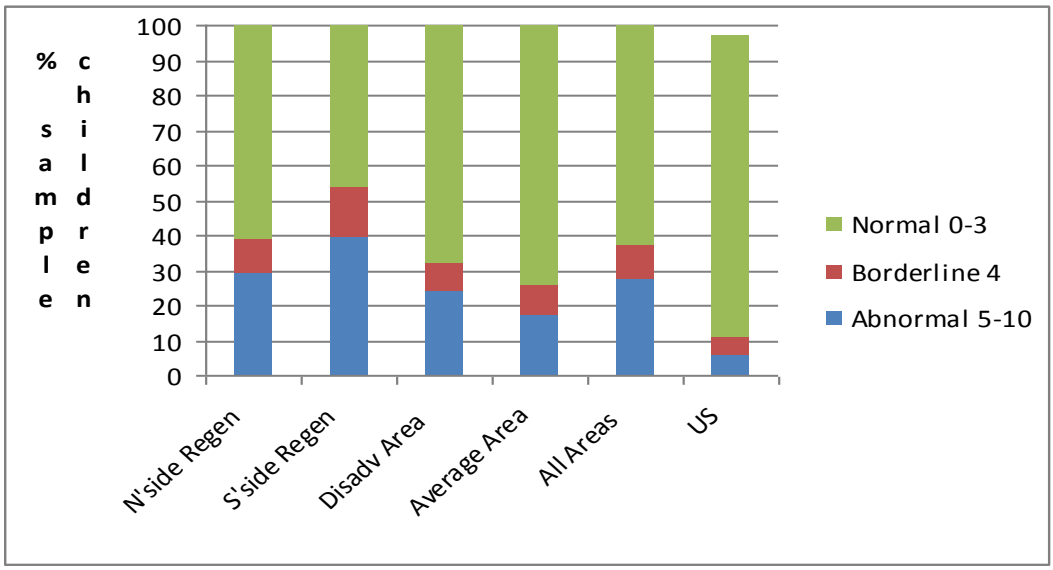
In relation to Emotional Symptoms, in the Southside Regeneration Area, some 54 per cent of sample children are in the abnormal (40%) or borderline (14%) range, while in the Northside Regeneration Area, 31 per cent are in the abnormal (29%) or borderline (10%) ranges (Figure 4.18). This compares with 25 per cent in these categories (17% abnormal and 8% borderline) in the Average Control Area. Differences between the study areas on this scale are statistically significant. In comparison with US norms, the proportion of children in the abnormal range is 20 percentage points more in All Areas included in this study (i.e. 27.3% versus 7.6% in the American child population).

In regard to Conduct Problems, rates in abnormal or borderline ranges are significantly higher in the regeneration areas. Some 49 per cent of children in the Southside Regeneration Area are in the abnormal (37%) or borderline (12%) ranges, and 33 per cent of children in the Northside Regeneration Area are in the abnormal (25%) and borderline (18%) ranges compared with 15 per cent in these categories in the Average Control Area (6% abnormal and 9% borderline) – Figure 4.19. There is an approximate 10 percentage point difference between All Areas in this study and American

[15] This reference population was the "closest" available to the study population covering the large age range from 3-17 years.
[16] The norms generated from this study relate to 9 year olds. Irish norms are not available for the broad age range of the child population investigated in this study.

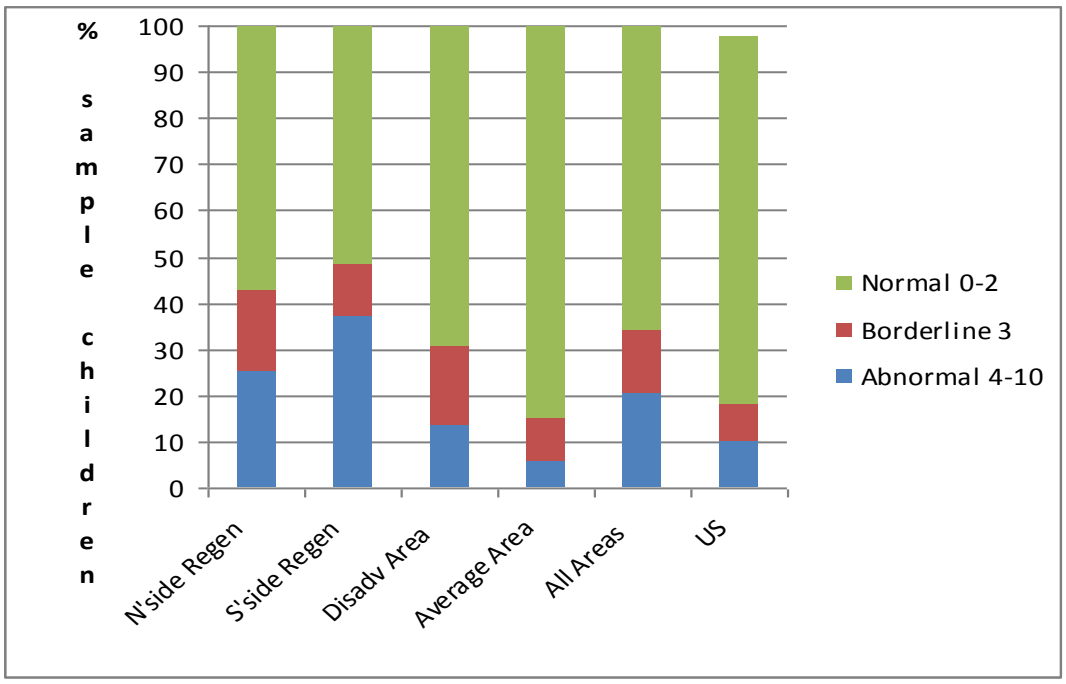
children in the abnormal range (20.3% in the abnormal range in All Areas compared with 10.7% in the American child population) and a 6 percentage point difference between All Areas and American children in the borderline range (14.1% All Areas and 8.4% in the American child population).

Figure 4.18: Emotional Symptoms: Classification by normality ranges and comparison with US child population (4-17 years)



Note: SDQ scales / scores for American 4-17 year olds - Sample size US N=9,878; All Areas N=355
Statistical Tests across study areas: Chi Sq = 15.73 (df=6), p<0.05 (p=0.02), Cramer's V = 0.15

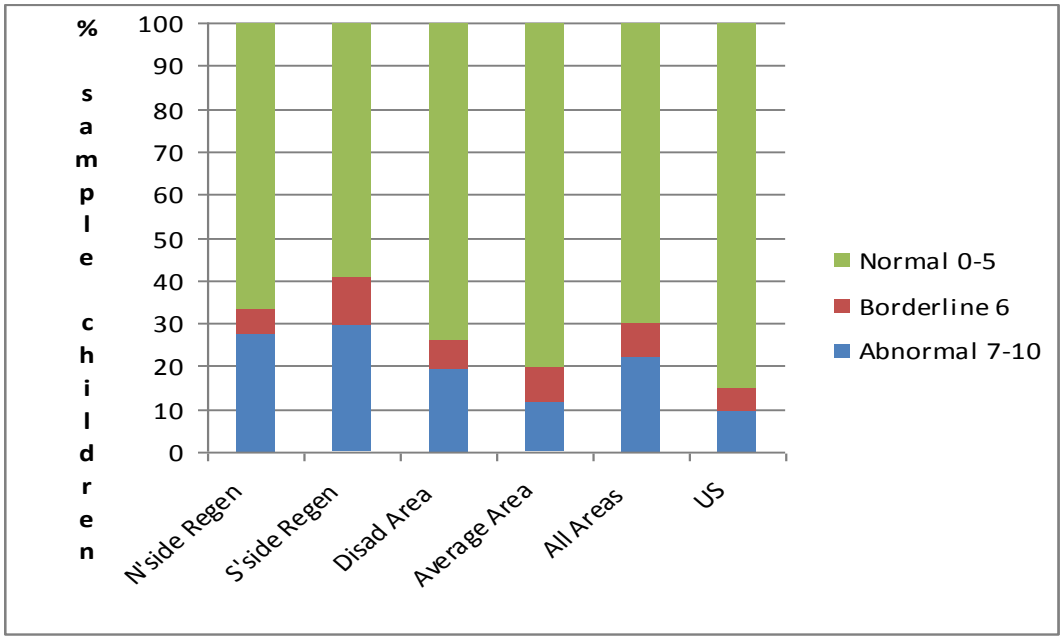
Figure 4.19: Conduct Problems: Classification by normality ranges and comparison with US child population (4-17 years)



Statistical Tests: Chi Sq = 34.75 (df=6); Cramer's V=0.22, p<0.001
Note: American 4-17 year olds, Sample size N=9,878; All Areas N=355

The Hyperactivity / Inattentive Problems scores show the same pattern, with the highest rates of children in abnormal and borderline ranges in the Southside Regeneration Area (41%), followed by the Northside Regeneration Area (33%), and the Disadvantaged Control Area (26%), and the lowest rates in the Average Control Area (20%). There is more than twice the rate of children in the abnormal range in All Areas in the study (22%) compared with the population of American children (9.3% in the abnormal range) (Figure 4.20).

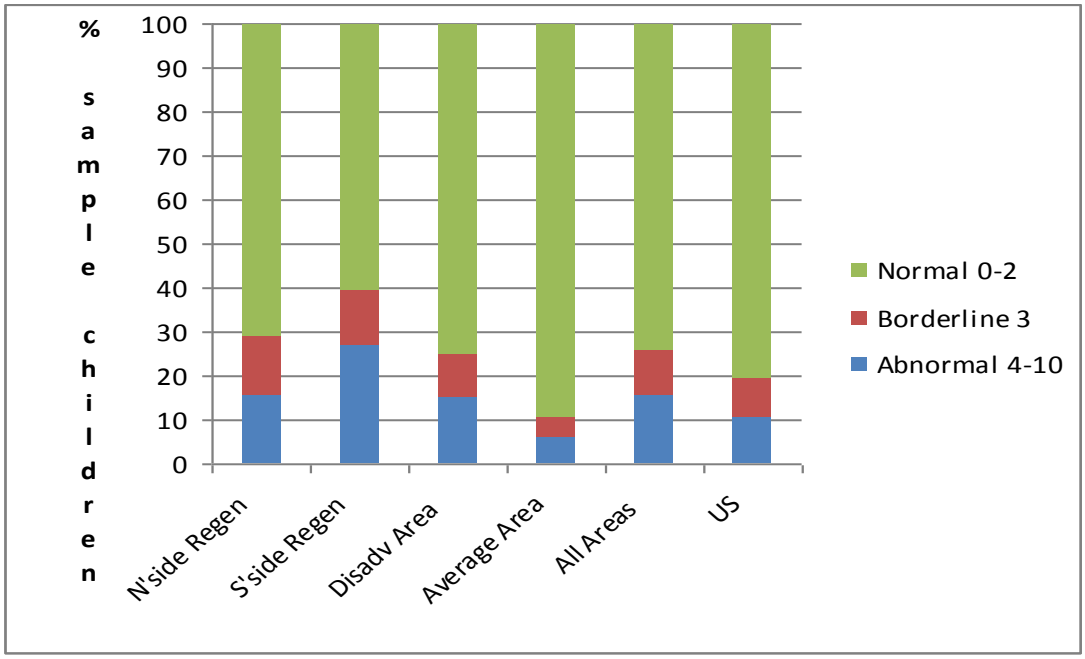
Figure 4.20: Hyperactivity / inattentive problems: Classification by normality ranges and comparison with US child population (4-17 years)



Statistical Tests Between Four Study Areas: Chi Sq = 12.71 (df=6); Cramer's V=0.13, p=0.05
Note: American 4-17 year olds, Sample size N=9,878; All Areas N=355

Peer Problem scores by area are shown in Figure 4.21. There are large differences here between the area with the most severe problems (Southside Regeneration Area) and the area with the least problems (the Average Control Area). The Southside Regeneration Area has 27 per cent in the abnormal range and 13 per cent borderline, compared with 6 per cent and 5 per cent in these categories respectively in the Average Control Area. While the findings are in the same general direction as other scales, they show less divergence between children across All Areas in this study and American population norms in terms of the proportion in the abnormal range (15.5% in all areas v. 10.3% in the American child population).

Figure 4.21: Peer Problems: Classification by normality ranges and comparison with US child population (4-17 years)



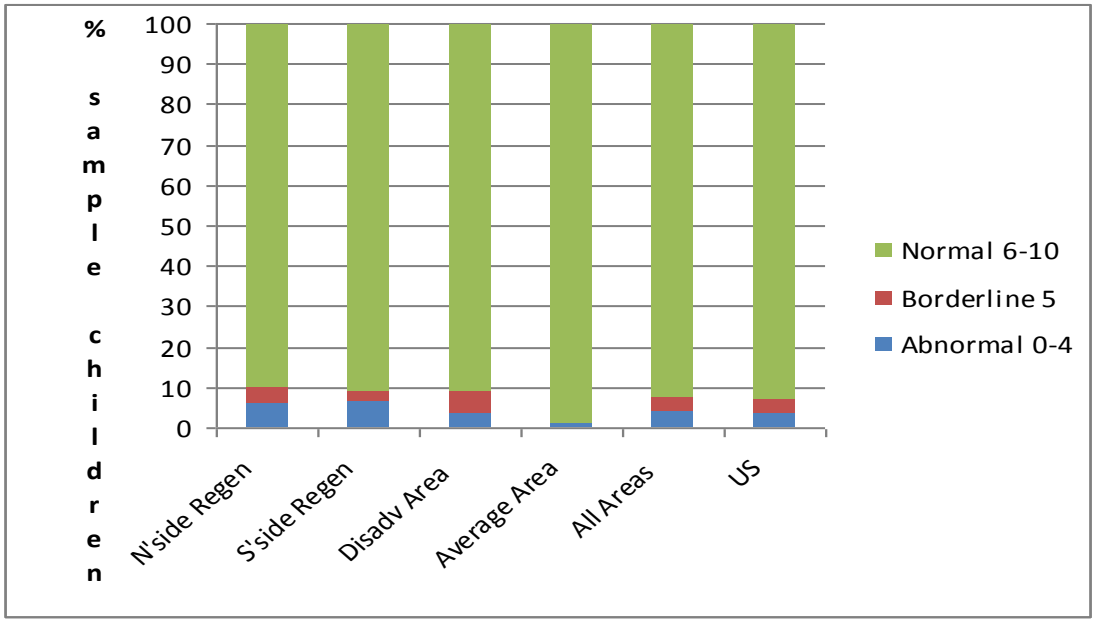
Statistical Tests: Chi Sq = 20.92 (df=6); Cramer's V=0.17, p<0.001
Note: American 4-17 year olds, Sample size N=9,878; All Area N=355

The Pro-social scale, which seeks to measure child strengths, takes into account aspects of the child's behaviour, such as the child being kind, helpful, considerate of other people's feelings, and prepared to share with other children. In this case higher scores, 6-10, are in the normal range. Much smaller proportions of children across all areas (1%) are in the abnormal or borderline ranges on this scale (Figure 4.22). All disadvantaged areas are very similar and the Average Control Area shows the smallest proportion in borderline and abnormal ranges. There are no statistically significant differences between the study areas on this indicator. Similarly, differences between the child population in All Areas in this study and American norms are very small.

Focusing on the Total Difficulties Scale (based on the four scales which measure difficulties and excluding the Pro-social Behaviour scale), the Southside Regeneration Area shows the most severe child difficulties (33% abnormal range and 14% borderline), followed by the Northside Regeneration Area (29% abnormal range and 6% borderline) and then the Disadvantaged Control Area (15% abnormal and 9% borderline). The Average Control Area has a profile of lesser child difficulties, with the lowest proportions in the abnormal (7%) and borderline ranges (7%). On this scale, there is a significant difference between the child population in All Areas and American norms. While 21.1 per cent of children in All Areas in this study are in the abnormal range and 8.7 per cent in the borderline range, the rates for the American child population are 7.4 per cent and 5.4 per cent respectively. According to the findings of the *Growing Up in Ireland* study (ESRI 2010), based on the mother's

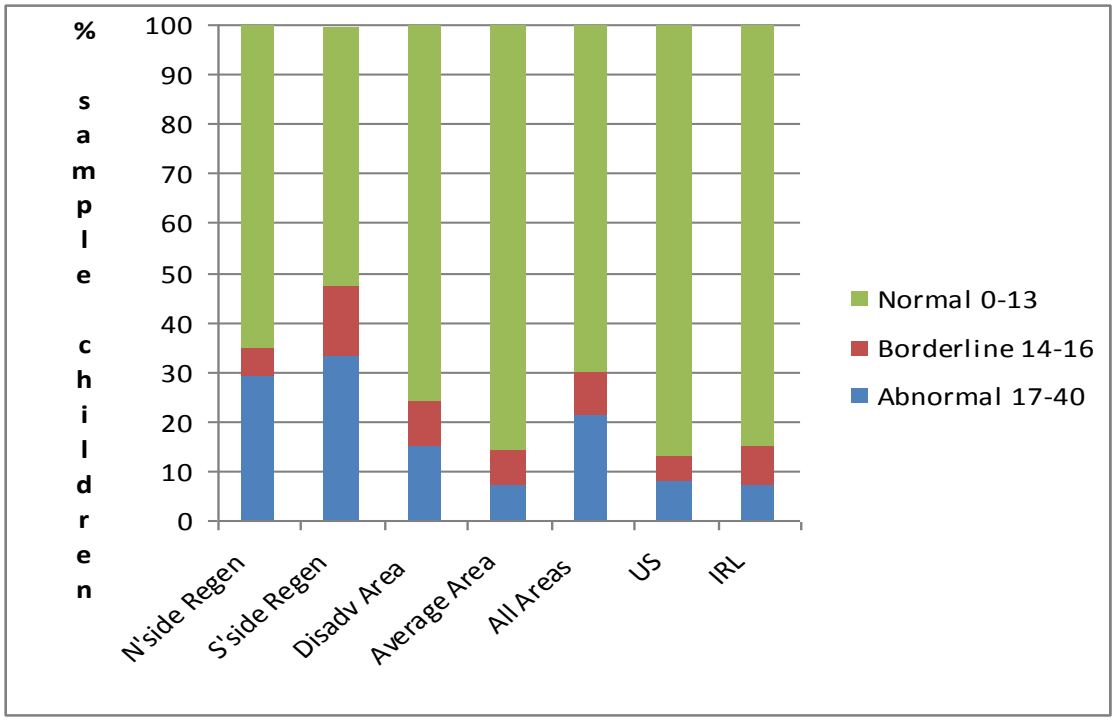
report, 85 per cent of nine-year old children are in the normal range, 8 per cent borderline and 7 per cent in the abnormal range (Figure 4.23).

Figure 4.22: Pro-Social Behaviour: Classification by Normality Ranges and Comparison with US Child Population (4-17 years)



Statistical Tests: Chi Sq = 8.86 (df=6); Cramer's V=0.11, p=0.18, not significant
Note: American 4-17 year olds, Sample size N=9,878; All Area N=355

Figure 4.23: Total Difficulties Scale: Classification by Normality Ranges and Comparison with US Children (4-17 years) and Irish 9 year olds



Statistical Tests between Four Study Areas: Chi Sq = 29.76 (df=6); Cramer's V=0.20, p<0.001

Drawing on these findings, average scores on scales which measure difficulties (Emotional Symptoms, Conduct Problems, Hyperactivity, Peer Problems, Total Difficulties), show relatively poor outcomes for children across All Areas in the study compared with norms for an American child population. It has also been established that the difficulties are more severe in the child population in the regeneration areas (below the average for All Areas). Consequently, it can be concluded that the proportion of children in the abnormal ranges in these areas is significantly above (i.e. greater than) what would be expected in a normal (American) child population. The proportion in the abnormal range in All Areas is also well above that reported for nine year olds in Ireland (ESRI, 2010).

A further finding here is that a larger number of children overall are in the abnormal range (75 children) compared with the number of children diagnosed with learning difficulties, behavioural problems or mental health problems (58 children). In the case of children with diagnosed learning, behavioural or mental health problems, twenty (20) of those are diagnosed with dyslexia or dyspraxia (which is not a behavioural problem). Thus the analysis suggests that many children with behavioural difficulties have not been diagnosed with such problems and that they are not being "picked up" by the system in primary care and / or education.

4.2.6 Child perceptions of strengths and difficulties

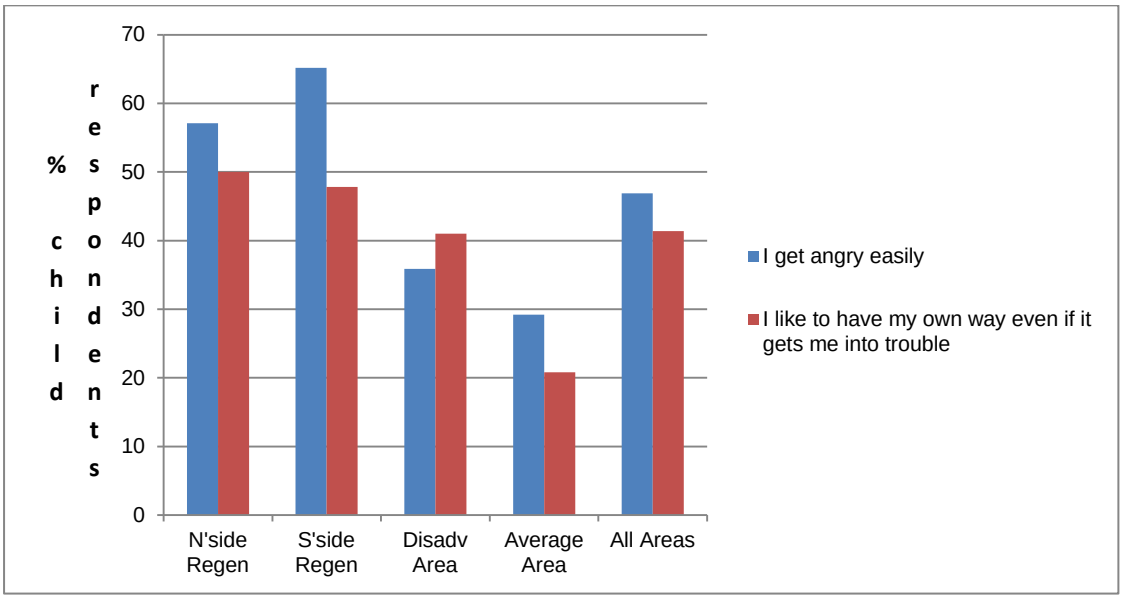
Some aspects of strengths and difficulties were explored with children in the child survey, in terms of their perception of themselves and their relationships with friends. The questions addressed to children address items explored in the Conduct Problems and Peer Problems scales.

A larger proportion of children in the regeneration areas report that they "get angry easily" compared with the control areas (Figure 4.24). This is highest in the Southside Regeneration Area (65%), followed by the Northside Regeneration Area (57%), and the Disadvantaged Control Area (36%), with the lowest in rate in the Average Area (29%). Larger proportions of children in the Disadvantaged Areas (Northside, 50%, Southside, 48% and Disadvantaged Control, 41%) compared with the Average Control Area (21%) report that they "like to get their own way even if it gets me into trouble". Differences between the areas on the latter indicator are not statistically significant.

Children have strongly positive perceptions of how they relate to their peers. Child perceptions overall and in the Regeneration Areas in particular are more positive that parent perceptions with reference to the sample child and the larger number of items explored (specific questions) with parents in the SDQ module. All children in the Southside Regeneration Area, the Disadvantaged Control Area and the Average Control Area state that they have some good friends and that they like being with their friends. While the proportion of children stating that "other kids like me, I'm popular" is highest in the Average Control Area (92%) and lowest in the Northside Regeneration Area (86%), positive self-

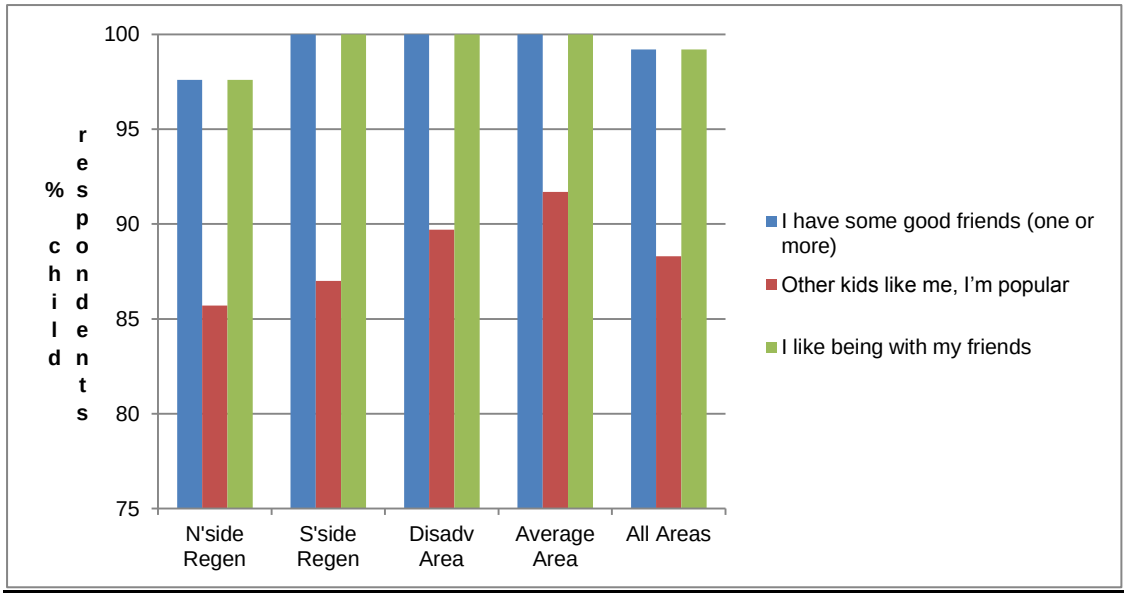
perceptions are high amongst children across all areas (Figure 4.25). Differences between the areas on these indicators are not statistically significant.

Figure 4.24: Conduct problems as perceived by the child



N All Areas=128; Statistical Tests: Angry easily Chi Sq=9.80(df=3), p<0.05 (p=0.02), Phi=0.28; Like to have own way=Not significant

Figure 4.25 Peer problems as perceived by the child



N All=128. Statistical Tests = not significant

4.2.7 Children and physical exercise

Lifestyle factors, including regularity of "hard" and "moderate" physical exercise are associated with positive outcomes for children in terms of health (physical fitness and lower body weight) and well-

being. The frequency at which the sample child takes physical exercise was explored with parents / carers.

More than half of children (57%) across all areas take at least 20 minutes of "hard" physical exercise every day or almost every day (Table 4.5). The proportion engaged in this level of "hard" physical exercise is largest in the Northside Regeneration Area (69%) and lowest in the Average Control Area (49%). However, the proportion of children taking the specified level of physical exercise three to four times per week is highest in the Average Control Area. If the cut-off is placed at three to four times per week *or more* then the rates for the Northside Regeneration Area (75%) and the two Control Areas (both 72%) are comparable, with the Southside Regeneration Area showing the lowest rate (59%). The differences between the two Regeneration Areas on this indicator could relate to better facilities in the northside communities, particularly Moyross, while the pattern in the Average Control Area could relate to more structure to "hard" physical exercise activities in this area.

Table 4.5: Frequency at which sample child takes at least 20 minutes "hard" physical exercise by area

Frequency	N'side Regeneration Area		S'side Regeneration Area		Disadvantaged Area		Average Area		All Areas	
	No.	%	No.	%	No.	%	No.	%	No.	%
Never	12	11.5	14	17.5	12	14.3	11	13.3	49	14.0
1-2 times per week	14	13.5	19	23.8	12	14.3	12	14.5	57	16.2
3-4 times per week	6	5.8	7	8.8	14	16.7	19	22.9	46	13.1
Almost / everyday	72	69.2	40	50.0	46	54.8	41	49.4	199	56.7
Total	**104**	**100**	**80**	**100**	**84**	**100**	**83**	**100**	**351**	**100**

Statistical tests: Chi Sq=21.48 (df=9); Cramer's V=0.14; p<0.05 (p=0.01)

In terms of frequency at which the sample child engages in at least 30 minutes of moderate physical exercise, there are no statistically significant differences between the areas. Across all areas, some 86 per cent of children engages in this level of physical exercise every day or almost every day and a small proportion overall (3%) never engages in at least 30 minutes of moderate physical exercise (Table 4.6).

Table 4.6: Frequency at which sample child takes moderate physical exercise by area

Frequency	N'side Regeneration Area		S'side Regeneration Area		Disadvantaged Area		Average Area		All Areas	
	No.	%	No.	%	No.	%	No.	%	No.	%
Never	3	2.8	3	3.6	2	2.2	5	5.3	13	3.4
1-2 times per week	7	6.5	5	6.0	3	3.2	2	2.1	17	4.5
3-4 times per week	7	6.5	7	8.3	5	5.4	4	4.2	23	6.1
Almost / everyday	91	84.3	69	82.1	83	89.2	84	88.4	327	86.1
Total	**108**	**100**	**84**	**100**	**84**	**100**	**95**	**100**	**380**	**100**

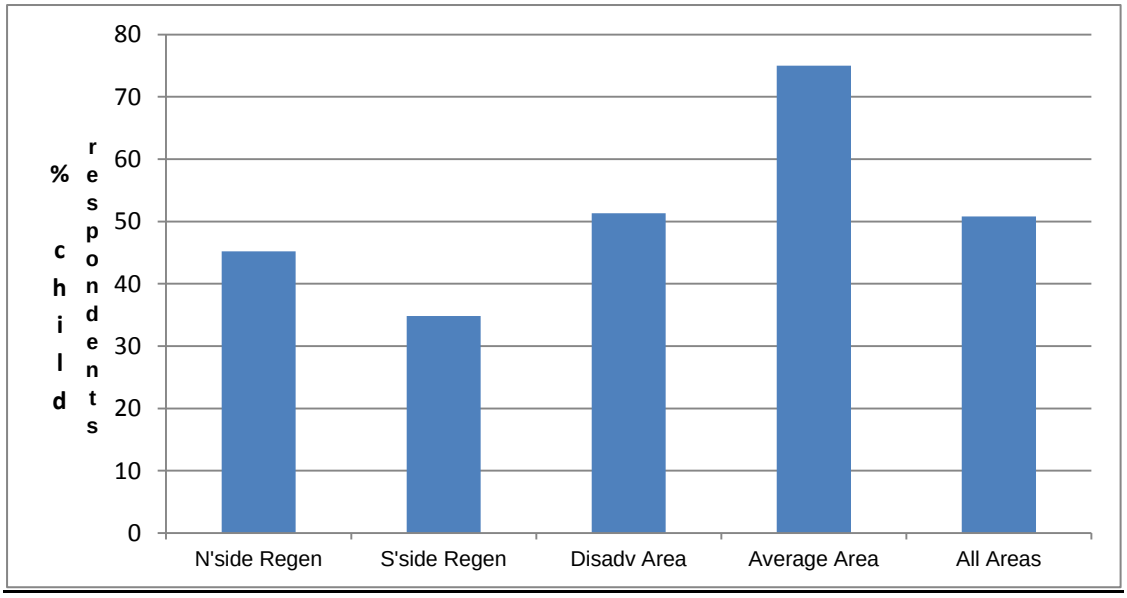
Statistical Tests: Not significant.

Note the larger number of cases here compared with the data on "hard" physical exercise. The cases taking moderate physical exercise including very young children who are walking / mobile.

The findings of the child survey give some support for the notion that there is more structure to physical exercise activities in the Average Control Area, compared with other areas, and better structure (in terms of membership of sports clubs) in the Northside Regeneration Area compared with the Southside Regeneration Area. Whether this is actually the case, and if so the reasons for it, would need to be investigated further.

Across all areas, just over half of the children surveyed (51%) are involved in a sport's club (Figure 4.26). The proportion of children in a sport's club is largest in the Average Control Area (75%), followed by the Disadvantaged Control Area (51%) and lowest in the Southside Regeneration Area 35%). In terms of the frequency of engaging in sport for at least 20 minutes (Table 4.7), the majority of children across all areas play sport every day (62%) and this is quite close to the proportion (57%) reported by parents / carers as doing at least 20 minutes "hard" physical exercise everyday / most days (also across all areas). A smaller proportion of children, compared with parents and carers, reports "never" playing sport or doing physical exercise for at least 20 minutes: 7 per cent across all areas reported by children compared with 14 per cent reported by parents / carers. Unlike the parent / carer report, there are no statistically significant differences between the areas on this indicator.

Figure 4.26: Child involvement in a sport's club by area



N All = 128; Statistical Tests: Chi Sq 8.51 (df=3), p<0.05 (p=0.04); Phi=0.26

Table 4.7: Frequency child respondent engages in sport / physical exercise by area										
	N'side Regeneration Area		S'side Regeneration Area		Disadvantaged Area		Average Area		All Areas	
Frequency of sport/physical exercise for at least 20 minutes	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Never	5	11.9	1	4.3	2	5.1	1	4.2	9	7.0
1-2 times per week	7	16.7	6	26.1	7	17.9	4	16.7	24	18.8
3-4 times per week	4	9.5	2	8.7	6	15.4	4	16.7	16	12.5
Almost / every day	26	61.9	14	60.9	24	61.5	15	62.5	79	61.7
Total	**42**	**100**	**23**	**100**	**39**	**100**	**24**	**100**	**128**	**100**

Statistical Tests: 4.12 (df=9), p=0.90; not significant

Children were asked on how many days of the week they do physical exercise for at least 60 minutes. Generally, children found it difficult to answer this question. Across all areas, 57 per cent report doing 60 minutes physical exercise seven days per week while some 13 per cent report doing 60 minutes physical exercise on "no days" (Table 4.8). The percentage reporting "no days" of this level of exercise is highest in the Northside Regeneration Area (24%), while the largest percentage reporting seven days per week is in the Average Control Area (75%). There are no statistically significant differences between the areas on this indicator.

Table 4.8: Frequency child respondent does physical exercise for at least 60 minutes per day, by area										
	N'side Regeneration Area		S'side Regeneration Area		Disadvantaged Area		Average Area		All Areas	
No. of days (in last 7) of physical exercise for one hour in total	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
0 days	10	23.8	2	8.7	2	5.1	2	8.3	16	12.5
1 day	3	7.1	0	0	1	2.6	1	4.2	5	3.9
2 days	2	4.8	2	8.7	4	10.3	2	8.3	10	7.8
3 days	0	0	2	8.7	2	5.1	0	0	4	3.1
4 days	0	0	1	4.3	5	12.8	0	0	6	4.7
5 days	5	11.9	1	4.3	3	7.7	0	0	9	7.0
6 days	1	2.4	1	4.3	2	5.1	1	4.2	5	3.9
7 days	21	50.0	14	60.9	20	51.3	18	75.0	73	57.0
Total	**42**	**100**	**23**	**100**	**39**	**100**	**24**	**100**	**128**	**100**

Statistical Tests: 28.87 (df=21), p=0.12; Cramer's V = 0.27; not significant

4.3 Education and Active Learning

Education and active learning, and support for the child in this process, were explored in both the parent / carer and child surveys. This involved a comprehensive assessment including structure of the child population in terms of type of school attended, childcare arrangements, assessment of progress in educational attainment, quality assessment of the school attended and of teaching, learning support,

parent / school relationships and child experiences in school. Child experiences in school also address outcomes related to feeling "secure in the immediate ... environment" and "safe from accidental and intentional harm".

4.3.1 Child population at school and type of school

The profile of the sample child population (parent / carer survey) in terms of types of school attended by area is shown in Table 4.9. Some 14 per cent of the sample children are not at school. This group is mainly children who have not yet started school (13%). Just under half of the children and, the largest proportion, are at primary school (49%). The next largest group, at just over one-fifth, is at secondary school (22%), 12 per cent attend playschool / pre-school, while 3 per cent attend a special school or other facility such as Youthreach. There are no statistically significant differences between the areas in the type of school attended.

Table 4.9: Type of school attended by sample child (parent / carer survey)

School type	N'side Regeneration Area		S'side Regeneration Area		Disadvantaged Area		Average Area		All Areas	
	No.	%	No.	%	No.	%	No.	%	No.	%
Playschool / Pre-school / montessori	14	11.8	14	15.6	12	11.5	12	11.4	52	12.4
Primary School	59	49.6	40	44.4	48	46.2	58	55.2	205	49.0
Secondary School	28	23.5	25	27.8	23	22.1	15	14.3	91	21.8
Special School	3	2.5	2	2.2	1	1.0	1	1.0	7	1.7
Other facility like Youthreach	2	1.7	1	1.1	1	1.0	0	0	4	1.0
None – left school	1	0.8	1	1.1	3	2.9	0	0	5	1.2
None – not started school	12	10.1	7	7.8	16	15.4	19	18.1	54	12.9
Total	**119**	**100**	**90**	**100**	**104**	**100**	**105**	**100**	**418**	**100**

Statistical Tests: not significant

In the child survey, with the exception of one case of a child who has left school, all are enrolled at school. In terms of the structure of the school population, some 65 per cent attend primary school, 29 per cent attend secondary school and 6 per cent attend another type of facility. Again, there are no statistically significant differences between the areas in terms of structure of the school population. Linked to these findings, the school population across all areas is relatively homogeneous, meaning that roughly similar proportions in the different areas "attend school" and are "not yet at school", and roughly similar proportions in the different areas attend the various types of school (pre-school, primary, secondary, special, other).

4.3.2 Childcare arrangements

Childcare arrangements for children not yet at primary school and in-school were explored in the parent / carer survey. Of children not yet in school (106 cases), just under half are minded in day care on a regular basis (i.e. two days per week or more). There are no differences between the areas on this indicator. Of those pre-school children in regular childcare, some 67 per cent are in a crèche, which is the most common type of childcare, just over one-quarter are cared for by an unpaid relative or friend, and 12 per cent by a childminder. The number of cases of pre-school children in regular childcare is small (51). Crèches are more important in the regeneration areas (linked to the presence of community crèches there). For instance, 75 per cent of children not yet at school in the Northside and 82 per cent in the Southside are in this type of care. In contrast, care by childminders is practically insignificant (1 case) in these areas. The findings related to types of childcare arrangements for pre-school children show no statistically significant differences between the areas.

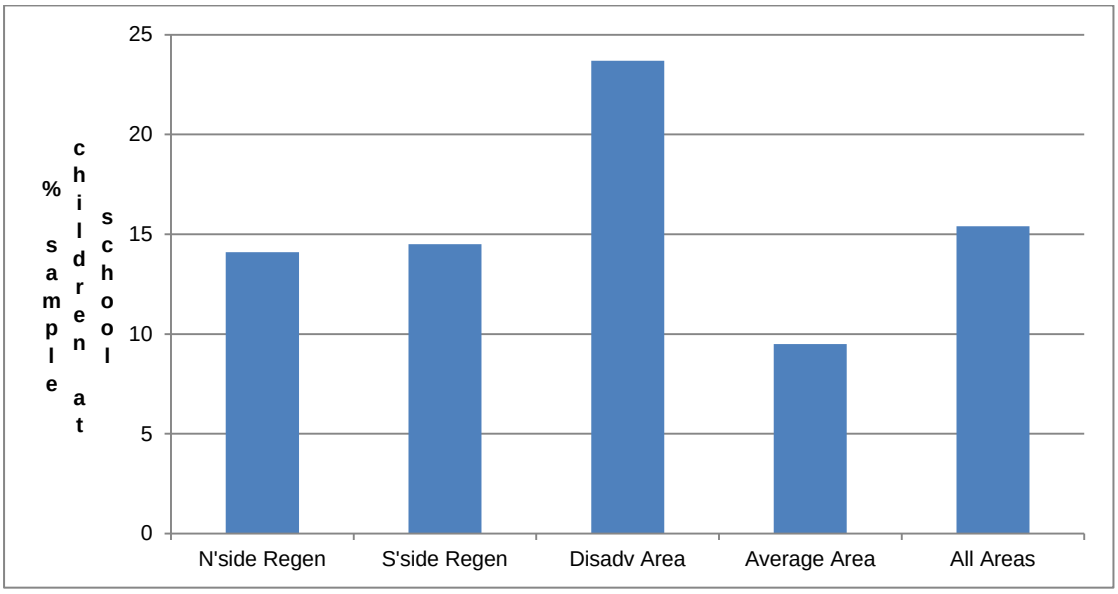
Focusing on children in school (primary / secondary) and those who have left school, children are mostly cared for by the parent / resident partner (84% across all areas). The next largest category is care by the child him/herself or by an older sibling (12%), followed by care by an unpaid relative / friend (8%). Only small proportions are cared for in an in-school facility (2%) or by a paid childminder (1%). The only arrangement which shows statistically significant differences between the areas is care by the child him/herself or by an older sibling. In the Southside Regeneration Area, some 20 per cent of school children (14 children) use this arrangement; it is next highest in the Northside Regeneration area (12%, or 11 children), followed by the Average Area (11% or 8 children) and lowest in the Disadvantaged Control Area (4% or 3 children).

4.3.3 Special educational needs and learning support

Findings related to the prevalence of children with special educational needs and learning support by area, as reported by parents / carers, were not as expected given the levels of deprivation in the regeneration areas, the designation of schools in these areas under the DEIS programme[17], and the likely profile of educational disadvantage in these areas. Across all areas, based on parents' / carers' reports, some 15 per cent of the child population at school are assessed as having special educational needs (Figure 4.27). The largest proportion assessed with special educational needs is in the Disadvantaged Control Area (24%), with approximately equal proportions in the regeneration areas (14% Northside and 15% Southside) and some 10 per cent in the Average Control Area. There are no statistically significant differences between the four areas on this indicator.

[17] However, it should be noted that not all children living in Regeneration Areas go to the local school in the area and not all attend schools with DEIS status.

Figure 4.27: Sample children assessed with special educational needs by area (%)



N All=312; N Northside=93; N Southside=69; N Disadvantaged=76; N Average=74
Statistical Tests: not significant

In terms of explanation of the lack of variation here, discussions with educational providers (teachers in focus group discussions) indicate that schools in regeneration and other disadvantaged areas make provision to address children's educational needs – i.e. they make provision for children who need extra support but do not have a formal assessment of special educational needs. This may be done by securing additional resources at school level (better pupil: teacher ratios, for instance), extra help in the classroom, and special schemes (such as Reading and Maths Recovery programmes) rather than going the route of assessments for individual children. While this arrangement might work well in terms of provision of additional support to children who need it in school, it can also mean that parents are not fully aware / informed of their child's level of education attainment relative to expectations for his / her age group and of the child's special educational needs.

Of those children assessed as having special educational needs as reported by parents (48 cases), 83 per cent (40) receive learning support and the remainder (17%, 8 children) do not. There are no differences between the areas on this indicator. Of the 40 children who are assessed as having special educational needs and who receive learning support, parents / carers are very satisfied (60%) or satisfied (25%) with the learning support provided, while the remaining 15 per cent are not satisfied with it. The number of cases by area is very small in terms of reporting the breakdown of findings here, and there are no statistically significant differences between the areas.

4.3.4 Parents' / Carers' engagement with the school / school staff

There is very high reported attendance of parents at parent / teacher meetings. Some 93 per cent of parents / carers attended a parent / teacher meeting concerning the sample child in the last twelve

months. Rates of attendance are highest in the Southside Regeneration Area (96%). There are no statistically significant differences between the areas.

Parents / carers were also asked whether they discussed specific issues with a teacher / member of staff at the school. There are differences by area in terms of the level of interaction between the school and parents on specific issues. For instance, there are higher rates of interaction between parents and school staff to discuss learning progress in all disadvantaged areas (42% Disadvantaged Control, 34% Northside Regeneration and 28% Southside Regeneration) compared with the Average Control Area (6%). On other issues, the main differences are between the Northside Regeneration Area (more interaction) and all other areas. For instance, non-attendance at school and the child's bad behaviour in school was discussed with teachers and parents to a greater extent in the Northside Regeneration Area (13% in each case) compared with other areas. Improvement in behaviour, attendance or performance, which could mean the need for improvement or actual improvement, (15%, Northside) and other children bullying or excluding the child (14%, Northside) were also discussed to a greater extent by parents and school staff in the Northside Regeneration Area compared with other areas – See Table 4.10 for details of findings and statistical tests.

Table 4.10: Whether parent / carer of sample child discussed any of the following with a teacher / school staff in the last 12 months by area											
Issues	**N'side Regen**		**S'side Regen**		**Disadvant-aged Area**		**Average Area**		**All Areas**		**Statistical tests**
	Yes, No.	**Yes, %**	**Yes, No.**	**Yes, %**	**Yes, No.**	**Yes, %**	**Yes, No.**	**Yes, %**	**Yes, No.**	**Yes, %**	
Learning progress	32	34.4	19	27.5	32	42.1	4	5.6	87	28.2	Chi Sq = 26.93 (df=3); Phi = 0.30; p<0.001
Cases N	**93**		**69**		**76**		**71**		**309**		
Non-attendance at school	12	12.9	2	2.9	2	2.6	1	1.4	17	5.5	Chi Sq = 14.29 (df=3); Phi = 0.21; p<0.001
Cases N	**93**		**69**		**76**		**72**		**310**		
Child's bad behaviour in school	12	12.9	3	4.3	1	1.3	4	5.6	20	6.5	Chi Sq = 10.34 (df=3); Phi =0.18; p<0.05 (p=0.02)
Cases N	**93**		**69**		**76**		**72**		**310**		
A teacher's behaviour towards the child	5	5.4	1	1.4	0	0	4	5.6	10	3.2	Not significant
Cases N	**93**		**69**		**76**		**72**		**310**		
Improvement in behaviour, attendance, performance	14	15.1	5	7.2	4	5.3	2	2.8	25	8.1	Chi Sq = 9.71 (df=3); p<0.05 (p=0.02); Phi=0.18
Cases N	**93**		**69**		**76**		**72**		**310**		
Other children bullying / excluding child	13	14.0	3	4.3	5	6.6	3	4.2	24	7.7	Chi Sq 7.61 (df=3), p=0.05, Phi = 0.16
Cases N	**93**		**69**		**76**		**72**		**310**		

4.3.5 Absence from school and school exclusion

Parents / carers were asked about the number of days the sample child was absent from school in the last school year (from September 2009). Across all areas, the most common period of absence is from one to five days (47%) while 17 per cent are absent for 11 days or more (11% for 11-20 days and 7% for more than 20 days).

The findings indicate that a larger proportion of children in regeneration areas are absent for more days (11-20 days and more than 20 days) compared with children from the control areas (Table 4.11). The largest proportion absent for more than twenty days is found in the Northside Regeneration Areas (11%). However, differences between the areas are not statistically significant. Based on discussions

with educational providers in specific schools, it would seem that school absences are under-reported by parents / carers. The rates of absence for 20 days or more are up to, and exceed, 30 per cent in some areas.

Table 4.11: Days sample child was absent from school in the previous 12 months by area

Absence	N'side Regeneration Area		S'side Regeneration Area		Disadvantaged Area		Average Area		All Areas	
	No.	%	No.	%	No.	%	No.	%	No.	%
0 days	11	11.8	4	5.8	11	14.7	7	10.4	33	10.9
1-5 days	37	39.8	34	49.3	36	48.0	36	53.7	143	47.0
6-10 days	26	28.0	16	23.2	16	21.3	16	23.9	74	23.4
11-20 days	9	9.7	11	15.9	7	9.3	6	9.0	33	10.9
More than 20 days	10	10.8	4	5.8	5	6.7	2	3.0	21	6.9
Total	**93**	**100**	**69**	**100**	**75**	**100**	**64**	**100**	**304**	**100**

Note: excluded those children "not in school last year" as well as those not started school yet
Statistical Tests: Chi 11.07(df=12), p=0.52, Cramer's V=0.19; not significant

The main reasons for absences cited by parents / carers were, in order: illness (87% across all areas) followed by the family going on holiday (11% across all areas), illness of a parent or a family problem (5% across all areas), and refusal by the child to go to school (4% across all areas). The only reason for absence where differences were close to statistical significance was the family going on holiday (Chi Sq=7.98 (df=3), Phi=0.17; p=0.05). In the Average Control Area, some 18 per cent of children were absent for this reason; 12 per cent in the Northside Regeneration Area, nine per cent in the Southside Regeneration Area and three per cent in the Disadvantaged Control Area.

In terms of school exclusion (suspension, being expelled), based on parent / carer reports, some four per cent of the sample children across all areas were excluded from school in the last 12 months. While rates of school exclusion were higher in the regeneration areas (8% in the Northside and 6% in the Southside) compared with the control areas (1% in each area), differences between the areas are not statistically significant.

4.3.6 Homework

Parents were asked about the frequency of the child getting homework from school, and the extent to which the parent / carer helps the child with homework. The vast majority of children across all areas get homework daily on most days (91%), and most of the remainder get homework a few times a week (7%). A small proportion overall are reported never to get homework (2%). The pattern in individual areas is very similar, and differences between the areas are not statistically significant.

Using child reports, 99 per cent across all areas state that they get homework from school. Some 83 per cent across all areas do their homework mainly at home, 13 per cent do it at a homework club and the remainder (4%) does it elsewhere. In the regeneration areas, a larger proportion compared with

other areas does homework in a homework club (17% in both regeneration areas compared with 8 per cent in the Average Control Area).

There are differences across areas in the frequency of parents / carers helping the child with homework. The largest percentages helping children always / almost always (44%) or regularly (31%) are found in the Average Control Area, which also has the smallest proportion never helping the child with homework (4%). The proportion helping the child always / almost always is lowest in the Southside Regeneration Area (19%). The proportion never helping the child with homework is largest in the Northside Regeneration Area (23%) followed by the Southside Regeneration Area (21%). The pattern in the Disadvantaged Control Area is "in-between" – i.e. more frequent support for the child with homework compared with the regeneration areas but less compared with the Average Control Area (Table 4.12).

Table 4.12: Frequency at which parent / carer helps sample child with homework, by area

Frequency	N'side Regeneration Area		S'side Regeneration Area		Disadvantaged Area		Average Area		All Areas	
	No.	%	No.	%	No.	%	No.	%	No.	%
Always / almost always	35	39.3	13	19.4	27	37.0	31	44.3	106	35.5
Regularly	10	11.2	25	37.3	18	24.7	22	31.4	75	25.1
Now and then	13	14.6	7	10.4	9	12.3	8	11.4	37	12.4
Rarely	11	12.4	8	11.9	6	8.2	6	8.6	31	10.4
Never	20	22.5	14	20.9	13	17.8	3	4.3	50	16.7
Total	**89**	**100**	**67**	**100**	**73**	**100**	**70**	**100**	**306**	**100**

Statistical Tests: Chi Sq = 29.46 (df=12); p<0.001; Cramer's V = 0.18

The pattern here could reflect differences in parents' own education (much lower levels of educational attainment by parents in the regeneration areas) and capacity to help the child, as well as different attitudes vis-à-vis the role of parents in the child's education.

4.3.7 Assessment of the educational attainment of the child

Parents were asked to assess how the child is performing at key subjects compared with expectations of attainment levels for the child's chronological age. They were asked to consider this with reference to the child's school report and parents' knowledge of the child's school work. The findings, both in relation to maths and English, show a similar pattern across all areas, and no statistically significant differences between the areas.

Focusing on attainment in maths (sums), across all areas, just over two-thirds of parents / carers rate the child's level of attainment as excellent (37%) or good (30%). The proportion rating the child's attainment in maths as excellent or good is lowest in the Disadvantaged Control Area (60%) followed by the Southside Regeneration Area (64%) and highest in the Average Control Area (75%). The proportion rating the child's attainment in maths as poor or very poor is highest in the Southside

Regeneration Area (16%) followed by the Northside Regeneration Area (12%) and lowest in the Average Control Area (4%) – Table 4.13.

Table 4.13: Parent / Carer assessment of how sample child is doing at maths (sums) compared with other children his/her age, by area

Levels	N'side Regeneration Area		S'side Regeneration Area		Disadvantaged Area		Average Area		All Areas	
	No.	%	No.	%	No.	%	No.	%	No.	%
Excellent	35	37.6	22	31.9	26	34.7	31	43.1	114	36.9
Good	29	31.2	22	31.9	19	25.3	23	31.9	93	30.1
Average	18	19.4	14	20.3	22	29.3	15	20.8	69	22.3
Poor	9	9.7	9	13.0	6	8.0	2	2.8	26	8.4
Very poor	2	2.2	2	2.9	2	2.7	1	1.4	7	2.3
Total	**93**	**100**	**69**	**100**	**75**	**100**	**72**	**100**	**309**	**100**

Statistical Tests: not significant

Focusing on parent / carer assessment of attainment in English (reading), some 82 per cent of parents across all areas rate the child's attainment as excellent (47%) or good (36%) while 6 per cent rate the level of attainment as poor (4%) or very poor (2%). In the Northside Regeneration Areas, the smallest proportion (69%) compared with other areas rate the child's attainment as excellent (38%) or good (31%) and the largest proportion (12%) compared with other areas rate the child's attainment in English as poor (10%) or very poor (2%). In the Average Control Area, some 82 per cent rate the child's attainment as excellent (53%) or good (29%) and only one per cent rates the child's attainment in English as poor or very poor.

The child was also asked to self-assess their performance in maths (sums), English (reading) and sport. A similar pattern is in evidence here in terms of higher ratings for attainment in English compared with maths, and no statistically significant differences between the areas. In terms of performance in maths (sums), 43 per cent of children consider themselves "very good" and 48 per cent "good" while 9 per cent rate themselves as "not very good" (Table 4.14). In the Southside Regeneration Area, a smaller proportion rate themselves as "very good" (35%) or "fairly good" (44%) and a larger proportion rate themselves as "not very good" (22%) compared with other areas. Again, the Average Control Area has the best profile – all children rate themselves as either "very good" (58%) or "fairly good" (42%) at maths (sums).

Focusing on attainment in English (reading), the vast majority of children across all areas rate their attainment as very good (71%) or fairly good (26%) and only a small proportion rate their level of attainment as not very good (3%) – Table 4.15.

In terms of whether the child considers him/herself good at sport (PE), some 70 per cent across all areas rate themselves as very good and a further 20 per cent as good, while 10 per cent rate themselves as not very good.

Table 4.14: Child respondent's perception of how good s/he is good at maths by area										
	N'side Regeneration Area		S'side Regeneration Area		Disadvantaged Area		Average Area		All Areas	
How good are you at maths?	No.	%	No.	%	No.	%	No.	%	No.	%
Very good	21	50.0	8	34.8	12	30.8	14	58.3	55	43.0
Fairly good	18	42.9	10	43.5	23	59.0	10	41.7	61	47.7
Not very good	3	7.1	5	21.7	4	10.3	0	0	12	9.3
Total	**42**	**100**	**23**	**100**	**39**	**100**	**24**	**100**	**128**	**100**

Statistical tests: Chi sq = 11.28 (df=6); p=0.08; Cramer's V = 0.21 Not significant

Table 4.15: Child respondent's perception of how good s/he is good at English / reading by area										
	N'side Regeneration Area		S'side Regeneration Area		Disadvantaged Area		Average Area		All Areas	
How good are you at English / reading?	No.	%	No.	%	No.	%	No.	%	No.	%
Very good	30	71.4	17	74.0	27	69.2	17	70.8	91	71.1
Fairly good	11	26.2	3	13.0	12	30.8	7	29.2	33	25.8
Not very good	1	2.4	3	13.0	0	0	0	0	4	3.1
Total	**42**	**100**	**23**	**100**	**39**	**100**	**24**	**100**	**128**	**100**

Statistical tests: Chi sq = 11.26 (df=6); p=0.08; Cramer's V = 0.21; Not significant

This research did not provide the opportunity to engage in objective testing of attainment levels of children in maths and English, nor were such data available to the Research Team. However, discussions with educational providers suggested that attainment levels are lower on average in schools in disadvantaged areas of the city (see Chapter 5). Furthermore, when conducting the fieldwork (one-to-one interviews), some children, particularly in the regeneration areas, found the language in the questionnaire quite difficult (e.g., they had difficulty following the sentences and understanding the questions asked) and generally showed less capacity to read the text as the interviewer conducted the child survey, and to complete the consent forms. Lower standards of educational attainment, linked to the profile of children enrolled in schools in disadvantaged areas, are a phenomenon established in the academic literature.[18] If this is the case in the Limerick context also, then the findings reported here (based on the parents' / carers' reports) exaggerate the levels of attainment of the child, particularly (but perhaps not only) in the regeneration areas. This would further suggest that parents in the most disadvantaged areas in particular, are not in a position to provide an assessment of educational levels achieved based on norms for attainment levels by chronological age.

4.3.8 Satisfaction with schools and teaching quality

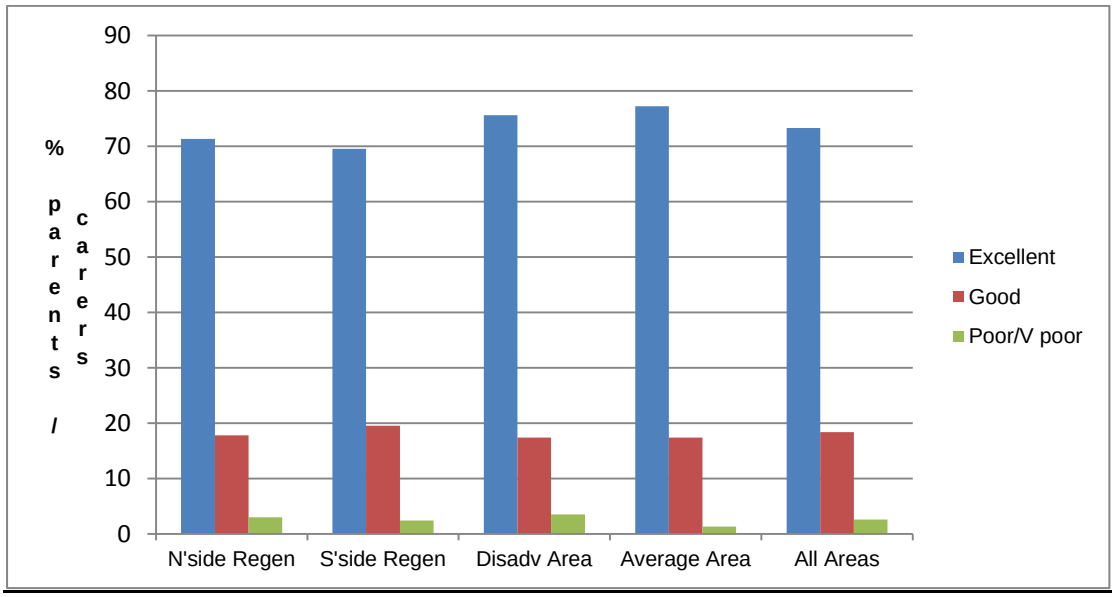
Parents / carers were asked about the extent to which they are satisfied: with the sample child's school or pre-school; with his/her teachers; and that the child is reaching his/her potential at school.

[18] Lower educational attainment levels in schools are often cited as one of the key sources of so-called neighbourhood effects in the problem of concentrated disadvantage.

Satisfaction ratings by parents / carers on all of these indicators are high, and there are no statistically significant differences between the areas.

In terms of parents' level of satisfaction with the child's school or pre-school, some 73 per cent across all areas rate the school as excellent and a further 18 per cent rate it good while three per cent rate the school as poor/very poor (Figure 4.28).

Figure 4.28: Parental / carer level of satisfaction with the sample child's school / pre-school

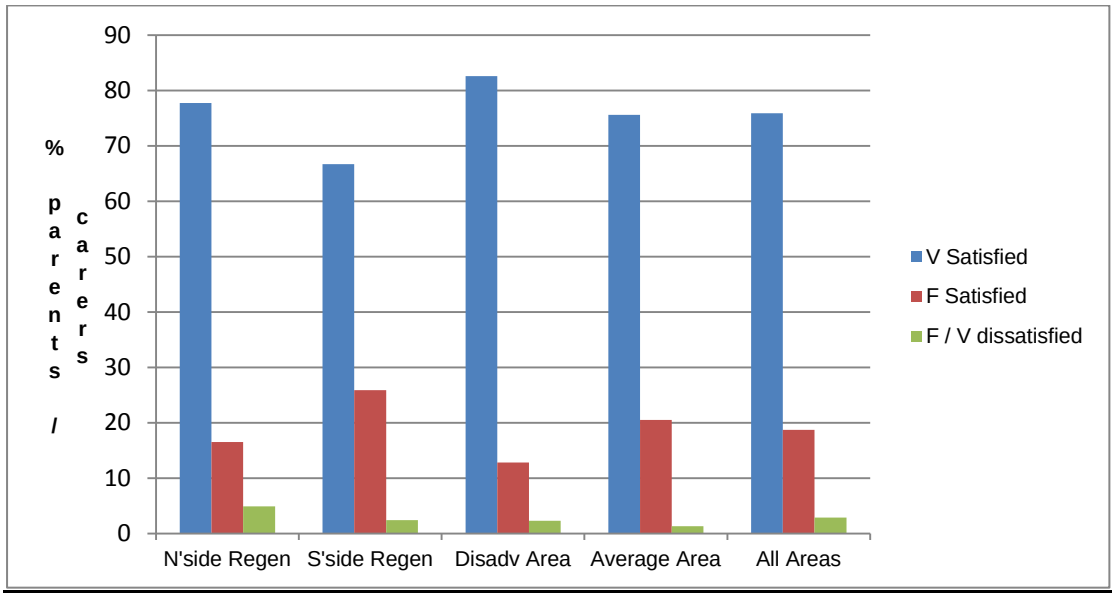


N All=348; N Northside=101; N Southside=82; N Disadvantaged=86; N Average=79
Statistical Tests: not significant

The pattern is similar for parent / carer satisfaction levels with the child's teachers. Some 76 per cent across all areas are very satisfied with the child's teacher(s) and a further 19 percent fairly satisfied, while three per cent are fairly dissatisfied or very dissatisfied (Figure 4.29).

With regard to parents' level of satisfaction that the sample child is reaching his/her potential, the large majority across all areas is very satisfied (76%) that the child is reaching his/her potential, a further 16 per is fairly satisfied, while 7 per cent is fairly dissatisfied or very dissatisfied. Levels of satisfaction of parents on this indicator are slightly lower in the Southside Regeneration Area (67% very satisfied and 10% fairly dissatisfied or very dissatisfied) but differences between the areas are not statistically significant.

Figure 4.29: Parental / carer level of satisfaction with the sample child's teachers



N All=348; N Northside=101; N Southside=82; N Disadvantaged=86; N Average=79. Statistical Tests: not significant

Focusing on the child's perspective, based on findings of the child survey, children mostly "like" school. Across all areas, some 59 per cent of children "like it a lot" (38%) or "like it a bit" (21%). In the Disadvantaged Control Area, the largest proportion compared with other areas "like it a lot" (54%). In the Southside Regeneration Area, children like school the least with 39 per cent finding it "just ok" while more than one-quarter "don't like it" / "don't like it at all" (26%). Differences between the areas, however, are not statistically significant (Table 4.16).

Table 4.16: Extent to which child respondent likes school by area

	N'side Regeneration Area		S'side Regeneration Area		Disadvantaged Area		Average Area		All Areas	
How much you like going to school?	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Like it a lot	14	33.3	6	26.1	21	53.8	7	29.2	48	37.5
Like it a bit	13	31.0	2	8.7	6	15.4	6	25.0	27	21.1
Just OK	9	21.4	9	39.1	6	15.4	7	29.2	31	24.2
Don't like it	3	7.1	4	17.4	5	12.8	3	12.5	15	11.7
Don't like it at all	3	7.1	2	8.7	1	2.6	1	4.2	7	5.5
Total	**42**	**100**	**23**	**100**	**39**	**100**	**24**	**100**	**128**	**100**

Statistical Test: not significant

Differences in the extent to which children like or dislike school according to the type / level of school were explored. The findings show very little difference between primary and secondary schools in the extent to which children like school – 40 per cent of children in primary school and 38 per cent in secondary school "like school a lot" and 19 per cent in primary and 24 per cent in secondary school "like school a bit". While the numbers attending other types of school are very small (7 in total), the largest proportion reporting that they "don't like" school or "don't like it at all" was

for these other schools (3 cases, 43%). This is not surprising in that these are children who were unable to remain in mainstream school. Similarly, there are no statistically significant differences by type of school.

The findings also indicate that children, generally, like their teachers. There are statistically significant differences between the areas here. Children in the Average Control Area like their teachers to the greatest extent with 86 per cent stating that they like the class teacher (they have just one) or like all teachers (Table 4.17). While the majority of children in the Southside Regeneration Area like their class teacher (52%) or all teachers (13%), significantly higher proportions here, compared with other areas, like "just one or two teachers" (13%) or no teacher (13%). In the Northside Regeneration Area, the smallest proportion, compared with other areas, like their class teacher (19%) or all teachers (33%).

Table 4.17: Extent to which child respondent likes his / her teacher(s) by area

	N'side Regeneration Area		S'side Regeneration Area		Disadvantaged Area		Average Area		All Areas	
How many of your teachers do you like?	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
My teacher – I just have one	8	19.0	12	52.2	21	53.8	15	62.5	56	43.7
All teachers	14	33.3	3	13.0	13	33.3	5	20.8	35	27.3
Some teachers	14	33.3	2	8.7	4	10.3	4	16.7	24	18.8
1-2 teachers	2	4.8	3	13.0	1	2.6	0	0	6	4.7
No teacher	2	9.5	3	13.0	0	0	0	0	7	5.5
Total	**42**	**100**	**23**	**100**	**39**	**100**	**24**	**100**	**128**	**100**

Statistical tests: Chi Sq 31.83 (df=12), p<0.001; Cramer's V = 0.29

The findings indicate that teacher(s) generally tell children when they are "doing well" at school. For instance, when asked whether the "teacher(s) tells me when I am doing well in school work", some 84 per cent of children across all areas indicate that this is definitely true, while an additional 12 per cent indicate that it is mostly true. Four per cent indicate that it is not true. There are no statistically significant differences between the areas on this indicator. However, children attending other types of school (7 cases) report to a greater extent that it is not true that teachers tell them when they are doing well at school (43%). Differences by type of school are statistically significant ($p<0.001$).

Other aspects of the relationship between children and teachers are explored with reference to safety at school - addressed below. The general findings, based on parent and child reports, are that there are high rates of satisfaction with school, relationships between parents and school (teachers) are good, and parents discuss their child's progress with teachers (high rates of attendance at parent / teacher meetings). Generally, the child's perception of school is positive, and the relationship between the child and teachers in school are good.

4.3.9 Expectations of progress in education

Parental expectations of the sample child's progress in education were explored. The key finding here is the high expectation by parents across all areas (81%) that their children will progress to third level education. The large majority of parents in regeneration areas aspire to third level education for the sample child (71% Northside and 73% Southside Regeneration Area). However, there are differences between the areas on this indicator – almost all parents in the Average Control Area (97%) expect their child to progress to third level education as compared to 71 per cent and 73 per cent in the Northside and Southside Regeneration Areas respectively. The Disadvantaged Control Area (81%) is situated between the Average Control and the regeneration areas on this indicator (Table 4.18).

Table 4.18: Parent / carer's expectations of how far the sample child will pursue education, by area

Education level	N'side Regeneration Area		S'side Regeneration Area		Disadvantaged Area		Average Area		All Areas	
	No.	%	No.	%	No.	%	No.	%	No.	%
To Junior Cert level	0	0	2	2.4	1	1.1	0	0	3	0.8
To Leaving Cert / Leaving Cert Applied level	29	28.2	21	24.7	17	9	2	2.3	61	16.7
Into apprenticeship / training	1	1.0	0	0	1	3	1	1.1	5	1.4
To Third Level education	73	70.9	62	72.9	4	76	85	96.6	296	81.1
Total	**103**	**100**	**85**	**100**	**89**	**100**	**76**	**100**	**365**	**100**

Statistical Tests: Chi Sq = 37.46 (df=9); p<0.001; Cramer's V=0.18

If the child's expectations of how far they will progress in education are considered, the pattern is somewhat similar. Some 75 per cent across all areas expect to progress to third level education (87%, Average Area, 77%, Southside Regeneration, 76% Disadvantaged Control and 65% Northside Regeneration). Differences between the areas are not statistically significant.

4.3.10 Safe in school

Various aspects of school life which provide indicators of the extent to which children feel safe in school were explored in the child survey. The large majority of children indicate that it is definitely true that they feel safe at school (90%). While the numbers are small, it is only in the regeneration areas that any children state it is not true that they feel safe at school (4 cases on the Northside, 10%; 1 case on the Southside, 4%). While sense of safety at school is greater in the control areas (in the Average Control Area, based on child reports, children feel most safe), the differences on this indicator are not statistically significant (Table 4.19).

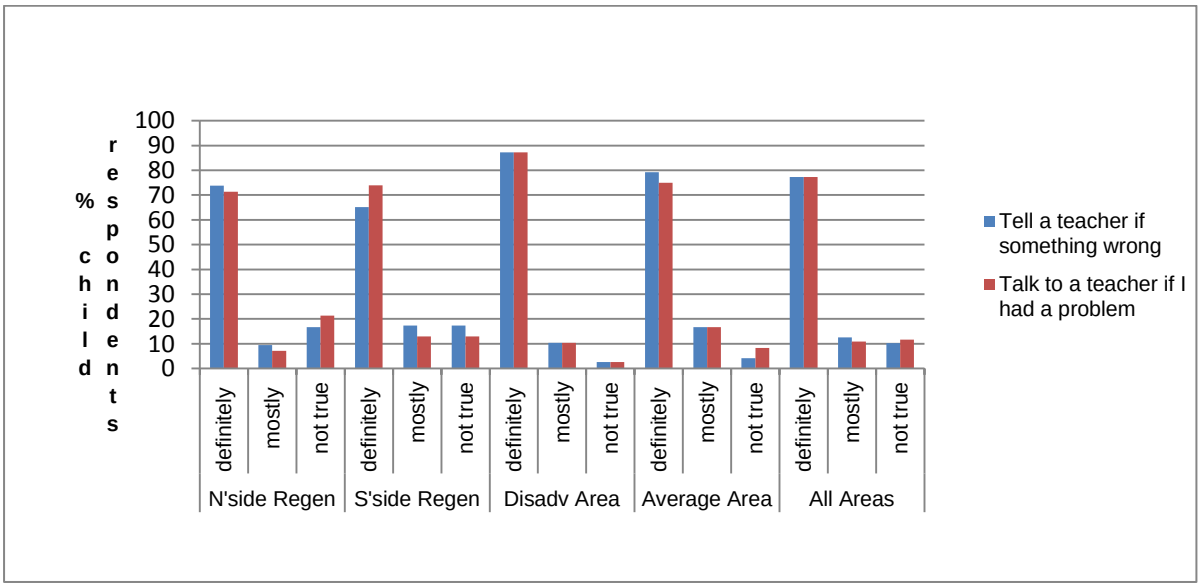
Table 4.19: Extent to which child respondent feels safe in school [training place] by area										
	N'side Regeneration Area		S'side Regeneration Area		Disadvantaged Area		Average Area		All Areas	
I feel safe in school?	No.	%	No.	%	No.	%	No.	%	No.	%
Yes, definitely true	36	85.7	20	87.0	36	92.3	23	95.8	115	89.8
Yes, mostly true	2	4.8	2	8.7	3	7.7	1	4.2	8	6.3
No, not true	4	9.5	1	4.3	0	0	0	0	5	3.9
Total	**42**	**100**	**23**	**100**	**39**	**100**	**24**	**100**	**119**	**100**

Statistical Tests: not significant

There are differences, however, by type of school ($p<0.05$). While the numbers are very small, children attending schools in the "other" category (7 cases in total) feel less safe (29% report it is not true that they feel safe at school).

Children were also asked whether they would talk to a teacher(s): (i) when something is wrong and (ii) if they had a problem. The high proportions, overall, who state that it is definitely true that they would talk to a teacher if something was wrong (77%) or if they had a problem (77%) are indicative of the good relationships, generally, between children and teachers. In the regeneration areas, however, relatively higher proportions of children compared to the other areas indicate it is not true that they would approach a teacher when something is wrong (17% for both Northside and Southside) or if they had a problem (21% Northside and 13% Southside). Again, the numbers are small overall and differences between the areas are not statistically significant (Figure 4.30).

Figure 4.30: Extent to which child could speak to a teacher(s) if problems, by area



N All=128; Statistical Tests – not significant

If these issues are explored by type of school (primary, secondary, other), higher proportions in the "other" category report that it is not true (i) that they would tell a teacher when something is wrong (57%) compared with primary (2%) or secondary school (16%) and not true (ii) that they could talk to a teacher if they had a problem (43% "Other" compared with 7% primary and 16% secondary school). The differences here are statistically significant.

In terms of discipline at school, the vast majority of children across all areas (91%) indicate that it is definitely true that they will "get into trouble if they break the rules" at school while most of the remainder (9% or all except one child) state that this is mostly true. Again, this is true to a lesser extent for children who attend school in the "other" category (86% definitely true) and secondary schools (78% definitely true) compared with children in primary school (96% definitely true). The differences here are statistically significant ($p<0.05$).

Specific incidents of bad behaviour towards the child and the location of such incidents, if they occurred, were explored in the child survey. The number of reported incidents overall is small, and there are no statistically significant differences between the areas. The rates reported by children are generally higher in the regeneration areas but, on some indicators, it is the Disadvantaged Control Area that has the highest rate. The specific incidents, and the rates of these incidents for each area in order of highest rates (worst) to lowest rates (best), are listed below. The reference period (over which the incidents occurred) is "the last few weeks" in all cases:

a) someone tried to or actually kicked me or hurt me – Southside (30%), Northside (19%), Disadvantaged Control (18%) and Average (8%);
b) someone said they would beat me up – Southside (22%), Northside (19%), Disadvantaged Control (10%) and Average (4%);
c) someone tried to make me give them money or my things – Southside (13%); Northside (10%), Disadvantaged Control (5%) and Average (4%);
d) someone tried to break or actually broke my things – Disadvantaged Control (10%), Southside (9%), Northside (5%), Average (0%);
e) someone said mean things about me – Disadvantaged Control (36%), Northside (33%), Southside (26%), Average (13%);
f) someone sent mean texts to me – Northside (5%), Southside (4%), Disadvantaged Control (3%) and Average (0%);
g) some left me out / excluded me – Disadvantaged Control (21%), Southside (17%) Northside (17%) and Average (8%).

Further details are provided in Appendix II (additional statistical tables).

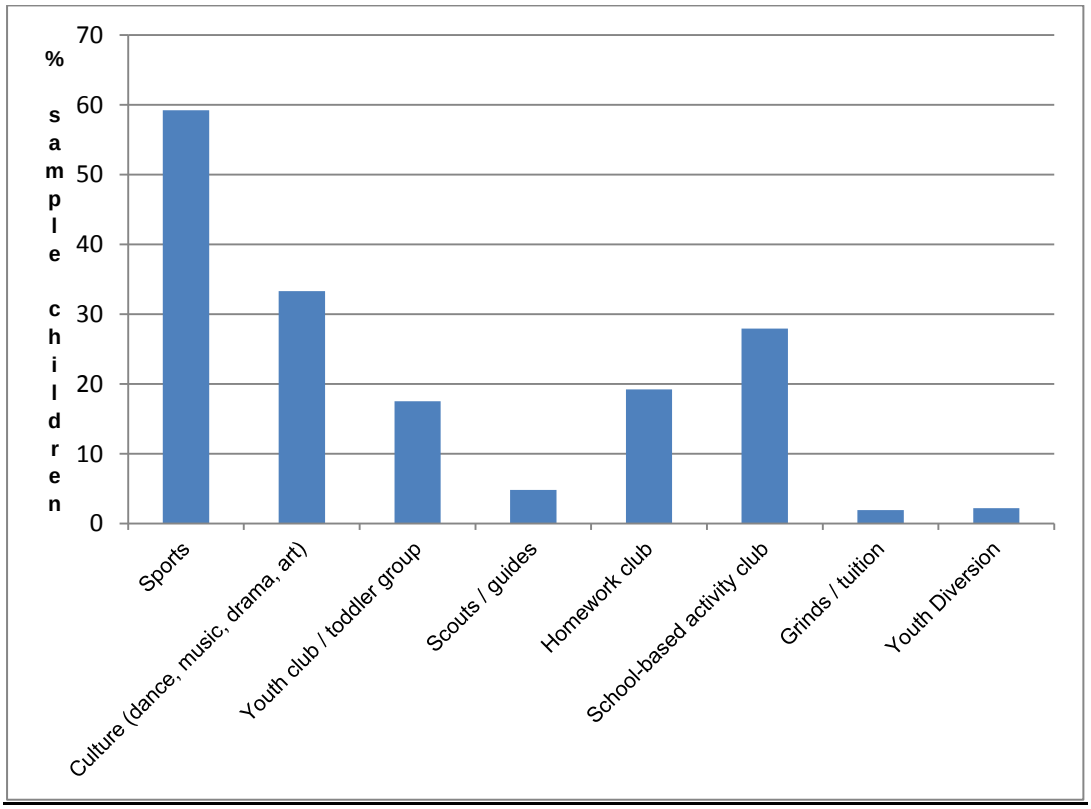
In terms of the location of such incidents, they are roughly equally divided between school and the area in which the child lives.

4.3.11 Involvement in activities outside of school

Acknowledging that education and active learning is not exclusively conducted in the school environment, the engagement of children outside of school and home, and the types of activities involved, were explored with parents / carers. Across all areas, some 65 per cent of sample children (all 418 cases, including infants) are engaged in activities outside of school and home. The rates are similar across all areas (67% Northside, 62% Southside, 60% Disadvantaged Control and 70% Average Control Area) and there are no statistically significant differences between the areas.

The types of activities in which children are involved are shown in Figure 4.31 below. The largest proportion across all areas are involved in sports (59%) followed by cultural activities such as music, dance, drama, art (33%), a school-based activity club (30%), a homework club (19%) and a youth club / parent and toddler group (18%).[19]

Figure 4.31: Types of activities in which the sample child is involved – All areas



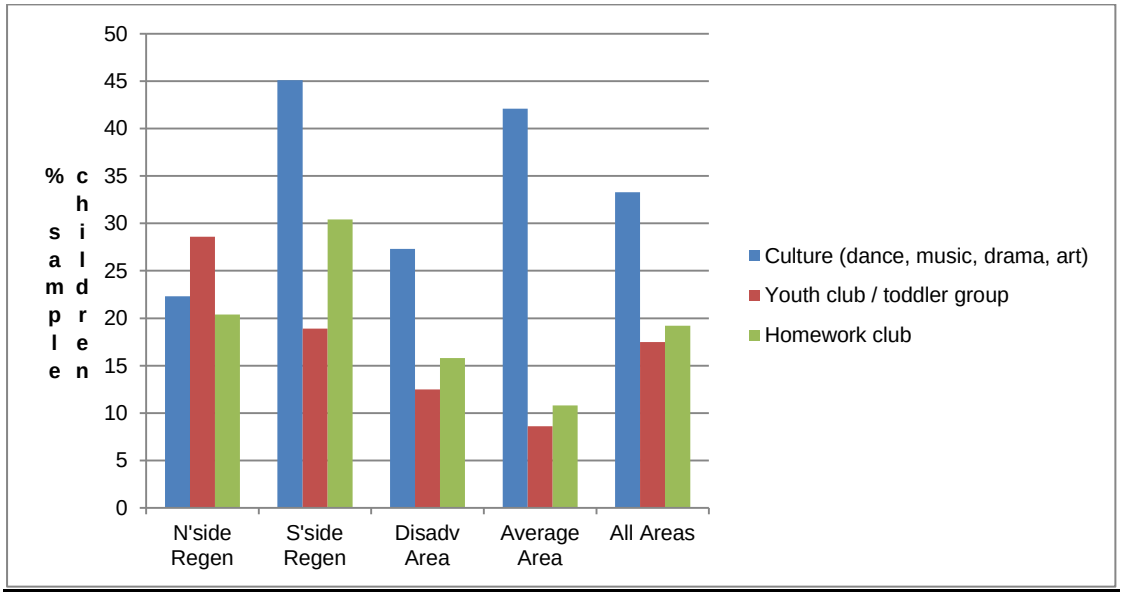
N All Scouts / guides, homework club, school-based activity, grinds / tuition, Youth Diversion=312; N All Sports=316; Culture=318; Youth club / parent toddler group=418

In relation to some of these activities – shown in Figure 4.32 below – the differences between areas are statistically significant. The largest proportion of children involved in cultural activities (dance, music, art) is in the Southside Regeneration Area (45%) followed by the Average Control Area

[19] The number of cases varies with reference to some activities – engagement in sport and cultural activities includes some children not yet at primary school while the category youth club / toddler group applies to all children. The remainder apply to children who have started primary school.

(42%). The high rate of participation in the Southside Regeneration Area seems to be associated with the availability of tuition in music in the schools. There are higher participation rates in youth clubs and parent / toddler groups in the regeneration areas, highest in the Northside (29%) followed by the Southside Regeneration Area (19%). This is associated with the availability of such services in these areas. While some could be targeted services (e.g. Youth Diversion), parents report them as youth clubs. Linked to better provision in the regeneration areas – especially on the Southside – there are higher rates of participation in homework clubs in these areas (30% Southside and 20% Northside).

Figure 4.32: Sample child's involvement in specific activities, by area

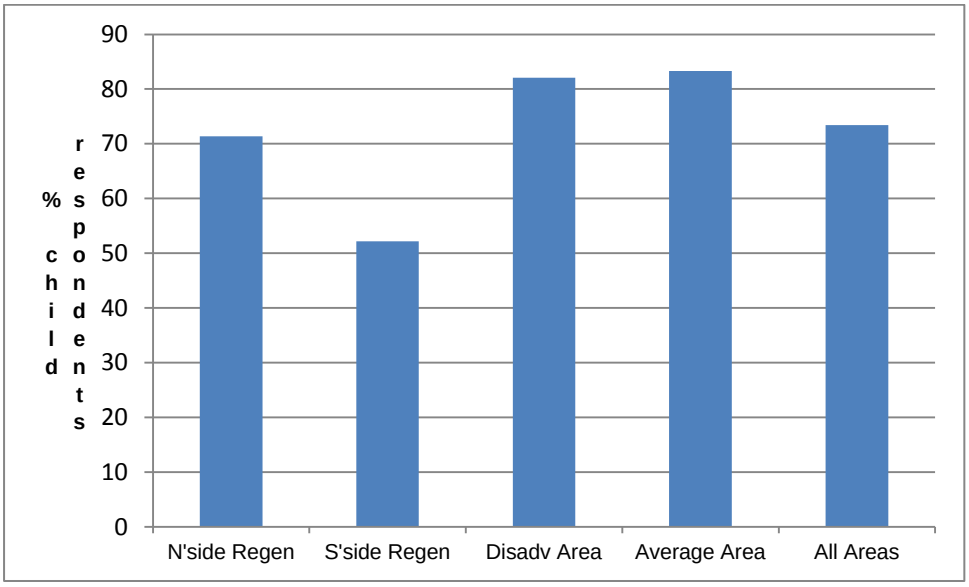


Statistical Tests: Cultural activities: Chi Sq=13.42 (df=3); Phi=0.21; p<0.001; Youth clubs / toddler group: Chi Sq=17.85 (df=3); Phi=0.21; p<0.001; Homework club: Chi Sq=9.62 (df=3); p<0.05 (p=0.02)

Children were also asked about activities in which they engage when they are not in school. There is a high degree of consistency in reported activities by parents / carers and by children. Larger proportions of children report engaging in sport / going swimming (82%) compared with parents'/ carers' reports of child engagement in this activity. This, in part, is explained by the age group of the child survey (children from 7 to 17 years) compared with the parent survey (a sample child from birth to 17 years in the latter). The activity mentioned most often by children is "hanging out with friends" (91%) while 79 per cent report "helping with jobs at home" and 19 per cent babysitting younger children. The large majority also reports watching TV and / or playing computer game (89%).

Related to education and active learning, children were asked whether they "read books for fun". Rates are highest in the Average Control Area (83%) and lowest in the Southside Regeneration Area (52%). The differences between areas are statistically significant (Figure 4.33)

Figure 4.33: Whether child respondents read book for fun (% yes)



N All=128; Statistical Tests: Chi Sq (df=3); p<0.05 (p=0.04), Phi =0.25

4.3.12 Parents' education

It has been established already in profiling parent /carer respondents (Chapter 3) that levels of educational attainment of parents is much lower in the regeneration areas, particularly compared with the Average Control Area. Parental education levels and parent engagement in education influences the child's educational outcomes and attitudes toward education (Deforges and Abouchaar, 2003). Parents were asked whether since leaving full-time education they have done, or are currently doing, any courses or adult education classes. They were also asked about their orientation towards adult education opportunities in future.

It is in the Average Control Area (where education levels of parents are highest) that the largest proportion of parents / carers is currently (6%) or has in the past (69%) undertaken adult education courses (Table 4.20). In the Southside Regeneration Area, while a small proportion is engaged with adult education at present (2%), rates of engagement in adult education in the past (64%) are high relative to the Northside Regeneration Area (38%). It is in the Northside Regeneration Area that the largest proportion has not engaged in adult education since leaving full-time education (56%).

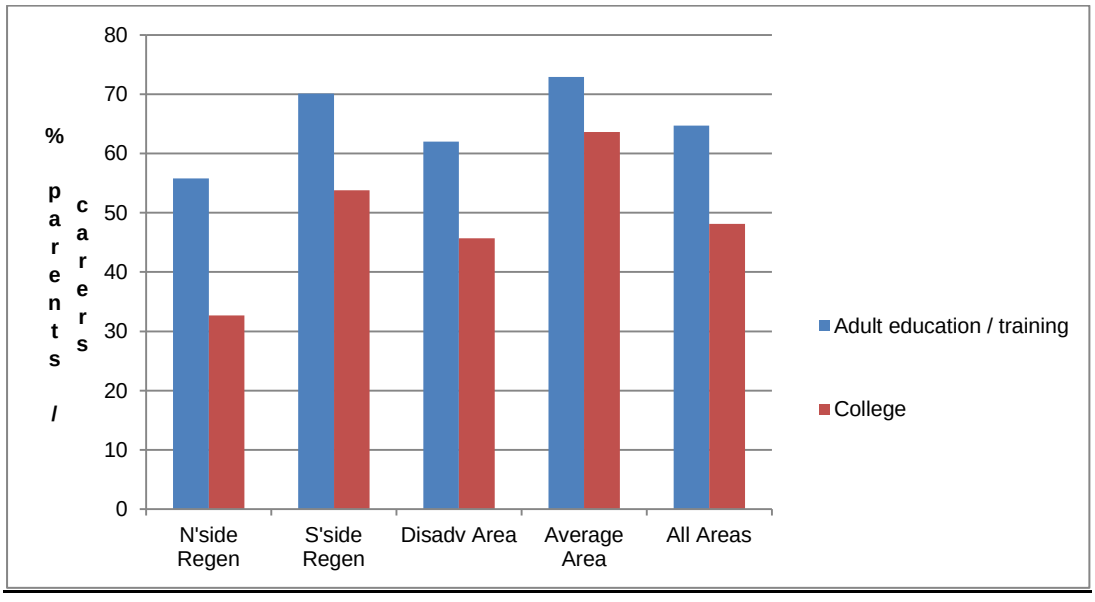
Association between engagement in adult education and family structure (single v. two parent families) was explored. The findings show that there is no difference in engagement in adult education between single parents and parents living as a couple (married or cohabiting).

Table 4.20: Whether respondent parent / carer has undertaken adult education since leaving full-time education, by area										
Adult education participation	**N'side Regeneration Area**		**S'side Regeneration Area**		**Disadvantaged Area**		**Average Area**		**All Areas**	
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Yes, doing currently	8	6.7	2	2.2	2	1.9	6	5.7	18	4.3
Yes, did in the past	45	37.8	58	64.4	53	51	72	68.6	228	54.5
No	66	55.5	30	33.3	49	47.1	27	25.7	172	41.1
Total	**119**	**100**	**90**	**100**	**104**	**100**	**105**	**100**	**418**	**100**

Statistical tests: Chi Sq=30.37 (df=6), p<0.00; Cramer's V=0.19

Parents in the Average Control Area have the strongest orientation towards on-going / further education. In the Average Control Areas, just under three-quarters (73%) would like to participate in adult education and 64 per cent would like to go to college. A large proportion of parents in the Southside Regeneration Area, where educational levels are low, also report that they would like to pursue adult education (70%) and college (54%). The lowest proportion reporting a desire to pursue further educational opportunities or go to college is in the Northside Regeneration Area (56% adult education and 33% college). Differences between the areas on both of these indicators are statistically significant (Figure 4.34).

Figure 4.34: Parents' / carers' orientation towards education in future



Return to adult education N All=388 Northside N=113; Southside=87; Disadvantaged=92; Average=92
Go to college N All=362; Northside N=104; Southside N=78; Disadvantaged N=92; Average N=88
Statistical Tests:

(a) Return to adult education: Chi Sq=14.62 (df=6), p<0.05 (p=0.02); Phi=0.19
(b) Go to college: Chi Sq=20.76 (df=6); p<0.001; Phi=0.22

The association between orientation towards adult education in the future (in the next two years) and family structure was explored. While respondents in two parent families report that they are more likely to participate in adult education (61%) compared with single parents (59%), the differences here are small and not statistically significant.

4.4 Relationship with the Child and Parenting

Various aspects of the parent-child relationship, including family activities, quality of the relationship, monitoring of the child's activities and problems in the family were explored with parents and the child. These issues are relevant to the child outcomes "safe from accidental and intentional harm" and "part of positive networks of family".

4.4.1 Family activities

Parents / carers were asked about the frequency of engaging in family-based activities with the sample child. These activities include: watching TV, having a meal together, going shopping, visiting relatives and various types of outings.

Having a meal together is the activity in which parents and children engage with the greatest frequency. Across all areas, some 96 per cent have a meal together most days. Watching TV and / or playing computer games is next in order, with 75 per cent doing this most days. There are no differences between the areas on frequency of engagement in these activities.

There are differences between the areas in the frequency of engaging in all other family activities. In terms of going shopping, the pattern is one of more frequent shopping with the sample child in the regeneration areas. Thus 33 per cent of parents in the Northside Regeneration Area and 28 per cent in the Southside Regeneration Area report shopping with the sample child most days, as compared to rates of 15 per cent and 10 per cent in the Disadvantaged Control Area and Average Control Area respectively (Table 4.21). Across all areas the most common pattern is shopping less often than most days but at least once a week and more than half of the parents / carers report this level of activity with the sample child in the Average Control Area (61%) and Disadvantaged Control Area (56%). These differences between area are perhaps associated with differences in economic circumstances (more income in the Average Area), differences in planning household expenditure (budgeting), availability of transport and time available to parents (e.g. more households with cars and more parents working in the Average Area).

Table 4.21: Frequency of going shopping with sample child, by area										
How often do you go shopping?	**N'side Regeneration Area**		**S'side Regeneration Area**		**Disadvantaged Area**		**Average Area**		**All Areas**	
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Most days	39	33.1	25	28.4	15	14.6	10	9.7	89	21.6
Less often but at least once a week	43	36.4	29	33.0	58	56.3	63	61.2	193	46.8
Less than once a week	21	17.8	18	20.5	14	13.6	19	18.4	72	17.5
Never / almost never	15	12.7	16	18.2	16	15.5	11	10.7	58	14.1
Total	**118**	**100**	**88**	**100**	**103**	**100**	**103**	**100**	**412**	**100**

Statistical Tests: Chi Sq 34.59, (df=9), p<0.001, Cramer's V =0.17

With regard to activities centred on sport, the largest proportion of parents / carers never or almost never play or watch sport, or go to games / matches with the sample child (47%) while approximately one-quarter do this less often than most days but at least once a week. The rate of never engaging in this type of activity is higher in all the disadvantaged areas (55% Southside, 51% Disadvantaged Control, 47% Northside) compared with the Average Area (36%) – Table 4.22.

Table 4.22: Frequency of playing sport / going to matches with sample child, by area										
How often do you play sports / go to matches?	**N'side Regeneration Area**		**S'side Regeneration Area**		**Disadvantaged Area**		**Average Area**		**All Areas**	
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Most days	22	19.3	14	16.3	13	12.9	5	4.9	54	13.4
Less often but at least once a week	23	20.2	12	14.0	23	22.8	41	40.2	99	24.6
Less than once a week	15	13.2	13	15.1	14	13.9	19	18.6	61	15.1
Never / almost never	54	47.4	47	54.7	51	50.5	37	36.3	189	46.9
Total	**114**	**100**	**86**	**100**	**101**	**100**	**102**	**100**	**403**	**100**

Statistical Tests: Chi Sq 29.19 (df=9), p<0.001, Cramer's V =0.16

With regard to the frequency of visiting friends or relatives with the sample child, the largest proportion of parents does this most days (44%) followed by once a week (38%). Visits most days are more common in the regeneration areas (Southside 56% most days; Northside 53% most days) and least common in the Average Control Area (23% most days). In the latter area, the majority and largest proportion of respondents visit friends and relatives once a week (61%) – Table 4.23.

In terms of going out for something to eat or on an outing (e.g., cinema), the largest proportion of parents / carers does this with the child once a week (46%) and the next largest proportion, less than once a week (30%). Rates of going out with the child once a week or more often (most days) are highest in the Average Control Area (63%) compared with other areas (43% Northside, 51% Southside, 54% Disadvantaged Control). In the regeneration areas, the largest proportion (25% in each area) compared with other areas never, or almost never, goes for an outing with the child – Table 4.24.

Table 4.23: Frequency of visiting friends or relatives with sample child, by area										
How often do you visit friends or relatives?	**N'side Regeneration Area**		**S'side Regeneration Area**		**Disadvantaged Area**		**Average Area**		**All Areas**	
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Most days	62	52.5	50	56.2	47	45.2	24	23.3	183	44.2
Less often but at least once a week	36	30.5	21	23.6	39	37.5	63	61.2	159	38.4
Less than once a week	13	11.0	10	11.2	10	9.6	14	13.6	47	11.4
Never / almost never	7	5.9	8	9.0	8	7.7	2	1.9	25	6.0
Total	**118**	**100**	**89**	**100**	**104**	**100**	**103**	**100**	**414**	**100**

Statistical Tests: Chi Sq 41.22 (df=9), p<0.001, Cramer's V =0.18

Table 4.24: Frequency of going out for something to eat / cinema / outing with sample child, by area										
How often do you go out for something to eat / cinema / outing?	**N'side Regeneration Area**		**S'side Regeneration Area**		**Disadvantaged Area**		**Average Area**		**All Areas**	
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Most days	15	12.7	5	5.7	3	2.9	2	2.0	25	6.1
Less often but at least once a week	36	30.5	40	45.5	52	51.0	62	60.8	190	46.3
Less than once a week	37	31.4	21	23.9	32	31.4	31	30.4	121	29.5
Never / almost never	30	25.4	22	25.0	15	14.7	7	6.9	74	18.0
Total	**118**	**100**	**88**	**100**	**102**	**100**	**102**	**100**	**410**	**100**

Statistical Tests: Chi Sq 39.33 (df=9), p<0.001, Cramer's V =0.18

Some 45 per cent of parents / carers go for walks / bike rides with the sample child most days, while just over one-quarter (26%) never or almost never engages in this activity. Larger proportions in the disadvantaged areas compared with the Average Control Area never or almost never engages in this activity (36% Southside, 29% Northside, 29% Disadvantaged Control, 10% Average Control Area) (Table 4.25). Differences here could be related to the quality of the environment of neighbourhood, particularly, the poorer environment (physical and in terms of safety) in the Southside Regeneration Area.

The data on activity patterns were re-coded to create a composite score (an average) across all family activities, in order to assess whether there are differences between the areas in the intensity of family-based activities (parent with the child). Based on these scores, there are no differences between the areas. This, in turn, indicates that families in the different areas undertake a roughly equivalent level of activities together but there are differences in the frequency with which they undertake specific types of activities between the areas. Variations seem to be associated with differences in economic circumstances, social factors and the environment in the neighbourhood.

Table 4.25: Frequency of going for walks / bike rides with sample child, by area										
How often do you go for walks or bike rides?	**N'side Regeneration Area**		**S'side Regeneration Area**		**Disadvantaged Area**		**Average Area**		**All Areas**	
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Most days	52	44.1	34	38.6	50	48.1	50	48.5	186	45.0
Less often but at least once a week	19	16.1	14	15.9	17	16.3	32	31.1	82	19.9
Less than once a week	13	11.0	8	9.1	7	6.7	11	10.7	39	9.4
Never / almost never	34	28.8	32	36.4	30	28.8	10	9.7	106	25.7
Total	**118**	**100**	**88**	**100**	**104**	**100**	**103**	**100**	**413**	**100**

Statistical Tests: Chi Sq 26.32 (df=9), p<0.001, Cramer's V =0.15

4.4.2 Parenting and quality of parent / child relationship

Parents / carers were asked to assess how well they are coping with parenting / caring for their child(ren) at present. The majority across all areas (58%) indicates that they are "coping pretty well" while an additional 39 per cent indicates that "sometimes they are coping well, but sometimes things get on top of me". Approximately 4 per cent indicates they are either "hardly ever coping" or "not coping these days". Differences between the areas are statistically significant (Table 4.26). The area where parents are coping best is the Average Control Area (73% coping well, and 25% stating sometimes things get on top of me), followed by the Disadvantaged Control Area (58% and 39% respectively for these two categories), and the Northside Regeneration Area (52% and 43% respectively). In the Southside Regeneration Area more parents / carers report that "sometimes things get on top of me" (49%) than consider that they are coping well (47%).

Table 4.26: Self-assessment of how well parent / carer is coping with parenting / caring for their children, by area										
Categories	**N'side Regeneration Area**		**S'side Regeneration Area**		**Disadvantaged Area**		**Average Area**		**All Areas**	
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Coping pretty well	62	52.1	42	46.7	60	58.3	77	73.3	241	57.8
Sometimes coping well, sometimes things get on top of me	51	42.9	44	48.9	40	38.8	26	24.8	161	38.6
Feel I'm hardly ever coping	2	1.7	4	4.4	2	1.9	2	1.9	10	2.4
Not coping these days	4	3.4	0	0	1	1.0	0	0	5	1.2
Total	**119**	**100**	**90**	**100**	**103**	**100**	**105**	**100**	**418**	**100**

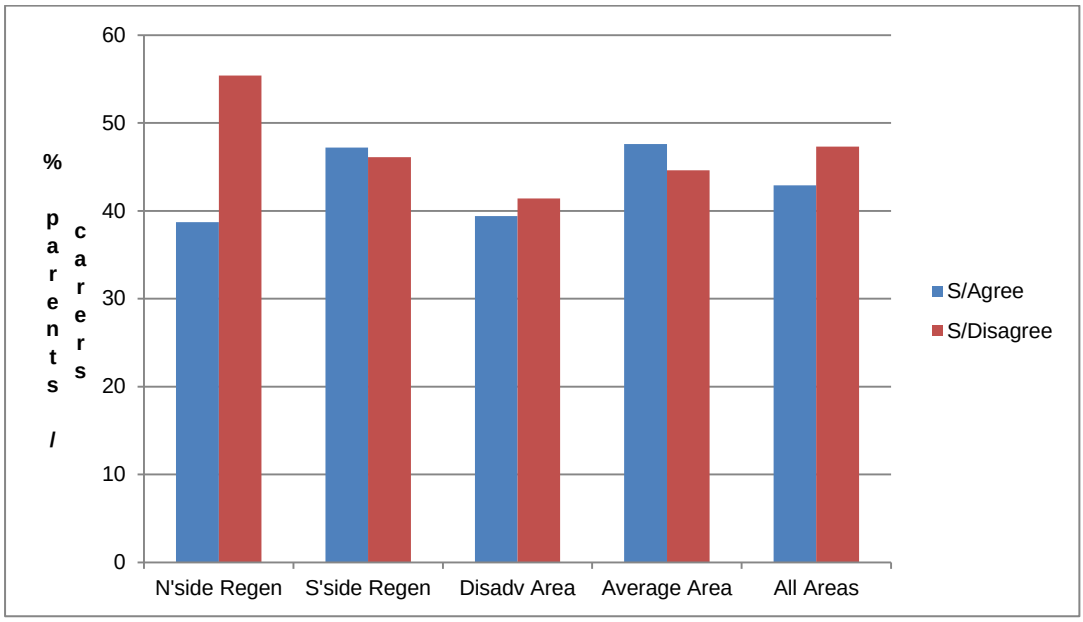
Statistical Tests: Chi Sq 24.27 (df=9), p<0.001, Cramer's V =0.14

The quality of the parent / child relationship was explored with reference to positive indicators (warmth and involvement, 3 items) and negative indicators (hostility and criticism, 2 items). The vast majority of parents across all areas strongly agree (92%) or agree (6%) that they have a "warm affectionate relationship" with the sample child. Eight parents (2%) disagree / strongly disagree with

this statement. Similarly, the vast majority of parents across all areas strongly agree (94%) or agree (6%) that they take "lots of interest" in the sample child, and no parent disagrees with this statement. In terms of praise, the large majority also strongly agrees (69%) or agrees (26%) that they are "always finding reasons to praise" the sample child while six parents (2%) disagree or strongly disagree with this statement (and the remainder, 4%, do not have a view). There are no statistically significant differences between the areas on any of the three indicators.

In terms of indicators addressed to hostility towards, and criticism of, the sample child, the findings show some differences between parents / carers in the different study areas. Across all areas, more parents disagree than agree that they are "often angry" with the child. Just under half (47%) disagrees with the statement: 18 per cent disagreeing and 29 per cent strongly disagreeing. In the Average Control Area and the Southside Regeneration Area, the proportions agreeing that they are "often angry" with the sample child are higher (48% Average Area and 47% Southside Regeneration Area) than the proportions disagreeing (45% and 46% respectively) (Figure 4.35). In the Northside Regeneration Area, the largest proportion (55%) compared with other areas disagrees (19% disagree and 36% strongly disagree) that they are "often angry" with the child while the proportion agreeing with the statement is 39 per cent (which is the same for the Disadvantaged Control Area).

Figure 4.35: Extent of agreement that parent is often angry with the sample child

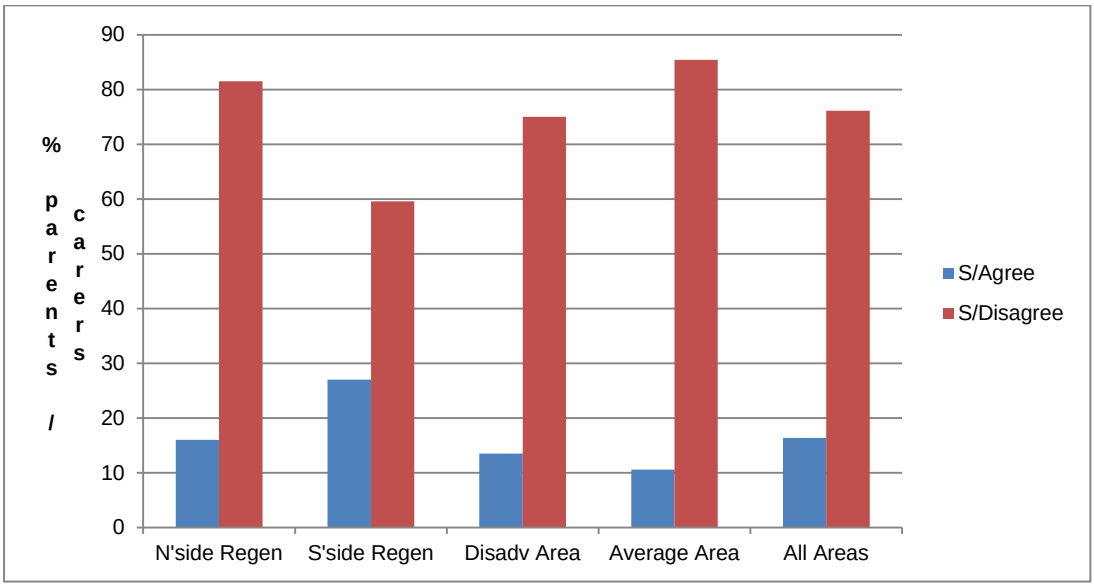


N All=415 N Northside=119; N Southside=89; N Disadvantage=104; N Average=103
Statistical Tests: Chi Sq 36.20 (df=12), p<0.001, Cramer's V =0.17

Some 16 per cent of parents across all areas either strongly agree (3%) or agree (13%) that they are "constantly criticising the child". The large majority (76%) either disagrees (27%) or strongly disagrees (49%) with this statement. In the Southside Regeneration Area, the largest proportion (48%) compared with other areas strongly agree (3%) or agree (24%) that they are "constantly criticising" the child, and the smallest proportion disagrees (18%) or strongly disagrees (41%) with the statement

(Figure 4.36). In the Average Control Area, the large majority of parents / carers disagrees (86%) that they are "constantly criticising" the child.

Figure 4.36: Extent of agreement that parent / carer is constantly criticising the sample child



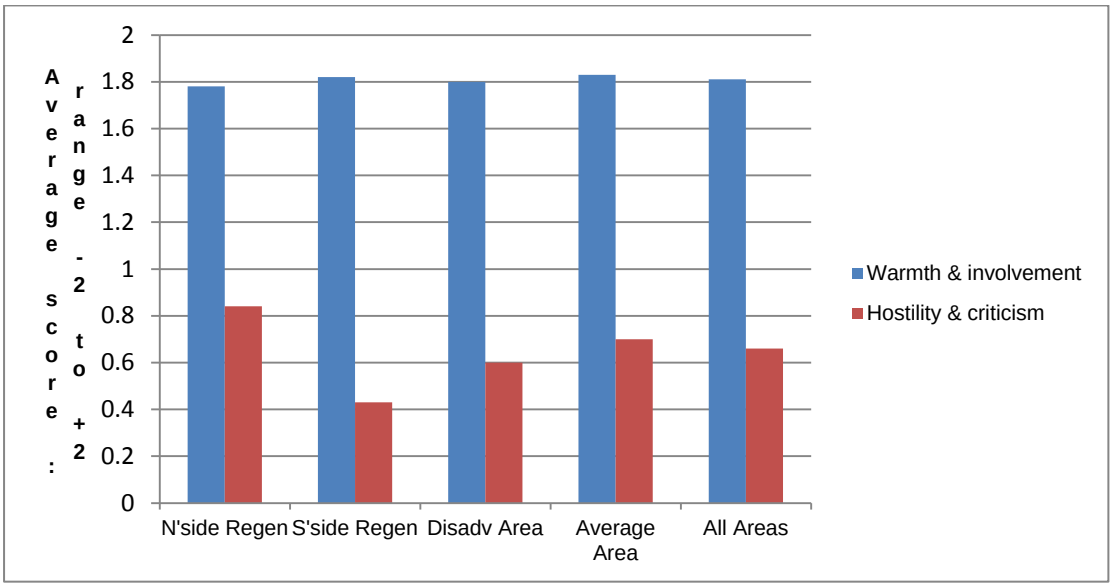
N All=415 N Northside=119; N Southside=89; N Disadvantage=104; N Average=103;
Statistical Tests: Chi Sq 40.07 (df=12), p<0.001, Cramer's V =0.18

These data can be combined to create a composite (average) score for (i) warmth and involvement (3 items) and (ii) hostility and criticism (2 items). There are virtually no differences between the areas in terms of parental affection and interest in their child (warmth and involvement). Overall, levels of parental affection and interest are very high (Figure 4.37; the highest possible score is 2). For the hostility and criticism indicator, items are reverse scored so that higher values indicate less hostility and criticism by parents[20]. The highest score is in the Northside Regeneration area (parents / carers less often angry and constantly critical of their child), and the lowest score in the Southside Regeneration (parents/ carers relatively more hostile and more critical of the child). The scores for hostility and criticism, however, are more positive than negative, meaning that parents, on average, are not oriented towards these types of behaviour.

Possible associations between hostility and criticism and other factors (e.g. children with greater difficulties, family size, age of parent, family structure) were explored. The strongest association with hostility and criticism is for the total child difficulties scale (Pearson's Correlation -0.43; p<0.001). This means that parents have a greater tendency to show hostility and criticism when the child presents with behavioural difficulties. Youngest and oldest parents (18-24 years and 55-64 years), on average are the least hostile and least critical towards the child; those in the age group 35-44 years tend to be most hostile and critical towards the child.

[20] The scoring is: strongly agree= -2, agree= -1; neither = 0; disagree = +1, strongly disagree= +2. The larger the value on the scale (range -2 to +2), the less hostile and critical parents are.

Figure 4.37: Summary scores for "warmth and involvement" and "hostility and criticism"



Statistical tests: Warmth & involvement=not significant; Hostility & criticism: Oneway ANOVA F=2.51; p=0.06 (not significant)

The quality of the parent / child relationship was also explored in the child survey, though to a limited extent. The findings give a positive impression of the quality of the parent / child relationship and corroborate the findings above on "warmth and involvement". Across all areas, the vast majority of children (98%) report that their parents "do things with them that they like", that their mam or dad talks to them (the child) about things, "like if I am worried or upset" (98%), and their mam or dad "often tell me that they are proud of me or that I'm good" (98%). There are very small differences between the areas on these indicators, and they are not statistically significant.

4.4.3 Parental monitoring of the child

Aspects related to parental monitoring of the child were explored with parents / carers, including the frequency with which the sample child is allowed to go out unaccompanied by the parent / carer**.** Just under half of parents (48%) across all areas report that the child always or most times goes out unaccompanied while just over one-fifth (22%) reports that the child never goes out unaccompanied. Larger proportions of children in the disadvantaged areas are reported to go out unaccompanied (55% Southside, 54% Northside and 53% Disadvantaged Control) compared with children in the Average Control Area (30%). It is in the Average Control Area that the smallest proportion (30%), compared with other areas, often goes out unaccompanied (Table 4.27).

Table 4.27: Frequency at which sample child goes out unaccompanied by the parent / carer, by area										
How often does the sample child go out without you?	**N'side Regeneration Area**		**S'side Regeneration Area**		**Disadvantaged Area**		**Average Area**		**All Areas**	
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Always / most times	58	53.7	47	55.3	51	52.6	29	29.6	185	47.7
Often	13	12.0	10	11.8	15	15.5	29	29.6	67	17.3
Sometimes	19	17.6	10	11.8	9	9.3	14	14.3	52	13.4
Never	18	16.7	18	21.2	22	22.7	26	26.5	84	21.6
Total	**108**	**100**	**85**	**100**	**97**	**100**	**98**	**100**	**388**	**100**

Statistical Tests: Chi Sq 26.32 (df=9), p<0.001, Cramer's V =0.15

These differences are not explained by age differences. While children in the Average Control Area have a slightly younger mean age compared with children in other areas, the differences in mean age are small. Similarly, they are not linked to parents' / carers' perception of the neighbourhood: based on parent / carer reports, safety in the neighbourhood environment, generally, is more problematic in the regeneration areas followed by the Disadvantaged Control Area compared with the Average Control Area.

In undertaking the fieldwork, many parents / carers commented that they use mobile 'phones to monitor the child's activities when they are out unaccompanied (which was regarded as positive) but some also commented that using mobile 'phones is not entirely reliable as children can report to the parent they are in a specific location when, in fact, they are somewhere else. This issue is addressed in more detail in the report of the focus groups with parents.

Parents / carers were also asked about knowing where the sample child is when s/he is out of the house unaccompanied by the parent / carer. 96 per cent of parents / carers across all areas report that they always know and 3 per cent report that they often know. No parent reported that they never know where the child is when s/he is out unaccompanied. In terms of whom the sample child is with when out unaccompanied, some 96 per cent across all areas report that they always know, or know most times, while 3 per cent often know. Three parents report that they know sometimes while one parent reports that s/he never knows. There are no statistically significant differences between areas on these indicators.

On the issue of parent / carer knowledge of what the child is doing when out, 93 per cent of parents across all areas report that they always / most times know and 5 per cent report that they often know. In the Northside Regeneration Area, a larger proportion, compared with other areas, report that they often (10%), sometimes (4%) or never know (2%). Differences here are statistically significant (Table 4.28).

Table 4.28: Whether and extent to which the parent / carer knows what the sample child is doing when out, by area										
When s/he goes out, how often do you know what s/he is doing?	**N'side Regeneration Area**		**S'side Regeneration Area**		**Disadvantaged Area**		**Average Area**		**All Areas**	
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Always / most times	80	84.2	71	95.9	78	96.3	71	95.9	300	92.6
Often	9	9.5	3	4.1	2	2.5	3	4.1	17	5.2
Sometimes	4	4.2	0	0	1	1.2	0	0	5	1.5
Never	2	2.1	0	0	0	0	0	0	2	0.6
Total	**95**	**100**	**74**	**100**	**81**	**100**	**74**	**100**	**324**	**100**

Statistical Tests: Chi Sq 17.38 (df=9), p<0.05 (p=0.04), Cramer's V =0.13

In terms of whether the parent / carers know what time the child will return home, again 96 per cent across all areas report that they always know or know most times, and 3 per cent report that they often know. No parent reported that they never know when the child will be home. There are no statistically significant differences between the areas on this indicator. Parents again often refer to the importance of mobile 'phone contact to monitor the time the child is expected home.

Parents / carers were also asked whether, and the extent to which, the child comes home more than one hour late against the parent's wishes. Across all areas, some 84 per cent of parents report that the child never comes home late, 11 per cent reports that the child sometimes comes home late while 6 per cent reports that the child often (3%) or always (3%) comes home late (Table 4.29). In the Northside Regeneration Area, the lowest proportion of parents, compared with other areas, reports that child never comes home late (70%) and larger proportions report that the child sometimes (18%), often (6%) or always (5%) comes home late.

Table 4.29: Whether, and the extent to which, the sample child comes home late										
Does s/he ever come home more than an hour late against your wishes?	**N'side Regeneration Area**		**S'side Regeneration Area**		**Disadvantaged Area**		**Average Area**		**All Areas**	
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Always / most times	5	5.3	2	2.7	3	3.8	0	0	10	3.1
Often	6	6.4	1	1.4	2	2.5	0	0	9	2.8
Sometimes	17	18.1	8	10.8	5	6.3	4	5.4	34	10.6
Never	66	70.2	63	85.1	70	87.5	70	94.6	269	83.5
Total	**94**	**100**	**74**	**100**	**80**	**100**	**74**	**100**	**322**	**100**

Statistical Tests: Chi Sq 22.47 (df=9), p<0.05 (p=0.01); Cramer's V =0.15

Based on parent / carer reports, there is a high level of parental monitoring of children. In terms of going out unaccompanied in the first instance, there is less parental monitoring in Disadvantaged

Areas compared with the Average Control Area. There is slightly less parental monitoring on certain aspects (what the child is doing, being home late) amongst parents in the Northside Regeneration Area.

4.4.4 Disciplinary strategies applied by parents / carers

Disciplinary strategies were explored with parents / carers with reference to the sample child. Aggressive / harsh or inconsistent disciplinary practices are regarded as risk factors for anti-social behaviour and future difficulties in the child. Positive strategies involve rewarding good behaviour. The items used to examine disciplinary strategies are a shortened version of a 24 item Misbehavior Response Scale (Creighton et al, 2003 cited and also adapted in Finch et al 2006). The items measure non-aggressive responses, psychologically aggressive responses, and physical responses. Parents / carers were asked what they do when their children misbehave or upset them, and how often they have applied certain disciplinary strategies with the sample child in the last 12 months. Where the parent regarded the child as too young to be disciplined using certain practices, they were coded as non-applicable and excluded from the analysis.

Non-aggressive responses include: (i) discussing the issue calmly / explaining why the behaviour was wrong; (ii) making him / her take time out to think about the behaviour; (iii) grounding him / her or stopping treats; (iv) ignoring the behaviour; and (v) bribing the child. The first two of these strategies, in particular, are associated with inductive or positive disciplinary strategies.

The majority of parents across all areas report that they always (46%) or regularly (35%) discussed the issue calmly and explained why the behaviour was wrong; 19 per cent rarely (12%) or never (7%) used this strategy. This was the most frequently used parental disciplinary strategy. There are statistically significant differences between the areas here: larger proportions of parents in the regeneration areas report that they always (58% Northside, and 55% Southside) use this strategy compared with the control areas (37% Disadvantaged Control and 32% Average Control Area). The smallest proportion never using this strategy is in the Southside Regeneration Area (Table 4.30). This finding can be interpreted positively for the regeneration areas, in that discussing the behaviour calmly and explaining why it is wrong is a positive disciplinary strategy. In the course of the fieldwork / interviewing, some (young) parents (approximately 10) commented that they had learnt this practice in parenting courses and try to apply it consistently with their children.

Table 4.30: Discipline used with sample child: how often bad behaviour is discussed with, and explained to, the sample child, by area										
Discussed the issue calmly & explained why the behaviour was wrong	**N'side Regeneration Area**		**S'side Regeneration Area**		**Disadvantaged Area**		**Average Area**		**All Areas**	
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Always	61	57.5	46	55.4	35	37.2	30	32.3	172	45.7
Regularly	24	22.6	27	32.5	36	38.3	45	48.4	132	35.1
Rarely	16	15.1	8	9.6	11	11.7	12	12.9	47	12.5
Never	5	4.7	2	2.4	12	12.8	6	6.5	25	6.6
Total	**106**	**100**	**83**	**100**	**94**	**100**	**93**	**100**	**376**	**100**

Statistical Tests: Chi Sq 29.21 (df=9), p<0.001, Cramer's V =0.16

In terms of making the child "take time out" to think about the behaviour, this is the second most frequently used disciplinary strategy. Almost half of parents report that they used this always (21%) or regularly (29%) in the last 12 months, while 36 per cent never used this strategy. There are no statistically significant differences between the areas on this indicator (Table 4.31).

Table 4.31: Discipline: Frequency – Sample child made take time out, by area										
Made him / her take time out to think about the behaviour	**N'side Regeneration Area**		**S'side Regeneration Area**		**Disadvantaged Area**		**Average Area**		**All Areas**	
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Always	30	28.3	18	21.7	16	17.2	14	15.1	78	20.8
Regularly	22	20.8	28	33.7	30	32.3	28	30.1	108	28.8
Rarely	17	16.0	7	8.4	11	11.8	20	21.5	55	14.7
Never	37	34.9	30	36.1	36	38.7	31	33.3	134	35.7
Total	**106**	**100**	**83**	**100**	**93**	**100**	**93**	**100**	**375**	**100**

Statistical Tests: not significant

With regard to "grounding" the child, stopping treats, or not allowing him/her out, some 14 per cent of parents across all areas report that they used this always, 31 per cent regularly and 37 per cent never used it. Differences between the areas are not statistically significant (Table 4.32).

Table 4.32: Discipline: Frequency grounded the sample child / stopped treats, by area										
'Grounded'; wouldn't allow out; stopped treats	**N'side Regeneration Area**		**S'side Regeneration Area**		**Disadvantaged Area**		**Average Area**		**All Areas**	
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Always	25	23.4	11	13.3	9	9.5	8	8.7	53	14.1
Regularly	30	28.0	28	33.7	28	29.5	32	34.8	118	31.3
Rarely	19	17.8	9	10.8	20	21.1	17	18.5	65	17.2
Never	33	30.8	35	42.2	38	40.0	35	38.0	141	37.4
Total	**107**	**100**	**83**	**100**	**95**	**100**	**92**	**100**	**377**	**100**

Statistical Tests: Chi Sq 15.70 (df=9), p=0.07, Cramer's V =0.12; not significant

Focusing on less positive but non-aggressive strategies, these are used with less frequency than the previous strategies. The large majority of parents (74%) report that they never ignored bad behaviour while 12 per cent did this always (1 parent, 0.3%) or regularly (11%). Parents in the regeneration

areas use this strategy more frequently compared with the control areas (19% Northside, 19% Southside, 6% Disadvantaged Control and 2% Average Control Area did this regularly or always). Differences between the areas are statistically significant (Table 4.33).

Table 4.33: Discipline: Frequency ignored bad behaviour of sample child, by area

Ignored bad behaviour	N'side Regeneration Area		S'side Regeneration Area		Disadvantaged Area		Average Area		All Areas	
	No.	%	No.	%	No.	%	No.	%	No.	%
Always	1	0.9	0	0	0	0	0	0	1	0.3
Regularly	20	18.2	16	18.8	6	6.3	2	2.1	44	11.4
Rarely	15	13.6	11	12.9	12	12.6	17	17.7	55	14.2
Never	74	67.3	58	68.2	77	81.1	77	80.2	286	74.1
Total	**110**	**100**	**85**	**100**	**96**	**100**	**92**	**100**	**386**	**100**

Statistical Tests: Chi Sq 23.82 (df=9), p<0.001, Cramer's V =0.14;

Some 55 per cent of parents across all areas report that they never bribed the sample child or promised him/her things if s/he behaves while 3 per cent always and 16 per cent regularly did this over the last 12 months. Parents in the regeneration areas use this strategy more frequently (always or regularly) compared with the Average Control Area in particular. However, there are no statistically significant differences between the areas (Table 4.34).

Table 4.34: Discipline: Frequency bribed the sample child, by area

Bribe him / her, promised things if s/he behaved	N'side Regeneration Area		S'side Regeneration Area		Disadvantaged Area		Average Area		All Areas	
	No.	%	No.	%	No.	%	No.	%	No.	%
Always	5	4.5	2	2.4	3	3.3	2	2.1	12	3.1
Regularly	18	16.4	17	20.0	16	16.8	10	10.4	61	15.8
Rarely	19	17.3	22	25.9	22	23.2	38	39.6	101	26.2
Never	68	61.8	44	51.8	54	56.8	46	47.9	212	54.9
Total	**110**	**100**	**85**	**100**	**95**	**100**	**96**	**100**	**386**	**100**

Statistical Tests: Chi Sq 16.30 (df=9), p=0.06, Cramer's V =0.12; not significant

Turning finally to psychologically aggressive responses to misbehaviour, just under half (48%) of parents report that they never shouted or swore at the sample child in the last 12 months, 37 per cent did this rarely and 14 per cent more regularly (1% always and 13% regularly). Larger proportions of parents / carers in regeneration areas always or regularly shouted / swore at the child (21% Northside, and 18% Southside) compared with parents in the control areas (12% Disadvantaged and 7% Average Control Area) – Table 4.35.

Across all areas, 72 per cent of parents / carers report that, in the last year, they never threatened to slap the child, 20 per cent rarely did so and 8 per cent always or regularly used this disciplinary strategy. In the Northside Regeneration Area, a larger proportion of parents compared with other areas report that they regularly (15%) threatened to slap the child and a lower proportion (57%) reported never threatening to slap the child (Table 4.36). In the Southside Regeneration Areas, the largest proportion (82%) of parents / carers compared with other areas report that they never threatened to slap the child.

Table 4.35: Discipline: Frequency shouted or swore at the sample child, by area										
Shouted or swore at him / her	**N'side Regeneration Area**		**S'side Regeneration Area**		**Disadvantaged Area**		**Average Area**		**All Areas**	
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Always	4	3.6	1	1.2	0	0	0	0	5	1.3
Regularly	19	17.3	14	16.5	11	11.6	7	7.3	51	13.2
Rarely	46	41.8	33	38.8	32	33.7	33	34.4	144	37.3
Never	41	37.3	37	43.5	52	54.7	56	58.3	186	48.2
Total	**110**	**100**	**85**	**100**	**95**	**100**	**96**	**100**	**386**	**100**

Statistical Tests: Chi Sq 19.14 (df=9), p<0.05 (p=0.02), Cramer's V =0.13

Table 4.36: Discipline: Frequency threaten to slap the sample child, by area										
Threaten to give him/her a slap but didn't actually do it	**N'side Regeneration Area**		**S'side Regeneration Area**		**Disadvantaged Area**		**Average Area**		**All Areas**	
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Always	0	0	0	0	0	0	1	1.0	1	0.3
Regularly	16	14.5	5	6.0	8	8.4	1	1.0	30	7.8
Rarely	31	28.2	10	11.9	16	16.8	20	20.8	77	20.0
Never	63	57.3	69	82.1	71	74.7	74	71.1	277	71.9
Total	**110**	**100**	**84**	**100**	**95**	**100**	**96**	**100**	**385**	**100**

Statistical Tests: Chi Sq 27.38 (df=9), p<0.001, Cramer's V =0.15

In terms of physical discipline, approximately 15 per cent report having actually slapped the child in the last 12 months, while 85 per cent report that they never used that form of discipline. Less than three per cent report that they always or regularly slapped the child and 13 per cent did so on a rare occasion. Use of this form of discipline is more prevalent in the Northside Regeneration Area compared with other areas (5% always or regularly slapped, and 21% rarely) (Table 4.37). Differences between the areas are (almost but) not statistically significant (p=0.05).

Table 4.37: Discipline: Frequency slapped the sample child, by area										
Gave him / her a slap	**N'side Regeneration Area**		**S'side Regeneration Area**		**Disadvantaged Area**		**Average Area**		**All Areas**	
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Always	1	0.9	0	0	0	0	0	0	1	0.3
Regularly	4	3.6	2	2.4	3	3.2	0	0	9	2.3
Rarely	23	20.9	5	6.0	10	10.5	11	11.5	49	12.7
Never	82	74.5	77	91.7	82	86.3	85	88.5	326	84.7
Total	**110**	**100**	**84**	**100**	**95**	**100**	**96**	**100**	**385**	**100**

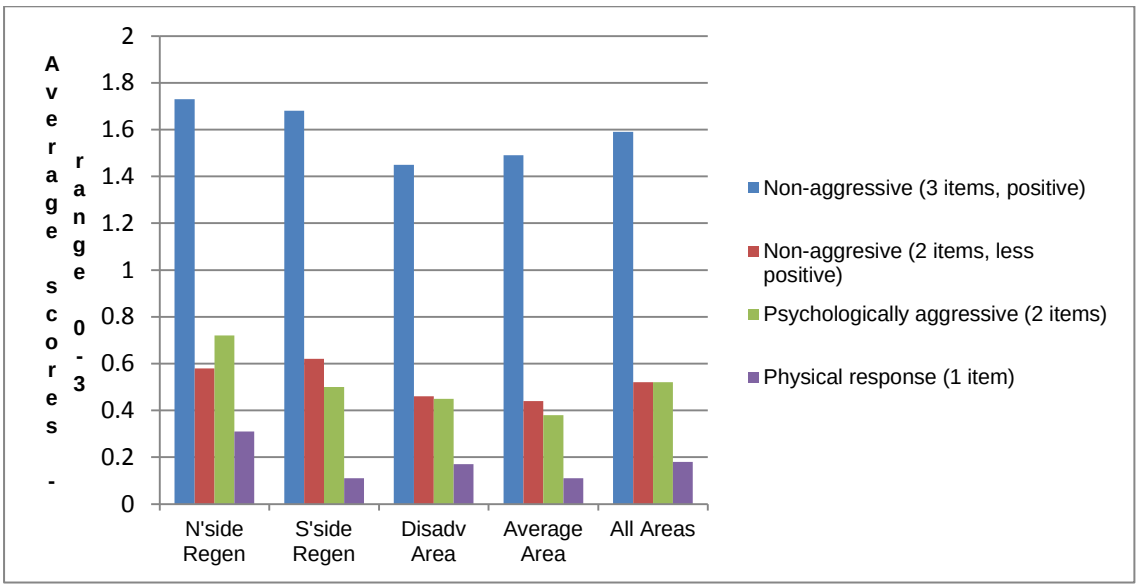
Statistical Tests: Chi Sq 17.13 (df=9), p=0.05, Cramer's V =0.12; Not significant

In order to bring this analysis together, composite scores for frequency of use of disciplinary strategies, by categories of disciplinary strategies, were created.[21] The findings are reported in Figure 4.38. This shows that parents use multiple disciplinary strategies but the most frequently used over all areas are positive non-aggressive disciplinary strategies. While other methods including the least desirable strategies (psychologically aggressive strategies and physical response) are used more

[21] 0=Never; 1=Rarely; 2=Regularly; 3=Always

frequently in disadvantaged areas compared with the Average Control Area, parents in the regeneration areas also use the positive disciplinary strategies with greater frequency than parents in the control areas.

Figure 4.38: Parental disciplinary strategies – summary measures by area (score)

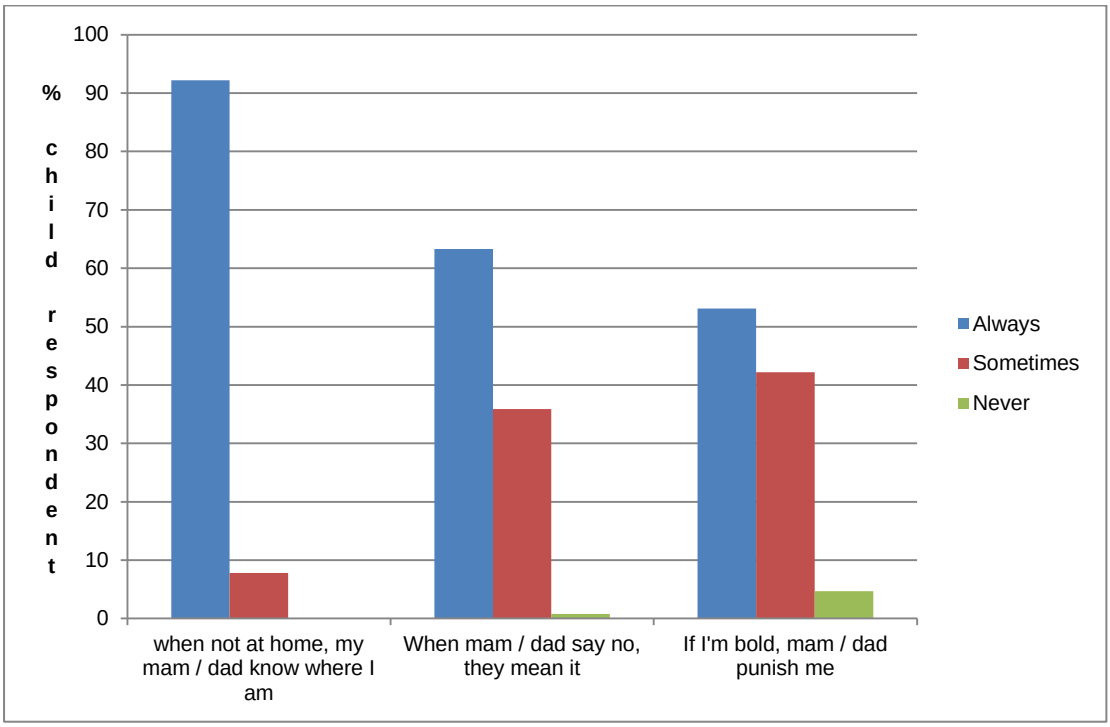


Statistical Tests: Physical response F=4.37; p<0.001; psychologically aggressive F=7.41, p<0.001

Focusing on the child perspective as obtained from the findings of the child survey, children across all areas report a high level of parental monitoring of where they go unaccompanied. For instance, 92 per cent of children surveyed across all areas report that when they are not at home, their "mam or dad know where I am, I have to tell them" while 8 per cent report that their parents know "sometimes" where they are.

In term of discipline and consistency from parents, children were asked "when mam or dad say no, do they mean it" and if they misbehave, do "mam or dad punish me" with the response options, always, sometimes or never. In both cases, very small numbers of parents are reported "never" to mean no when they say no (1 case) and never to punish the child when s/he misbehaves (6 cases). Based on child reports, parents are less consistent on the last two indicators than on monitoring the whereabouts of the child. The findings are very similar across all areas and are shown for all areas in Figure 4.39 below.

Figure 4.39: Child perceptions of discipline exercised by parents (% children)



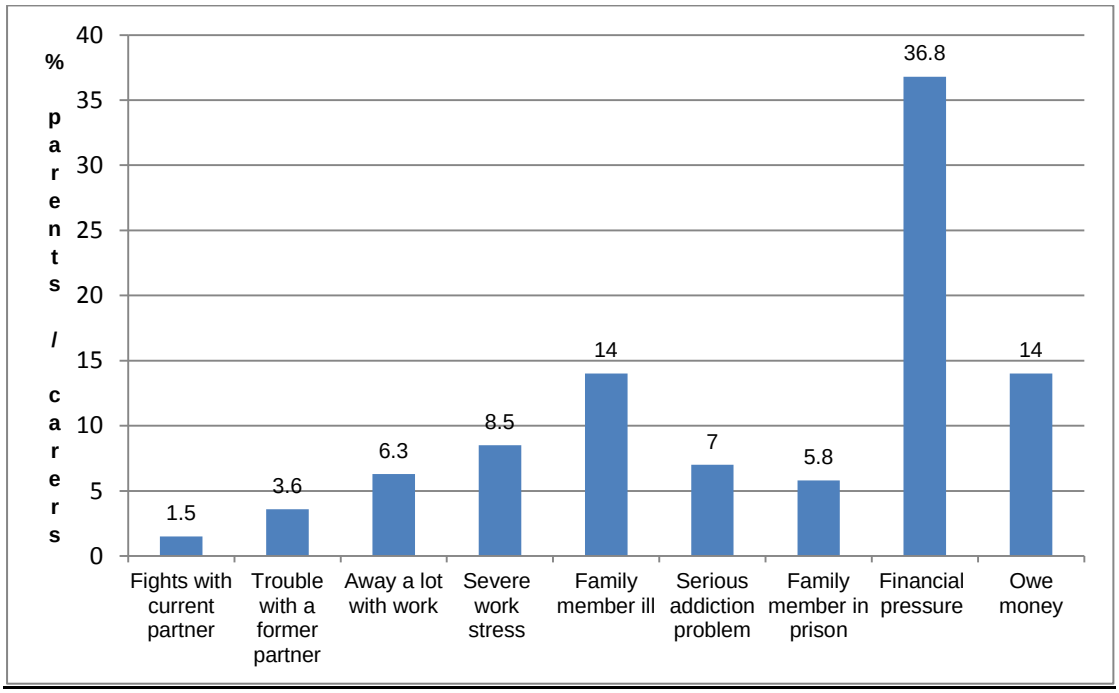
N All=128; Statistical Tests: not significant

4.4.5 Problems in the family

Parents / carers were asked whether any specific issues are a problem for them at present. Some of the issues explored (domestic violence in the home, addictions, family members in prison) are particularly sensitive and this may lead to under-reporting of problems.

Across all areas, the most common family problem is financial pressure because a parent / carer is out of work and / or has reduced income (37%), followed by owing money (14%) and a family member very ill (14%) (Figure 4.40). In terms of "fights or arguments" with a current partner, based on discussions with respondents in the course of interviews, it would seem that this is under-reported in the survey. This is linked to sensitivity in reporting this and other issues related to attitudes and behaviour. For instance, to some extent, domestic violence is normalised by some women, in that having regular arguments or fights, including physical violence, is not regarded as unusual (i.e., it is what they expect) and is not seen particularly as a "problem".

Figure 4.40: Family problems: All Areas



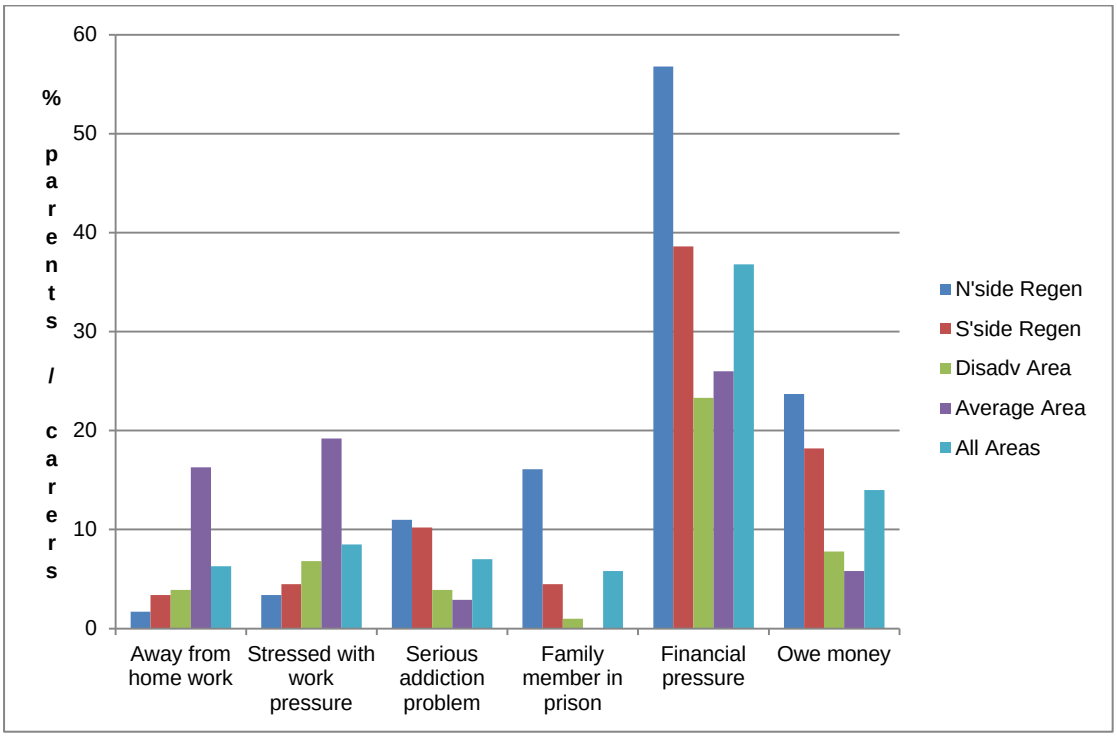
N All=413

Findings on family problems where there are statistically significant differences between the areas, are shown below by area (Figure 4.41).

Problems which are greater in the Average Control Area compared with the disadvantaged areas (regeneration areas and the Disadvantaged Control Area) are: the parent / partner away from home a lot because of work (16% in the Average Area, 4% Disadvantaged Area, 3% Southside Regeneration and 2% Northside Regeneration); and the parent / partner stressed with severe work pressure (19% Average, 7% Disadvantaged, 5% Southside and 3% Northside).

Problems which are greater in the regeneration areas include: a family member with a serious problem of alcohol or drug addiction (11% Northside, 10% Southside, compared with 3% in the Average Control Area); and a family member in prison, which, based on parent reports, is considerably higher in the Northside Regeneration Area (16%) compared with the Southside Regeneration Area (5%) and the Disadvantaged Control Area (1%). No parent reported that they had a family member in prison in the Average Control Area. Under-reporting could be an issue in relation to both these problems. In the case of addiction, those who, by objective standards, have addiction problems may not acknowledge this themselves.

Figure 4.41: Selected family problems by area



N=413 N; Northside=118; N Southside 88; N Disadvantaged=103; N Average=104
Statistical Tests: Away from home Chi Sq=24.30(df=3), p<0.001; Phi=0.24; Stressed with work pressure: Chi Sq=21.57(df=3), p<0.001; Phi=0.23; Addiction problem: Chi Sq=8.88(df=3), p<0.05; Phi =0.14; Family member in prison=Chi Sq=33.91(df=3), p<0.001; Phi =0.29; Financial pressure: Chi Sq=33.70(df=3), p<0.001; Phi =0.29; Owing money: Chi Sq=19.68(df=3), p<0.001, Phi=0.22.

While financial pressure (37%) and owing money (14%) are the most common problems in all areas, they are considerably more prevalent in the regeneration areas than in the two control areas. Financial pressure was least prevalent in the Disadvantaged Control Area (reported by 23%) and most prevalent in the Northside Regeneration Area (reported by 57%).

A composite score (an additive index) was prepared to capture the extent to which families have multiple problems (family problem score) and to assess whether there are differences between the areas on this indicator.[22] The findings show the following order of areas in term of most to least family problems (mean number of family problems): Northside Regeneration, Southside Regeneration, Average Control and the Disadvantaged Control Area. While specific parents / carers in the regeneration areas report they have up to five problems (the highest number of problems reported by any one family), the average scores per area are low, indicating that many families do not have multiple problems or, at any rate do not report having these problems. As mentioned above, under-reporting could arise for a variety of reasons including sensitivities in the interview situation, and failure to recognise the existence of a problem.

[22] The overall score for each case (parent /carer) is the sum of the scores across all nine problems where Yes=1; No=0, and the possible range is 0-9

Table 4.38: Family problem scores, by area					
Areas	**Mean Score**	**Standard Deviation**	**Min**	**Max**	**Cases N**
Northside Regeneration	1.36	1.32	0	5	N=118
Southside Regeneration Area	0.98	1.15	0	5	N=88
Disadvantaged Control Area	0.63	0.96	0	4	N=103
Average Area	0.87	1.13	0	4	N=104
All Areas	0.98	1.18	0	5	N=413

Statistical Tests: One way ANOVA, F=7.73 (df=3), p<0.001

4.5 Parent Health

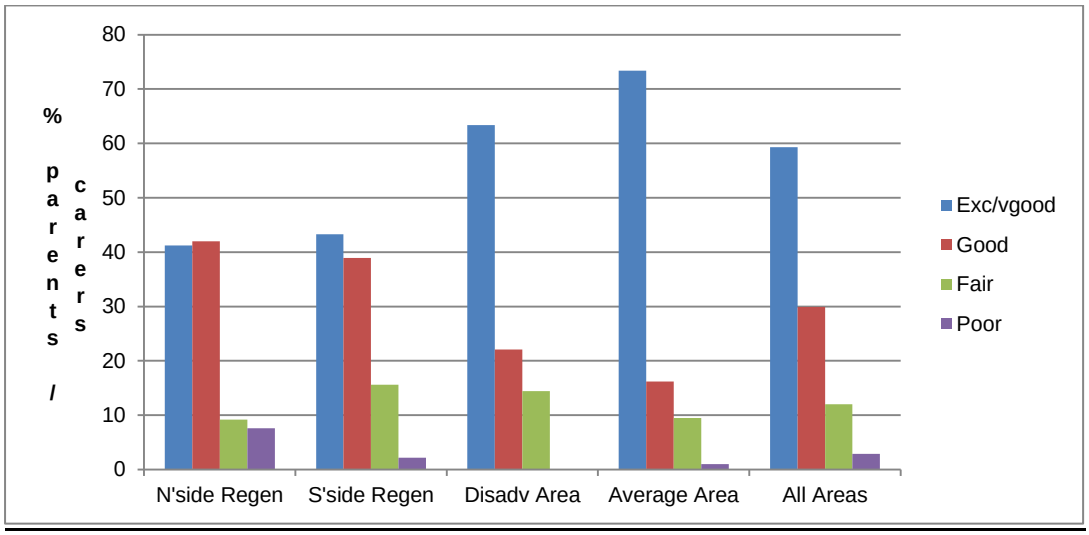
Parents' / carers' general health, and assessment of physical and mental health status, was undertaken using the SF-12 (version 2) assessment instrument, as described in the Methodology Chapter (Chapter 2). Parental health, especially mental health, is known to impact on child outcomes (Deforges and Abouchaar 2003).

4.5.1 Overall self-rated health assessment

Parents / carers were asked to self-rate their general state of health. The findings show that some 60 per cent rate their health as excellent (26%) or very good (33%), while 15 per cent rate it fair (12%) or poor (3%).

There are (statistically) significant differences between the areas on self-rated health, with health ratings much higher in the Average Control Area (73% excellent or very good) compared in particular with the regeneration areas (41% Northside and 43% Southside, rated excellent or very good). Larger proportions of parents rate their health fair or poor in the regeneration areas (9% fair and 8% poor, Northside; 16% fair and 2% poor, Southside) in contrast especially with the Average Control Area (10% fair and 1% poor). The Disadvantaged Control area is in an intermediate position between the Average Control Area (best reported parent / carer health) and the regeneration areas (poorest reported health) – Figure 4.42.

Figure 4.42: Self-rated health of parent / carer by area (%)

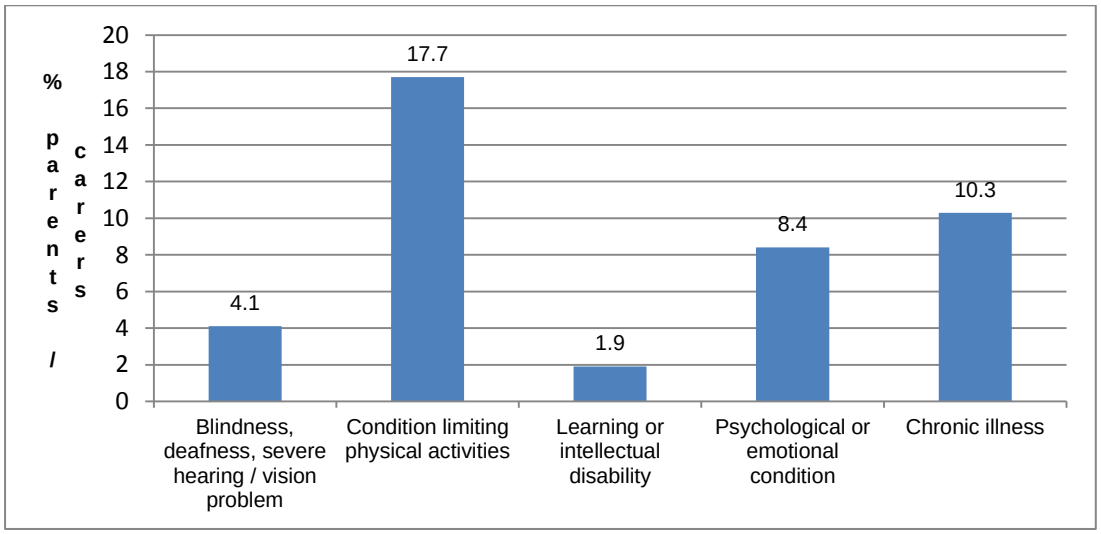


N All=418. Statistical Tests: Chi sq=52.155(df=12); p<0.001; Cramer's V=0.24

4.5.2 Prevalence of illness and types of illnesses

Just over one-third of parents / carers (34% or 143 cases) have one or more long-standing health problems. Rates of reported illness are highest in the Northside Regeneration area (43%) compared with other areas (36% Southside, 32% Average Area and 25% Disadvantaged Area). In terms of types of long-standing illness, the most prevalent health issue is a "condition limiting physical activities" (18%), followed by a chronic illness (10%) and a psychological or emotional condition (8%) – Figure 4.43. Rates of psychological or emotional conditions are higher in regeneration areas (Southside, 13%; Northside, 12%) compared with the control areas (6% Disadvantaged; 3% Average Area). It is only on this condition that differences between the areas are statistically significant.

Figure 4.43: Long-standing health problems of parent / carer



N All=418. Chi Sq=9.75 (df=3), p<0.05, Phi = 0.15

4.5.3 Analysis of parent health based on SF-12

Based on the 12 questions (items) which comprise the SF-12 health assessment instrument in the parent / carer questionnaire, measures were developed for eight scales of health (explained in the Methodology Chapter). Using these eight scales, in turn, two standardised summary scores, involving norm-based scoring using general US population statistics, are calculated to produce the Physical Component Summary (PCS) and Mental Component Summary (MCS) scores. The meaning of the scales and methods of calculation of the scores are outlined in Chapter 2.

The scores on the eight health dimensions and the Physical (PCS) and Mental Component Summary (MCS) scores vary on a scale of 0 to 100 where 0 represents the poorest health and 100 the best health and 50 is the average. Scores on each scale are presented for the population and by area, reporting means, median (50^{th} percentile), standard deviation, the number of cases included in the analysis and tests of statistical significance.[23] Detailed findings are presented in Appendix II.

In terms of the eight scales, there are no statistically significant differences between the areas on the following scales: Bodily Pain (mean 87.08 across all areas) and Vitality (mean 63.22 across all areas), the latter measuring whether or not the respondent is full of energy versus worn out/ tired. On the remaining six scales, there are statistically significant differences between the areas.

On the Physical Functioning scale (measuring limitations versus no limitations in performing physical activities) the lowest mean score is in the Northside Regeneration Area (83.61) while it is highest in the Southside Regeneration Area (91.94). The Role Physical scale (measuring problems versus no problems with work or other activities due to physical health) has lowest mean scores in the Northside Regeneration Area (83.09). The General Health scale (self-assessment of health as reported above) shows lowest mean scores in the regeneration areas and the highest mean score in the Average Area (78.14).

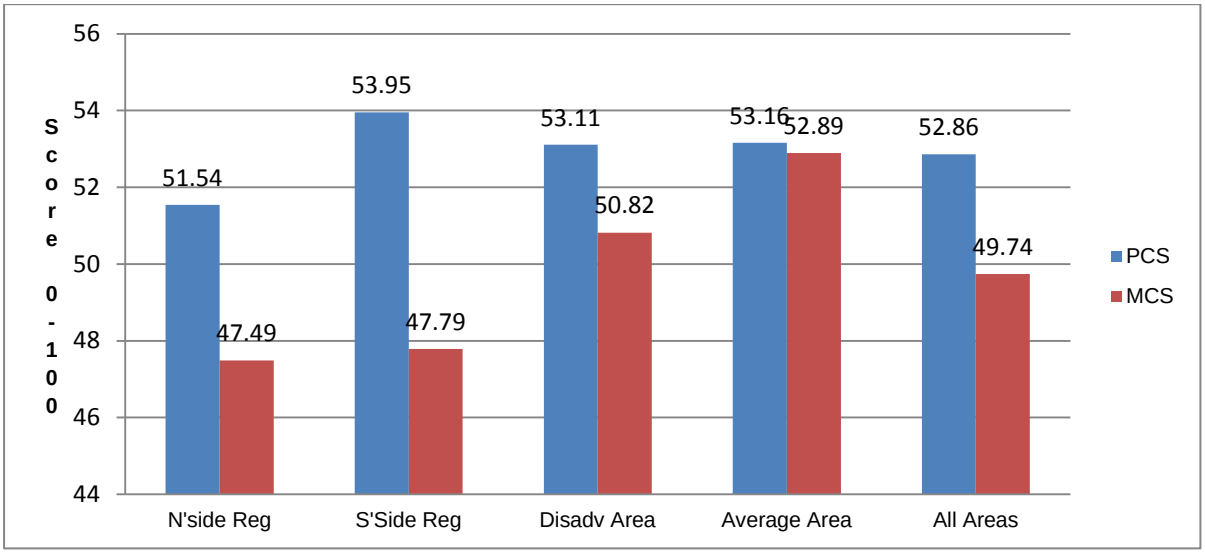
Three of the scales relate more closely to mental health - Social Functioning (measuring ability to perform normal social activities linked to physical or emotional health), and Role Emotional (measuring problems with work or other activities due to emotional problems), and Mental Health (measuring nervousness and depression versus being peaceful, calm, happy). Mean scores on these scales are lower in regeneration areas than other areas. On all of these scales, parents in the Northside Regeneration Area have the lowest mean scores.

On the summary scales, there are no statistically significant differences between the areas on the Physical Component Score (PCS) but there are differences on the Mental Component Score (MCS). Mental health is worse (lower scores) in the regeneration areas. Parents / carers in the Northside

[23] In reports of such data, the % of the population at the floor (score of 0) and ceiling (score of 100) are often presented but this is not done here.

Regeneration Area have substantially lower Mental Health Component Scores compared with the Average Area (Figure 4.44). A further observation is that in all disadvantaged areas, there is a greater difference or "gap" between mental health and physical health summary scores in favour of the latter, compared with the Average Control Area (where this difference is very small). The difference between Physical and Mental Health is greatest in the Southside Regeneration Area.

Figure 4.44: Physical (PCS) and Mental Health (MCS) Summary Scores by Area



N All=418. Significance: PCS not significant; MCS p<0.01 (p=0.001)

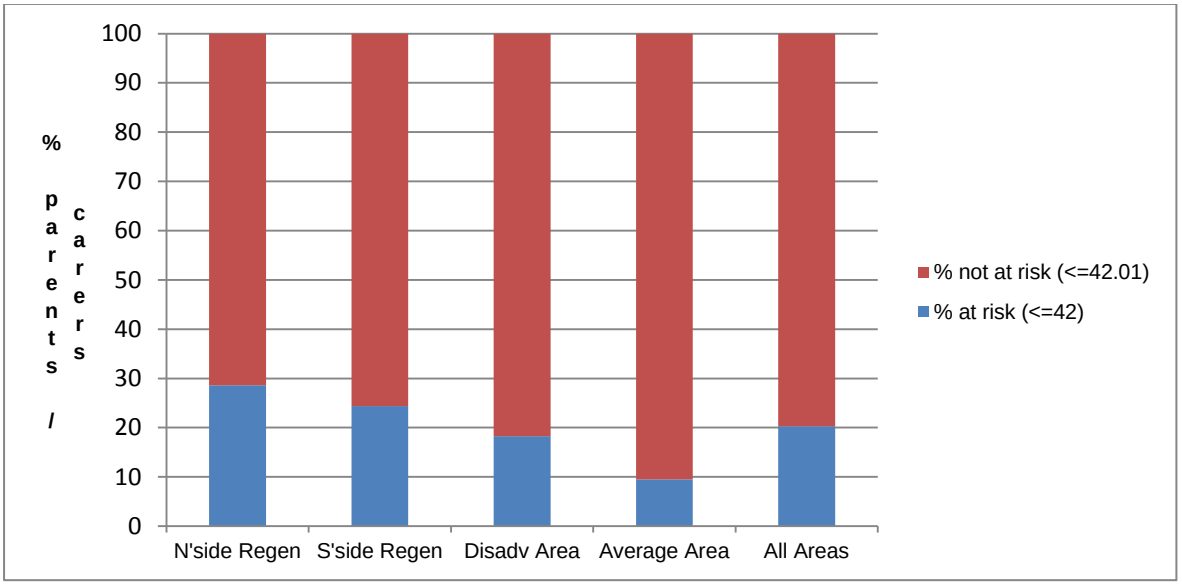
According to the developers of the SF-12 (Ware and Kosinski et al, 1993), scores of 42 or less on the Mental Component Score (MCS) is the cut-off point to be used as a preliminary screener to identify respondents at risk of depression (but not to be used as a diagnostic measure). Applying this measure, one-fifth of parents / carers across all areas (20%) are "at risk" of depression. Rates are highest in the Northside Regeneration Area (29%) and lowest in the Average Control Area (10%). Differences between the areas here are statistically significant (Figure 4.45).[24]

The age-related Mental Health Component Scores and Physical Health Component Scores for the sample of parents / carers differ from population norms in a Canadian sample of the adult population (Hopman et al, 2000). These norms suggest that in the younger age groups, Mental Health Component Scores tend to be lower, on average, than Physical Health Component scores. However, with increasing age, Physical Health Scores decrease in each successive age cohort and Mental Health Scores increase. In the sample of parents / carers physical health scores by age group are broadly similar in all age groups (with the exception of the youngest age group where the study population has some cases younger than 25 years). Mental health scores are just below the average (50) in the

[24] Rates of "at risk" of depression is also influenced by gender – higher for females than males- - and the Average Control Area has the highest proportion of male respondents. Controlling for gender, variations between the areas are significant for females but not for males.

youngest age group, and are lower than expected particularly in the older age groups (from 45-54 years) where they would be expected to increase. The overall profile of all study areas compared with the Canadian population is poorer mental health in the former compared with the latter (Table 4.39).[25]

Figure 4.45: Parent Mental Health Component Score: at risk of depression by area (%)



Statistical Tests: N All=418; Chi Sq=13.77 (df=3), phi=0.18; p<0.01

Table 4.39: Mean Score for Physical Component & Mental Component By Age Group for All Areas and Canadian Adult Population, using SF-12 (Limerick) and SF-36 (Canada)

	All Areas		Canadian adults*	
Age groups	**Physical Component**	**Mental Component**	**Physical Component**	**Mental Component**
	Mean **SD** *N*	Mean **SD** *N*	Mean **SD** *N*	Mean **SD** *N*
18-34 years	54.60 7.88 N=161	49.37 11.57 N=161	53.0** 7.2 N=398	50.1** 9.6 N=398
35-44 years	52.03 9.65 N=178	50.72 10.14 N=178	52.0 8.0 N=497	50.9 9.0 N=497
44-54 years	51.55 11.16 N=69	47.85 11.91 N=69	51.3 9.0 N=1688	51.4 9.2 N=1688
55-64 years	48.41 10.39 N=10	51.13 12.86 N=10	49.0 9.2 N=2271	53.7 8.2 N=2271
All age groups	52.85 9.39 N=418	49.74 11.08 N=418	N=4854	N=4854

*Based on a total sample of 9408 randomly selected Canadian adults. Includes adults from 25 years up to oldest old (>75 years).

** Canadian study involved adults 25 years, while this research included 10 cases of adults aged 18-24 years.

[25] The Canadian sample, however, has a better gender balance than the Limerick City sample (mainly female)

Association between parental mental health (Mental Health Component Score) and difficulties in the child (Total Difficulties Score) were also explored. The pattern of negative association between the two scales (Pearson's correlation coefficient = -0.26) can be interpreted as indicating that good mental health of the parent / carer (higher scores) is associated with lower levels of total difficulties in the child (lower scores on the Total Difficulties Scale); and conversely poor mental health in the parent (lower scores) is associated with higher levels of total difficulties (higher scores) in the child. The relationship is statistically significant (N = 355, $p<0.001$).

4.5.4 Parents / carers and physical exercise

Parents / carers were asked about the frequency of taking "hard" physical exercise – for at least 20 minutes – in a typical week. The largest proportion (66%) responded that they never take this level of exercise, some 14 per cent takes 20 minutes hard physical exercise 1-2 times per week, 11 per cent 3-4 times, and 9 per cent every day or almost every day. Differences between the areas are statistically significant with parents / carers in the Average Control Area undertaking hard physical exercise more frequently, particularly compared with parents / carers in the regeneration areas (Table 4.40). In the Average Control Area, 60 percent take hard physical exercies 3-4 times per week and 34 percent everyday or almost every day compared with 7 percent and 21 percent in these categories respectively in the Southside Regeneration Area. Greater frequency of taking hard physical exercise in the Average Area may be associated with higher incomes.

Table 4.40: Extent to which parent / carer takes hard physical exercise in a typical week, by area

At least 20 minutes hard physical exercise	N'side Regeneration Area		S'side Regeneration Area		Disadvantaged Area		Average Area		All Areas	
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Never	94	34.4	63	23.1	69	25.3	47	17.2	273	65.6
1-2 time	9	15.0	16	26.7	18	30.0	17	28.3	60	14.4
3-4 times	6	13.3	3	6.7	9	20.0	27	60.0	45	10.8
Almost / every day	9	23.7	8	21.1	8	21.1	13	34.2	38	9.1
Total	**118**	**100**	**90**	**100**	**104**	**100**	**104**	**100**	**416**	**100**

Statistical Tests: Chi Sq 48.35 (df=9), $p<0.001$; Cramer's V = 0.20

Some 67 per cent of parents / carers take moderate physical exercise for at least 30 minutes every day or almost every day, while 11 per cent never takes takes this level of moderate physical exercise. The patterns of moderate physical exercise are similar across all areas: variations between areas on this indicator are not statistically significant (Table 4.41). In the regeneration areas, where access to a car is less prevalent, many parents / carers walk to school and the shops and get regular exercise in this way.

Table 4.41: Frequency parent / carer takes moderate physical exercise in a typical week, by area										
At least 30 minutes moderate to light physical exercise	**N'side Regeneration Area**		**S'side Regeneration Area**		**Disadvantaged Area**		**Average Area**		**All Areas**	
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Never	11	13.3	9	10.0	17	16.3	8	7.6	45	10.8
1-2 time	15	15.0	9	10.0	14	13.5	9	8.6	47	11.2
3-4 times	11	13.3	4	4.4	15	14.4	15	14.3	45	10.8
Almost / every day	82	68.9	68	75.6	58	55.8	73	69.5	281	67.2
Total	**119**	**100**	**90**	**100**	**104**	**100**	**105**	**100**	**418**	**100**

Statistical Tests: Chi Sq 14.91 (df=9), p=0.09; Cramer's V = 0.11; Not significant

4.6 Service Utilisation and Quality Assessment

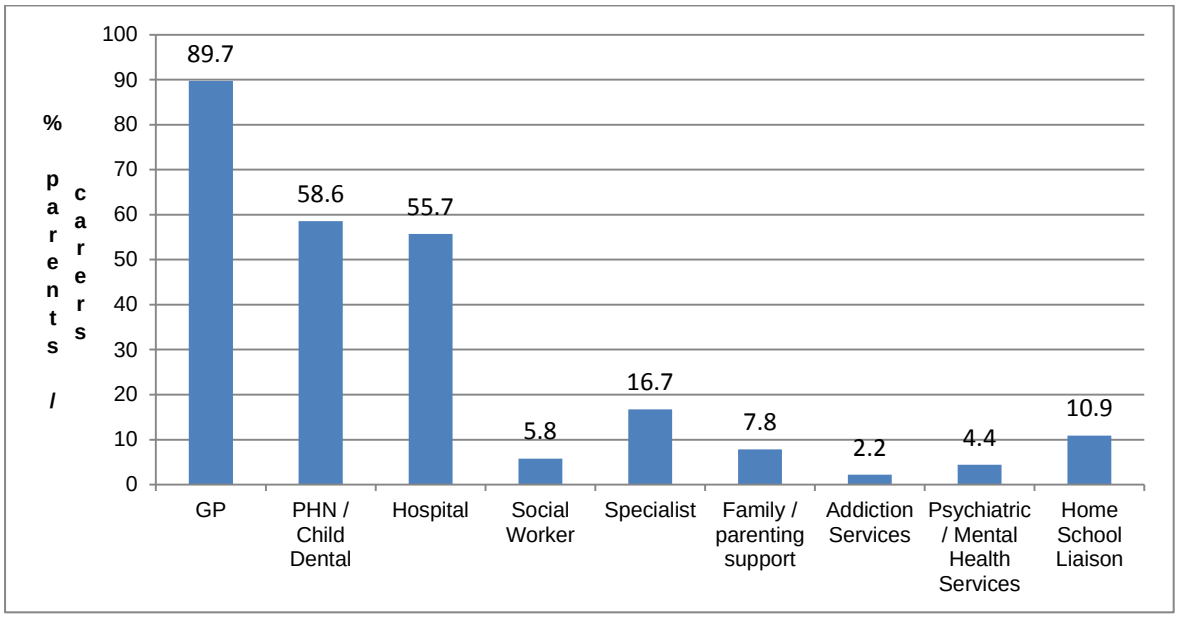
Parents / carers were asked about the use of certain services for parents and children over the last 12 months and they were also asked to rate the quality of services in health and social care, leisure / recreation and local services.

4.6.1 Service utilisation

In terms of service utilisation, the services used most frequently in the last 12 months by parents for any of their children or for advice on parenting was the General Practitioner – some 90 per cent had contact with the GP – followed by the Public Health Nurse / Child Dental Services (59%) and then the hospital (56%) which includes A&E, in-patients, and outpatients. Some 17 per cent had contact with a specialist service such as a Speech Therapist or Child Psychologist. All other services examined were used to a much lesser extent. For instance, some 6 per cent reported contact with a Social Worker, 8 per cent with Family Support / Parenting Support Services, 4 per cent with psychiatric / mental health services and 11 per cent with Home School Community Liaison (Figure 4.46).

The only services where there are statistically significant differences in utilisation rates between the areas are psychiatric / mental health services (Chi Sq=10.28(df=3), $p<0.05$, Phi=0.16) with higher rates of contact by parents / carers in the regeneration areas (9% Northside, 6% Southside, 0% Disadvantaged Area and 3% Average Area) and Home School Community Liaison (20% Northside, 16% Southside, 6% Disadvantaged Control and 1% Average Area) which is targeted on schools in disadvantaged areas (Chi Sq=25.77 (df=3), $p<0.001$, Phi=0.25).

Figure 4.46: Contact with services for any of your children or to help with parenting: All Areas

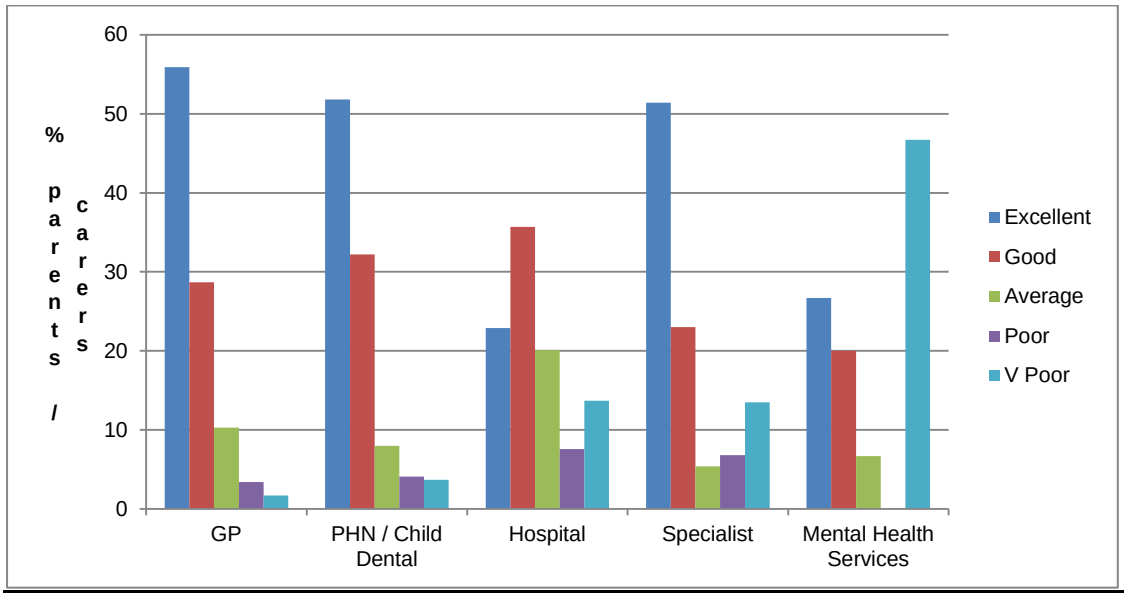


4.6.2 Quality assessment of selected health and social care services

GPs, public health nursing / child dental services and specialist services such as psychology, and speech and language therapy are rated highest in that order: 85 per cent rate the GP as excellent (56%) or good (29%) while 5 percent rate the GP as poor (3%) or very poor (2%); 84 per cent rate the public health nurse / child dental services as excellent (52%) or good (32%) and 8 percent rate these services as poor (4%) or very poor (4%); 74 percent rate specialist services as excellent (51%) or good (23%) but a larger proporation compared with the previous two services rate the specialist services as poor (7%) or very poor (14%). Access to specialists was mentioned by some parents in the fieldwork as problematic (i.e. long time periods on waiting lists).

The quality rating of hospital services (A&E, in-patients, outpatients) is less satisfactory. Nonetheless 58 per cent rate the services as excellent (23%) or good (36%) while 22 per cent rate them poor (8%) or very poor (14%). The number responding to the question on quality of psychiatric / mental health services is small (29 cases), with 52 per cent rating these services as excellent (24%) or very good (28%), and 38 per cent rating them as poor (14%) or very poor (24%). There are no statistically significant differences between the areas on the quality ratings of any of these services.

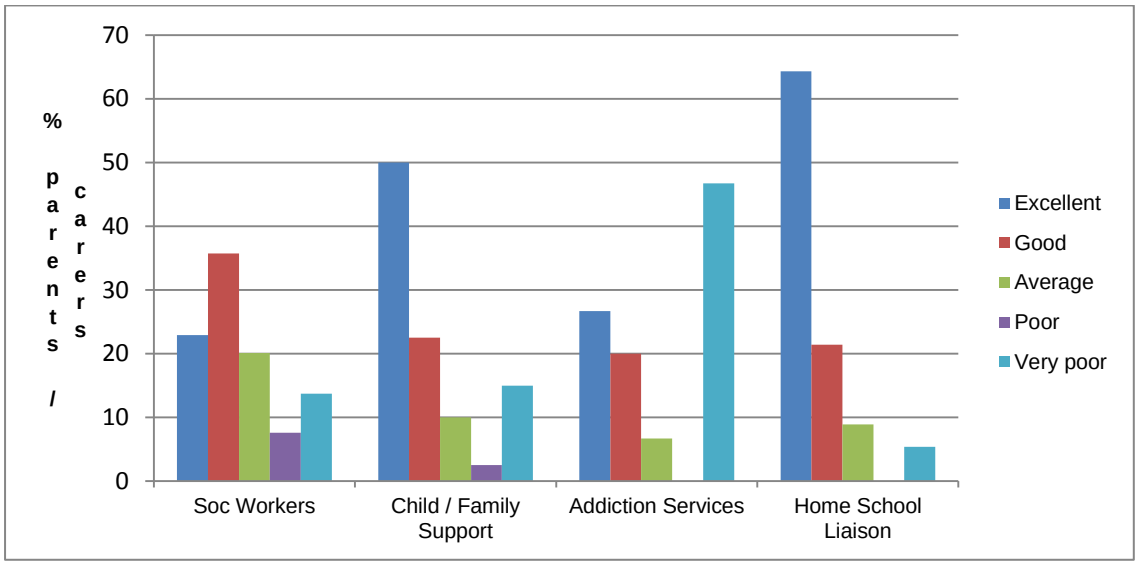
Figure 4.47: Quality rating of various health services by parents / carers: All Areas



N All GP=408; N All PHN/ CD=301; N Hospital=314; N All Specialist=74; N Mental Health=29

Focusing on services in social care, the numbers of parents / cares who responded by rating these services are smaller and some are very small (31 cases responded regarding social workers, 15 regarding addiction services). Some are services where there are likely to be sensitivities in reporting use. Mostly users are satisfied with the quality of the services but they are more satisfied with some than with others. Of these services, the highest satisfaction ratings are for the Home-School-Community Liaison Service with 85 per cent rating it excellent (64%) or good (21%) and 5 per cent rating it very poor (Figure 4.48). Child / family support and parenting services are also highly rated with 73 per cent rating the services as excellent (50%) or good (23%) and 18 per cent rating them as poor (3%) or very poor (15%). In terms of social workers, almost 60 per cent of those who responded to quality assessment rated this service as excellent (23%) or good (36%) while just over one-fifth rated the services as poor (8%) or very poor (14%). Addiction services receive the lowest satisfaction ratings, with equal proportions (47%) rating them excellent (27%) or good (20%) and very poor (47%). There are no differences between the areas on satisfaction ratings of these services.

Figure 4.48: Quality rating of various social care services: All Areas



N Soc Workers=31; N Child/family support=40; N Addiction Services=15; N HSL=56

4.6.3 Quality assessment of services for families in the local area or locally accessible

Parents / carers were asked to rate the quality of child care and leisure services for families that they use at present or may have used in the past. This question focuses on services in the local area or that are easily accessible to respondents. The services examined here are community-based services. The question was structured such that respondents could indicate, from their knowledge, that there are no such services in / or accessible to the local area.

In terms of quality of community crèches / child day care, 71 per cent of parents across all areas rate them excellent (50%) or good (21%) and 10 per cent rate them poor (4%) or very poor (6%). The satisfaction rating of excellent is accorded most frequently in the Southside Regeneration area (68%). Reflecting the presence of such facilities in regeneration areas, no parents in these areas reported an absence of these facilities. In the Disadvantaged Control Area, the largest proportion reported that there were no such facilities there (29%). Differences in ratings between the areas are statistically significant (Table 4.42).

Table 4.42: Quality of community creches / child day care by area

Quality rating	N'side Regeneration Area		S'side Regeneration Area		Disadvantaged Area		Average Area		All Areas	
	No.	%	No.	%	No.	%	No.	%	No.	%
Excellent	35	48.6	34	68.0	24	41.4	24	46.2	117	50.4
Good	19	26.4	8	16.0	7	12.1	14	26.9	48	20.7
Average	6	8.3	5	10.0	4	6.9	2	3.8	17	7.3
Poor	5	6.9	3	6.0	2	3.4	0	0	10	4.3
Very Poor	7	9.7	0	0	4	6.9	3	5.8	14	6.0
None here	0	0	0	0	17	29.3	9	17.3	26	11.2
Total	**28**	**100**	**50**	**100**	**58**	**100**	**52**	**0**	**232**	**100**

Statistical Tests: Chi Sq = 51.33 (df=15), p<0.001; Cramer's V = 0.27

Almost half of parents / carers across all areas report that after-school activities are excellent (27%) or good (22%). Satisfaction ratings are higher in regeneration areas compared with the control areas, and highest in the Southside Regeneration Area (34% excellent and 33% good). In the control areas, approximately half (52% in the Disadvantaged Control Area and 47% in the Average Control Area) report that there are no such facilities in their area or easily accessible to them. Again, differences between areas in quality ratings of this service are statistically significant (Table 4.43)

Table 4.43: Quality of after-school activities by area

Quality rating	N'side Regeneration Area		S'side Regeneration Area		Disadvantaged Area		Average Area		All Areas	
	No.	%	No.	%	No.	%	No.	%	No.	%
Excellent	24	32.4	20	33.9	13	19.7	10	19.6	67	26.8
Good	17	23.0	20	33.9	11	16.7	8	15.7	56	22.4
Average	10	13.5	2	3.4	0	0	2	3.9	14	5.6
Poor	2	2.7	6	10.2	3	4.5	4	7.8	15	6.0
Very Poor	7	9.5	5	8.5	5	7.6	3	5.9	20	8.0
None here	14	18.9	6	10.2	34	51.5	24	47.1	78	31.2
Total	**28**	**100**	**59**	**100**	**66**	**100**	**51**	**0**	**250**	**100**

Statistical Tests: Chi Sq = 51.31 (df=15), p<0.001; Cramer's V = 0.26

In terms of recreation facilities for families, satisfaction ratings are much lower, with only 3 per cent across all areas rating such services as excellent and 10 per cent as good. The main differences between the areas are in the rating of facilities as poor, very poor and not present in the area. In the control areas, larger proportions report the absence of recreation facilities for children and families – for instance, 66 per cent in the Disadvantaged Control and 61 per cent in the Average Control Area respond that there are "none here" compared with 35 per cent in the Northside Regeneration Area and 46 per cent in the Southside Regeneration Area. Differences between the areas are statistically significant (Table 4.44).

Table 4.44: Quality of recreation facilities for children and families

Quality rating	N'side Regeneration Area		S'side Regeneration Area		Disadvantaged Area		Average Area		All Areas	
	No.	%	No.	%	No.	%	No.	%	No.	%
Excellent	5	4.9	4	4.7	1	1.1	2	2.1	12	3.2
Good	12	11.8	6	7.1	4	4.3	15	15.5	37	9.8
Average	2	2.0	2	2.4	7	7.6	7	7.2	18	4.8
Poor	14	13.7	6	7.1	7	7.6	9	9.3	36	9.6
Very Poor	33	32.4	28	32.9	12	13.0	5	5.2	78	20.7
None here	36	35.3	39	45.9	61	66.3	59	60.8	195	51.9
Total	**102**	**100**	**85**	**100**	**92**	**100**	**97**	**0**	**376**	**100**

Statistical Tests: Chi Sq = 51.36 (df=15), p<0.001; Cramer's V = 0.22

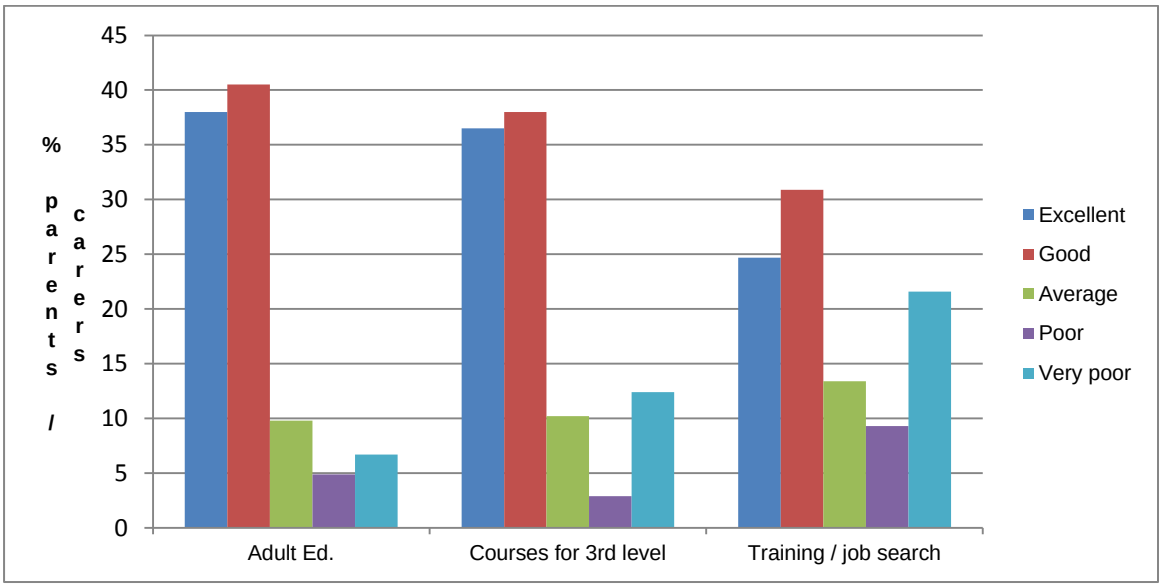
4.6.4 Quality assessment of other local services

This section reports on the quality assessment of adult education, courses for adults to go to third level education, and training and job search.

Of these services, the quality of adult education and third level access courses is rated highly, with 79 per cent rating adult education services as excellent (38%) or good (41%) and 75 per cent rating

courses for adults to go to third level education as excellent (37%) or good (38%). Training and job search services receive lower quality ratings, with 56 per cent rating them excellent (25%) or good (31%) and 31 per cent rating them poor (9%) or very poor (22%). Just under half of respondents (194 cases or 46%) responded to the question rating quality of the training / job search services. This, in turn, reflects increasing contact with such services as unemployment grows. Differences between the areas on these indicators are not statistically significant.

Figure 4.50: Quality rating of adult education and training services: All Areas



N All Adult Ed=163; N All Access courses=137; N Training /job search=194

In terms of other services, just over half who responded to this question rate the local Gardaí as excellent (17%) or good (36%) and 20 per cent rate them poor (8%) or very poor (12%). Satisfaction ratings are lowest in the Southside Regeneration Area (34% excellent or good and 30% poor or very poor). Differences between the areas here are statistically significant (Table 4.45).

Table 4.45: Quality of local Gardaí by area

Quality rating	N'side Regeneration Area		S'side Regeneration Area		Disadvantaged Area		Average Area		All Areas	
	No.	%	No.	%	No.	%	No.	%	No.	%
Excellent	23	20.4	5	6.3	9	11.4	20	27.8	57	16.6
Good	42	37.2	22	27.8	33	41.8	28	38.9	125	36.4
Average	25	22.1	28	35.4	25	31.6	15	20.8	93	27.1
Poor	7	6.2	12	15.2	4	5.1	4	5.6	27	7.9
Very Poor	16	14.2	12	15.2	8	10.1	5	6.9	41	12.0
Total	**113**	**100**	**79**	**100**	**79**	**100**	**72**	**0**	**343**	**100**

Statistical Tests: Chi Sq 29.68 (df=12), p<0.001, Cramer's V = 0.17

Just under half of respondents rate estate management as excellent (12%) or good (36%) and 36 per cent rates it as poor (9%) or very poor (28%). The lowest satisfaction ratings are in the Southside Regeneration Area with 45 per cent rating estate management as poor (12%) or very poor (33%). Satisfaction ratings are high (not highest) in the Northside Regeneration Area (54% excellent or good

and 34% poor or very poor) (Table 4.46). There are different issues with estate management in different areas. The City Council is responsible for estate management in public housing estates in the City and the clean-up work is undertaken under the Community Employment (CE) scheme (which is highly visible in Moyross, for instance). In private estates, parents / carers either indicate that residents are responsible for estate management, or there may be uncertainty about who is responsible. A source of dissatisfaction in some new private estates (e.g. in parts of Rhebogue) is incomplete works / unfinished estates where the construction company / developers are no longer in business.

Table 4.46: Quality of estate management by area

Quality rating	N'side Regeneration Area		S'side Regeneration Area		Disadvantaged Area		Average Area		All Areas	
	No.	%	No.	%	No.	%	No.	%	No.	%
Excellent	20	17.5	5	6.1	5	5.6	14	19.7	44	12.3
Good	42	36.8	22	26.8	37	41.1	28	39.4	129	36.1
Average	14	12.3	18	22.0	17	18.9	6	8.5	55	15.4
Poor	11	9.6	10	12.2	6	6.7	4	5.6	31	8.7
Very Poor	27	23.7	27	32.9	25	27.8	19	26.8	98	27.5
Total	**114**	**100**	**82**	**100**	**90**	**100**	**71**	**100**	**357**	**100**

Statistical Tests: Chi Sq 24.32 (df=12), p<0.05 (p=0.02), Cramer's V = 0.15

Local authority services have the lowest satisfaction ratings overall, with 13 per cent of parents / carers indicating that planning and development services of the City Council are excellent (1%) or good (12%) and 72 per cent assessing them as poor (14%) or very poor (58%). While satisfaction ratings are lower in the regeneration areas compared with the Control Areas, the differences here are not statistically significant (Table 4.47).

Table 4.47: Quality of planning and development (City Council) services

Quality rating	N'side Regeneration Area		S'side Regeneration Area		Disadvantaged Area		Average Area		All Areas	
	No.	%	No.	%	No.	%	No.	%	No.	%
Excellent	1	1.0	0	0	1	1.3	2	3.1	4	1.3
Good	8	8.2	6	7.5	14	18.2	8	12.3	36	11.3
Average	9	9.2	14	17.5	12	15.6	14	21.5	49	15.3
Poor	17	17.3	10	12.5	12	15.6	5	7.7	44	13.8
Very Poor	63	64.3	50	62.5	38	49.4	36	55.4	187	58.3
Total	**98**	**100**	**80**	**100**	**77**	**100**	**65**	**100**	**320**	**100**

Statistical tests: not significant

Just under half of rate the quality of local shops as excellent (14%) or good (35%) while 29 per cent rate local shops as poor (7%) or very poor (21%). Satisfaction ratings are significantly lower in the regeneration areas compared with the control areas and lowest in the Northside Regeneration Area with 30 per cent rating them as excellent (5%) or good (25%) and 53 per cent rating them as poor (9%) or very poor (44%) (Table 4.48). In the regeneration areas, there are no shops (e.g., Moyross) or few shops on the estates, and lower car ownership to facilitate bulk shopping by households / residents.

Table 4.48: Quality of local shops by area										
Quality rating	**N'side Regeneration Area**		**S'side Regeneration Area**		**Disadvantaged Area**		**Average Area**		**All Areas**	
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Excellent	6	5.1	7	7.8	16	15.5	27	25.7	56	13.5
Good	29	24.8	21	23.3	47	45.6	46	43.8	143	34.5
Average	19	16.2	25	27.8	29	28.2	26	24.8	99	23.9
Poor	11	9.4	8	8.9	7	6.8	4	3.8	30	7.2
Very Poor	52	44.4	29	32.2	4	3.9	2	1.9	87	21.0
Total	**117**	**100**	**90**	**100**	**103**	**100**	**105**	**0**	**415**	**100**

Statistical Tests: Chi Sq 108.82 (df=12), p<0.001, Cramer's V = 0.30

Finally, with regard to the Probation Services, very small numbers overall rated this service (21 cases) and no respondents in the Average Control Area rated the service. Of those who rated the service, just under half rated it as excellent (48%) and a further 29 per cent rated it as good, while 10 per cent rated it as very poor.

4.6.5 Overall assessment of services

In terms of services used by children and families, the services most widely used are in education and health, namely schools (drawing on earlier analysis), the GP, public health nursing / child dental services and hospital-based services. Quality assessment of schools is particularly high, and so too are satisfaction ratings with the GP and public health nursing / child dental services. More parents are satisfied than dissatisfied with hospital-based services. There is much lower utilisation of specialist services and mental health services (in the latter case with low satisfaction ratings of the service); there is low reported use of services such as social work; and low reported use of family support and other targeted services. There may be sensitivities with reporting contact with some of these services but generally it would seem that utilisation rates of services such as social workers and addiction services are low, the latter indeed very low.

In relation to community-based services for children and families (crèches, after-school activities, recreation services), there is a lack of some of these services in areas outside of the regeneration areas. Satisfaction ratings with crèches and after-school activities are high. Satisfaction ratings are less favourable for locally-based / locally accessible recreation facilities for children and families.

Adult education and third level access courses are highly rated across all areas. Training and job search receive less favourable satisfaction ratings. In terms of other local services, there are differences between the areas in quality ratings. Thus local shops receive much higher quality ratings outside of regeneration areas, and while more than half of respondents rate the local Gardaí as excellent or good, only one-third do so in the Southside Regeneration area. Less than half rate estate management as excellent or good but the picture is quite mixed here between the regeneration and the control areas here; the reasons for lower satisfaction rating are also varied and relate to specific

conditions / arrangements in different estates or parts of estates. The lowest satisfaction ratings overall are with local authority services (planning and development).

4.7 Model of Factors Affecting Child Outcomes

Multivariate analysis of the data set was undertaken (using linear multiple regression) with a view to identifying a set of factors independent of each other[26], which explain better and worse outcomes in children. The outcome variable used is the Total Child Difficulties Scale. The independent or predictor variables relate to demographic and socio-economic factors, neighbourhood factors, parent mental health and quality of the parent / child relationship (affection and interest, and hostility and criticism). A range of additional factors were tested including: area type (regeneration v. other areas), gender of the child, age of the parent, household structure (lone parent v. two parent family), household size, and measure of multiple family problems.

An explanation of the results of the analysis is presented below while the detailed statistical findings are presented in Appendix II.

Table 4.49: Factors explaining variations in child difficulties (Total Difficulties Scale: 0 no difficulties to 40 severe difficulties)

	Nature of relationship
Predictor / independent variables	
Age of sample child (in years 0-17)	Older children, greater difficulities
Parent level of education (lowest to highest)	Lower parental education, greater difficulties
Parental Mental Health (MCS 0 worst to 100 best)	Worse parental mental health, greater difficulties
Neighbourhood problem concentration score (0 none to 4 very big problems)	More problematic neighbourhood environment, greater difficulties
Hostility & criticism scale (-2 worst to + 2 best)	More parental hostility and criticism towards the child, greater difficulties
Warmth & involvement scale (-2 worst to +2 best)	More warmth and involvement in the parent child relationship, lesser difficulties in the child
Adjusted R^2 (proportion of variation explained)	**0.30**
Statistical Tests F-statistic	**13.03 (p<0.001)**
N=cases	**348**

The results of the multivariate analysis show that the combination of predictors identified above explains 30 per cent of the variation (value of adjusted R^2) in child outcomes (using the child difficulties score as the outcome variable).

In terms of demographic factors, age of the child is negatively associated with child difficulties, meaning that older children have greater difficulties. While the literature indicates that boys tend to

[26] Where factors are highly correlated with each other, the modelling process involves removing variables which are not significant and retaining those which are and which add explanatory power to the overall model.

have greater difficulties compared with girls – for instance in the *Growing up in Ireland* study (ESRI 2010) – gender of the sample child was not retained in the model as an explanatory factor.

In terms of socio-economic factors, parental education is associated with variations in child outcomes. Higher levels of parental education are negatively associated with child difficulties, meaning that children of parents with higher levels of education have lesser difficulties and low parental education is associated with greater child difficulties. There is a negative association between parental mental health (scaled from worst to best) and total difficulties in the child, meaning that children of parents with poorer mental health also have greater difficulties themselves. On factors related to the neighbourhood environment, there is an association between poorer environment (i.e., greater concentrations of problems including anti-social behaviour) and greater child difficulties. The social capital variable did not prove to be significant (as it is highly correlated with other factors such as neighbourhood problem score and level of parental education etc.).

Measures of quality of the parent/child relationship were retained in the model and add explanatory power. Where the parent child relationship is characterised by more warmth (affection) and interest in the child, there are lesser child difficulties; where parents are more hostile and critical towards the child, child difficulties are greater.

4.8 Summary: Main Findings of the Household Survey

A wide range of themes was explored in the survey. The specific questions were oriented to comprehensively "measuring" the current situation with reference to outcomes for children and families and the inter-relationships between the various factors and aspects of their lives which could explain differences in outcomes. The findings of the child survey (which involved a smaller number of cases drawn from households included in the parent / carer survey) generally corroborate the findings, as reported by parents, and provide additional insights. The main sources of data / findings on child outcomes, however, are derived from parent / carer reports with reference to one sample child in the household. The sample child was randomly selected as the child whose birthday comes next. The sample children span the broad age range of children from 0 to 17 years. The summary findings by themes are presented in this section.

4.8.1 Neighbourhood, Safety and Social Capital

Various aspects of neighbourhood life, safety and social capital were explored in the survey.

4.8.1.1 Quality of Neighbourhood Life

There are lower satisfaction ratings with the quality of the neighbourhood as a place to bring up a family in the regeneration areas (34 % Northside and 31% Southside rate it excellent or good) compared with the control areas. In the Average Control Area, some 87 per cent rate the

neighbourhood as excellent or good. In the Disadvantaged Control Area, quality rating are also high (70% rate it good or excellent). While the large majority of children across all areas (81%) report that they like where they live, a larger proportion in the regeneration areas (almost half) compared with children in the control areas (8%) report that they would like to move from the area.

Based on parent / carer assessment of the extent to which certain aspects of life in the neighbourhood are a problem, there are more serious neighbourhood problems in regeneration areas compared with the control areas. For instance, on the eleven problem issues explored in the survey, less than 10 per cent of the population in the Average Control Area indicate that any issue is a big or a very big problem. Stigma of area, or the area having a bad reputation in the city and more widely, is regarded by parents / carers in the regeneration areas as a very big or big problem (73% Northside and 88% Southside). Problems with the physical environment of the neighbourhood such as boarded up houses, crime, drug dealing / drug availability and various forms of anti-social behaviour are all much more serious problems in the regeneration areas. The Average Area has the lowest concentration of such problems.

4.8.1.2 Safe Places for Children and Teenagers

Less than one-third of parents across all areas reports that there are "safe places" for young children to play in the area. Based on parents' / carers' report, the availability of safe places for children to play is least favourable in the Southside Regeneration Area (only 5% indicate there are safe places for children to play). The situation is better for children compared with teenagers. Only 13 per cent of parents / carers across all areas report that there are safe places for teenagers to meet in the neighbourhood. The situation here is most favourable in the Northside Regeneration Area where some 20 per cent of parents / carers state that there are safe places for teenagers to meet. Taking the child perspective, on some indicators ("being afraid to go out", agreeing that "lots of mean kids are living" in the area), children in regeneration areas feel less safe, especially compared with children in the Average Control Area. However, on other aspects including "knowing grown-ups" and "grown-ups being friendly" to them, children in all areas have a positive sense of the social capital of the neighbourhood.

4.8.1.3 Social Capital

Aspects of social capital were explored in terms of (i) the extent to which people know their neighbours and trust people in general in their community. Generalised trust is an important indicator of community cohesion as it affects, for instance, willingness to engage as a community and to work together towards collective action; and (ii) the extent to which parents / carers and children have social networks which provide practical and emotional support in times of need. These are the "closest ties" of family and friends, who are socially similar, and this type of social capital is often described as "bonding" social capital.

Findings related to community social capital indicate that this is most developed in the Average Area, least developed in the regeneration areas with the Disadvantaged Control Area in an intermediate position. Parents / carers in regeneration areas know their neighbours to a much greater extent (90% Northside and 92% Southside know most) compared with parents /carers in the control areas (68% Disadvantaged Area and 49% Average Area know most). However, trust in people in general in the neighbourhood is lower in the regeneration areas and lowest in the Southside Regeneration Area (where 46% trust only a couple of people or nobody) compared particularly with the Average Control Area (where 18 per cent trust only a couple of people or nobody). The "gap" between knowing and trusting neighbours is greatest in the Southside Regeneration Area (an indicator of low social capital) while in the Average Control Area, a larger proportion of parents / carers trust most (60%) compared with the proportion who know most people (49%).

Taking the child perspective on their own social networks, the majority of children in all areas including regeneration areas report that they know their adult neighbours and have positive attitudes towards them (e.g. the grown-ups are friendly). The findings also indicate that there are positive influences in children's peer networks. Large proportions of children across all areas, including regeneration areas, have best friends who receive awards / prizes and help others voluntarily. However, children in regeneration areas, to a greater extent, have friends who engage in bad behaviour (e.g. being sent home from school for bad behaviour). The vast majority of children have an awareness of age-inappropriate (smoking, drinking), risk behaviour (drug-taking) and bad behaviour (fighting, stealing etc.) – indicating that they understand these behaviours are wrong.

In terms of support for parenting drawing on the parents' / carers' social networks – which is a manifestation of "bonding" social capital – the vast majority confirm that they have support in terms of parenting advice and practical help when needed. There are differences in the sources of support between the areas – with parents in the Average Area relying much more on their partner compared with the regeneration areas in particular. Grandparents, friends, neighbours and other family are important across all areas. As such, extended family networks are an important source of support to families in all areas.

Drawing on the child perspective, children across all areas are in regular contact with wider family. Grandparents and a parent who does not live in the family home are relatively more important in the regeneration areas. Almost all children report that they have someone they could talk to if they were worried or upset about something. As such, children and families are part of positive networks but with some differences in the actual composition of the networks.

Involvement in civic activities and voluntary activity are other important indicators of social capital. The survey findings with children indicate that they engage in civic activities including unstructured

voluntary activities (individual children helping people), activities through the schools and, to a lesser extent, civic activities in communities (clean up, parades etc.).

4.8.2 Child health

Various aspects of child health were explored in the parent / carer questionnaire with reference to the sample child. The main findings are reported in this section.

4.8.2.1 Parent / Carer Assessment of the Child's Health

The large majority of parents / carers rate the sample child's health as excellent (66%) or good (26%). Children in the Average Control area have the best health ratings; while health ratings of children are poorer in regeneration areas (i.e. less are assessed as in excellent / good health, more in fair / poor health), and the child health profile is poorest in the Southside Regeneration area.

4.8.2.2 Diagnosed Health Problems in the Child

Some 30 per cent of the sample children are diagnosed by a medical doctor or other health professional with a physical health problem. Of these children, 63 per cent are diagnosed with asthma (18% of all sample children). A lower proportion of the sample children (14%) are diagnosed with learning difficulties, behavioural or mental health problems. Of these children, some 35 per cent are diagnosed with dyslexia / dyspraxia, the same proportion (35%) with other difficulties, followed by 29 per cent with ADHD. Rates of diagnosis of ADHD are higher in disadvantaged areas (and while the overall numbers are small, differences here are almost statistically significant).

4.8.2.3 Peri-natal Health, Early Years Development and Accidents & Injury

The sample child's physical health development across a range of indicators, on average, shows a good health profile (birth weight, weight gain), high rates of take-up of immunisation and developmental checks, and no differences between the areas on any of these indicators.

The rate of admission to hospital (A&E, in-patients) for accident and injury in the sample child is 55 per cent. There are no statistically significant differences between the areas, neither on rates of hospital admissions for accidents and injury, nor on the mean number of accidents and injuries requiring hospitalisation of the sample child.

4.8.2.4 Experience of Emotionally Traumatic Events

Children in regeneration areas, on average, experience more emotionally traumatic events in their lives (i.e. greater experience of multiple trauma) and have greater experience of specific traumatic events. These include higher rates of bereavement of a close family member and of separation from parents compared with the control areas.

4.8.2.5 Strengths and Difficulties in the Child

A standardised and widely used screening instrument, the Strengths and Difficulties Questionnaire (SDQ) (Goodman 1997) was administered as part of the parent / carer survey to assess strengths and difficulties in the child (the sample child). The assessment of strengths and difficulties is based on five scales, four of which measure difficulties and one of which measures strengths. Scales to measure difficulties are: emotional symptoms, conduct problems, hyperactivity and peer problems scales. These four scales can be further analysed or combined to develop an overall scale measuring total child difficulties. The pro-social scale is a measure of child strengths.

In terms of child difficulties, based on average scores and the proportion falling into abnormal ranges (the latter drawing on the methodology of the developers of the screening instrument), the findings indicate that children in the Southside Regeneration Area have the greatest difficulties, followed by the Northside Regeneration Area, then the Disadvantaged Control. Children in the Average Control Area have the least difficulties. Differences between the areas are greatest in relation to conduct problems and peer problems.

In terms of child strengths, there were no statistically significant differences between the areas on the Pro-social scale, indicating that children are similar across the areas in terms of being kind, considerate and helpful towards others.

Regrouping or banding scores into abnormal, borderline and abnormal ranges, there are larger proportions of children in the abnormal and borderline ranges on all scales to measure difficulties (i.e. all except the Pro-social scale) in the regeneration areas compared with the control areas. The Average Control Area consistently shows the lowest level of child difficulties and the Southside shows greatest child difficulties followed by the Northside Regeneration Area (marginally lower levels). For instance, in relation to conduct problems, the proportion in the abnormal range in the Average Control Area is 6 per cent compared with 37 per cent in this category in the Southside Regeneration Area; on emotional symptoms, 17 per cent are in the abnormal range in the Average Control Area compared with 40 per cent in the Southside Regeneration Area; on hyperactivity problems, 12 per cent are in the abnormal range in the Average Control Area compared with 30 per cent in the Southside Regeneration Area; on peer problems, some 6 per cent are in the abnormal range in the Average Area compared with 27 per cent in the Southside Regeneration Area; and on total difficulties, 7 per cent are in the abnormal range in the Average Control Area compared with 33 per cent in the Southside Regeneration Area.

Compared with norms for an average population, using data from a study of US children aged 4-17 years[27] and data for nine-year olds in Ireland from the *Growing Up in Ireland* study (2010), rates of

[27] www.sdq.

child difficulties in the study population are high. For instance, on the total difficulties scale, the proportion in the abnormal range for a population of US children is 7.4 per cent and for Irish nine-year olds it is 9 per cent.

Taking into account findings on diagnosed learning, behavioural and mental health problems, as reported by parents / carers, it would seem that many children who have emotional and behavioural difficulties (based on proportions in the abnormal range) have not been "picked up" by the system (i.e. are not diagnosed with problems).

4.8.2.6 Child's Perspective on Strengths and Difficulties

A more limited exploration of strengths and difficulties was undertaken in the child survey. There is some evidence that children have greater conduct problems in regeneration areas compared with the control areas. However, based on child reports, they have strong positive perceptions of themselves in their relationship with peers (having good friends, being popular etc.).

4.8.2.7 Lifestyle Factors (Physical Exercise) and Child Health

Examination of the child's participation in physical exercise shows that more than half takes at least 20 minutes "hard" physical exercise every day or almost every day while 86 per cent takes at least 30 minutes of moderate physical exercise every day or almost every day. The frequency of taking 20 minutes "hard" physical exercise is lowest in the Southside Regeneration Area. Better facilities on the northside of the city may explain greater frequency of children taking "hard" physical exercise in the Northside Regeneration Area.

Based on findings of the child survey, just over half of children (7-17 years) are involved in a sports club. Rates of involvement in a sports club are highest in the Average Area (75%) and lowest in the Southside Regeneration Area (35%).

4.8.3 Education and Active Learning

Various aspects of children's educational experiences and active learning, parental engagement with schools and quality assessment of educational provision as well as parent's own orientation towards further education were explored in the survey.

4.8.3.1 Children in School and Type of School

The large majority of children (87%) selected as the sample child in the parent / carer survey are in school. Focusing an all sample children, 12 per cent are in playschool / pre-school, 49 per cent in primary school, 22 per cent in secondary school, and 13 per cent not started school. The remainder is in special schools or other provision such as Youthreach (3%) or has left school (1%). While the Average Control Area has a higher proportion in primary education (55%) and a lower proportion in secondary school (14%), there are no statistically significant differences between the areas on the structure of the school population.

4.8.3.2 Childcare Arrangements

In terms of pre-school children (106), just under half (48%) are minded on a regular basis in a form of childcare. There is a wide spread of care settings with the largest numbers of pre-school children who are in childcare cared for in crèches (32, 67%) and the smallest numbers cared for by paid childminders (6, 12%). The overall numbers in different types of care arrangements (e.g. childminders, care by relatives) are small.

In terms of school-going children (308), the large majority (84%) is cared for by the parents / carer or partner and 12 per cent cared for by him/herself or older sibling. Parents / carers in regeneration areas use the latter arrangement to a greater extent compared with the control areas (and this arrangement is used most in the Southside Regeneration Area).

4.8.3.3 Special Educational Needs

The findings indicate that small numbers of children overall are assessed as having special educational needs (48 children or 15% of the child population at school). The highest rates are in the Disadvantaged Control area (24%), roughly equal rates in the regeneration areas (14% Northside and 15% Southside) and the lowest rate in the Average Control area (10%). Discussions with education providers indicate that provision is made for additional support to children who need it in schools in regeneration areas. However, it would seem that, in the absence of formal assessments or no recollection of assessment on the part of the parent / carer, some parents are not fully aware of the attainment levels nor the educational needs of their child.

Of those children assessed with special educational needs, 83 per cent receive learning support; and of those who receive it (40) the level of satisfaction with learning support is high (60% very satisfied, 25% satisfied and 15% not very satisfied).

4.8.3.4 Parental Involvement with the School and Absence from School

The findings indicate high levels of parental involvement with the school in terms of attendance at parent / teacher meetings (93% in the last 12 months).

Parents' reports of absence from school in the last school year indicate that just under half (47%) were absent from one to five days, 17 per cent were absent for a period of more than 11 days and 7 per cent for more than 20 days. While there are higher rates of absence reported for children from regeneration areas, based on enquiries with teachers in specific schools in these areas, rates of absence seem to be under-reported in the survey (i.e. there are higher rates for absence for 20 days or more, up to and exceeding 30 per cent in some cases). The main reason given by parents / carers for absence from school is illness of the child (87%).

Parent reports of exclusion from school indicates that rates of school exclusion (e.g. suspension) are low (4%); absence and exclusion rates are higher in the Regeneration Areas but differences between the areas are not statistically significant.

4.8.3.5 Homework

In terms of homework from school, based on parent / carer and child reports, the vast majority of children (91% parent report, 99% child report) get homework every day or most days. Children in regeneration areas do their homework in homework clubs (17%) to a greater extent compared with children in the control areas (who mostly do it at home). Parents in the Average Control Area help their children with homework with greater frequency compared with parents in the regeneration areas, while parents in the Disadvantaged Control Area are in an intermediate position. Patterns here may reflect parents' own level of educational attainment (i.e. lower in regeneration areas) and capacity to help the child.

4.8.3.6 Perceptions of Child's Level of Attainment in Maths and English

Parents / carers were asked to assess the level of competency of their child in maths (sums) and English (reading) with reference to expectations of attainment for the child's chronological age. They were asked to do this by drawing on the child's school report and the parent's knowledge of his/her schoolwork. There are no statistically significant differences between the areas on parent's assessment of child's level of competency in maths and English.

Just over two-thirds of all parents rate their child's attainment in maths (sums) as excellent or good. Rate of reporting excellence in maths is highest in the Average Control area (43%) and lowest in the Southside Regeneration (32%). Over 80 per cent rate their child's level of attainment in English as excellent or good. Rate of reporting excellence in English (reading) is highest in the Average Control (53%) area and lowest (41%) in the Southside Regeneration Area.

A similar pattern is in evidence in the child's own reporting of attainment in English (higher compared with attainment in maths) and maths. Ratings of attainment are highest in the Average Control Area and lowest in the Southside Regeneration Area. As with parent / carer reports, there are no statistically significant differences between the areas.

The research did not provide the opportunity for objective testing of levels of attainment in maths and English. It should be noted again that ratings are based on parent / carer and child reports and their perceptions of attainment levels. Parents (and children) may not be fully aware of levels of attainment expected by chronological age of the child. This may particularly apply in situations where parents have low levels of educational attainment themselves (which is particularly the case in the regeneration areas).

4.8.3.7 Quality Rating of the Child's School, Teachers and Child's Potential

Quality ratings by parents for the child's school are high overall (73% excellent, 18% good and 3% poor/very poor). Satisfaction ratings for the child's teachers similarly are high (76% very satisfied, 19% satisfied and 3% dissatisfied). Satisfaction ratings in terms of the child reaching his/her potential at school are also high (76% very satisfied, 16% satisfied, 7% dissatisfied). The level of satisfaction on these indicators is slightly lower in the Southside Regeneration area. However, differences between the areas are not statistically significant.

Based on child reports, children mostly have positive perceptions of school – the majority of children report that they like school (59%) – and they like and have good relationships with their teachers. Children in the Southside Regeneration Area like school least (26% "don't like it" or "don't like it at all" in the Southside Regeneration Area compared 17% across All Areas).

Generally, parents have high expectations of their child's progress in education in that over 80 per cent expect their child to progress to third level education. While the majority of parents in regeneration areas expect their child to go to third level (71% Northside, 73% Southside), these are still below the rates for the Average Control Area where almost all (97%) expect their child to progress to third level education.

4.8.3.8 Safety at School

The majority of children report that they feel safe at school and could speak to teacher(s) if something was wrong or they had a problem. While children in regeneration areas feel less safe and less inclined to speak to teachers when things go wrong, differences between the areas are not statistically significant. There are more negative perceptions of safety issues and of reporting problems to teachers by children attending "other" schools (i.e. children who have left mainstream education to attend special school / other provision).

Based on child reports, discipline is applied in school (i.e. if they break the rules they get into trouble). Children do indicate that they have experienced incidents of bad behaviour from their peers (but small numbers overall report that this is the case). These incidents happen equally within and outside of school. There are more such incidents reported by children in regeneration areas, but differences are not statistically significant.

4.8.3.9 Active Learning: Children's Involvement in Activities Outside of School

Children engage in active learning through involvement in activities outside of school and home. The findings of the parent / carer survey indicate that almost two-thirds of children (sample child) are involved in at least one activity outside of school and home. Of those involved in activities, the highest percentage is involved in sport (45%) followed by cultural activities (33%) and a school-based activity club (30%). There are higher rates of participation of children from regeneration areas in

youth clubs / kids clubs, and homework clubs and, in the Southside Regeneration Area, in cultural activities (music).

In terms of children reading books for fun, rates are highest in the Average Control area (83%) and lowest in the Southside Regeneration Area (52%).

4.8.3.10 Parental Engagement in Adult and Further Education

Parental engagement in adult education since leaving full-time education and their orientation towards further education (adult education and access to college) were explored in the survey, as level of parental education and attitudes towards education influence the child's educational outcomes.

Rates of engagement in adult education since leaving full-time education are highest in the Average Control Area (where parental education is highest), high in the Southside Regeneration Area and lowest in the Northside Regeneration Area. Similarly, orientation to pursue further adult education and go to college is highest in the Average Control Area followed by the Southside Regeneration Area and lowest in the Northside Regeneration Area.

4.8.4 Relationship with the Child and Parenting

Various aspects of the parent / child relationship and of family life were explored in the survey.

4.8.4.1 Family-based Activities

Parents engage regularly with their child in family-based activities – having a meal together (the most frequent activity), watching TV, shopping, going out for an outing and walks / bike rides. The findings show there are no differences between the areas in terms of the intensity of family-based activities but there are differences in the frequency of engagement in certain types of activity. For instance, parents in regeneration areas take their children shopping more frequently and visit family and friends more frequently than parents in the Average Control Area; parents in the Average Control Area take more outings with the child, attend or watch sport more frequently and go for walks / bike rides more frequently. These differences are associated with differences in income, social factors, and the quality and perhaps safety of the neighbourhood environment (i.e. more places to walk, safer recreation areas etc.)

4.8.4.2 Parenting and the Parent / Child Relationship

The majority of parents (58%) indicate they are coping well with parenting. Parents in regeneration areas are coping less well compared with than those in the control areas. For instance, some 43 per cent in the Northside and 49 per cent in the Southside Regeneration Area indicate that "sometimes (they are) coping well, but sometimes things get on top on me" while a further 5 per cent Northside and 4 per cent in the Southside Regeneration Area indicate that they are "hardly ever / not coping these days"; while 73 per cent in the Average Control Area indicate they are "coping pretty well".

The vast majority of parents have a warm and affectionate relationship with the child and are involved in the child's life (i.e. interested in how they are doing and praising them often). Using a scale created to measure parental "warmth towards, and involvement with", the child, there are no differences between the areas here. The findings also show that most parents / carers are not often angry and not always criticising the child. On a scale to measure "hostility and criticism" towards the child, parents in regeneration areas score less well compared with parents in the control areas. However, the differences between the areas on the "hostility and criticism" scale are not statistically significant (just above the cut-off point of $p<0.05$). Stronger orientation towards hostility and criticism is associated with greater child difficulties (i.e. greater child behavioural problems measured using the total difficulties scale).

4.8.4.3 Parental Monitoring of the Child's Activities

Various aspects of parental monitoring of the child's activities were explored in the survey. The findings indicate that approximately half of the parents across all areas allow their children to go out unaccompanied. Rates of going out unaccompanied are higher in the disadvantaged areas (where the environment, as reported by parents, is less safe) compared with the Average Control Area. However, the vast majority of parents / carers report that they always know where the child is, with whom s/he is (96%) and what s/he is doing (93%). The vast majority also know what time the child is expected home (96%) while a smaller majority reports that the child never comes home late (84%). Based on parent reports, as such, there is a high level of parental monitoring of the child.

There is slightly less parental monitoring of certain aspects in regeneration areas (knowing what the child is doing, being home late against the parent's wishes), particularly the Northside Regeneration Area. The differences here are statistically significant.

4.8.4.4 Parental Disciplinary Strategies

Parents were asked about the frequency of using different types of disciplinary strategies with the sample child when s/he misbehaves or upsets the parent (in the last 12 months).

The findings show that parents use multiple disciplinary strategies.

The most frequently used across all areas are non-aggressive strategies oriented to rewarding good behaviour in the child (e.g. discussing the issue calmly and explaining why the behaviour is wrong, getting the child to take time out to think about the behaviour). By far the least frequently used disciplinary strategy is physical response or actually slapping the child (15% report that they ever slapped the child in the last 12 months while 85% never did so). Other non-aggressive strategies (ignoring the child, bribing the child/promising things if s/he behaves) and psychologically aggressive responses (shouting, swearing at the child; threatening to slap the child) are used with approximately equal frequency but to a considerably lesser extent by parents / carers. For instance, almost three-quarters of parents / carers report that they never ignore bad behaviour in the child and just over half

report that they never bribe the child (promise him/her things if s/he is good). Just under half report that they never shouted or swore at the child in the last 12 months while the large majority (72%) report that they never threatened to slap the child in the last 12 months.

Parents in regeneration areas use positive non-aggressive strategies to the greatest extent (but differences between the areas here are not statistically significant). However, parents in the regeneration areas also use psychologically aggressive (shouting, threatening to slap) and physical response (slapping) strategies to a greater extent compared with the control areas. Differences between the areas on these more negative disciplinary strategies are statistically significant.

4.8.4.5 Problems in the Family

The extent to which there are problems in the family at present was explored with parents / carers. These questions addressed issues including: domestic violence, trouble from a former partner, family member seriously ill, family member in prison, addiction problems in the family, financial problems, being away from home / family because of work, and work stress. As such, they include some issues which are particularly sensitive, and such sensitivities may have affected the reporting of such problems. Financial pressure (37%) followed by owing money (14%) are the problems reported by the largest proportion of parents / carers across all areas. While families in the Average Control Area have greater problems in terms of work stress and a parent being away from home a lot due to work (and because they are in work to a much greater extent), families in the regeneration areas have greater problems in terms of financial issues, serious addiction problems and a family member in prison.

On issues related to domestic violence, addiction and family members in prison, the actual extent of problems may be under-reported. This is linked to sensitivities (as mentioned above) as well as some of such behaviours being quite normalised and not perceived as such serious problems particularly but perhaps not only in the regeneration areas. Even with under-reporting, there is higher incidence of multiple problems in families in regeneration areas

4.8.5 Parent / Carer Health

Parents / carers were asked to rate their overall health at present, and were asked additional questions in order to assess various aspects of their health. The SF-12 (v.2) research instrument was used for self-assessment of parent health. The scales generated from this instrument to measure specific dimensions of health can be further analysed to produce two summary scales, one to measure physical health and the second to measure mental health.

4.8.5.1 Overall Health Assessment

The majority of parents / carers (60%) rate their overall general health as excellent or good. Parent self-assessed health is rated lower in the disadvantaged areas particularly the regeneration areas – i.e. lower percentages report that they are in excellent and good health and higher percentages in fair or

poor health - compared with the Average Control Area. Parents in the Southside Regeneration area have the poorest self-rated health while parents in the Average Control Area have the best self-rated health. Differences between the areas in self-rated general health are statistically significant.

4.8.5.2 Long-standing Illnesses

Just over one-third of parents / carer have one or more long-standing illnesses. Rates of illness are highest in the Northside Regeneration Area (43%) and lowest in the Disadvantaged Control Area (25%). Rates of diagnosis of psychological or emotional conditions are higher in the two regeneration areas (12-13%) compared with the control areas. Differences here are statistically significant.

4.8.5.3 Parental Physical and Mental Health

Based on the 12 items or questions used to measure different aspects of health (SF 12, v.2), the summary findings indicate that parents' / carers' physical health profile is just above average. There are no statistically significant differences between the areas on the physical health status (self-rated health) of parents / carers. However, the mental health profile is poorer in the regeneration areas where mental health scores are below average. The Northside Regeneration Area shows the lowest mental health scores (low scores indicate worse health). Taking into account what is known from the wider literature on the relationship between mental health and physical health – i.e. that people with poorer mental health have higher risk of on-set of chronic illness and higher mortality rates – the findings provide evidence of inequalities in health linked to social status.

Based on comparison with norms for an adult population (a Canadian sample), physical health scores for different age-sub-groups in the population of parents / carers in all areas (averages) are broadly similar to the reference population. The mental health profile of parents / carers in all study areas, however, is poorer, particularly in older age groups of parents. Analysis of the correlation between parental mental health and child difficulties (based on the total difficulties scale) indicates that there is an association between these factors – i.e. that children with greater difficulties tend to have parents with poorer mental health – and this association is statistically significant.

4.8.5.4 Parents and Physical Exercise

Lifestyle factors were explored to only a limited extent in the household survey. Parents in the Average Control Area take "hard" physical exercise to a greater extent than parents in regeneration areas. The majority of parents / carers (67%) take moderate physical exercise (walking for at least 30 minutes) every day or most days. High rates of taking moderate exercise in the regeneration areas is linked in part to walking to everyday activities (such as school and shops) and less access to a car in these areas.

4.8.6 Service Utilisation and Quality Assessment

Take-up and quality assessment of different services to children and families, including health and social care, community-based and local services were explored with parents / carers in the survey.

4.8.6.1 Take-up and Quality Assessment of Health and Social Care Services

The main types of services used across all areas by parents for their children or related to parenting in the last 12 months are the GP (90%) followed by the Public Health Nurse / Child Dental Services (60%) and hospital services (56%). There are no statistically significant differences between the areas on utilisation of these services.

A relatively small proportion used specialist health services (psychologist, speech therapist) in the last 12 months (17%). There is low reported use of social workers (6%), child counselling / family / parenting support (8%), addiction services (2%) and psychiatric services (4%). There were higher rates of utilisation of psychiatric services in the regeneration areas. While rates of utilisation of specialist health services are somewhat higher in disadvantaged areas (the regeneration areas and the Disadvantaged Control Area), with the exception of psychiatric services, there are no statistically significant differences between the areas on take-up or utilisation of these services.

In terms of the quality of service provision, GPs (85% excelllent / good), public health nursing / child dental services (84% excellent / good) and specialist services (74% excellent / good) are rated highest by parents / carers. Quality rating of hospital services (A&E, in-patients, outpatients) is less satisfactory but still quite high (58% excellent / good). Psychiatric services are rated as excellent / good by 52%, and as poor or very poor by 38%. There are no statistically significant differences between the areas on any of these quality ratings.

In relation to services in social care, users are mostly satisfied but, as indicated above, reported usage is low. Home-School-Community Liaison Services, linked into schools, receive the highest satisfaction ratings (85% excellent/ good) and addiction services, with very few users, the lowest (47% rate them excellent or good while a further 47% rate them poor / very poor).

4.8.6.2 Quality of Community Based and Local Services

There are differences between the areas in parent / carer assessment of the quality of community-based services (crèches, after-schools facilities, recreation facilities) and in the extent to which they report that specific services are available in the local area or easily accessible to them. Satisfaction ratings with provision of crèches and after-school facilities are higher in the regeneration areas. In relation to community crèches, 84 per cent of parents / carers rated them as excellent or good in the Southside Regeneration Area and 75 per cent excellent or good in the Northside Regeneration Area. For after-school facilities the corresponding ratings (excellent or good) were 68 per cent in the Southside and 55 per cent in the Northside Regeneration Area. In the control areas, with the

exception of recreation for children and families, larger proportions of parents compared with the regeneration areas report that there are "none of the services here".

In relation to other local services, adult education (79% excellent / good) and courses for adults to go to college (75% excellent / good) are highly rated by parents / carers while training and job search service receive lower quality ratings (56% excellent / good). There are no statistically significant differences between areas on quality ratings for any of these services.

Local shops are rated as poorer in regeneration areas compared with the control areas. Just over half rate the local Gardaí as excellent / good but satisfaction ratings are lowest in the Southside Regeneration Area (34% excellent / good, and 30% poor / very poor). Differences here are statistically significant. Very few parents / carers offer an opinion on the probation service. The highest quality ratings on estate maintenance / management are in the Northside Regeneration Area (54% excellent / good) and the lowest in the Southside Regeneration Area (45% poor / very poor). An explanation of low satisfaction with estate maintenance / management in the Average Control area is that there is uncertainty about future management of new estates in parts of the study area (Rhebogue) where some estates have not been adequately finished and developers are now out of business.

Assessment of quality of planning and development shows low rates of satisfaction overall (13% excellent / good, 72% poor/very poor).

4.8.6.3 Identifying the Set of Factors Affecting Child Outcomes

Bringing the various findings together, multivariate analysis of the data set identifies a set of factors, independent of each other, which explain a proportion of the variation in child outcomes (using the Total Difficulties Scale as the outcome variable). This analysis shows that greater difficulties in the child are associated with: older children; low levels of parental educational attainment; poorer parental mental health; higher concentrations of neighbourhood problems; more hostility and criticism in the parent child relationship; and lower levels of affection / warmth and involvement (e.g., interest, praise) in the parent /child relationship.

5. FINDINGS FROM THE FOCUS GROUPS

5.1 Introduction

This chapter profiles the qualitative findings of this research report. Qualitative data were gathered through focus groups which were conducted with parents and providers across a variety of locations in the Northside and Southside Regeneration areas of Limerick city, during the late spring, summer and early autumn of 2010.

A total of fifteen focus groups were conducted in all, comprising a total of eight parent focus groups, six on the northside (27 participants) and two on the southside (5 participants) and seven provider focus groups, four on the northside (16 participants) and three on the southside (27 participants). In the interest of guaranteeing anonymity, focus group participants are only identified in terms of whether they participated in a parent or provider focus group, and all provider and parent participants are referred to as female. As already noted in Chapter 2, Methodology, additional focus groups continued to be planned and conducted for as long as the Research Team identified gaps in types of participants and in the information generated from the discussion. The focus groups continued until the Research Team was satisfied that: (i) they had captured the diversity of views sought and (ii) had reached saturation point in terms of the views articulated (i.e. no new information was emerging from additional focus groups)'

There were some difficulties in recruiting parent participants and most especially in terms of obtaining a cross section of the population. This was despite the dedicated efforts of key personnel such as the Home School Community Liaison (HSCL) co-ordinators and other service providers, who on several occasions rescheduled meetings in order to increase the possibility of greater parental participation. Parent participants were recruited through HSCL coordinators, crèches, Youth Diversion projects and community connections. There was a large number of 'no shows' and also a reluctance to speak on particular topics such as experiences of engagement with services such as social workers or probation. Participants in the service provider focus groups were recruited through Youth Fora and Youth Services, and, in the case of education providers, through the OSCAILT network of Primary and Secondary DEIS band 1 schools in Limerick city.[28]

The nature and quality of data gathered through qualitative processes is deeply dependent on the nature and quality of relationships that researchers are able to establish with the research participants, and indeed the atmosphere and ethos of the research conversation itself. In this instance the researchers were well known to, and had longstanding interaction with, both the communities and the

[28] OSCAILT is a network of the twenty two DEIS band 1 schools in Limerick city, the Department of Education and Skills (DES), Limerick City, and Mary Immaculate College. The DES successfully secured Dormant Accounts funding to enable schools to maximise the use of their premises and facilities for their communities. The OSCAILT network facilitated the sharing of information and good practice for the duration of this initiative.

service providers across the city, and this enabled the researchers to establish a safe and conducive context in which participants and researchers engaged in discussion. It is also of note that the service providers were accustomed to meeting and interacting, as they were members of Youth Fora and the OSCAILT network.

The focus group design and questions were developed in consultation with the Research Subcommittee of the Children's Services Committee (CSC).The focus group discussions were structured into three specific areas of inquiry, namely Neighbourhood, Services, and Education and Support for Active Learning. This framework has been adopted as the reporting structure for this chapter. In combination, these areas offer an insight into the quality of children's lives in terms of their lived experiences in their communities, and in terms of the effectiveness of services in addressing their needs.

Area one, **'Neighbourhoods'** (5.2) aimed to construct an understanding of the nature of the neighbourhood in which children were living, and exploring opportunities for social inclusion. This was achieved by asking participants to identify positive and negative aspects of their neighbourhoods as places to bring up children, to discuss the facilities in the neighbourhood, and to identify the age groups best served by current provision. The researchers asked participants to explore the nature of the community itself in terms of community spirit, peer pressure and their networks of supports. Finally, participants explored opportunities to get involved in activities outside their immediate communities.

Area two, **'Services and How to Improve Them'** (5.3), aimed to generate an understanding of the nature of services operating within the Regeneration communities. The research design was informed by the 'Five Essential Service Characteristics' identified to promote the 'Seven National Service Outcomes for Children' contained in the 'Agenda for Children's Services: A Policy Handbook (Department of Health and Children and Office of the Minister for Children and Youth Affaire, 2007).Participants were asked to discuss the service outcomes, to consider how services were connecting with family and community, to comment on the quality and accessibility of services, to explore the issue of integrated services, and to share their opinions on the operation of the Youth Fora.

Area three, **'Education and Support for Active Learning'** (5.4), investigated the broad area of education and explored the supports that exist for active learning. Participants were asked about the nature and quality of provision of pre-schools, schools and non-mainstream education and after-school clubs. Parental education and a broad range of educational issues were also explored. Parents identified the attributes of a 'good school' and spoke of their relationships with the school and their level of satisfaction with the services provided for their children.

5.2 Neighbourhoods

When asked about the qualities of their neighbourhood, participants highlighted some positive elements which included good neighbours, facilities, resilience and compassion of residents, celebration of community life and aspects of the natural environment. However, the negative elements of these neighbourhoods predominated across all conversations. Negative elements included bad parenting practices, traffic, drugs, feuds, firearms and intimidation, anti-social behaviour, physical environment, and the normalisation of the presence of the Emergency Response Unit (ERU) and Gardaí.

While the negative elements were to the forefront, and caused high degrees of stress and fear, it was evident that these are not homogenous neighbourhoods and that the quality of the participants' experience of their neighbourhood was to some degree dependent on the residents' personal resources, the supports they had access to, the specific street they lived on, their immediate neighbours and the services they engaged with.

This section tells a complex story of the quality of lives of residents living within these communities.

5.2.1 Neighbourhoods: positive aspects

5.2.1.1 Good neighbours: 'neighbours stick together and support each other'

The parent focus groups highlighted the importance of good neighbours as a support mechanism for residents living in the Regeneration communities. Many parents acknowledged that they had *'great neighbours'* and gave examples of neighbours doing the shopping for elderly residents. Some parents related that they had close neighbours who looked out for children stating that '*you would have someone looking out for the kids and hijack them and bring them home to you'* (if they strayed out of the immediate vicinity). It was also highlighted that some neighbours '*stick together and support each other'* by warning each other when *'robbed cars* [are] *coming down the road'*. This relates to the constant vigilance of parents to ensure that their children are safe. Another positive aspect was that while all participants acknowledged the destructive impact of the troublesome families, the number of families causing trouble was considered small, '*there is a lot of lovely lovely people in our area. Lovely working class people. And you just get the few that kind of ruins everything for everyone*'. A parent noted the practical support she got from her neighbours stating that '*if somebody died in your family, they* (neighbours) *are the first people in your door there. They come in, do you need this?'.* The presence of families who work hard for their children was echoed by a provider who noted that '*it is important to acknowledge that there are fantastic families living in the area who would do everything and anything for their kids you know'*. The age profile of the community was also mentioned as a positive element, with one provider highlighting that there are '*some very, very pleasant nice older people living in the community'.* Parents discussed the different kinds of micro

neighbourhoods that can co-exist within one estate and gave an example of one small area of an estate which they saw as *'stable'*, in comparison to other areas within the estate. They attributed this to the fact that '*people bought houses there, and they had to make it what they want*'. However, parents also noted that in other areas of the estate children's opportunity to mix with other children could be compromised as '*sometimes where you live there isn't anyone nice that you can send them out with'*. Fundamentally, parents believed that in order to live successfully within the estates you must '*know your own circle. You know the ones you can't approach'*.

5.2.1.2 Facilities and services: 'keeping kids safe'

Parents on both the northside and southside of the city identified activities such as summer camps and community games as positive elements. Parents greatly valued after school clubs because they provided a safe haven for their children, stating, '*we put kids into the clubs like, 'cos you can't leave them out down there with the road. The world of cars flying up and down the road*'. Parents were conscious of '*putting them* (children) *into anything that's going to keep them off the road. You can't let them hang around'* stating that sometimes children '*fight with you'* but '*they have to go*'.

Providers identified the diversity of services and the level of communication between and across services, the young people's engagement, and the commitment and stability of staff as positive elements of the neighbourhoods in which they worked. They also noted that some of the young people who had come through their services had achieved highly within their fields and that this offers positive role models within the community. While providers felt that young people can identify with their communities, they were conscious that they can also become isolated from the broader society and reticent to consider moving out of the community to go to college, make friends etc. The commitment of personnel was also raised by providers as a positive element of the environment '*the huge positive is that there is a very strong will to do good for the young people. And that is very strong. And is obviously very present at those meetings* (Youth Fora) *and that is very positive I think'*.

Parents shared a variety of personal experiences in relation to raising children within their communities. One parent felt that in the specific area she lived it was safe to let her child go '*straight out with the soccer ball over to the soccer field, soccer, rugby, golf ball'*. However another parent, not living too distant from the first, would not let her child outside the front gate without standing at the gate to monitor him. She acknowledged that his frustration was building as she shared her child's cries for more personal freedom, '*but Mam I am big now. He can't understand. And 'look at them, they are allowed out of their gardens'*.

5.2.1.3 Resilience and compassion: 'people with great heart'

Providers spoke of the resilience of some of the young people as a major positive attribute and noted that sometimes against all the odds, the children were like '*flowers coming out of tarmac – that no*

matter what circumstance they are living in still something beautiful can come out of it'. Providers remarked on the resilience of residents and their compassion for the young people stating, '*they* (residents) *have survived many storms and they are still there. And I think they are a people with great heart, even when they look at people who annoy them most of all in the worst troubled parts of it. Even the people who are mostly affected there have a great kind of understanding of the children and the younger ones who do get in their way'*. Parents, while in no way condoning the behaviour of those involved in the criminality, also spoke with some compassion and highlighted the vulnerability of young people who get caught up in various aspects of the drug culture, '*whether they are good, bad, or indifferent they are somebody's'* . Parents, conscious of the importance of stability in their children's lives and the efforts they were making to ensure their own children's safety, also showed compassion for the children living in feuding families and the need to provide services to support them, stating that '*you won't fix everybody, but at least if a child comes from a bad family or a feuding family, that they might want that chance in life*'.

5.2.1.4 Celebration of community life

Participants named community events as positive aspects of their neighbourhoods. Providers and parents identified a community festival in which community services and facilities were showcased as a positive aspect in one community, and in another focus group parents spoke of the plan to build a community wall to celebrate the lives of young people, and acknowledged that the school and other community agencies would be involved in it.

5.2.1.5 Natural environment

Some aspects of the natural environment were identified as positive. In one estate parents spoke of children playing on the greens in the summer and neighbours watching that the children would not stray to the river. They also acknowledged the location of their estate with a view of the mountains and proximity to the river.

5.2.2 Neighbourhoods: Negative aspects

5.2.2.1 Negative parenting practices

Parents and providers spoke of the negative parenting practices within some households where young children were allowed to behave as they pleased without any consequences. One parent noted that '*children at 10 are throwing bricks at cars and children are not out of nappies and telling you to fuck off*'. Parents said that they were afraid to complain if children from particular families vandalised their property as they believed it would only make things worse for themselves. The lack of support from some parents for their children's education was also raised by parents who noted that *'a lot of parents they just don't seem to encourage their kids'.* Parents were aware that children who are out of control, get into serious trouble that often escalates and that '*out of control children'* are, *'robbing vans and*

burning down clubs'. They acknowledged that it is *'important how children are reared and brought up'* as they need to be disciplined and need to show respect.

5.2.2.2 Traffic: robbed cars, horses and motorbikes

The negative aspects of neighbourhoods identified by parents included danger from stolen cars, which meant '*you can't let the kids out with cars coming up'.* Parents described their community as '*a ghost town up here with the kids, there is no one out'* because of the dangers from joy riding. One parent related how a *'scumbag'* had knocked at her door in previous weeks to inform her that '*there is a robbed car coming. Get your small one in*'. However, this was seen as the exception rather than the norm. When asked if joy riding happened a lot, a parent answered '*Thank God there was none yesterday*', showing that this is a constant worry and danger. Parents also noted that the joy riders can be glamorised by their peers, which perpetuates the problem. Horses and motorbikes were also identified as traffic dangers within the communities.

5.2.2.3 Drugs: 'needles on the green'

The impact of drugs on the quality of life was discussed at length by parents and providers. Apart from the detrimental effects on the drug users themselves, the invasive drug culture had a serious impact on the quality of life of the broader community. Firstly, parents were acutely aware that the availability of drugs was a major issue, '*they are selling them* (drugs) *at every corner* '. The impact of the drug culture was seen not only in terms of drug usage but also in terms of young people being lured into carrying drugs and developing drug debt. This was compounded by the '*glamour*' of the alternative lifestyle lived by some community residents. As one parent put it '*they* (young people*) see the glamour of all the style ... and 'Mam give us 5 euro' and there is their friend now and he is going into town with 1,000 euro in his pocket'.* According to one provider the glamour extends to children of primary school age, noting that a child from a family involved in drugs is *'nearly put up on a pedestal because of a flash car and she is idolised in school* (by peers)*, and she herself does not have anything to do with it'.* Parents spoke with frustration of '*struggling all the time'* while their children looked at the drug dealers who '*are supposed to be on the dole and they are driving Passats, Audis, and they want for nothing. Do you know what I mean? And we are struggling'*.

Parents graphically described the visibility of drug misuse and said that there are '*heroin addicts going into burned out houses*' and '*needles on the green*'. They felt that, as a result of this, the environment is very unsafe for children and this militates against the development of facilities. According to one parent, '*if you have a playground you will have the junkies up there sitting on the swings'*. Parents also reported that awareness of the drug culture begins at a very early age as parents said that '*at 3 and 4* (years old) *children know about hash'*. Providers also believed that very young children were being lured into running drugs stating that drug running '*is more common than we believe it to be because the kids are younger. They are not even teenagers*'. Parents also highlighted

the power of the drug dealers who '*control the children and are "dipping the Zanex" into other stuff and making them addicts. The kids then "owe the drug dealer" and have to "do windows" or "shoot for the drug dealer"*. One parent vented her frustration that the '*big boys'* don't get caught but that it is *'the penny boys* (who) *are doing time for them'*. Parents were also conscious that under-age children were experimenting with drinking alcohol, and that young people had access to false ID.

5.2.2.4 Feuds, firearms and intimidation: 'you could be shot'

Parents were very aware of the high death rate of young people, be it through drug-related deaths, feuds, or car accidents. In relation to criminal activity, parents were conscious of the availability of guns within the communities, and felt compromised in their ability to address anti-social issues, because they felt if they approached certain families they would be '*putting their lives in danger'* as they '*could be shot'*. They also spoke of the impact on children of specific incidents, including shootings, '*one of the shootings was at 3 o'clock* (in the afternoon) *when all the kids were coming home. There was actually bodies the children were looking at'*. Providers were also concerned that young children had witnessed crimes and seen armed personnel in action.

Providers spoke of the impact of feuding on the community at large and the tensions this created, noting that '*the families who are living with it, it is unimaginable what they are dealing with'*. They reported that young people can at times identify with factions within the feud, and, while there may be no evidence of actual involvement, young people can believe '*they are actually part of the feud'*, and that this contributes to their isolation from the broader society.

Parents of young men were very aware that their sons could be a victim of mistaken identity. As one parent put it, '*my youngfella is 16. He wears the same clothes as all the boys. Some days you are kind of thinking, cars passing, they are going to think he is somebody else. It is a terrible worry'*.

While acknowledging the need to address crime and anti-social behaviour across the areas, parents were also aware of the normalisation of the presence of services like the ERU and Gardaí, and the negative message that might send out to the broader society. Parents and service providers believed that the media play a significant role in forming and perpetuating a negative impression of communities, in that they fail to adequately acknowledge the positive elements of their communities.

5.2.2.5 Anti-social behaviour and intimidation: 'afraid to leave their house'

The presence of negative role models and young people displaying antisocial behaviour was also named as a negative aspect of the community. Parents said they '*worried about who they* (their children) *are mixing with constantly*' and were explicit about needing to monitor their children, '*my children know who I want them with and who I don't want them with and they know the minute I see them with somebody that they are not supposed to be with. I don't give out. I just say 'Come on, in!' I keep them in then for so long, and then when I leave them back out again they know not to walk over*

to that person'. Another parent echoed this sentiment stating that if she sees her son with a rough gang she will *'pull up the car and pull my son into it'*. While participants were fearful of approaching particular families one parent related how she called to a house and said, '*my child is not allowed play with your child'* . She said she was able to do this because *'I have enough family I don't need to be afraid of them'*, highlighting the importance of extended family networks.

Parents felt that while they could monitor children when they were younger, the dangers increased as children got older, and one parent spoke of her anxiety stating that she is '*dreading mine getting older*'. Parents reported that they had to monitor their property stating that '*the only thing I find is at night time the gang. And they would kind of be watching your car. And you have to kind of be looking out. You are kind of a bit nervous. That's all I find it's at night time if they are hanging around drinking, now that is the only thing*'.

One parent described how she taught her child '*to stand up for himself'* by telling him to hit back if another child hit him first. However when he acted on this advice, the result was '*two days later there was about 6 or 7 with him* (the child who hit the participant's child) *and was throwing stones at my window and my car was scraped and the whole lot. My car is wrecked, scraped from keys and coins. And you can't go out like. I went out, and I was like 'keep away'. And I was called 'whores and prostitutes, everything*'.

In another focus group a parent stated that she felt so unsafe in her neighbourhood that she was afraid '*to leave a window open'*. Parents specifically highlighted the plight of the elderly, '*who are in a wilderness situation. They would have to give up their houses they raised their children in and pay rent somewhere else'* and noted that the '*elderly people suffer from broken windows. The only ones protected is the drug dealer. People are afraid of the drug dealers 'cos of the guns*'. Indeed one of the providers noted that '*you have a feeling as well that people are afraid to leave their house*'. The feelings of fear extend beyond the community as some parents said that if they were in town they were '*frightened to say where you are from, just in case*'.

5.2.2.6 Physical environment: soul destroying and depressing

Parents and service providers spoke at length of the negative aspects of the physical environment. Much of this centred on the quality of housing and the current situation with boarded up housing across the estates and the migration of residents to other parts of the city.

One service provider noted *'the heart is gone out of the community because they have taken the people out and they have also taken out the community spirit'* and another provider called the physical conditions in which people live '*soul destroying and depress*ing'. Concern was raised by providers about the psychological impact on residents of living in this '*soul destroying environment*', with one provider saying *'the physical appearance of an area has to have an impact'*, noting that '*you have to*

be happy with where you live to feel safe'. In the process of discussing the neighbourhood contexts, and in particular the deterioration of the physical environments, providers showed compassion for *'the poor families who have to live there'* who are conscious of *'what the kids are dealing with and living with every day'.* Providers spoke of '*people living in the middle of a row of houses that is boarded up every side of them and there is rats and rubbish and we are expecting them to function as a normal person in society. You couldn't possibly do that'.* And providers also recognised the frustration at the pace of change, *'well I suppose the environment is very unappetising at the moment. There are boarded up houses and that which is all well and good when things are moving. But it seems to be in a hiatus at the moment. And I think people are becoming a little bit sceptical about it and are saying "when is this actually going to kick in?" you know. Now I know there are a whole lot of other factors involved, but I have to say it is a fairly depressing area to live in at the moment'* .

While boarded up houses were seen to be unsightly there are more sinister elements associated with them also. Parents said that burned out and boarded up houses are used as hiding places for drugs and as magnets for rubbish, '*they are no sooner boarded than everyone throws their rubbish into the gardens'.* They also reported that the empty houses are used as corrals for horses. Providers cautioned against investing in the physical regeneration to the detriment of the social regeneration, noting that improving the physical aspects of the estates is short sighted investment stating that '*you could leave the houses in* (estate) *and focus on the social regeneration. But if you knock the houses and put the same people into the houses and the same issues it will be the same thing again in 10 or 15* (years) ... *it has been proven again when you look at* (estate)*, you know'.*

5.2.3 Neighbourhoods: Impact and implications of living in these communities

Participants described the impact and implications of living and working in these communities. Fundamentally the negative aspects of community described above adversely affected the quality of life for adults and children. One provider captured the sentiments of both parents and providers as she profoundly questioned the morality of raising children in such dangerous and toxic environments:

> *Is it a safe place for any child or is it fair on any child to face such uncertainty and restriction? Not being able to play outside or go outside. Is it fair to live in a place with such restrictions? Can't cycle a bike. Can't be seen outside. Can't kick a ball. Can't do anything*.

5.2.3.1 Impact on children's mobility: 'I stop worrying when the front door is locked and the bolt is on and they are all in'

Parents spoke of keeping children indoors and in their back gardens to keep them safe. Yet, they were conscious of the adverse effects of limited mobility on their children, conscious that if they protected them too much, children would be *'gullible'* or '*not streetwise'*. The parents involved in this study

spoke of trying to balance the tension between over-protection and not allowing children to '*mix with the thugs'*, all the time conscious that the children needed to develop the skills to survive in society. Parents said they were more at ease during bad weather as '*it is easier to watch them* (children)*'*, noting that while '*I love the summer now but I love the rain better'*. One parent summed up her mixed feelings about her neighbourhood stating, '*I have a young child and I feel that where I live is not a proper environment for him at all. And I just feel what do I do? I am at a standstill. I have put in for a transfer for the last 10 years, not that there is anything wrong with where I live. I love my home, love my neighbours, but just to give him a better shot like*'. Another parent with a young child shared that when she did allow her son to go out to play on the road that she stayed out to watch him, '*if he is out I am out and if he is in I am in*'. Parents spoke of the dangers and temptations being presented to young people as '*you don't know who they are going to come up against and what they are going to offer them'*. Parents said that they had more control over the whereabouts of their younger children and worried more about their children as they got older, saying they only stopped *'worrying when the front door is locked and the bolt is on, and they are all in'*.

5.2.3.2 Impact on adults' mobility: 'I would not dream of walking up that way'

It was evident that not only was children's mobility compromised within the estate but adults' mobility also. One participant said '*I would not dream of walking up that way'* referring to a particular area of the estate that she lived in. Another parent noted that when she visits her friend who lives in the same estate, she leaves her handbag in her friend's house to be collected the following day, so that she *'can pass the crowd'* on her way home.

5.2.3.3 Impact on service delivery: 'GPs don't do house calls where we live'

Participants also felt that the negative environment affected normal delivery of services. They noted that *'GPs don't do house calls where we live'* and only one fast food delivery company will deliver in the area, and that the delivery person will phone the resident who must come out to the car to collect the food. One participant, highlighting the deterioration in the community, stated that, '*first the doctors used to come with the guards now the guards are coming with the doctors. Now the guards come with the fire brigade and the ambulance you know*'.

5.2.3.4 Normalisation

Parents described the various negative aspects as outlined above but then spoke of being disturbed by the normalisation of this environment, where *'kids have heard it* (shootings) *so many times*'. They recalled one morning when '*X was shot, and you had kids coming down to school, passing, who saw him who saw what happened and who saw it . And who saw his body afterwards. They are down there in school having a conversation at the table as if it is nothing. That is scary'*.

5.2.3.5 Parental vigilance: 'keep ringing them and seeing where they are'

Parents spoke of the constant vigilance necessary to support their children, since '*you can give the best to your kids all your life and, like that, one incident could undo the whole lot'*. One parent noted that '*I don't like fighting but you know I will do whatever I have to for my kids do you know what I mean?'*. Parents spoke of the need to keep tabs on the older children saying '*you keep ringing them and seeing where they are ... I would not give her an inch'*. Parents also stated that they monitored their children's mobility closely by only allowing them *'to visit a few houses and to mix with certain children'* or by inviting their children's friends to play in their homes stating that they would *'rather have four in the house than let them out'*.

Another aspect of living in the areas covered by this strand of the research was the sense that people were always on alert. As one provider observed, '*if you want to look at the pattern it goes in cycles'. For a while peace and stability and it turns into something where it is usually drug related so that brings up all the tensions again. And ... I suppose this time* (it is) *just the usual people who are doing it but there is a few new families involved*'. A parent reflected that when things are quiet '*you feel fear, you keep children in back gardens, you know something is going down'*, and when you *'see their children* (children of criminal families) *being brought in you make sure your children are in'*.

5.2.3.6 Lost potential: 'glimpses of a proper childhood'

The loss of potential in young people's lives was highlighted as a disturbing outcome of living in such conditions. As one provider put it '*and you say to yourself, "what could these guys have actually achieved if they were at zero? A neutral starting point". It is so negative, so far back on the scale'*. Another provider decried the loss of childhood and noted that children *'just get glimpses of what I would call proper childhood. We have kids getting themselves up in the morning, getting their brothers and sisters up, feeding the baby you know'*. Parents also acknowledged the loss of potential and unrealised dreams, and the need to build the children's dreams and confidence *'you build on their dreams, which I think is vital. Because I think a lot of them ... lose their dreams ... and I mean lots of boys there maybe wanted to be soccer players or ... they could be a doctor they could have been a nurse ... they could have been anything. But I just feel it that there is nothing there to encourage kids to hang on to their dreams you know'*.

5.2.3.7 Personal safety

Apart from the inherent dangers outlined for children and adults living in these areas, some providers also highlighted that at times staff safety can also be an issue if they are working late into the evening or with particular families. Not all providers interviewed saw their personal safety as an issue, some providers felt that over time they had built relationships within the broader community and with families you '*might be afraid of*' and consequently to date they did not experience fear for their own

safety. However, providers acknowledged that they leave the community at the end of the day, leaving the young people behind to cope with whatever they are '*exposed to at night time'*.

5.2.3.8 Feuding: 'wishing guns were taken away and thrown in a big hole'

The issue relating to the feuds arose across both the providers and parent focus groups. As mentioned earlier, there was a tension around the behaviour of young people from feuding families and yet also a compassion for them. One provider spoke of the impact of the feud on the families that she worked with and relayed the distress experienced by young people living in those families, noting that some young people wished that '*all guns were taken away and thrown in a big hole in the ground and they wished it was just all over*' . While it was acknowledged that the young people may behave as if they find it acceptable, the provider said that '*I think deep down they don't like it at all and they wish it was all over*', thus offering an insight into the tensions in these particular young people's lives.

5.2.3.9 Poor image within the broader community: 'if somebody sees your address you won't get a job'

Parents also spoke of the impact of living in a community whose image is so negative in the broader society. They felt that the media '*only want the negative side*' and that this '*gives a wrong impression of us*' because the minute you name the estate you are from '*people look down on you'*. This they believe affects their ability to gain employment, stating '*if someone sees your address you won't get a job*'. Fundamentally, **'***your address is what it is all about*', and if you want *'to move on you move out*'.

5.2.4 Community spirit

Participants were asked to describe the communities they lived in. In the preceding sections we already described the positive and negative aspects of the community in terms of raising children. Here we explore the community itself and relate how both parents and providers view the communities.

Parents and providers referred to the incentives offered to residents in the past to move from the neighbourhoods. It was felt that this out-migration of residents had a detrimental effect on the community as those residents represented some of the most engaged and stable in the community. Furthermore, with regeneration there has been another exodus from the communities.

Participants identified both positive and negative aspects of their communities which impact on community spirit. One resident simply stated '*our area is a community'* in which '*everyone else is working class. We might not be on the higher bracket. We are ordinary working class people, that just want our heating, our food, and shelter and the ESB*'. The positives related to the support they got from neighbours who '*you could run to if you needed anything*'. Neighbours offered help in times of trouble, as one parent put it '*If I didn't know any of my neighbours anyway I would get a nervous*

breakdown. I would have no one to talk to'. Neighbours also helped to monitor children's mobility. One parent told her children '*that no matter if it takes six months down the line I will always hear*', as the neighbours would report misdemeanours to her. Participants also noted that they looked out for each other's children, taking turns to look after them in their homes. Parents showed compassion for children growing up in troublesome families, and while they would not like their children to endure negative peer influences they still had compassion for children born into troublesome families. Many participants also had family members living close by who helped out with babysitting and provided psychological and financial support in times of need. Some participants were so trusting of their neighbours that they were willing to leave spare house keys with them. It was also evident that strong connections with the local school helped to build a sense of community, one parent noting '*a great sense of community around here'*, as parents chatted around the school in the mornings. Some parents said that if given the option they would not move out of the area but that was because they had developed an understanding of *'the devil you know'*, and were acutely aware of serious problems in other estates across the city. A sense of involvement in community games also featured as a positive aspect of community. On both the north and south sides of the city, focus groups identified local sporting heroes as role models.

While all of the above attest to positive aspects of communities they must be understood within a wider context of the challenging circumstances which prevail. These were graphically described by people who live and work within these communities. The issue of drug dealers exploiting young people who end up '*in the graveyard'* (parent), or in debt and selling drugs to pay off their debts to the dealers was discussed across the focus groups. The level of drug misuse was also discussed with one parent believing that '*there is hundreds and hundreds around here addicted'* (parent). The gangs who intimidate residents who have to '*look out for their cars'* when young people are '*hanging around drinking'* (parent) paints a picture of an unstable and dangerous community. Young people driving cars and motorcycles irresponsibly poses a danger to all residents and most especially children and elderly people. Parents believe that the level of criminal activity has had an impact on the quality of people's lives, noting that '*the shooting would be going on every night. I didn't sleep for months'*. One parent, conscious of the dangers in her immediate community noted that she '*wouldn't trust no one down my way'*. As a result of this, participants noted that many residents would like to '*get out'*, but were afraid of going from the '*frying pan into the fire*' as at least they knew '*who to avoid'* within their own communities. A number of households comprised mothers and children, and this introduced another layer of vulnerability as they sought to cope with anti-social behaviour in communities.

The issue of the quality of life of the elderly residents was raised across the focus groups. Parents felt that elderly residents were especially vulnerable, and were treated badly by young people who were out of control with little or no parental guidance. One parent believed that '*the old people just ... are*

frightened ... because they don't know who they are dealing with'. In another focus group a parent noted how she has to go to the shop for her elderly neighbour because her neighbour is '*terrorised*'.

Fundamentally, the focus groups revealed a situation where '*people are really frightened to go out on the road now* ', and compared it to the past when '*you could leave the door open and go down the road to someone else's house – you could leave your key in your door'*. One parent who had lived in an estate for over 30 years said that *'it was great* (in the past). *Ruined by 2 or 3 families. Now the community spirit is gone. Your next door child is robbing you now'*. In some cases parents said that they were afraid of being involved in the community and were at times reticent to go to a meeting for *'fear of being seen to be involved in stuff*'.

5.2.5 Networks and support from family and friends

Parents discussed the levels of support they gave and received from family and friends. We already alluded to support parents got from neighbours, or indeed the level of fear they experienced because of their neighbours. We elaborate on these issues below.

Parents spoke of the challenges of raising children in a low income household when parents are separated. Specifically, mothers spoke of the stresses caused by financial strain when their children's father would not pay maintenance. Some were up to 2,500 euro in arrears. They also spoke of the strain that develops when two parents have different expectations of the children's behaviour, the father, usually more being lenient when children visit him, and the mother dealing with "the fall out" when children return home. Parents spoke of the impact of separation on the children and children making decisions to side with one parent or another, '*they get to 12 or 13, when they see what kind of life I* (mother) *have, and "I can get more off that fella* (father*), I might as well use him"'*. The issue of parents separating and forming new relationships and having multiple families arose. One parent said that it was really important for the children of the various relationships to know each other because '*if they keep the kids separated even though they have different mothers ... when they get older they won't know each other and could end up being in relationships with each other'*.

Parents spoke at length about the value of family support, according to one young parent, '*you need the support from your family, if you bottle it up you would be dead'*. Another young parent stated '*if a woman had four kids and no family and no supports from social workers she would have no hope'* or indeed another parent remarked '*if I didn't have my sister I was screwed*'.

Parents valued their children's friendships with their cousins, stating that early childhood friendships would '*help them to stay together*'. Some parents had sisters and mothers living close by who helped out with childminding and this was considered very valuable and not to '*be abused*'. Family members played a part in motivating and supporting the young people and listening to their problems.

5.2.6 Influence of peers

The influence of peers also featured throughout the focus group conversations. Parents highlighted that it is not easy to know who your children are *'hanging around with'* when they go to secondary school. They were very conscious of the negative impact of peers and they '*try to find* out' who their children are with. One parent said that when she found out who her child was with she advised her child to stay away from her new acquaintance saying '*I don't want you hanging out with her, and I have my reasons love. You don't need to know'*.

Parents were very aware of the vulnerability of children who can '*be easily led',* and aware that one mistake could change their whole lives. The pressure on young people to '*join in if they are in company and things are going on'* was raised, especially in relation to drugs, with parents recounting stories from their own experiences. Again parents highlighted the increased vulnerability of children with learning difficulties, and the glamorisation of the criminal lifestyle. Some parents believed that peer pressure kicked in as early as primary school, when boys and girls as young as ten years old can become sexually aware. Some parents also saw a gender dimension to peer pressure noting that *'when boys get older they are more influenced when they see the fellas driving around with big cars and that is a draw. It attracts the girls'*. In terms of role models, service providers worried that young boys would look to the *'hard men who are tough and can threaten and intimidate'* as role models.

Parents also showed compassion for young people who were easily led by the gangs, as one parent remarked, *'when I would meet him I would say, mind yourself love'* and then '*he was told* (by gangs) *more than once to bring a car in. And he is the nicest youngfella you could meet. And you could see it in his face 'if I doesn't do it they are going to kill me'. And he got caught then and the rest are still walking the road'.*

5.2.7 Safety and security within the neighbourhood

Safety and security was a major issue for all participants interviewed. Participants across focus groups acknowledged the potential of services to provide safe places for young people to mix with their peers and with responsible adults. As mentioned in the previous section, parents were aware of the dangers in the community and this is a motivation to get their children involved in programmes and activities beyond the intrinsic value of the activity itself. As one parent noted '*she* (her child) *is popped in at ten to nine and I don't see her till half four, so she is better off than up on the road. Safer'*. Attendance at after school clubs also enables young people to mix with their peers in a safe environment.

Parents described how they employ a number of strategies in order to keep their children safe. For younger children this means limiting their mobility, ensuring they are involved in activities out of

school time, and for the older children it means constant worry and keeping tabs on them with mobile phones.

Parents spoke of their '*constant* worry' when their children went to other parts of the estates or went outside the community. Parents said they '*kept ringing them up'* but were also conscious that a young person could say they were in one location but might be somewhere else. Fundamentally, this raised the issue of the lack of safe places for teenagers to meet, as one parent put it *'there is no place for them to go if you think about it'*. Service providers spoke of the fear expressed by parents when they were informed that the providers bring young people across the city to attend clubs or mix with other young people. They said that parents were fearful and replied '*Oh you can't bring them over there*'. Again the issue of the feud was raised, and the misconceptions that some children and young people have that they are actually part of the feud which in turn hinders their mobility within the city.

Parents' fears about their children extended beyond traffic and drug availability. Parents spoke of their fear of their young daughters becoming pregnant. Teenage pregnancy was a major issue in some neighbourhoods. The vulnerability of young people was graphically described by one parent who observed, *'like there is different girls. Young ones up here now at the moment. They are from Weston, Moyross. They are all chasing. And you would know to see the faces. In another few weeks they are going to be in trouble. They are going to be pregnant or in trouble'*.

5.2.8 Neighbourhood-based facilities and amenities

Parents and service providers spoke of the facilities that existed and their level of use within neighbourhoods. Each community had its own distinct profile of facilities. Participants discussed the level of facilities available within their communities, often in comparison to other communities. Furthermore, they discussed their awareness of what facilities existed, how to gain access to facilities, and the extent to which facilities were open to the community.

Parents across the city identified the need for information sharing so that they are more aware of what services and facilities exist in their communities, stating that '*there is no information'* about events and activities in the community.

Across the city both parents and service providers claimed that existing facilities could be used more extensively. However, it was argued that the extended use of existing facilities is dependent on increased levels of staffing. As one provider noted: '*there could be 30 to 40* (young people in a programme) *but we could double that easily if you had the staff and the funding to do it and again a community bus … transport probably takes up a lot of funding for community programmes'*. Providers in another focus group acknowledged that *'the* (names the facility) *is a huge resource here … even today … the '3 to 5' club you will have over 40 kids here … that's just one example of what goes on right throughout the week you know. But there is scope there for an awful lot more , going*

back to the original argument ... is around resources, resources, resources ... if we had the staff here'. Extending the use of local community facilities to host Leaving Certificate grinds at weekends was also raised by both parents and providers.

Parents across communities were aware that some communities had more facilities than others. They felt that if the level of needs is similar, communities should have the services and facilities to meet these needs: '*you would imagine if one community can have it why not everyone? You know we would have nothing like that in our community'*. Parents in one neighbourhood said that they felt '*neglected compared to other parishes'* and highlighted the urgent need for services and facilities stating that, '*we could badly do with things. There is children down there going mad and all they are'* (as they have nothing to do).

Parents identified gaps in service provision and highlighted the need for supervised parks, a swimming pool, youth clubs, dressing rooms at the pitches and pedestrian lights to make access to facilities safer for children. Parents also identified a need for more services for teenagers who hang around and are treated with suspicion by residents who '*see gangs of teenagers around and they think they are up to something, if they sit on the walls or anything like that'.*

Some service providers suggested there had been improvements in services in recent times, especially in sports and youth clubs. Parents stated that '*the gymnastics that goes on ... there is an awful lot of things that goes on in the evenings there. But some people don't know about them'*. However, while there is a local hall '*that is all say for clubs, local lads on their own couldn't go in like'* highlighting the need for a safe place for young people to drop in.

5.2.9 Provision for different age groups

While parents noted that '*there are gaps for all of the age groups'*, they also acknowledged that it can be an on-going challenge to engage young people '*I know from School Completion, ... that ... the target students are invited on the summer camps . They don't want to go'*. Parents also identified a gender issue in relation to provision, in that sometimes '*boys might be into sports'* but '*there is nothing there for the girls'*. The issue of providing universal services across age groups was highlighted, as well as the value of working with young children as a preventative measure. At the same time, service providers are conscious of the need to achieve a balance between building parental skills and parental responsibilities and the role of service providers, '*if you start working with kids at such a young age you are already presuming that the parents are not actually good parents'*.

In terms of provision, parents again highlighted the value of homework clubs that provide a safe environment and extend the school day: '*they* (children) *are there until 5 o'clock. The minute their homework is over their youth club starts straight away. They have youth club every day. They go swimming, play games, do drawing, they are involved in so much'*.

Parents were most appreciative of summer provision and the opportunities extended to their children, but advised '*over 8 and under 12 you are ok for summer based activities*', acknowledging the gap for younger (younger than 8 years old) and older children (teenagers). However, it was pointed out that the School Completion Programme catered for young people from first year upwards. In another focus group the gap in provision for children over 10 years was highlighted by a provider, '*Youth Diversion only work with children from 10 upwards yet* (younger) *kids are causing a huge hassle outside of school and are quite manageable in school and there is nothing for them'*.

The crèche and preschool in Moyross was identified as being '*state of the art'*, with a parent noting' *the new crèche is brilliant, and with the extension now they take babies'* and that the staff is very accessible and understanding . However, the crèche in St. Mary's Park was deemed to be very small.

Services like the School Completion Programme, the Northside Learning Hub, the local community centres, schools, Family Resource Centres , "the Bays" (Moyross), crèches, the Youth Diversion programme, sports facilities and sports organisations, Youth Cafes, and Barnardos along with after school provision provided through the local schools were also acknowledged.

Parents spoke of their worry for their older children '*once they were out of sight'* and highlighted the need for safe local services for young people. They said that young people sometimes go '*to Supermacs to hang out*'. They also acknowledged the challenges of working with teenagers within an embedded drug culture, and that some teenagers are not easy to engage. According to one parent, *'I think it all depends on the teenagers themselves. You have the rowing, right, rugby, the band you know. All children are not suited for that and they are not able to go for that discipline of turning up you know what I mean ... whereas if that youth centre was opened and there was a couple of pool tables and computers there'* . The needs of older teens were also raised, with parents contending that they needed customised provision, '*I think there should be more here for around 17, 18 year olds and they should be talking with them and there should be something that would interest them, just to come in and probably say how they are feeling and chat you know ... men like you know ... so that they could talk'*.

Parents were appreciative of the facilities but very conscious of the need to increase the level of provision: '*and like you have ... down there you have the kick boxing you have a snooker hall you have a lot of stuff for the older kids down there ... the 14s up ... and they would be kids that are at risk of offending or have offended. ... but a lot of kids are linked with clubs as well and they have an after schools group as well ... from 5 to 7 pm with those same age group again .. and sure there is a waiting list* .

Providers also highlighted the need to develop and increase the level of services available to young people stating, '*you could treble your numbers easy. They are constantly asking for different activities*

to be ran. I think if there was more facilities and more activities then we wouldn't have half the amount of hassle that we do have'.

5.2.10 Opportunities to get involved outside the community:' I would like to take a piece of that sky and put it in over my house'

Parents recognised the value of children getting involved in activities and events outside of their communities. Transport costs became an issue when they wished to go to the cinema or a leisure centre or swimming pool. There is no cinema or pool on the north side of the city. Their capacity to access facilities outside their communities was hindered by the cost of transport and the cost of activities themselves. However, the parents interviewed spoke of their efforts to bring their children to the cinema and on trips away from the city to Connemara. They also *'brought them over to the park, went from Shelbourne Park to the People's Park'* stating that '*Shelbourne is fabulous'*. Parents spoke of '*making an effort to do something together as a family'* and bringing their children to Grove Island and Delta. Going to Delta (activity centre) costs about 8 euro per child and was considered *'a huge treat'* (parent). Apart from this they spoke of attending parades including the St. Patrick's Day parade and the Bike Parade in the city.

The parents in the focus groups were largely either unemployed or on FÁS Community Employment (CE) schemes, and consequently their incomes were very low. They receive 23 euro a week on social welfare per child and said it would hardly take them '*to the cinema*'. Participants acknowledged that the children's allowance was '*needed for bills'*, and noted the '*very narrow line there, barely able to afford everything'.* Parents also stressed that there are sometimes costs associated with children being involved in clubs and activities within and outside the area and they are '*hard pushed*' to meet these costs. One parent told us that her daughter was in a lot of clubs across the city but '*but it is all money'.* Nevertheless, participants noted that despite this they will always try '*to take them somewhere with your allowance*'. It is through their involvement with activities /clubs that young people experience life outside of their immediate area. Providers spoke of the importance of providing young people with experiences to broaden their horizons as young people can become ghettoised and isolated from the broader society. This provider quoted one of the young people, who in the middle of enjoying surfing and experiencing life outside of their community, commented '*I would like to take a piece of that sky and put it over my house'.*

Participants' experiences of exclusion were located as earlier indicated in their experiences of discrimination based on their addresses. Also it was noted that young people identify themselves as being part of the feud and this further isolates them from services and the broader society. Participants also raised the issue of stigmatisation in relation to accessing services, with one parent relating how children attending a summer camp sponsored by a charitable organisation were discriminated against

by other students who realised the former group of students were being funded by a charity, and advised each other to avoid those children.

5.3 Services and How to Improve Them.

5.3.1 Introduction

Services and how to improve them is the second area of investigation in the qualitative dimension of this study. This section explores the nature of services including *Outcomes* (5.3.2), *Connecting with Strengths of Families and Community* (5.3.3), *Quality* (5.3.4), *Access to services* (5.3.5) and *Integration of services* (5.3.6). Finally, it addresses the relatively recent development of Youth Fora across the city (5.3.7).

During the focus groups, participants reflected on the nature of the services in which they are involved either as services providers or service users. Providers defined the mechanisms they used to examine whether or not their services were successful. These included personal reflection and evaluation, staff reflection and evaluation (in some services), and feedback from parents and young people. The voices of service providers, all of whom were members of either the Youth Fora or the OSCAILT network of DEIS band 1 Primary and Secondary schools, predominate. It should be remembered that not all constituent organisations of the Youth Fora were represented nor were the participants empowered to speak on behalf of their individual services. Service providers were sharing their opinions as members of organisations and as workers in the field. Where parents were in a position to contribute, this has been included. The parents were recruited through service providers such as the HSCL scheme and as such may well represent some of the most engaged parents. Not all parents had direct experience of services and, even if they did, there was some sensitivity around disclosure.

In the service provider focus groups, the Hardiker model was used to generate discussion across levels of need and service provision. This model, based on the work of Pauline Hardiker, conceptualises needs at four distinct and escalating levels. They move from level 1: Universal, to level 2: Vulnerable, level 3: Complex and finally level 4: Severe (Hardiker, 1991).

The context in which services are delivered has already been outlined in section 5.2 'Neighbourhoods', and described in detail in the previous chapters 3 and 4. The providers who attended the focus groups worked within a variety of services to children and families across the city. They highlighted that understanding the contexts in which services are delivered is the key to realising the nature of services required and addressing the challenges involved in their delivery. Providers noted that service users can be under a lot of pressure on a day-to-day basis, trying to find the wherewithal to pay the everyday bills like the ESB, and the more problematical bills such as drug debts and money lender debts.

5.3.2 Outcomes

Providers from different types of services defined positive and negative outcomes for service provision. The way in which positive outcomes were defined depended on the provider's understanding of the needs of the specific young people or families, and the nature of the service in which they work. Consequently, a wide variety of outcomes are profiled in this section. At a most basic level one provider focus group suggested that the fact that the young person is *'still alive'* is a positive outcome. More generally, good outcomes for children and families, as defined by the providers, mean that young people have positive *'childhood experiences with their families'* and within their communities. Effective integrated services were seen as a mechanism by which young people and their families are empowered to develop the skills, attitudes and behaviours to enable them to live happy lives. An effective system was not seen as static, but as a dynamic process of engagement, referrals, assessments, interventions and after care. As one provider noted, with reference to the Hardiker model, services need to be able to '*move them on and move them down'* (i.e., to lower levels of needs).

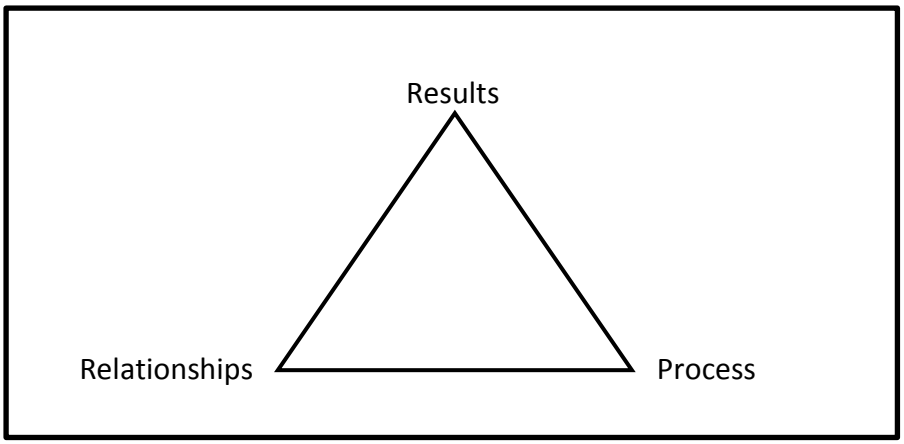
The capacity of services to meet the level of need plays a fundamental part in determining the quality of service outcomes, and services need to be resourced to meet the level of needs. It was clear across the discussions that system failure has both a short and long-term negative impact; not only does the system not meet the need of the young person in any one instance, but it also engenders negativity in the service users, prompting them to disengage further from services.

5.3.2.1 Dimensions of success

In order to create a comprehensive framework in which to investigate outcomes we draw on a model 'Dimensions of Success' created by Interaction Associates (IA). IA propose that there are three core dimensions to '*sustainable success'*, namely attention to results, relationships and process. Results are described as '*the completion of the task and achievement of goals*' (IA, 1997, section 2-2). Relationships relate to '*how people experience each other, how people relate to the organisation, how people feel about their involvement and contribution'* (IA, 1997, section 2-2), and finally, Process relates to '*how the work gets done, how the work is designed and managed, how the work is monitored and evaluated*'(IA, 1997, section 2-2).

The argument of IA is that in order to build sustainable success, it is necessary to move beyond simply focusing on measuring results, to also consider process and relationships as core components for sustainable success. Drawing on this model, a healthy service or a web of integrated services is one in which outcome, process and relationships are in balance. We will now locate the focus group feedback on the issue of outcomes within this framework.

Figure 5.1 Dimensions of Sustainable Success in Service Delivery



(Source: Interaction Associates, 1997, section 2-2)

Results:

Providers spoke of their commitment to achieving positive results and gave many examples of the challenges faced in realising these goals. These challenges include working with young people and families with complex needs, working within communities experiencing extreme poverty, poor planning, and anti-social behaviour, and working within services which are under-resourced. Positive results were defined in terms of prevention, self-development, engagement and attainment. Indicators of positive results for young people and their families under each of these headings were identified as follows:

Prevention and early intervention

- Early and appropriate intervention (in terms of age and onset of needs);
- Keeping young people away from criminal activities;
- Children receiving the appropriate supports and not going into care;
- Reducing the number of cases of children on Youth Fora lists.

Self-development

- Enhanced self-esteem for the young people and family members;
- Increased confidence for the young people and their families;
- Building and maintaining resilience in young people and their families;
- Building personal, social and interaction skills to enhance relationships with family, community and services;

- Support for young people and family members to take personal responsibility for their lives.

Engagement

- Successful engagement with services;
- That children and young people, and their families, would have positive experiences of services;
- Improved school attendance;
- Increased engagement of parents with the educational system;
- Developing relationships within the community and engaging with community groups;
- Young persons and parents engaged in decision making, e.g. as part of Youth Fora.

Attainment

- Educational attainment;
- Keeping young people with their families or foster parents;
- Skills development;
- Young people becoming employed in services;

Negative results are the failure of services to identify and meet the needs of services users. The antithesis of positive results are manifested through goals not being met for young people and their families, young people leaving the services without appropriate after care, inadequate universal services, over-emphasis on emergency responses (*'fire fighting'*) and not enough emphasis on prevention, and failure of the young person to take up opportunities and further training.

Relationships:

Positive relationship-building was envisaged by focus group participants as multi-dimensional, with recognition of the need to build positive relationships between the service users and service providers, within the services themselves, and across services. Also, a core aim of services was seen as enhancement of the capacity of the young person to build relationships within their families and communities.

Providers identified the capacity to build positive relationships with service users as core to developing effective services, as *'when you develop relationships with the people then everything becomes more successful'.* The complexity of engaging young people not only involved building

relationships with the young people themselves, but extended to *'working with the whole family in order to work with the young person'*.

Fundamentally, providers contended that the capacity of the provider to build relationships with young people and their families facilitated effective delivery of services. The providers noted that relationship building requires sustained effort, and is dependent on the providers having the time, skill, patience, and commitment to engage with service users. This level of personal commitment was affirmed across focus groups where providers, reflecting on the commitment of their colleagues, noted that *'because they care they will go the extra mile'.* In another focus group a provider noted that *'money would not pay you really. You have to have another dimension to it'*.

Negative relationships on the other hand are manifested through impersonal services, stigmatisation of the services, service users and their communities, disrespectful relationships, and breakdown in services.

Process:

Process relates to the mechanisms employed to design, deliver, implement and evaluate programmes, and includes decision-making and levels of engagement in decision making. The degree to which processes are agreed, transparent and collaborative within and across services was seen as central to success and sustainability. Providers identified strategic and integrated working practices across agencies as key mechanisms to enable the delivery of effective services. In this context the HSCL scheme was highlighted as a strategic conduit between the family, school, community and services.

Another critical aspect of process is the response rate: i.e., the rate of response from referral to assessment, to intervention, to follow-up and after-care. Providers felt that success depends on early and appropriate intervention, and not just '*fire brigade'* tactics, but *'get*(ting*) in there early'* to prevent needs arising and subsequently escalating. They also identified as important the flexibility of the service in responding to the young person's changing needs.

According to providers, the process of effective delivery of services must also take cognisance of the current migratory pattern of families in the city from the regeneration areas to a variety of other areas. Fundamentally, the service needs to *'follow the child'* as sometimes *'services are restricted to areas they* (young people) *are from, and there needs to be more fluidity within those services'*.

Negative processes are manifested through inadequate planning, inadequate monitoring and evaluation, lack of appropriate information sharing, late, slow and diluted interventions, lack of flexibility in service delivery, too many meetings and not enough contact time, inadequate follow-up to 'no-shows' for appointments, and the stigmatisation of services.

If a system fails, the quality of the young person's life may deteriorate or indeed, as mentioned across focus groups, the young person could even lose their life. For the providers, at a personal and professional level, there is frustration and stress. At an economic level, there is little return on investment. For society the cost is incalculable.

5.3.2.2 Roles and responsibilities of service providers

Service providers are the key agents in service delivery. During discussions, the complexity of the role of service providers was discussed at length. The roles of providers, and the degree to which providers are actively engaged in planning, implementing and evaluating their services, were seen to vary across services.

As already stated, providers had mixed opinions on the safety of the areas in which they work, which was dependent on the specific area, and on the nature of the service provision. Providers also spoke of the stability of staff across agencies as a strength, noting, for example, that in a time when there were opportunities for teachers to move from DEIS schools, they chose to stay, due to their commitment to the children and the communities. Providers also saw that part of their remit was to address the isolation and ghettoisation of young people by designing joint programmes with agencies across the city. One provider noted that in her service they base '*the majority of our programmes around joint work with agencies from different parts of the city'*.

A number of issues arose in relation to the roles and responsibilities of service providers. These included:

- Issues about personal safety of staff, working with specific families and at specific work hours;
- The need for creativity in order to respond to the dynamic nature of needs: *'people's remits are not broad enough'*. Providers noted that it is necessary to sometimes move beyond their job descriptions in order to facilitate greater uptake of services, e.g. a provider might drive a service user to a service and negotiate access;
- The match between the person's job description and the actual work they do: *'if you look at our job descriptions and the three year plan, one does not match the other'*;
- Pay cuts and instability: providers felt that one year contracts and *'organisations implementing pay cuts'* mean that people worry about their jobs. They are being asked to '*do more for less pay'* with possible impact on morale and motivation;

- Working in the unique Limerick 'disadvantaged' context: the challenges of working in this context extended to the quality of the built environment, the profile of need and the extent to which services have the capacity to meet those needs;

- Cultural differences between service providers and service users: providers noted the challenges associated with coming from a 'middle class' background to work in a 'disadvantaged' context, and needing to navigate the cultural differences in order to '*connect with people*';

- Provider's fears of their own limitations: '*I would have a personal fear of my own limitations. You don't want to be going into what a psychologist should be dealing with, or a counsellor, you know*';

- Gender issue: the issue of female service providers being treated disrespectfully, and service users assuming that their male providers are superior to female providers;

- Need for supervision and support: providers noted the need for supervision and support, most especially in light of the sometimes traumatic contexts in which they are working. It was noted that supervision in some services was not treated as a priority, and that this can have a *'fierce effect on your morale as they* (management) *don't seem to appreciate the work you do'*;

- Stress management: providers spoke of the negative impact of working in this context. There can be a lot of frustration working with families with complex needs.

5.3.2.3 Recording, reporting and measuring

While service providers agreed that recording, reporting and measuring are of value, they also noted that these tasks are complex, time consuming, and at times frustrating, due to the inadequacy of reporting templates. There was also some discussion on the extent to which reports are read and taken on board by management and funders. A tension emerged between the responsibility of services to report to the funder in their pre-described mode and the value of taking a more holistic approach in which the report writing might offer an opportunity for reflection and evaluation. Fundamentally, providers agreed that in order to have effective reporting of outcomes, effective planning is needed so that they are not *'going hell for leather'* without clarity about what it is expected they will achieve.

Report writing was considered time consuming. Some services had an allocation of a specified number of hours per week to do this work, but this was considered inadequate. There were also different requirements across different services. In order to measure outcomes it was argued that reporting must involve both quantitative and qualitative elements, and must be cognisant of the

context in which services are being delivered. One provider noted that *'sometimes the template does not suit the young people you are dealing with. The tools are not there'* and another provider highlighted the deficiency of the recording templates, noting that they had adopted a measuring template in the previous year *'and it was totally unrealistic'* as it involved quantitative data only.

In terms of measuring outcomes, providers noted that the fact that young people are still alive is a positive outcome in some services but that *'there was no box to tick on the returns'* but you '*would be able to find a box if the person was killed'*. Nor indeed was there a box to tick '*for relationship building',* which is at the very core of effective service delivery. Providers noted that to understand the outcomes you need to be a reflective practitioner who measures *'what outcomes you get on a day to day basis'*. Depending on the needs profile of the young person or family, significant outcomes can be as basic as getting a young person or a family to engage in a conversation, or getting them to turn up for an appointment.

The fundamental danger in this specialised work, according to one provider, is that *'children's services in general have become businesses in themselves, and in order to get funding, especially now, people* (adopt) *business models, where statistics and quantification has almost been prioritised over everything else'*. Providers also raised their frustrations in terms of how their managers/funders respond to their reports saying, '*sometimes you feel as if you are sending this in, is anybody going to bloody look at it? Is it just going to be thrown into a filing cabinet?'*.

5.3.2.4 Improving service outcomes

Providers and parents outlined a number of ways in which services could be improved.

1. More flexible boundaries across and within services, to enable providers who do similar work across the city to share good practice and support each other;
2. Need to be strategic in the design, delivery and evaluation of services;
3. Service providers need to define and clarify their roles in relation to their own service and how their services fits with the overall service provision;
4. Need to strategically invest in universal services;
5. Need to review how funding is allocated, and how best to maximise returns for investment;
6. In light of the current economic situation, services need to be clear on what they can realistically offer service users, what resources they have, and how they can best respond to need within an overall system of integrated service provision;

7. Providers are working within challenging environments. Managers and funders need to be cognisant of maintaining and building morale, by offering supervision, opportunities for reflection, and engagement in planning and evaluation;

8. The model of service delivery needs to be reviewed in terms of the hours that services are available to service users. Providers and parents noted that services generally operate a '9 to 5' service - the time when young people are in school. It is at weekends and evenings that there is an increased level of risk for young people and services need to be designed specifically to address this.

5.3.3 Connecting with Family and Community

There was broad agreement that connecting with family and community was the most responsible and ethical mechanism for service providers to address a young person's needs. There was also agreement among providers that many parents want *'to get it right for their kids but that life comes crashing down around them'*.

Providers acknowledged the key role of family in the child's life and ultimately viewed the services as mechanisms that enabled families to fulfil that role more effectively, stating that *'in theory connecting with family and community is the right way to go. You don't achieve anything by doing it in isolation no matter how bad the family environment is, it is still where the child is going to want to be'.* Fundamentally, according to providers, *'if you have the parents on board, really part of the battle is won. But it is not an overnight thing'*.

However, a tension emerged in the discussions between the aim of supporting children within the context of their family home and the need in some instances to remove them to foster care. It was acknowledged that *'there are some cases with kids, who are inevitably going to end up in the system and they* (parents) *can't manage them and they can't give them love, safety, protection, nourishment'.* By the time the children are taken into care their ability to adapt and reach their potential can be compromised. According to providers, parental capacity to meet their children's diverse needs can be compromised by *'environmental and mental health issues'* and the immaturity and incapacity of parents themselves. Some parents may not have had their own needs met at key stages in their lives, and this perpetuates the cycle of disengagement and dysfunction, and consequently *'extra support is needed to break the cycle'.* It was also noted that services need to be cognisant of the patterns of disengagement and dysfunction within families to enable them to intervene at earlier stages with younger children whose siblings had come to the attention of the services.

Reflecting on the diversity of the parent population, providers who offer courses to parents acknowledged that there is a cohort of parents who respond positively to opportunities. However, there is also a cohort of parents who are more difficult to engage, and working with these parents

demands time, patience and commitment. However, some providers feel that there is marked improvement over the past decade due to the work of the HSCL initiative and other interventions.

5.3.3.1 Profile of families

Parents in the regeneration communities, like residents of all communities, are a diverse group with different life experiences. In order to appreciate the diversity of population and the complexity of need, it is important to have an understanding of the challenges faced by parents and providers living and working in these areas. Providers noted that sometimes parents can be operating at survival levels, and are not in a place '*to consider their own strengths'*. Providers believed that encouraging parents to actively engage in Youth Fora and other initiatives in which they are supported to take an active part in decision-making is core to parents developing a greater sense of their capacity to help their children.

There was broad agreement that '*underneath it all every parent wants the best for their child no matter how much neglect you see. They are working to the best of their own ability. And for us it is how to increase that ability and make it better'.* What was in question was parents' capacity to fulfil that role, based on their life circumstances and resources. As one provider noted, *'I think there are very few parents who don't give a damn'*. However, *'they have so much stuff to be met before you can get to talking about ethics and values and aspirations, and all that. It is just like, how are they going to get through the next day?'.*

Having acknowledged the aspirations that parents hold for their children, and the constraints under which they live, the providers highlighted the following issues in relation to the unique context in which service delivery is taking place.

- Many parents are young and immature and may not have had their own developmental needs met;
- Parents are sometimes operating at a basic level of survival and it was proposed that this impacts on their capacity to take up services;
- Because some parents have very low skill levels, the types of supports necessary may be to provide opportunities for parents to learn basic skills such as how to *'cook a meal, use a washing machine and care for children'*;
- Parents may have low self-esteem;
- Parents may suffer from mental health problems like depression and apathy, and have other problems linked to mental illness;

- Parents may fear services such as social workers and believe they might *'take their children away'* and consequently are slow to engage;
- It was noted that parents' ability to access services is augmented if the school is involved as a conduit between the parent and service;
- Parents can exhibit destructive behaviour including '*holding their children back'* for selfish reasons including their fears of losing an allowance if the young person makes progress;
- Parents may be early school leavers with literacy and numeracy difficulties and consequently have difficulty in providing academic support to their children.

5.3.3.2 Extended family support

The level of support provided by the extended family was also explored in this study. Many children have close ties to their cousins, grandparents and aunts and uncles, many of whom live close by in their neighbourhoods. However, it emerged that not all families can actually draw on support from extended family. Providers noted that there was *'very little social mix'* (across extended families), and that extended families may not be in a position to offer support, as *'some of those* (extended) *families would have as many problems'*.

5.3.4 Quality of services

Providers reflected on the quality of current provision, identifying what is working well, and ways in which quality could be improved. Specific components of 'quality' provision include the effective use of resources, the extent to which services are achieving high quality standards, the extent to which services are needs-led, and responsive to needs, the extent to which they are inclusive of the voices of young people and families and the extent to which they are socially inclusive.

Services need to be properly resourced to meet the needs of service users. Providers argued that investment in quality services was cost effective, as the cost of not providing preventative and high quality intervention services means that young people could end up in high cost services. It was noted that poor quality services could have a negative impact on service users, causing them to withdraw from active engagement with services, e.g. if a child is waiting two years for an assessment the parents may lose heart and give up on the services. The appointment when it eventually comes may not be kept, and the young person may never receive the intervention needed. As noted by one provider, intervention may be the difference between '*the child staying in school or staying at home'*.

The quality of services was seen to be dependent on a number of attributes including:

- Attention to outcomes, relationships and process;

- The capacity of the service to respond to needs;
- The timeframe between referral, assessment and intervention;
- Post-appointment follow up to enable the service user to stay engaged;
- The development and nurturing of trusting quality relationships between service providers and service users. These relationships could deteriorate due to poor quality services, e.g. if service users are waiting extended periods for appointments for specialist services then they may disengage due to frustration;
- Preventative early years services that nurture personal growth, development and self-esteem;
- Effective preventative programmes to prevent children progressing to the higher levels of the Hardiker scale;
- Early detection and successful intervention to prevent young people presenting with higher levels of need;
- An integrated transparent model where each service is realistic about its resources, capacity and limitations, and where it fits within an integrated model of service delivery;
- Services follow the service user, either within the school system as a child moves from first to second level, or geographically if a family migrates to other areas of the city;
- Service flexibility to respond creatively to the dynamic nature of needs;
- Comprehensive understanding of the profile of needs and capacity of services to address gaps in provision;
- Appropriate location of services, e.g. parents felt that it was inappropriate to co-locate mental health services and services for people with drug addiction.

5.3.4.1 Threats to service quality

Participants noted that the quality of services can be compromised in a number of ways. For example, participants noted that service quality is compromised when a child is deemed in need of a specific support, e.g. a Special Needs Assistant (SNA), but that support is not granted by the Special Educational Needs Organiser (SENO). Quality of services can also be compromised through insufficient staffing levels and also through discontinuation of services when the service provider goes on leave and is not replaced. The lack of foster care places was raised, as were gaps in provision for teenagers, and insufficient capacity within the system to provide the level of assessment and support

needed in schools. For instance, some schools fundraise for psychological assessment and speech and language therapy costs.

The age at which services engage and disengage with young people was also discussed. Early intervention (in terms of the age of service users and stage of development of a need) was highlighted as key to delivering high quality services. Providers noted that some services disengage when the young person is 18 years, even though they may still be in the school system and require continued support to enable them to complete their education. The lack of a long-term vision for service provision was also mentioned, with participants noting that, while a lot of energy goes into dealing with the problems as they arise, for an effective quality service it is necessary to do more than *'throw money at the problem'* but to engage in long-term planning.

The quality of services was also deemed to be compromised by the lack of research to inform the field, and the lack of support to service providers to enable them to research and track their work. It was noted that the quality of service provision is also compromised when the service providers do not have sufficient opportunity to engage in reflection and planning.

In one of the service provider focus groups it was contended that, *'quality services are depending on quality people, who are hardworking'*, and the process of nurturing engagement is *'a slow and delicate process'*. This means investment in staff and staff training and support is necessary. Providers noted that services must be sufficiently flexible to respond to needs as they emerge. The changing nature of the context in which service delivery takes place was also discussed, as providers are conscious of the dynamics of migration across the city, and the danger that young people may be *' lost'* if the supports are not flexible enough to respond to this dynamic environment.

5.3.4.2 Making the best use of resources?

Providers considered the most effective use of resources and reflected on how resources are currently allocated. They were acutely aware of the constraints of the current economic situation. These constraints put more pressure on them, as one provider noted in relation to her staff, '*you always seem to be asking them to give a bit more. And I am saying some day that seam is going to burst. They are going to rev up and rise out like'.* Providers were conscious that the Regeneration Agency will make strategic investments in communities over the coming years. While recognising the need to address the poor quality of the built environment, providers feel that without prioritising strategic and targeted investment in the social dimension of regeneration the building process will have limited impact. The building programme needs to fit within an understanding of the holistic needs of communities and be understood as one aspect of the regeneration process.

Providers identified a number of ways in which they make good use of resources. These include services sharing their facilities and transport. Sharing of resources was seen to be maximised through

structures such as the Youth Fora, which enable the sharing of both physical resources and of good practice. It was also acknowledged that, more recently, summer provision of services is better co-ordinated.

However, providers also identified a number of ways in which resources could be used more effectively. These include extended use of facilities such as school buildings and community centres which have playing pitches, stages and cooking facilities. The value of the Dormant Accounts funded initiative, 'Maximising community use of school premises and facilities' was acknowledged. Participants noted that there are many unemployed graduates who might be available to volunteer in communities, but the process of engaging volunteers is complex. It also involves training and Garda vetting which can take a long time, after which the graduates may have moved on to other work. However, while volunteers are most welcome, it was noted that if the cohort of trained staff was increased it would maximise the use of existing facilities.

Effective and strategic planning and integration of services were identified as mechanisms to maximise return on investment. The issue of integration of services is dealt with in section 5.3.6. Fundamentally, it was proposed that if projects adopt an integrated approach in service delivery, they could offer a more comprehensive service and indeed could also make some savings in terms of administration and running costs. Another area that providers identified for attention was the limitations of Community Employment (FÁS) schemes in providing sustained support to services. It was acknowledged that workers on schemes often originated in, or lived in, the communities. While is it seen as a positive investment in the local skill pool, the duration of their contracts is problematic as *'depending on their age, they might only have a year or they might have three years in a place, and that is it then,* (they are) *gone, and they have been given all this fantastic training and they are gone'*.

The way in which funding is allocated, and the rules related to the timeframe in which it must be spent, were also areas of concern. According to providers, there is undue emphasis on spending monies within a tight timeframe, as this put undue pressure on services to spend it or return it. The issue of returning funding raised fears as to whether similar levels of funding might be allocated in the following year. It was proposed that there should be a more flexible arrangement for allocating and reporting on expenditure.

Providers identified investment in preventative services as the best way of ensuring the best use of resources. They contended that this would decrease the substantial investment needed if young people end up in specialised care or services. This is without calculating the impact of their criminal activity on people or property.

Another way in which it was felt that services could bring added value is to improve communication between services. There was much disquiet in relation to assessment and intervention appointments

not being met when parents fail to bring children for their appointments. This is primarily a loss to the child but also a waste of service providers' time and resources. Providers suggested that this could be addressed in a number of ways including reviewing the location of services and the role of the school as a site for delivery of services. Better communication between services so that, for example, the HSCL coordinator or school principal is informed by the service that a child has an appointment could encourage attendance. However, services only send appointments to the family home at present.

Staff turnover was also noted as a contributing factor in the waste of resources. As already noted, quality services are dependent on quality personnel who can build relationships. One parent spoke of meeting a different social worker every week and *'you are telling one story to one and then the following week you start from the beginning again',* and *'just when the kids are getting used to someone there is someone new brought in'*. If there is instability in staffing, or a high degree of staff turnover, this will mitigate against effective use of resources as the incoming person has to invest in building relationships which takes both time and energy.

Lack of flexibility in the system was mooted as an area which needs to be addressed. Release of personnel for training was seen as problematic, even when funding had been secured. Again, the unique context in which services are operating needs to be understood, and senior management needs to have the courage to establish new protocols.

Participants noted that strategic investment would also entail reviewing current provision prior to investing in new services, to ensure that there was no duplicating of existing services.

5.3.4.3 Are services achieving high quality standards?

Providers identified a number of ways in which they considered that they were achieving high standards. Investment in relationships with service users and other service providers as well as maximising use of physical resources were named as key areas in which high quality standards were being achieved. Providers also highlighted instances where information was appropriately shared between services, culminating in positive outcomes for service users. Providers noted that they endeavour to operate from an inclusive philosophy in which they make conscious efforts to listen to the opinions of the service users. They also felt that the quality of services had improved due to the existence of the Youth Fora, as these facilitate interagency collaboration, provide a mechanism for constructive family engagement, and enable sharing of resources and sharing of good practice.

However, they also identified a number of ways in which the quality of services could be improved:

- There are gaps in services that need to be addressed including services for the rehabilitation of drug users;

- Current services in the youth sector do not have the capacity to address the current level of needs;
- Children sometimes reside with their families over a long period of time and are subsequently taken into foster care. The outcomes for the children might be better if the stage at which individual children are taken into care was reviewed, most especially in light of pre-existing patterns of siblings being taken into care
- Need to revisit the remit of the Youth Fora and act strategically to identify the level of young people's need, and to address these need within an overall integrated network of service provision;
- The need for clarification between the role of the Youth Fora and the role of HSE in child protection emerged as an area needing further consideration;
- Need to deliver preventative services and consequently reduce the level of '*fire fighting'* and prevent young people progressing to the higher levels of the Hardiker scale;
- It was noted that due to the level of needs presenting, the mental health services and speech and language services are over burdened and the level of resourcing needs to be reviewed;
- All age groups need provision levels reviewed;
- A review of the timescale between referrals, assessments and intervention with the view to both shortening this timescale and also ensuring better use of resources including exploration of how to promote and support uptake of appointments.

5.3.4.4 Are services sufficiently needs-led?

When providers were asked to reflect on whether current services were sufficiently needs-led, a discussion ensued on how needs might best be identified, basically questioning who determines the needs and who are the target population of the services. The point was made that if 4,000 prison places are created, one can then justify their existence by filling them, even though prison may not always be the most appropriate response to supporting the person to change their behaviour. It was also noted that services must not only understand the level of need, but must respond with the types of initiatives that young people and families want to engage with.

The challenge of securing funding played a part in how needs were identified and met. Service providers felt that at times they were forced to look at the objectives of the funder and mould their service provision to match the funder's objectives. This caused a tension to some degree between working to the objectives of funders and working to the needs of service users. However, providers emphasised the need to be realistic and pragmatic, and to find opportunities to fund the work that needs to be done.

As already noted, providers and parents highlighted gaps in service provision, most especially in terms of the level of universal services available in neighbourhoods. This was a recurring theme

throughout the research, with one provider capturing the general sentiment as follows, *'the reason why more kids and more kids come up to this point* (higher point on Hardiker scale) *is because there is no investment at the bottom. It is not rocket science. You need investment here* (lower levels) *in order to reduce the amount of kids coming up along'*. Another provider echoed this sentiment and said that, *'in order to get a programme and activities you* (a child or family) *have to do something bad you know'*. A parent whose child was misbehaving, related how she had approached a social worker to try to get help for her child and said that she was told that the child *'needed to get into trouble first before he will get services'*.

The need for specialist services to address the behavioural needs of young people was also raised. A parent spoke of her worry about her child and her frustration with services. This parent had a heightened sense of the danger her child was in and told researchers that at the age of fourteen she put two Zanex in the child's tea to put him to sleep, so that he would not get into a robbed car. This parent graphically described her struggle to get appropriate service response and engagement for this child. The parent wanted her child to be put into a secure *'lock down'* unit so that he would be protected from the dangers he was living in and so that his behaviour would not deteriorate any further. She saw this as a means of keeping her child out of prison further down the line. The issue of supporting families who place their children in voluntary care was also raised, highlighting the need to support the family through this traumatic experience. A parent also raised the issue of how her community, in contrast to other communities, was not supported to deal with trauma when tragic events take place. This parent wondered if '*services think that communities become immune to the effects of criminality and are not traumatised'.* The issue of foster care also arose with providers noting that, at times, *'the HSE don't have foster places so sometimes they actually have nowhere to put the kids, kids who are presenting with certain concerns around health and wellbeing and stuff. They really have nowhere to put them. So that is a very real problem'.*

5.3.4.5 Are systems responsive to needs?

Services are not always successful in responding to needs. This, among other possible reasons, may be as a result of a capacity issue, a communication issue, or disengagement on the part of the service user. Service providers were realistic also about parents' capacity to engage with support programmes if they have to deal with immediate serious problems such as *'a money lender sitting in the house'.* Fundamentally, for services to be effective they have '*to meet people where they are at*' in the overall context of their lives.

Parents and providers identified a number of aspects of service provision that need to be addressed:

- Dental and orthodontic services need to expand to meet the needs (Parents);

- Timescales for referrals, assessments and interventions need to be realistic (Parents and Providers);
- The stage of intervention needs to be reviewed and more emphasis put on prevention and early intervention (Parents and Providers);
- The capacity of services to meet needs should be reviewed. Levels of service intervention need to be matched to level of need, e.g. art therapy for children suffering the outcomes of trauma and bereavement (Providers);
- The roles and responsibilities of the HSE in relation to child protection issues needs to be reviewed, specifically to identify the stage at which the HSE child protection services need to take action (Providers).

5.3.4.6 Listening to the voices of young people and families

In principle, service providers agree that listening to young people and families helps to ensure quality of services. Providers noted that getting young people and parents to engage in decision-making is a process that needs to be nurtured. Apart from individual providers consulting with families, the Youth Fora were seen as an effective mechanism to engage parents and young people. However, providers and parents agree that some parents are reluctant to engage with services for fear of being seen to collude with the system; others are slow to engage depending on what services are in question, and who the other service users are. Consulting with young people in the design of programmes also carries its own challenges, as young people, because of their lack of experience with the broader society, see limited options, and providers need to encourage them to expand their options. It was also noted that young people can see consultation as *'lip service'* if they do not see tangible outcomes. Finally, when evaluating an activity, young people can give negative feedback (*'sometimes it is not cool to be happy'*), which is contrary to the observations of the service provider.

5.3.4.7 Are services socially inclusive?

Social inclusion is complex. It may relate to inclusion within a community, across similar communities or across diverse communities. According to providers, services aim to be socially inclusive and work to build connections within and across communities.

Within the community, service providers spoke of the difficulty of directing a service to the needs of a specific cohort of young people while at the same time working to avoid stigmatisation. Both parents and providers raised the issue of how children in feuding families can become stigmatised within their communities. While parents had compassion for these young people, their fears of negative influences on their own children meant that they actively encouraged their children to avoid mixing with young people from feuding families.

Providers also reported significant difficulties in encouraging service users to engage with projects across the city. It was evident that there is a degree of ghettoisation or isolation within the psyche of young people and families which makes it very difficult for them to move beyond their own communities.

5.3.5 Access to services

Access to services was seen to depend on a number of variables including the capacity of services to respond to needs, the quality of relationships between providers and service users, and the level of awareness of services within the community. While the level of service provision dictates the level of opportunities for engagement, the challenge of engaging youth living within a complex and challenging environment was also acknowledged. One provider summed up the temptations that young people need to overcome saying *'why would they go and play a game of pool with us when they can do a drug run for one hundred euros'*. So developing access is more complex that simply '*throwing money'* at the problem. Successful development of access requires understanding the context in which young people are growing up, and having the capacity to provide the levels of support needed. As already noted, support to services comes in the form of adequate strategic resourcing, staff support and development, and research support to *'understand what works'*.

Parents believed that bureaucracy in service provision might contribute to making them less accessible. They noted one service to which people *'self-referred'* required a lot of '*form filling'*, and while understanding that the service *'had to account for itself'* the parents felt that the form filling '*can be off putting for people'.*

Access to services also depended on the age and stage at which young people engage with universal and targeted services. One provider noted that '*the stage in which the intervention kicks in in the child's life is very important. The child even by 3 has a lot of things embedded. If you don't have them* (positive experiences and nurturing), *you are at a disadvantage'.*

Drawing on the insights and experience of research participants, the following factors were noted to either promote or inhibit access:

Factors which promote/increase access:

- Positive relationships between service providers and service users (Parents and Providers);
- Collaboration and information sharing between services;
- Nothing succeeds like success! Positive experiences of services promote continued engagement;

- Services meeting identified needs;
- High levels of awareness of services within the community, e.g., parents' awareness of value of after school clubs in meeting the safety, social, nutritional and academic needs of young people;
- Having the financial means to access private services;

Factors which inhibit access:

- Cost of summer camps and cost of transport;
- Young people not being referred for services;
- Long delays between referrals, assessment and intervention. People get *'sick of the system 'cos it is so slow'* (Provider)
- Service fatigue, families engaging with multiple services;
- Negative prior family experiences of engaging with the system. If a system is slow and inadequate to meet the presenting level of need, families can disengage when other problems arise;
- Stigmatisation of services;
- Inappropriate location and co-location of services, e.g. mental health services co-located with drug support services may inhibit access;
- Lack of universal provision – behaviour needs to have deteriorated to a point where it matches the remit of the service as opposed to the service matching the level of need of the child;
- Limitations of job descriptions of providers, some job descriptions have a remit in relation to the needs of the young person but do not have 'family focus remit' as such. Service providers considered more effective to work with the young person within the family context;
- Living in an area, or attending a school, that is not designated under targeted interventions, even when the level of need is similar to that of families in designated areas;
- Insufficient resourcing and capacity in services to respond to the dynamic levels of need;
- Low levels of awareness of services within the community;

- Lack of summer provision for both younger and older children;
- Lack of sensitivity of service providers to the social class context of users, as perceived by users;
- Breakdown in system of referrals whereby a child may get an assessment but the service provider may not have the capacity to follow up with the family or school in order to move the process to the next stage.
- Restricted service opening hours.

5.3.5.1 Targeted versus universal services

There was broad agreement across parents and providers focus groups that there are a significant number of young people across the communities that need access to high quality universal and targeted services. While no formal definition of universal services was agreed, it was clear from discussions that service providers understood universal services to mean services that all young people and families could access. In the words of one provider '*universal services should be for everybody'* and should work with children *'before the crisis occurs'*. For example parents spoke of wanting their children to have access to after school clubs and summer camps and sometimes felt that the children who were misbehaving had greater access to these services. Providers spoke of all young people having access to art therapy and youth clubs as part of universal provision. Within other contexts art therapy might be viewed as a targeted service but in this context it was proposed as a universal service. Providers noted that while '*the services are targeting the most at need … there is a big group behind them becoming the most at need'*, highlighting the scale and complexity of the problem. They also proposed that the lack of universal services might cause resentment among some parents.

The balance of provision between targeted and universal services was discussed at length, with participants identifying a need for the systematic development of universal services which would enable clear referral from, for example, *'main line youth services'* (provider) to match service users with services at an early stage of need. As one provider noted *'by the time services come into play, and the red tape, you know, young people will be in jail'*.

Service providers suggested that a very important dimension of the dynamic between universal and targeted provision is that each service understands its own remit and how that fits within the broader framework of service provision, thus enabling effective referrals and use of resources.

Universal services across all age groups, were seen to act as a mechanism to address young people's needs at an early stage and to prevent the development and escalation of problems. The aim of comprehensive universal services as identified by both parents and providers was to promote and

nurture the holistic growth and development of the young person, offering them opportunities to nurture their emotional, behavioural, psychological, social and academic development through opportunities to socialise, learn skills (including academic skills), engage in activities and experience life beyond their own communities.

Providers felt that the balance between 'reaction' (targeted services) and 'prevention' (universal services) needed to be addressed. One provider, acutely aware of the need to extend universal services, described that as she drove around the estate she worked in, children would shout *'can I join the club, can I join the club?'*. Targeted services which offered young people varied and engaging programmes were sometimes resented by parents of well-behaved young people, and viewed as a reward for bad behaviour, '*if they play up they can get what they want'* (Parent) and this could be viewed as a dis-incentive for behaving well. Another parent noted *'those kids get spoilt rotten, they get to go horse riding, they get to go swimming, they get all that. The normal kids then, well not the normal kids, say the kids that don't have problems, say well 'if I don't do my homework I can do down there?'* . Indeed one provider empathising with this sentiment named this phenomenon as '*goodies for baddies'*. Another parent described how the previous year she approached a local provider and *'had war with her'*. The parent related that the provider was collecting a young person who *'robs cars, burns houses, is an addict'* while her own child *'is upstairs and does not rob cars, burn houses or take drugs'*. She challenged the provider that she was *'rewarding the scumbags and nothing about the good kids*'. Another parent reflected that *'good kids fade into the background'*. This negative perception of services by parents has a further dimension of not helping to build relationships between services and the broader community.

The need for targeted services to support young people suffering trauma was affirmed across the focus groups. The stage at which targeted services 'kick in' was already discussed, noting the long term effects of not responding effectively when a young person presents with needs to be addressed. The duration of the service offered to the young person, and the need to offer after care to young people who move outside the age remit of the services was also noted. The possibility of the school being used as the point of delivery of services such as counselling and art/music therapy was also positively viewed. While some schools have therapeutic interventions in place it was noted that the scale of needs of young people was not matched by the services available and that staff felt like they were '*playing God'*, selecting young people for engagement in these therapeutic initiatives, a similar sentiment was echoed by a provider who said that when selecting young people for inclusion in activities it felt like '*you were playing with people's lives*'.

5.3.5.2 Availability of information on services

It was argued in all focus groups that there is a need to publicise existing services for both parents and providers. Providers acknowledged that there is increased information sharing through engagement

with the Youth Fora. Also it was acknowledged that some services deliberately keep a low profile in light of the specific nature of their work. In the parent focus groups a need was identified for increased information sharing to ensure effective uptake of existing facilities and services. Information in relation to summer camp provision was identified as one area in which information sharing could be improved. Participants referred to initiatives such as leaflet drops, notes home from school, and community fairs as mechanisms to disseminate information on existing services. Indeed, the focus groups served as a mechanism for information sharing.

5.3.5.3 Outreach

Outreach was a significant element of the workload of providers. The HSCL remit is immersed in an outreach philosophy and these providers spoke of the centrality of reaching out and connecting with parents in their homes. Other services also identified outreach as a very important element of their work, stating their desire to work with the young people in the context of their families. It was also highlighted that some outreach work with particular families takes place outside of normal working hours (9-5) and as such providers need to be cognisant of safety considerations.

5.3.5.4 Referrals systems

A number of issues arose in relation to referrals. Providers made the point that if there was comprehensive universal provision, this would facilitate effective early referrals. Some parents felt that their children were not referred at a young enough stage by the educational system in order to receive the appropriate intervention they needed. Others felt that once the referrals had been made, depending on the service in question, the service user could wait up to two years for an assessment, with no guarantee that the level of intervention required was available subsequently. Another issue that arose specifically in terms of educational provision, was that a young person could be assessed by a psychologist and deemed to need an SNA to support their learning but that this recommendation subsequently could be quashed by the SENO without communicating any rationale for how this decision, in direct contradiction to that of the psychologist, was made.

Providers, while recognising the role of the Youth Fora in facilitating connections and communication between services, also noted that the array of service provision can *'be a quagmire'* and can be challenging even for service providers to navigate. They noted that accessing services at times must be daunting for service users who may be in trauma and have low literacy and communication skills. They also noted that more effective and structured referrals between services were necessary in order to put supports in place for the young person or family in a timely manner and in order to deliver a higher quality service.

Sensitivities of information sharing were also raised by providers who felt that there needs to be greater clarity about this issue, as different services/staff operate differently. Fundamentally, there

needs to be a shared understanding of the ethics, rationale, legalities and responsibilities regarding information sharing.

5.3.6 Integrated services

'You haven't a chance unless everyone is together working for shared goals' (Provider).

Integration is a philosophy that not only relates to systematic co-ordinated responses but also to the ethos of engaging parents and young people as active agents in finding solutions. Providers contended that the development and enhancement of integrated practice is best nurtured through consistent integrative practices across all levels of service provision from managerial to front line workers.

Practitioners with extensive experience of working with youth noted that young people are presenting with much higher levels of need than they did in the past, and consequently services need to respond in a strategic, integrated and co-ordinated manner. Providers noted that *'there are some examples of integrated services on the ground'* but sometimes they are dependent on individuals rather that policy and leadership. The image of individual services acting as pieces of an overall puzzle was proposed. Providers constructed a rationale for the development of integrated services, including:

- Better outcomes for young people and their families;
- Building connections between services helps to meet the needs of young people at different levels of the Hardiker scale
- There is reduced time lag in referrals;
- Integrated practice supports needs-led responses where instead *'of the service defining the child the child would define the service*';
- Integrative practice was deemed *'worthwhile'*, as it means you have a network of contacts to approach when you need to and it reduces red tape;
- Increased service uptake;
- Increased service effectiveness and hence better use of public money;
- Facilitates positive role modelling for young people when they see service providers from across the city working collaboratively;

Providers agreed that working in a systematic, holistic, integrated manner constitutes best practice. Providers gave examples of integrated practice which are currently in place, mainly through the formal structures of the Youth Fora and also informally through individual services like the HSCL. The latter was identified as a non-threatening mechanism through which integration of, and access to,

services could be nurtured. Parents spoke very positively about their relationships with the HSCL co-ordinators. Providers also noted that the School Completion Programme (SCP) *'has linked a lot of things with the schools'* also. The school was identified as a non-threatening service since, unlike social workers, it could not remove children from the family home. It was also noted that parents approached HSCL personnel when issues arose with other services they were engaged with, and when they needed to get access to services.

Providers gave examples of services sharing facilities and resources, and acknowledged that while integration has not happened to the extent people would wish, there is greater communication and collaboration between services: *'all the ducks are being lined up for the first time in the city'*. It was noted that a key component of helping services to operate in a more integrated manner is information sharing about services across services. Providers also noted there was a greater openness to working collaboratively at a very practical level of skills sharing. The following elements were identified as necessary components in order to work in an integrated way:

Integrated practice: Enablers

- The development of trusting relationships within and between services;
- Direction and support by clear policy and practice at management level;
- Services working from a shared ethos;
- Willingness of services to engage with each other in providing practical supports;
- Recognition that integrative practice has been operating to some degree across services and communities to date and that the challenge is to build on that;
- Development of service level agreements;
- Information sharing and effective communication;
- Integrative practice as part of job descriptions;
- Adequate staffing;
- Adequate funding;
- Getting the right balance between time at meetings and time with service users;
- Stability of staff to support the consistency of service delivery and to support building relationships with young people;

- Strategic design and funding of services to nurture integrative practice;
- Effective and transparent referrals systems.

Integrative Practice: Barriers:

- Lack of managerial commitment;
- Some decision makers are not sufficiently aware of the reality on the ground to make informed decisions about integration. Insufficient information about other services and their activities is also a barrier;
- Lack of shared understanding of problems and practice on information sharing;
- Data protection constraints on information sharing;
- Lack of dissemination/ sharing of research findings;
- Service provision and funding not coordinated;
- Increased workload, in particular, too much paper work – imbalance between *'doing the work and justifying your position'*;
- Requirement for significant investment of time and energy;
- Volume of caseloads;
- Inadequate resourcing;
- Staffing instability and inadequate levels of staffing;
- Waiting lists and complex nature of service delivery;
- It may be a new way of doing things for some services, staff, or families, so it takes time and confidence building;
- Parental and young people's capacity to engage needs to be nurtured;

Parents did not engage in extensive discussions in relation to services, apart from educational services, which will be dealt with in section 5.4. However, they did highlight that while emergency dental services were very responsive, orthodontist services are virtually not available - *'braces are a gimmick'* - and it could be ten or fifteen years before a child would see an orthodontist. Another parent, who revealed that she was a service user with Barnardos at the time of this research, praised their approach to working with her children and their support to her. Parents also praised the staff in

local health services and said they were very approachable. Other parents praised the work of specific initiatives like the Moyross Bays, the Northside Learning Hub and Youth Services. Parents decried the long waiting lists for assessments and medical procedures. They were dissatisfied with facilities for young people with mental health problems, saying that *'5B is not suitable for a child'* (i.e. adult psychiatric services).

Parents identified gaps in provision for drug rehabilitation and in universal services. They highlighted the need of support for families suffering trauma. They also highlighted the need for services in the evenings and at weekends. Parents spoke little of the Gardaí or probation service due to the sensitive nature of this provision, but did state that young people who '*go to prison in Dublin'* are treated badly.

5.3.7 Youth fora

The Youth Fora are a relatively new development in Limerick city. They provide a formal structure for service providers to work in a systematic way to address the needs of young people in their areas. According to providers, (many of whom were members of the Youth Fora), they have made *'a big difference',* and improved the impact of services, but are still at the initial stages, and have some way to go to meet their full potential. Fundamentally, their success is dependent on young people's needs being met.

The success of the Fora to date was deemed to be due to a number of factors. Providers noted that the creation of the Youth Fora provided a *'formal structure for the expansion of existing good practices'*. Also the practice of rotating '*the chair and vice-chair so that it is not personality driven*' was seen as a positive mechanism to ensure the Fora worked effectively. The inclusion of parents and young people as active stakeholders in decision making was also deemed a very positive, if challenging element of the Fora. As one provider noted, *'it is not easy but it is the right way to go'.*

Providers also noted that working with the Youth Fora makes demands in terms of time for meetings and building the management structures, but '*the huge time investment'* acts as a motivator in itself because if members have invested a significant amount of time they *'are not going to throw it away'.*

Providers identified a number of ways in which the Youth Fora might be improved:

- Each member organisation of the Youth Fora needs clarity about their remit (located within the Hardiker scale), and about the capacity and resources that their own organisation can bring to the Fora;
- Each member needs to makes a commitment to the Youth Fora in terms of attendance, communication etc.

- The Youth Fora need to have a defined system of referrals for young people whose needs the Youth Fora cannot meet;
- A clear mapping of services to levels of need so that there is attention to capacity, gaps in provision, and the dynamic nature of need;
- Clear understanding of where the responsibilities of the Youth Fora intersect with the responsibilities of the HSE in terms of child protection;
- Need to support and evaluate (quantitatively and qualitatively) the work of the Youth Fora through formative research practices;
- Attendance at Youth Fora meetings needs to be productive and providers need to feel that if they invest time in the fora, other organisations will also invest and there will be tangible outcomes;
- Need to review the age profile of service users, cognisant of levels of needs of very young children.

5.4 Education and Support for Active Learning

5.4.1 Introduction

This is the third and final section profiling the qualitative research findings. In the previous section, 'Services and how to Improve them', issues relating to service outcomes, quality, connection with family and community, access, and integration of services were discussed. This section specifically addresses educational provision and supports for active learning.

During conversations, participants recalled their own experiences as school-going children, and drew on their experiences as both parents of school-going children and as providers. This section explores the issues which arose when participants related their observations, experiences and expectations in relation to educational provision.

5.4.2 The environment and support for active learning - preschools

Providers and parents acknowledged the importance of early years education provision and spoke of the availability and quality of preschools in their communities. There was a variety of preschool provision including Early Start (DEIS initiative) and school and community-based provision. The value of collaboration between various 'early years' providers within neighbourhoods was raised. According to research participants, some neighbourhoods had better early years provision and preschool facilities than others. Parents spoke of the high quality, hygienic conditions, friendly and professional staff and purpose-built buildings as positive attributes of these services. Many parents in the focus groups had younger children who had attended these facilities, and they expressed their satisfaction with them. However, parents in different neighbourhoods raised issues in terms of the quality of buildings and the capacity of facilities to cater for the numbers of children requiring early

years care, especially in the context of the dynamics of migration of families. Parents spoke of the value of preschools in terms of preparing children for primary school, providing a social context for children to make friends who would progress on to primary school with them, and developing skills that would help them to settle in school, such as concentration and listening skills.

Providers said that preschool provision was *'affordable'* and noted that local residents who worked in the preschools with the Community Employment Schemes were highly trained but that their contracts were of a short duration. They also noted a value in having a preschool connected to the local primary school.

5.4.3 The environment and support for active learning - schools

It was evident across all focus groups that the school plays a central role in the life of the child and in the life of the community. The topics specifically in relation to the school which were discussed across focus groups include the role of the school in the community and the broader society (5.4.3.1), the school as a site for delivery of services (5.4.3.2), Delivering Equality of Opportunity in Schools (DEIS) and the unique context of Regeneration area schools (5.4.3.3), curriculum (5.4.3.4), choice of school (5.4.3.5), decreasing enrolments (5.4.3.6), attendance and suspension (5.4.3.7), literacy and numeracy attainment levels (5.4.3.8), school staff (5.4.3.9), special educational needs (SEN) (5.4.3.10), behaviour management (5.4.3.11), transition from primary to secondary school (5.4.3.12), after school provision (5.4.3.13) and non-mainstream educational provision (5.4.3.14).

5.4.3.1 The role and function of the school in society

The role and function of the school in society and the capacity and success of the school in meeting the needs of learners were central to this discussion.

It was evident that participants saw schools not only as part of a national system of education, but as individual entities operating within unique environments. In section 5.2 on neighbourhoods, the challenging environments in which children live has been described. The schools operate in these contexts and are charged with responding to the complex needs of young people and adults living in this environment. The stigma suffered by residents was echoed by a provider who noted that schools operating within DEIS contexts are '*fighting the prejudice of the rest of the world all the time. You are always up against the perception that we should just set fire to (named estate) and that life would be better for everyone'*.

Participants discussed the function and role of the school. The role was seen as extending from the very basic function of providing a safe, stable environment to preparing young people to live in society. At a basic level, school offered children an environment in which they '*got some sense of boundaries, were fed and looked after and got a new change of clothes*'. Indeed, a provider noted that

'*for a lot of children school is the safest place, the cleanest place, the warmest place'.* The role of the school in providing a safe and stable environment was highlighted by providers who noted that some children despite their personal circumstances '*were very good attenders in school because they hated their home environment'*.

Parents posited that the role of the school operating in a DEIS context demands that the school builds confidence and aspiration in children '*from day one*' as children can '*be ashamed of where they are from and it can hold them back'*. Concern was raised that the education system is at times '*trapped in the notion of having to feed the local economies rather than the enrichment of the innate talents that every individual has and the celebration of that*'. At a different level, the role of the school extended to making young people aware of local community resources and facilities, and building the young people's dreams and aspirations. Another role that was identified for the school was in supporting parents to access other services.

5.4.3.2 School as a site of multi-service delivery

Another function performed by schools was to act as a site for delivery of services. The delivery of services within the school was deemed to be a creative response to meeting children's needs, and indeed a welcome model of integrated service delivery, with providers highlighting the increased uptake of services when they are delivered locally and in a collaborative fashion. Fundamentally, delivery of services on the school site was deemed to be an effective way of making good use of resources since there was a greater chance that appointments would be kept and you wouldn't have *'therapists in empty rooms waiting for the clients to come in' (*Provider). However, some service providers gave examples of inviting others to deliver their services in schools in order to promote service up-take but that the services in question declined this invitation.

Providers noted that extending the role of the school needs to be monitored and supported. Concerns were raised that the delivery of non-educational services in school settings could impact on the integrity of the school day. Indeed an alternative model of schooling was proposed in one provider focus group, which advanced 'a wrap-around' integrated model of delivery of services and re-envisioned the school as a learning hub within the community where '*you would change your whole notion of school to a kind of a children's centre or family centre'* with education and other services working in an integrated way.

5.4.3.3 Delivering Equality of Opportunity in Schools (DEIS) schools and the unique context of regeneration area schools

Participants acknowledged the resources that a school receives as part of its DEIS designation. As one provider noted '*everything that is available is available here. It is all here, all the catch-up, and reading recoveries ... there are good services and good communication between them'* . This was

echoed by another provider who argued that *'in terms of attainment like, the Department can't do any more really in terms of maths recovery, reading recovery, first steps, all the different initiatives over the past ten years that has made a huge difference'.* Providers also acknowledged the pupil teacher ratio in DEIS schools as positive and noted that working in a DEIS context made professional demands not made within mainstream schooling.

The schools located in the study areas operate within a unique context. Part of understanding this context is to understand how feuding, over time, has impacted on educational provision. Providers acknowledged that their schools can have negative profiles within the community, due to the fall-out from criminal activity. Providers noted that parents sometimes make decisions to send their children to schools outside of the community as they don't want their children mixing with children '*from particular families'*. Providers also noted that children from opposing feuding families attend different schools at second level as otherwise there would be *'a very explosive situation, can you imagine the feuding families, at least when they find out that so and so is going to school there they can pick another one'*. Another provider noted how a parent who traditionally sent her children to the local school had, through fear, more recently decided to send her child to a school outside the community as her children *'were accused of an uncle being a lookout or something. It is that kind of stuff goes on in schools*'.

Indeed, it was noted that young people who identify with the feud, often without any substantial evidence of any actual involvement, can become very isolated from the broader society. They can feel *'safe'* within their own environments and can be very reluctant to access opportunities outside of it, including educational opportunities. Providers were aware that criminal activity in the community can have a negative impact on the image of the school, stating that the outside world does not see the quality of education but the presence of the ERU or Gardaí.

5.4.3.4 Curriculum

The appropriateness of the curriculum offered at primary and secondary schools was debated across focus groups. The difficulty of trying to keep some young people engaged at second level was discussed, with participants noting the over-emphasis on academic subjects when some young people would like to learn a skill like hairdressing (parent). According to one second level provider even with Leaving Certificate Applied (LCA) some young people struggle to attend for the number of days required to achieve the LCA. Some providers noted that the Junior Certificate School Programme (JCSP) *'helped to engage kids because a lot of it is project-based*'. At primary level it was also noted that teachers working within DEIS contexts need to adapt the curriculum and be very creative in order to facilitate children's learning, due to the profile of children's needs.

The challenge of keeping young people engaged at second level was raised by participants across locations. The need to have alternative provision at second level was acknowledged and highly regarded where it exists. However provision is complex. One provider noted that '*some kids will not stay in school after Junior Cert'*. It was also noted that some alternative educational provision at second level offers an allowance to students and this can sometimes act as a disincentive for some students to remain in mainstream second level. A similar sentiment was echoed by another provider who related the story of a young person coping well within secondary school with the aid of an SNA but who wanted to go to an alternative educational provision where he would get an allowance and is now *'starting to stay home from school'* saying '*I want to go to Youthreach'.*

5.4.3.5 Choice of school

School selection was raised as an issue by both providers and parents. As already mentioned, parents sometimes chose to send their children to schools outside their communities in order to ensure their children did not mix with children from certain families. As noted by one provider '*they think their kids are going to do better and in some ways it is kind of hard to blame them'*. During a discussion on secondary school selection, one parent advised that '*you have to pick whatever thing is best for your child and that is the main thing, to get their school'*. Another dimension relating to the issue of school selection that was raised was in relation to the concentration of young people from the same social background in schools. While the value of integrating young people from across socio-economic backgrounds was discussed, it was also noted that *'you would have a riot if you tried to merge the two'* (Provider).

5.4.3.6 Decreasing enrolments

Some of the schools in the study areas are suffering from decreased enrolments, which raised the issue of amalgamation of schools. Declining enrolment was seen to be due to parents making decisions to keep their children away from children of certain families, the negative impact of the drug culture, and out-migration of families due to the regeneration programme.

5.4.3.7 Attendance and suspension

Some parents raised the issue of some second level schools using suspension and not motivating young people to stay engaged with the educational system. Providers raised the issue of some young people disengaging and slipping through the system, '*getting lost'* and having great difficulty re-engaging with the formal system, as '*it is hard to get a child back into the system when they have been out for a while'*.

Attendance was also raised as an issue of serious concern, with one provider stating that *'there are huge attendance issues all over the city*'. Parents also recognise the issue of attendance and believe that *'parents should be held accountable'* for their children's attendance. Parents in one focus group

said that in previous generations '*travellers left school early'* but there is now a culture change and they are good attendees. The impact of poor attendance for children who are in educational '*recovery programmes'* was highlighted by providers who noted that *'if they are not in school they can't develop and progress'.*

5.4.3.8 Literacy and numeracy attainment levels

The importance of literacy attainment was recognised with one provider observing that *'literacy enhances lives and was core to all learning'.* Participants recognised that while the school played a key role in literacy skill development, other areas of the child's life including the home and after school clubs also needed to play their part in fostering literacy skills and achievement. Participants spoke of their concern about literacy levels, noting that *'despite intervention from Junior Infants, with reading recovery, first steps, maths recovery'* they have not as yet in some instances achieved the target outcomes, thus highlighting the complex nature of addressing educational disadvantage. Low literacy standards were seen to impact negatively on a young person's ability to make a successful transition to second level. Parental levels of literacy were also pertinent to this discussion.

5.4.3.9 School staff

The role of the Home School Community Liaison (HSCL) co-ordinator was recognised as central to developing and maintaining good communication between home and school. Parents noted how the HSCL motivated children to attend and achieve, '*the HSCL encourages him* (participant's child*) 'cos he does not have much confidence in himself. She was pushing him and praising him, and encouraging him. Do you know she kind of pushed him, and he is doing soccer now and he loves it'*. Participants considered that HSCL co-ordinators had detailed knowledge of family circumstances and were in a position to support the children and parents to engage in education. Focus group participants who had worked, or were working, as HSCL co-ordinators spoke at length of the challenges facing families living in these communities, noting that an important element of the solution to addressing the needs of the child resides in '*minding our moms, and in turn they may be able to help their children'* . HSCL co-ordinators noted that over time they had seen some significant successes in engaging parents but noted that '*it is very, very slow and it is not going to happen this year or next, it is a slow and gradual thing'*. One HSCL described herself as '*a teacher for parents'*. HSCL co-ordinators were also acknowledged by members of the providers' focus groups for the linkages they have made across services. There was also some discussion as to what constitutes success within this context, and one co-ordinator shared her recent experience of success on the previous day when she made a breakthrough with a mother she had '*been visiting for 3 years'* who '*invited* (her) *in yesterday'*.

The commitment of school staff was also noted by parents and by providers. Parents acknowledged the personal interest teachers took in their children and one provider, conscious of the huge barriers

that exist to children achieving their potential, remarked with gravitas, '*I refuse to give up',* noting that '*anything positive we provide for children in the school is improving the quality of their lives and helping them toward becoming happy adults'* .

5.4.3.10 Special Educational Needs (SEN)

Participants noted that supporting children with special educational needs must be resourced with an understanding of the context in which a child is growing and learning. Fundamentally, a child with SEN who is coming from an advantaged background differs from a child from a disadvantaged background as the latter *'don't have the supports at home'*.

A number of issues were raised in relation to the provision for children with SEN. These included the age at which a child was assessed, the waiting lists for assessments, the impact of SEN on the child's transition from primary to second level, the allocation of SNAs and the key role they play in keeping children engaged in schools, and the impact on children with SEN who move from a DEIS school to a non-DEIS school.

Participants were concerned at the length of assessment waiting lists, noting that when situations need immediate attention they could be waiting for two years for an appointment. Some schools related that they fundraise to meet the cost of private assessments as the level of assessments available through the National Educational Psychological Service (NEPS) was considered inadequate. Schools also fundraise to meet the costs of speech and language therapy as the public services are considered inadequate to meet the needs.

Participants queried the age at which children are assessed and the consequent allocation of resources. One parent was still awaiting an initial assessment for her 17 year old child. There was some discussion that while children with SEN are catered for in their local primary they no longer have the same level of support, even if the secondary school is able to access resource hours. Providers noted that children's language proficiency could act as an inhibitor to their learning and that effective speech and language services were essential to supporting children to progress in schools. It was also acknowledged that children might be granted a service but fail to attend. This prompted a debate on how best to deliver services so that they were accessible, with a number of participants highlighting the increased uptake of services when they are delivered in the school site.

The role of Special Educational Needs Organisers (SENO) in allocating resources was raised by participants who questioned the consistency of approaches and the lack of transparency. The key role played by Special Needs Assistants (SNAs) in supporting children to access learning and to engage with school was broadly acknowledged. One provider noted that the presence of an SNA enables children to '*really succeed'*. Providers noted that there are children with Asperger's Syndrome who

have no SNAs and that '*they are not going to survive in mainstream*', that they will '*fall through the cracks'*.

The complexity of addressing the learning needs of students with SEN was also raised. Participants discussed appropriate placements for children who, on assessment, are deemed best placed in special schools but who, due to *'the stigma of a special school',* will not take up the most appropriate placement for them.

The issue of assessing children was raised by providers and parents. According to providers, children with language difficulties or syndromes are prioritised for assessment. The system, as it currently operates, is not adequate to meet the needs, with some schools fundraising to meet the costs of private assessments. It was noted that there is a different model of resource allocation for primary and second level and this needs to be addressed. There was some debate around the ethics of assessment, a consciousness that the numbers of children diagnosed with ADHD has risen and a suggestion that there is a need to examine children's diet and lifestyle in order to understand their behaviours. Some providers and parents suggested that parents in some instances may be incentivised to have their children diagnosed with certain conditions because of the availability of allowances (additional income).

Again the issue of resources following the child as they migrate to non-DEIS schools was discussed, with providers highlighting the need for resources to be allocated to the child.

5.4.3.11 Behaviour management

The relationship between behaviour management and learning was raised across participant groups, both in terms of how behaviour is managed in the homes and in the school contexts. According to some parents, students can be suspended from some school too easily, and alternative forms of discipline such as *'keeping them back and making them do some cleaning'* were proposed. Parents noted that students can be suspended but that *'it is not punishment as they are going home and their parents are turning a blind eye'.* One parent related how a student she knew was suspended for not surrendering his mobile phone in school because he would be unable to pay the ten euro charge to retrieve it. Also there was an awareness among participants that the culture of behaviour management had changed dramatically in recent years and that teachers *'can be hauled up if they even look at a child'.* Young people's ability to self-regulate was also discussed, and while many participants acknowledged the positive behaviours of young people, it was also acknowledged that *'guys of 16 or 17 could be a father and operating at a 3,4 or 5 (age) level'* . One parent also related how her own child was totally out of control and needed special provision. She noted how she lived in fear of him, and felt that the services needed to be more proactive.

Providers noted that parental ability to manage behaviour is very important in terms of fostering engagement with the educational system. They gave, as examples of poor behavioural management, children being bribed with pocket money by parents to attend school. Parents themselves gave examples of having to collect children from school as they reported they were sick. When the child gets home, he just goes out to play and the parent has no control over that behaviour.

5.4.3.12 Transition from primary to secondary school

The issue of transition from primary to secondary school was discussed at length across all focus groups and was noted as a very important phase in a child's life. While it was noted that things have *'improved in the past two years'* there is still some worry that all children do not make a successful transition. As previously stated, making a successful transition to second level is challenging for many students, moving from a small to a big school, from working with one teacher to working with a team of teachers, coping without resources which were present in the primary context, and with particular challenges for children with SEN.

A number of other factors associated with making a successful transition to second level were discussed in the focus groups. One factor that was seen to impinge on a child making a successful transition was the age at which they transferred. Some parents felt that children were too young and immature to cope with secondary school, and would benefit from a further year in primary school. Some parents recalled the provision of middle infants in former years which offered children an extra year prior to first class, *'they took a year off the primary school which they should have left alone and now the kids are too young'*. Parents felt that this had helped children to mature and also to build their skills *' they are missing out on a basic year as well, learning and letters and numbers, they are missing out on a lot, they are rushed through, some of them need longer to learn'*. The presence of an SNA in a classroom was seen as a positive support to effective transition. While *'the SNA might be with one student in the class, it certainly makes a massive difference to the whole group 'cos there is an adult with them at all times, all day you know'*.

Poor literacy attainment was highlighted as one of the reasons some students might drop out or do not make a successful transition to second level. As one provider noted, *'they are leaving primary school and they have the level of education of a 6 year old'* and are not able to access the curriculum fully. The curriculum not meeting the needs of the child was also highlighted as reasons young people drop out of school or do not make a successful transition to second level.

5.4.3.13 Out of School Time (OST) provision

For the purposes of this report, OST provision is understood as the various activities before or after school hours, at weekends or during school holiday time, which children attend. Some of these activities take place within the school itself and others within local community facilities such as

resource centres, community centres, the Bays in Moyross, the Northside Learning Hub, family resource centres and others. There was broad agreement amongst participants on the value of OST facilities for children, most especially vulnerable children. Their value in providing safe environments in which children can meet with their peers was also discussed. Gaps in OST services were identified for younger and older children, as discussed previously.

The quality of OST provision was raised by both providers and parents. One parent related how she had contacted the school in relation to the curriculum of a summer camp in Irish and was very pleased with the outcome, as attendance at the summer camp had greatly supported her child's learning in secondary school. A provider noted that in her opinion after schools are not always run *'to a high enough standard'* and suggested there was a need for a system of recognised standards and inspections to ensure that they maximise their impact.

There was some discussion on the role and purpose of OST provision, with parents acknowledging the value of both homework support and a safe environment. The opportunity to support children's academic development was raised by a provider who noted that, '*while it is great to have all these clubs going on, there is not enough specific homework',* that there was a real need to address homework support, and *'develop literacy and numeracy clubs'* as a means of addressing literacy attainment. In some cases teachers got involved in OST services in order to address this dimension of the OST programme. The value of using creative means to support children's learning was also discussed, and the activities of the Northside Learning Hub received favourable mention as it facilitates children *'to explore through the arts'*. Parents were very aware of the types of programmes available in the OST services, with one parent sharing how her child first does his homework, then has a meal and then has youth club activities.

5.4.3.14 Non-mainstream educational provision

Non-mainstream provision included initiatives like Youthreach, St. Augustine's Youth Encounter Project, St. Canice's, and the Limerick Youth Service. Parents and providers felt that these services are limited in the numbers they can cater for, and some parts of the city are better served than others in terms of provision. Providers in particular highlighted the gap in provision for those under 15 years of age who drop out of school. They noted that young people who drop out of mainstream school can be very good attenders if they get a place in Youthreach, highlighting that, since they do not get an allowance until they reach 16 years, the allowance is not the motivating factor. An issue also arose in relation to the best placement for young people. Providers raised the issue of young people being assessed and Catherine McAuley school being identified as the most appropriate placement. However, due to the stigma of attending a 'special school', some families fail to act on the recommendation of the psychologist, and the young people may instead seek places in alternative provision such as Youthreach or the Youth Service, which presents challenges for these services. St. Canice's was also

mentioned as a school that provided specialised education for young people. Providers felt that investment in alternative provision was cost effective.

Parents recognised the value of having provision such as Youthreach for young people who do not easily settle within mainstream second level education, noting that there are '*a lot of teenagers that are not going to school, maybe they just can't and you can't expect schools if they are disruptive to keep them'.* They discussed the possibility of developing community centres so that young people would have a safe place to drop in to if they were out of school. Parents also recognised the value of providing locally based grinds to young people during exam years. They noted that there are many challenges in engaging teenagers.

Providers also raised the issue of young people being paid to attend Youthreach, and suggested that in a small number of cases the allowance might act as a disincentive to stay in mainstream school. It was also noted that not all areas of the city have Youthreach provision. Providers were also aware that services can be seen by young people to cater only for young people from specific areas of the city, and that this mitigates against them giving full consideration to all their options.

5.4.4 Parents as learners and supporters of their children's learning

Parents' capacity to support their children's education was deemed essential to children engaging successfully with the educational system. Parents are not a homogenous group, and when asked to comment on parents' roles in education both providers and parents agreed that parents can have both a positive and negative impact on their child's ability to succeed within the educational system. One provider brought this point home very clearly when she recalled attending a graduation of her former primary school pupils at their second level school. She was very struck by the observation that the young people who had continued to engage throughout second level and were graduating on the night '*weren't the brightest kids… . They were the kids who had the best supports at home. So there were actually some* (academically) *weak kids who managed to get through in dialogue with the school, and the support of the school, and the support of their families, maybe in an Applied Leaving Certificate course. But they had gone all the way and they were graduating'.*

5.4.4.1 Parental engagement with their children's education

As already noted in section 5.3.3, 'Connecting with Family and Community', there was broad consensus that working with parents was an effective way of optimising outcomes for children and young people, and that parental involvement in supporting young people through the education system was essential for success. The complexity of involving very young parents who themselves may be immature and not have had their own needs met, who may have mental health issues, who may have had negative experiences within the educational system and may have dropped out of school early, with consequent lack of skills and experiences, have already been discussed. There are

many challenges in promoting parental engagement in education, including, as noted by one service provider, the disorganisation of family life, with the only routine in some homes being that of the school-going child. This was considered not conducive to supporting educational engagement. The difficulty of securing parental engagement was illustrated by one service provider who noted that in some instances she had to revise her goals from promoting engagement in programmes to promoting their social and personal skills: *' a goal in working with parents is that they might raise their head and greet you, a goal in working with parents is that they might be able to come into the school without being petrified' .*

As already noted, providers felt that many primary school parents had great *'hopes for their kids'* but that, as the children progress to second level, some parents disengage as they do not have the capacity to support them. This is due to a number of factors such as *'mental health problems, alcohol, drugs and lack of education themselves'*. According to providers, parents can be *'nervous about their ability'* to support students at second level, and have a *'fear'* of *'actually walking in the* (school) *door'* due to negative experiences they may have had in the past when they saw the school as a place of fear and '*not a place of nourishment and learning to better their lives, and it is not because they don't want to, it is not because they don't care, because I think all parents love their children, they try but they just don't have the capacity'.*

Providers also raised the issue of parental understanding of the importance of bringing their children for various appointments. Some providers felt that parents did not fully realise the long term impact of not keeping speech and language appointments for their children. This issue also arose when providers noted that not all parents act in a responsible way in regard to giving their children medication prescribed for ADHD so that they can function well in school. It was noted that while many parents cared deeply for their children, there are children as young as *'second class getting themselves up, feeding themselves and coming down to school'*. In a tangible example of how children become adultified, one provider shared how she gave a child an alarm clock which she sets and gets herself to school every day. Another provider noted that the attitude of some parents to education can be very negative, and that it is a credit to the resilience of the child and to the support from the school that they manage to stay engaged.

The issue of gaining an insight into parental aspirations is complex. Parents in the focus groups spoke of their high aspirations for their children, indicating that they wanted them to stay in school and do well. One parent noted about her daughter, *'she sees me going to work* (low paid employment) *all the time and she knows she is not going to get anywhere just by leaving school and hanging around'.* A parent in another focus group spoke of how she visits her children's teachers every three months to check on their progress. But providers highlighted that not all parents had high aspirations for young people, most especially as the young people progress through to second level, and that for individual

young people it can be a very great struggle to stay engaged in the educational system when they have little parental supports, because the *'parents' expectations to succeed is very, very low'.* Other providers noted the importance of context in trying to understand parental aspirations, stating that '*even if parents have the will to support them in education, even if they have the value for education, they do not have the capacity or the financial supports to back them up in terms of succeeding'.*

It was evident from the parent focus groups that despite the challenging historical contexts, a lot of progress has been made in recent years in terms of connections between homes and schools. Parents in the focus groups described the positive relationships they have with schools and with individual staff. Parents were asked to describe what a 'good school' would look like, and the following profiles the elements of a 'good school' which they identified:

- Kids move from playschool to school together so kids settle well;
- Low pupil teacher ratio;
- Extra-curricular activities including after school clubs with varied programmes;
- Kids feel safe in school;
- Very good teachers;
- Provision at all levels up to 6th class;
- Positive relationships with teachers;
- Personal relationships between teachers and children;
- A school that encourages and motivates the children, and where teachers have high expectations;
- Good communication and involvement in decision making;
- Timely assessments;
- Sharing of information e.g. about summer schools;
- Adequate resources;
- Provides access to secondary school of choice – parents spoke of discrimination due to address;
- Supports parents to problem-solve when children get into trouble;

- A school where young people ‘got their exams’;
- Children have enough time to learn the skills they need in the early years (reference to value of a middle infants year);
- Teachers visiting sick children in their homes and providing support and visiting ex-pupils in prison to give them support and encouragement (examples of this were quoted);
- Effective and respectful responses to issues such as bullying;
- Teachers very approachable, parents have mobile numbers for HSCL;
- Good school secretary;
- Special events like sports day;
- Learning supports available in primary and secondary school and automatically following the child from one school to the next;
- Availability of SNAs where necessary;
- Early diagnosis of learning difficulties and supports;
- Speech therapy delivered in the school;
- After school support and homework clubs that are affordable.

5.4.4.2 Support for parent education

There was a widespread perception that parental formal educational achievement was low, and that many parents have high rates of illiteracy. Services have to be cognisant of issues like the literacy levels of parents when communicating with them. The *‘note home in the school bag’* is not always the most effective means of communication. Aside from literacy issues, the impact of low educational attainment was, according to some providers, manifested in parental inability to support their children at second level, stating that ‘*maybe they support primary because they did primary’*. Providers also noted that parents can be ‘*nervous about their ability’* to support their children, as they may be afraid of *‘being shown up by their own kids’.* Providers also noted that because of early school drop-out parents *‘don’t understand the second level system’* despite schools making efforts to explain it and to help them through it. As one provider put it, *‘we need to mind and nurture our moms and in turn they may be able to help their children’.*

Supporting parental education was seen to be complex, with opportunities for parent education being mediated through a wide range of organisations including the school, Barnardos, Family Resource

Centres and community organisations. According to one provider on the northside *'there are 200 adults registered this year for adult education classes, there is a huge amount going on in the area, incredible amounts between Moyross, Ballynanty and Kileely, as well. You are talking about over 50 courses'*.

Barriers to parental educational attainment had an inter-generational element with providers recognising that some grandparent's negative experiences of industrial schools, and some parents' negative experiences of primary and secondary school, contributed to both these groups having little faith in the educational system. Providers noted that '*small steps'* and a *'gentle approach'* are needed when working with people who have such experiences. Parents noted that it can be hard to find time to attend classes when you have very small kids.

Again, the issue of young parenthood was raised and attention drawn to the fact that many of these young parents may not be very long out of school and may not have had their own needs met. The parents who attended the focus groups described the challenges of parenting in these contexts, and these have been outlined already in section 5.2.

Providers also noted that measuring successful engagement goes beyond simply counting the numbers of parents who might turn up for a course, noting that you might be lucky to get six parents sometimes. Providers also noted that some teenage mothers, if they have the family support, will go back and '*finish their education'*.

Another issue that emerged in relation to working with parents was whether or not they should receive an allowance for attending programmes. Providers noted that there was increased interest in courses when an allowance was paid, but some felt that it is not always appropriate to offer such financial incentives and that instead participants should be encouraged to see the self-improvement potential of such opportunities.

5.5 Summary and Conclusions

In this chapter we endeavoured to set out the experiences and observations of parents and providers living and working in the regeneration communities, as enunciated by them in the focus groups which formed the qualitative strand of the research. The findings from the focus groups were divided into three sections, dealing with neighbourhoods, services and education and support for active learning.

Section 5.2 described both positive and negative elements of living in regeneration neighbourhoods as identified by focus group participants, and, while acknowledging the positive elements, this study highlighted the very challenging contexts in which children are growing up, which included the challenges posed by the prevalence of drugs, criminality and intimidation. Fundamentally, due to long standing lack of investment and poor planning, parents are presented with formidable challenges

in raising their children. Providers noted that some children only get '*glimpses of childhood'*, and disturbingly the cycle continues in many instances from generation to generation.

In section 5.3 we set out the focus group findings on services in terms of service outcomes, their capacity to connect with family, the quality of, and access to, services, and integration of services. It was argued that, in order to successfully meet the needs of residents in these neighbourhoods, services need to address the complexity of service provision and pay attention to the results, relationships and processes of service design and delivery as core elements in building and sustaining success. In order to do this, services need the capacity to meet the identified needs as well as the structures to support the development and delivery of integrated services. They also need to develop comprehensive early intervention in terms of age and stage of the onset of needs, and to be able to respond to the mobile nature of the population. Successful services were seen to be dynamic and informed by current research, with the capacity for reflection, planning, delivery, evaluation and follow-up.

In section 5.4, we specifically looked at educational provision, and attempted to unpack this complex and multi-layered area. Parents and service providers highlighted concerns in relation to the nature of provision from pre-school, through primary to secondary school, and also in relation to non-mainstream provision. While parental engagement was seen to be essential to supporting young people through the educational system, the challenges of nurturing parental engagement were also acknowledged.

As the parents and providers spoke with care and commitment, it was clear that the issues are complex and disturbing, and tensions emerged across the topics discussed. These tensions, outlined below, help to build a deeper understanding and appreciation of the challenges faced by parents raising children, and providers endeavouring to deliver effective services, within the regeneration communities. The tensions which emerged within the study include:

Tensions at service delivery level:

- The tension between parental aspirations and their capacity to support their children;
- The tension between restricting children's mobility to keep them safe and preparing them to survive in their worlds;
- The tension between providing payments to parents to attend programmes and encouraging parents to take responsibility for their own development;
- The challenge to provide a service without disempowering service users;
- The challenge to deliver services that do not stigmatise the service-users or the communities;
- The challenge to address the needs of young people with serious behavioural issues while at the same time not ignoring the needs of '*the good kids'*;

- The desire to make a difference in a child's life and the consciousness that at the end of the day they return to families and communities that may not be nurturing;
- The tension between valuing the development of local capacity and skills via placements on Community Employment (CE) schemes and the short term of contracts on CE;
- The challenge of listening to the voices of young people and their families and finding ways to incorporate them within current provision;
- The tension between the recognition of OST as 'safe places', and addressing the broader potential of OST provision in terms of academic, social and creative engagement with emphasis on quality of provision.

Tensions at service management level:

- The challenge to balance the tensions between reporting to funders and meeting needs of services-users;
- The challenge of working with limited resources within communities that have very high levels of need and consequently having to *'play God'* by selecting the young people to engage with a particular service e.g. Art Therapy;
- The challenge to balance the time between administration duties and working with service users;
- The tension between supporting the child within the family context and removing the child to foster care;
- Advocating investment in universal preventative care but not having the research to back this position up;
- The challenges related to appropriate information sharing;
- The need to clearly define the remit of individual services, and subsequently develop a shared understanding of how services can most effectively operate in an integrated manner and to do this management needs to play an active part;
- The challenge of working within the current economic constraints with increasing levels of needs and decreasing levels of service provision;
- The challenge of recognising the level of needs in the community and having the facilities but not the staff to meet those needs;
- The challenge of finding ways to measure both qualitative and quantitative outcomes;
- The challenge to balance universal and targeted services provision;
- The recognition that it is important to measure and track outcomes and limitations of existing tools;

The following elements emerged from the focus groups as key components in effective service delivery. These need to be taken into consideration as service provision is reviewed:

- Services need to have the capacity to meet the levels of need within the neighbourhoods. This extends to staffing and physical resources;
- Services need to adopt an integrated ethos at all levels to ensure buy-in;
- Universal services are essential to effective prevention and to developing effective referral systems to targeted services;
- Early intervention in terms of age and stage of onset of problems is essential to prevent more serious problems and effective resource use;
- Services need to develop streamlined systems of referrals, assessments, interventions and follow-up;
- Services need to be located where they are accessible to the service users;
- Services need to be dynamic and have the capacity to attend to changes in the profile of needs and to the migratory patterns of families;
- Services must meet service users at their needs level, and consequently parents may need pre-programme supports in order to access services;
- Services must pay attention to how they measure success, with due cognisance of the importance of the three elements of results, relationships and process as core elements in developing and nurturing sustainable success;
- Services need to develop their profiles within the communities;
- Service providers need support in terms of training and supervision;
- Effective reporting, recording and measuring system and templates need to be developed to support effective delivery of services;
- Services need to be supported and informed through research;
- Services need to engage with families, and not just young people in isolation, in order to maximise the chances of successful interventions.

6. CONCLUSIONS

This report of the findings of the research, ***How are our Kids?*** provides a detailed descriptive account of many aspects of the lives of children and families in Limerick City. The research was commissioned by the Limerick City Children's Services Committee, an inter-agency body comprising officials of the key agencies with a role in the provision of services for children and families in the city. The role of the Limerick City CSC is to progress strategic planning and policy, and promote integration and coordination of services for children and families in Limerick City.

6.1 Overview

The description of experiences and needs is structured to address the factors associated with "*good outcomes for children and young people*", as identified by national policy (*Agenda for Children's Services,* Department of Health and Children and Office of the Minister for Children and Youth Affairs, 2007). The research has a specific focus on children and families in the most deprived areas of the city now targeted under the Limerick Regeneration Initiative. This is with a view to establishing the extent to which children and families in the regeneration areas have different experiences (and needs) to the mainstream population. As a baseline or mapping exercise, it seeks to provide a definition of the problems and strengths of children and families in these areas, with reference to populations of children and families in areas of the city which are less deprived. For this purpose, two control areas were included in the research: a Disadvantaged Control Area categorised in the second tier of disadvantaged communities (better than the more deprived but lower than average), and an Average Control area.

The specific issues addressed in the research draw on national and international research in this field, so that the findings can be placed in a wider comparative perspective. The purpose is to develop the evidence base for policy interventions, and to improve the responsiveness of policy to needs (particularly for the most disadvantaged children and families in the city), linked to the strategic planning and coordination role of the Limerick City Children's Services Committee.

Limerick City has a socio-economic profile which is more disadvantaged than the national average. Over the years of economic boom (1996-2006), Limerick City fared less well than the State as a whole in terms of improved well-being on a range of indicators of economic and social development. The pattern was one of widespread dis-improvement across the whole urban area. The most deprived local areas remained in the same position while other local areas moved into the most disadvantaged categories such that they were relatively worse off in 2006 compared with earlier periods (1996, 2002). Considerable loss of population from the most deprived areas was a key trend. Because of the profile of people leaving the estates, including young single parents and their families, this population movement produced more widespread dispersal of deprivation in the city, parts of the suburbs and

county towns. The city is characterised by strong spatial inequalities at local area level – i.e. concentrations of affluence in small local areas (older / mature populations) on the one hand, and very strong concentrations of poverty in the local authority estates on the other. There are of course areas that fall between the extremes of affluence and deprivation, but this middle ground is occupied by fewer areas than might be expected for a city of Limerick's size.

6.2 Key Findings and Conclusions

The description of the lives of children and families, as reported in the findings, paints a picture of a much poorer quality of life, poorer experiences of childhood and worse outcomes for children living in the most deprived neighbourhoods of the city. On a scale to measure overall child difficulties, based on the reported incidence of emotional, conduct and behavioural problems in the child, there are much higher rates of child difficulties in the regeneration areas. On specific indicators of child outcomes, the Southside Regeneration communities, usually, have less favourable outcomes compared with the Northside Regeneration communities. The typical gradient of difficulties between the areas from least favourable to most favourable outcomes is: Southside, Northside, Disadvantaged Control and Average Control Area.

Explanation of the variations in the experiences and outcomes for children is associated with a range of factors which relate to: (i) characteristics of the families and parents, including family structure, level of parental education, social class, income and parental mental health status; (ii) characteristics of the neighbourhood, including the types and extent of problems as well as perceptions and reputation (and in the worst cases stigma); (iii) community social capital or social cohesion of place (which is affected by the types of individuals and families present); and (iv) aspects of parenting styles and strategies adopted in the parent / child relationships. The main findings relating to these factors (many of which are inter-related) are outlined below.

In terms of characteristics of people and households, children in the deprived areas are much less likely to live in two parent households, and the household is more likely to be headed by a female (lone) parent. While it is certainly not true in all cases, many children in these circumstances grow up without having a relationship with the parent who does not live with them, typically the father. Some parents and children in these circumstances consider this arrangement normal; however, in many cases, the adult relationships in the household (between parent and partner) lack stability. Parents in deprived areas are likely to start their families at a younger age and, over their young lives, they parent their children in difficult environments and with many stressors. Because of their profile and circumstances, many seem to be unable to take advantage of mobility opportunities that could be available to them.

In the most deprived areas of the city, parents, on average, have low levels of educational attainment and mostly they are early school leavers themselves. Low parental education affects child outcomes in various ways and, based on the findings of this research, is associated with greater total difficulties in the child.

Parents in deprived areas are likely to have greater difficulties in managing on their incomes (where there is strong reliance on social welfare as the main source of income); are less likely to be in employment; and, if in employment, are much more likely to be in low skilled occupations, and in the lowest social classes. This provides less economic security for the child, but also poor role models in terms of the mobility aspirations of children. In the current climate of economic recession and major job losses in the city and region, many families in areas outside of the most deprived areas and in average areas of the city are also under financial pressure. On average, however, families in the most deprived areas have greater financial pressures. The problems that parents in regeneration areas experience in gaining access to employment are more clearly structural in nature (arising from low education, low skills, and little experience of work) as compared with parents outside of these areas (who are better educated, have higher occupational skill levels, more employment experience, and more recent experience in employment). In the latter cases, unemployment is related more to economic cycles than serious structural problems. Parents / carers in regeneration areas are also more likely to face multiple problems in the family including domestic violence, addiction, family members in prison as well as more severe financial pressures including owing money. Some behaviours (aggression, violence in the home) are normalised on the regeneration estates. Such normalisation processes may not be unconnected with conditions on the estates including high incidence of various forms of anti-social behaviour. Children in families in regeneration areas are also more likely to experience specific traumas including separation from parents and bereavement in the family (including bereavement of young family members such as siblings and uncles).

In terms of the neighbourhoods, the environment and ecology of the most deprived areas offer much less favourable conditions as places to bring up children. The regeneration areas are much more likely to have serious problems in the physical environment (unoccupied / boarded up / burnt out houses; rubbish / litter problems); they are likely to be less safe as places for children to grow up, and to engage in normal activities, such as play, and to meet each other; while crime (car crime, violence, harassment / abuse) and anti-social behaviour are more prevalent as serious problems. Stigma of place is also an issue. Negative labelling / reputation of place affects both parents and their children, and their perceptions of their own social status in the city.

While the most deprived (regeneration) areas have many aspects of positive social capital, reflected in findings related to support for parenting from friends and neighbours, they are characterised by lower levels of social cohesion and lower levels of community social capital (based on indicators related

particularly to trust in people in the neighbourhood). This is the result of the clustering into these areas of people with characteristics associated with lower social capital (e.g. lower education), and the poorer experiences of civic and pro-social behaviour in these areas (i.e. more anti-social behaviour from neighbours and residents). These factors combine to negatively affect trust in people in general.

However, across all types of areas, extended families, friends and neighbours provide important sources of support for parenting, in terms of advice and practical help, and emotional support to children. This type of social capital, known as "bonding" social capital is positive in so far as it helps parents to "get by" and adds to the quality of life. Children, themselves, appreciate these positive aspects of social capital (knowing their neighbours, being friendly with them, having extended networks of family in whom they confide). In terms of extended family, grandparents, in particular, and uncles/aunts and cousins are an important source of support in all areas, especially, for children in regeneration areas. However, it cannot be assumed from this that all influences from such extended family networks are positive and supportive of best child outcomes.

While peer networks of children and families are often perceived as having mainly negative influences, the findings of this research indicate that there are positive influences in peer networks. This applies to children living in all areas including regeneration areas. While children in regeneration areas are more likely to have "best friends" who engage in inappropriate, risk and anti-social behaviours, they also have "best friends" who are "good at school", receive awards and engage in helping others. Generally, children across all types of area are aware of age-inappropriate, risky and negative behaviours, and mainly acknowledge that these are wrong. Children generally have positive perceptions of their relationships with their peers: they have friends; they like their friends; and they like being with friends.

In terms of child health, across all areas, children are diagnosed with both physical and mental health problems (higher percentages with the former (30%) compared with the latter (14%)). While the findings do not show variations by type of area in terms of rates of diagnosed health problems, parent assessment of child health indicates that children in the most deprived (regeneration) areas are more likely to have poorer general health. They are also more severely affected by ill-health. Based on parent assessment, children in the average area have the best health profile. The most common physical health problem in children is asthma (affecting 68% of those with a physical health problem and 18% of all sample children). In terms of learning difficulties, behavioural problems and mental health problems, children in regeneration areas are more likely to be diagnosed with ADHD.

Based on screening for child difficulties (using the Strengths and Difficulties Questionnaire), higher than average proportions of children are assessed as being in the abnormal ranges on individual problem scales (emotional symptoms, conduct problems, hyperactivity / inattention problems and peer problems) and on the total difficulties scale. These problems are severe in the regeneration areas, and

indeed the proportion in abnormal ranges on all problem scales for all of the areas in the study are well above the averages based on norms in a reference population of American children (4-17 years). However, while children in the most deprived areas are more likely to have emotional and behavioural problems, they are similar to their peers in the less deprived and average areas of the city in terms of pro-social behaviour - meaning that children are similar across all areas in terms of being kind, considerate and helpful towards others.

Based on the strengths and difficulties screening exercise, the number of children in abnormal ranges is well above the numbers with diagnosed behavioural and mental health problems. This, in turn, seems to indicate that many children with such difficulties are not being picked up by "the system" in primary care and education.

Based on self-assessed health, parents in the most deprived regeneration areas have poorer health status, particularly compared with parents in the average area, where health profile is best. Parents in regeneration areas are more likely to be diagnosed with emotional and psychological difficulties. Based on self-assessment, parental mental health is poorest in the Northside Regeneration Area, while mental health, on average, is significantly worse than physical health in the Southside Regeneration Area. The proportion of parents in the "at risk" of depression range (based on a cut-off point in mental health scores) is significantly higher in the regeneration areas compared with the Average Control Area (29% Northside; 24% Southside;10% Average Area).

Poorer parental mental health and greater emotional and behavioural difficulties in the child are associated with each other (i.e. they are likely to occur together). The direction of causality could be either way. Furthermore, both parental mental health problems and child difficulties could be associated with many additional problems more likely to be experienced by families in the most deprived areas. These include more difficult environments, poorer social cohesion, difficulties of parenting alone, experiences of traumatic events over the child's life (bereavement of close family members, separation from parents), and more problems in the family (violent behaviours in the family which may be normalised, family member in prison, financial pressures, addiction problems, etc.).

Based on what is known about the relationship between mental health and physical health status over the life course (i.e. that people in poorer mental health and with long exposures to psycho-social stress are more likely to be affected by the on-set of chronic physical health conditions and premature deaths), there is evidence in this research of large inequalities in health linked to social status. Furthermore, the poorer mental health (i.e. more emotional and behavioural difficulties) in the child population in the most deprived areas points towards the inter-generational reproduction of health inequalities.

In terms of the parent / child relationship, parents are strongly affectionate towards, and involved and interested in the lives of, their children. This is true of parents across all types of areas of the city. While the parent / child relationship generally is not characterised by constant criticism and hostility, there is a stronger tendency for parents in regeneration areas to display these behaviours in their relationship with their children. (This finding is just above the cut-off point to be statistically significant). The research findings also indicate that parents apply multiple strategies in disciplining their children. The most frequently used disciplinary strategies across all areas, including regeneration areas, are non-aggressive and positive, based on rewarding good behaviour. However, less positive disciplinary strategies (shouting, threatening to slap) are used to a greater extent by parents in regeneration areas. While parents across all areas monitor the child's activities when out unaccompanied (where they are, with whom, what they are doing etc.), some aspects of monitoring are less strictly applied by parents in regeneration areas (which are also less safe environments). Part of the explanation of these differences could be that parents react by using more aggressive strategies themselves, when they live in difficult, less safe and more aggressive environments and experience aggression in their relationships with other adults. However, notwithstanding these differences, the overall impression is that parents in these most deprived and difficult environments do try to be good parents to their children.

Education and active learning are key lines of action in promoting positive outcomes for children and young people. While it cannot be stated that all children like school, on average and across all areas, many more children like school, to varying extents, than dislike it. Children in the Southside Regeneration Area, however, are more likely to dislike school while children in the Average Control Area like school most. The variation on these indicators, however, is not statistically significant. While children on average like their teachers, children in the regeneration areas like them to a lesser extent than children in the control areas. Variations between areas here are statistically significant.

Based on children's experiences in school, on average, schools are safe places and discipline is applied by the school if children "break the rules". Children in the most deprived areas are more likely to report that they do not always feel safe in school, and are more likely to be exposed to bad behaviours from peers (hitting, hurting, threatening etc.). Children in the most deprived areas are somewhat less likely to approach a teacher when they have a problem. However, the differences between the areas on these indicators are not statistically significant. On indicators related to liking teacher(s), safety issues and reporting problems to teachers, there are statistically significant differences by type of school. The main variations here arise from more negative perceptions by children in "other" schools (i.e. children who have left mainstream education to attend special school / other provision). These children also tend to be amongst the most vulnerable.

The research findings indicate that relationships between parents and school staff (teachers) generally are good. Rates of attendance at parent teacher meetings are high, and parents discuss aspects of the child's progress, behaviour and attendance with teachers as necessary. Rates of absence from school are higher in the regeneration areas (but based on views of educational providers, rates of absence are under-reported by parents). On average, the large majority of parents rate the quality of schools, teachers, and the extent to which children reach their potential at school as excellent or good. There are no statistically significant differences in parental assessment of the quality of education, neither between the areas, nor according to the type/ level of school attended (primary, secondary, other). Based on parent reports, there are no differences between the areas in terms of the proportion of children assessed with special educational needs and the provision of learning support in school. Based on views of some educational providers, however, children in regeneration areas (or in schools in regeneration areas) are more likely to have special educational needs. In cases where learning support is needed, as far as possible, provision is made for this by arranging for additional resources at school level. However, the level of service that the National Educational Psychological Service (NEPS) can offer schools was deemed inadequate, and some schools reported fundraising to meet the costs of both assessments and speech and language provision. Children, therefore, may not have formal assessment of educational needs. Furthermore, it would seem that in regeneration areas many parents of children who are not achieving the educational attainment standards expected for their chronological age are unaware of this, and are not aware of their special educational needs status.

In the framework of this research, it was not possible to undertake objective assessment of actual levels of educational attainment (in maths and English) with reference to expected levels of attainment by chronological age. Based on parent and child reports of educational attainment (with reference to expectations for the child's age), levels of attainment in English and maths are high. Attainment levels are higher in English than maths. The findings show no differences between the areas on child educational attainment levels. However, based on evidence from some educational providers, this may not be the case. It is suggested that parents, particularly, in the most deprived areas are not in a position to provide assessment of attainment levels. This is linked to factors including different profiles of school enrolment and differences in parental levels of education and parental expectations of educational attainment in different areas of the city. Because of these factors, the research cannot provide definitive insights on actual variations in educational attainment outcomes by type of area nor on the reproduction or otherwise of educational disadvantage and educational inequalities.

The research findings also identify that the large majority of parents across all areas, including regeneration areas, aspire to third level education for their children. However, parents in the average or more advantaged areas of the city expect that their children will progress to third level education to a greater extent (i.e. almost all expect their children to go to college).

In terms of education and active learning opportunities outside of school and home, the majority of children across all areas participate in structured activities outside of school. The most common activities here are sports and cultural activities. There is greater participation in youth clubs / kids clubs, homework clubs and after-school activities in the regeneration areas. This is linked to better provision of such activities in these areas. While some of these may be targeted services, parents / carers and children perceive them as open to all and fun or leisure-based activities.

Focusing on services for children and families, the main services used by the large majority of parents and children are schools and their general practitioner (GP). For parents with young children, the public health nurse is a further important and regularly used service. These are the "gateway" services for children and families. Parental satisfaction with the quality of these services is also high. Specialist services are used to a much lesser extent. Based on parent reports, social workers and services targeted on people with difficulties (family support, addiction) are used by very small numbers of children and families and the research findings do not indicate that they are more heavily used by families in the most deprived areas of the city. Because of sensitivities here, there could be some under-reporting of the use of services such as social workers. Generally there is a negative perception of the role of social workers (e.g., they are there to "take your children").

The research findings indicate that provision of some community-based services for children and families (crèches, after-school activities) are more developed in the regeneration areas. Satisfaction ratings with these services, on average are high. Recreation services for children and families are generally lacking in the study neighbourhoods; consumer / private services (shops) are more developed and receive higher quality ratings outside of the most deprived areas of the city.

The findings of this research indicate that there are inter-dependencies and multi-causality in the problems and in the way the various factors shape and re-shape outcomes for children and families. For instance, poor parental mental health could be both a cause and an outcome of living in a deprived, unsafe neighbourhood, long exposures to different types of trauma, experience of multiple traumatic events, and parenting difficult children. Poor child outcomes and child difficulties could be a cause and an outcome of a similar set of factors.

6.3 Addressing the problems

The problems of children and families on the deprived estates, as presented in the findings of this research, could be described as "wicked problems" (Rittel and Webber, 1973). "Wicked" problems have a number of characteristics: they are difficult to define clearly; they have many inter-dependencies and are often multi-causal; attempts to address them may have unforeseen consequences; often, they are not stable; usually, they have no clear solutions; they are socially

complex; it is beyond the capacity of any one organisation to respond to them; they involve changing behaviours; and some are characterised by chronic policy failure.

Tackling "wicked problems" requires a systems approach which places high value on understanding the context, and the inter-connections or relationships between the different aspects of the problem, as well as changing attitudes and behaviour. A systems approach has profound effects on the way public agencies need to operate if they are to be more effective (cutting across all the issues and working from a deep understanding of context); this approach has implications in terms of the expertise and skills set needed on the part of public agencies and stakeholder partnerships to address the problems (WHO, *Strengthening Public Health*, 2011). Changing structures and services are not adequate in themselves as solutions. Changes in attitudes towards the people affected are also required. The priority focus must be on achieving changes in outcomes for the children and families who are most marginalised, rather than on issues such as retaining services, and preserving institutional roles or specific structures.

The detailed findings of the study provide a quantification of the baseline conditions across a wide range of indicators. They provide the baseline against which future progress in terms of bridging the gap between the most deprived children and families in the city and the mainstream can be assessed, linked to resources and support from public policy interventions. Some findings may indicate specific issues that could or should be addressed by constituent agencies of the Limerick City CSC. In terms of planning for improved services for children and families in the city, this is the future task of the CSC, drawing on the findings of this and other complementary strands of their research programme. The results of the multivariate analysis of the household survey provide indications of the key areas for attention. These relate to the following:

1. Improving levels of parental education for those with low levels of educational attainment. Based on observations from the fieldwork, many parents have learning difficulties, low levels of literacy and negative experiences themselves in education;
2. Improving the emotional health and well-being of parents, including support with conflict resolution, and promoting better quality of (adult) relationships;
3. Support with access to relevant training and employment opportunities, and on-going support to promote retention and progression in education, training and employment;
4. Services to support improved parental mental health;
5. Multifaceted interventions to improve the physical and social environment and safety issues in the neighbourhood. These should include incentives and sanctions to encourage more civic behaviour and collective responsibility;
6. On-going support to encourage parenting styles and strategies associated with the best outcomes for children.

However, the message is again emphasised that the potential for, and prospect of, finding solutions (better outcomes and a reduced gap) is not only about new or improved services and the role of institutions. It is also about attitudes supportive of social justice and equality, and empathy with those families and communities characterised by extreme social deprivation, that may, on occasions, exhibit (extremes of) un-civic behaviour.

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APPENDIX I: STUDY AREAS

Study Area	EDs	Neighbourhoods / sub-areas & key characteristics
Northside Regeneration Area	Ballynanty Limerick North Rural	Moyross comprising 12 parks constructed in various phases from the late 1970's. Some 1,100 households were originally constructed but now it has approximately 840 households.
	St. John's A	St. Mary's Park, originally constructed in 1935; in 2006, it had approximately 450 households. Estimated that it now comprises some 400 households.
Southside Regeneration Area	Galvone B (pt) Rathbane (pt)	Southill constructed mainly in 1960's and 1970's comprising four parks: Keyes Park (originally some 160 houses), O'Malley Park (originally some 600 houses), Kincora Park (some 210 houses), John Carew Park (originally some 260 houses). These area combined now comprise some 800 households.
	Prospect B (pt)	The regeneration area of Ballinacurra Weston, constructed mainly in the 1940's / 1950's, comprises Beechgrove Ave., Byrne Ave (part), Clarina Ave., Clarina Court, Clarina Park (mostly demolished), Crecora Ave., Hyde Ave., Hyde Rd., and Lenihan Ave. In 2006, the area comprised some 310 households. Estimated that there are now 230 households.
Disadvantaged Control Area	Singland A Abbey D	Garryowen, a traditional working class neighbourhood, includes areas such as Claughan, Singland, Well Field; Pike Ave., Fairview Crescent (approx. 10 years old), St. Lawrence Ave., Fair Green Road and new small housing estates off the Fair Green (Churchfields, Ballysimon Crescent), St. Patrick's Road; Kilalee (Keane St., Downey St., Flood St., Keating St); Sarsfield Ave., Kilmurray Rd., North Claughan, Pennywell (part). Estimated that there are approximately 1,170 households in the Garryowen study area (Singland A and Abbey D).
	Galvone A	Kennedy Park, an older local authority housing estate of approximately 400 housing units; and the Old Cork Road Area (now just over 170 housing units within the city boundary). The Old Cork Road areas was originally centred on Georgian Village (170 houses built in the 1980s). In recent years, some new infill housing has been constructed within the city boundary on the Old Cork Road. There are also new housing estates adjacent to the original development, in the County administrative area.
Average Control Area	Abbey A	Corbally includes the estates on the Mill Road (Silver Brook, Spring Grove, Meadowbrook, Siul na hAbhann, the Hermitage, Brookhaven Walk), Lower Park Road including Troy's Locke, Carrabullawn, and The Meadows, Danesfort, Abbeyvale, Abbeylocke and Richmond Park, College Park, Janemount Park, Old Park Road, Carriglea, Roseville Gardens, Rosendale Gardens and Park Gardens. It is estimated that this area of Corbally comprises approximately 1,225 housing units.
	Abbey B	Rhebogue comprising: Rhebogue Meadows, Cois hAbhann, Angler's Walk, Drominbeg, Brook Road, Brook Place and Drumroe. It is estimated that this area comprised some 430 housing units.

APPENDIX II: ADDITIONAL STATISTICAL TABLES

Demographic characteristics of child respondents

Table A1: Age profile of child respondents by area				
	Mean	**Standard Deviation**	**Min-Max**	**Cases (N)**
Northside Regeneration	11.14	2.46	7-16	42
Southside Regeneration	11.43	2.50	7-17	23
Other Disadvantaged Area	10.41	2.48	6-15	39
Average Area	10.25	2.74	7-16	24
All Areas	**10.80**	**2.54**	**6-17**	**128**

Statistical tests: not significant

Table A2: Nationality of Child Respondent by Area										
Age Categories	**N'side Regeneration Area**		**S'side Regeneration Area**		**Other Disadvantaged Area**		**Average Area**		**All Areas**	
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Irish	42	100	23	100	39	100	23	95.8	127	99.2
EU-CEC	0	0	0	0	25	24.0	4.2	4.2	1	0.8
Total	**42**	**100**	**23**	**100**	**39**	**100**	**24**	**100**	**128**	**100**

Statistical tests: not significant

Child's extended family networks

Table A3: Who child respondent would talk to if worried / troubled, by area										
Who would you talk to?	**N'side Regeneration Area**		**S'side Regeneration Area**		**Other Disadvantaged Area**		**Average Area**		**All Areas**	
Mam or Dad who doesn't live with me	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Yes	7	17.5	6	26.1	3	7.9	1	4.3	17	13.7
Total	**40**	**100**	**23**	**100**	**38**	**100**	**23**	**100**	**124**	**100**
Statistical Tests: Chi Sq 6.25 (df=3), p=0.10; Phi=0.22; not significant										
Grandparent(s)										
Yes	22	55.0	9	39.1	18	47.4	8	34.8	57	46.0
Total	**40**	**100**	**23**	**100**	**38**	**100**	**23**	**100**	**124**	**100**
Statistical Tests: Chi Sq 2.94 (df=3), p=0.40; Phi=0.13; not significant										
Brothers / sisters										
Yes	23	57.5	10	43.5	15	39.5	6	26.1	54	43.5
Total	**40**	**100**	**23**	**100**	**38**	**100**	**23**	**100**	**124**	**100**
Statistical Tests: Chi Sq 6.28 (df=3), p=0.10; Phi=0.22; not significant										
Aunts / uncles / cousins										
Yes	17	42.5	12	52.2	15	39.5	12	52.2	56	45.2
Total	**40**	**100**	**23**	**100**	**38**	**100**	**23**	**100**	**124**	**100**
Statistical Tests: Chi Sq 1.52 (df=3), p=0.68; Phi=0.11; not significant										
Friends										
Yes	19	47.5	9	39.1	15	39.5	12	52.2	55	44.4
Total	**40**	**100**	**23**	**100**	**38**	**100**	**23**	**100**	**124**	**100**
Statistical Tests: Chi Sq 1.35 (df=3), p=0.72; Phi=0.10; not significant										
Youth worker / HSL										
Yes	3	7.5	0	0	0	0	0	0	3	2.4
Total	**40**	**100**	**23**	**100**	**38**	**100**	**23**	**100**	**124**	**100**
Statistical Tests: Chi Sq 6.46 (df=3), p=0.09; Phi=0.23; not significant										

Child Health

Table A4: Types of physical health problems diagnosed in sample child, by area											
Health problems	**N'side Regeneration Area**		**S'side Regeneration Area**		**Other Disadvantaged Area**		**Average Area**		**All Areas**		**Statistical tests**
	Yes, No.	**Yes, %**	**Yes, No.**	**Yes, %**	**Yes, No.**	**Yes, %**	**Yes, No.**	**Yes, %**	**Yes, No.**	**Yes, %**	
Problems with arms, legs - arthritis / rheumatism	1	2.7	1	3.8	1	3.1	1	3.2	4	3.2	Not significant
Cases N	**37**		**26**		**32**		**31**		**126**		
Problems with sight or hearing	4	10.8	1	3.8	1	3.1	4	12.9	10	7.9	Not significant
Cases N	**37**		**26**		**32**		**32**		**31**		
Speech difficulty	5	13.5	4	15.4	5	15.6	3	9.7	17	13.5	Not significant
Cases N	**37**		**26**		**32**		**31**		**126**		
Asthma	22	59.5	19	73.1	19	59.4	19	61.3	79	62.7	Not significant
Cases N	**37**		**26**		**32**		**31**		**126**		
Skin problems such as eczema	6	16.2	2	7.7	5	15.6	2	6.5	15	11.9	Not significant
Cases N	**37**		**26**		**32**		**31**		**126**		
Epilepsy, fits, convulsion	3	8.1	0	0	0	0	1	3.2	4	3.2	Not significant
Cases N	**37**		**26**		**32**		**31**		**126**		
Congenital abnormality	2	5.4	1	3.8	4	12.5	1	3.2	8	6.3	Not significant
Cases N	**37**		**26**		**32**		**31**		**126**		
Kidney / bladder problems	2	5.4	0	0	1	3.1	1	3.2	4	3.2	Not significant
Cases N	**37**		**26**		**32**		**31**		**126**		
Other illness	2	5.4	7	26.9	4	12.5	4	12.9	17	13.5	Not significant
Cases N	**37**		**26**		**32**		**31**		**126**		

Table A5: Types of learning difficulties, behavioural problems, mental health problems in sample child, by area											
Health problem	**N'side Regeneration Area**		**S'side Regeneration Area**		**Other Disadvantaged Area**		**Average Area**		**All Areas**		**Statistical tests**
	Yes, No.	**Yes, %**	**Yes, No.**	**Yes, %**	**Yes, No.**	**Yes, %**	**Yes, No.**	**Yes, %**	**Yes, No.**	**Yes, %**	
ADHD	4	22.2	8	50.0	5	33.3	0	0	17	29.3	Chi Sq = 7.591 (df=3), Phi=0.362; p=0.55 (almost significant)
Cases N	**18**		**16**		**15**		**9**		**58**		
Autism / Asperger's or similar	0	0	2	12.5	1	6.7	1	11.1	4	6.9	Not significant
Cases N	**18**		**16**		**15**		**9**		**58**		
Dyslexia or Dyspraxia	8	44.4	3	18.8	5	33.3	4	44.4	20	34.5	Not significant
Cases N	**18**		**16**		**15**		**9**		**58**		
Anxiety or withdrawn behaviour	1	5.6	2	12.5	1	6.7	1	11.1	5	8.6	Not significant
Cases N	**18**		**16**		**15**		**9**		**58**		
Aggressive behaviour / conduct disorder	1	5.6	3	18.8	1	6.7	0	0	5	8.6	Not significant
Cases N	**18**		**16**		**15**		**9**		**58**		
Anorexia or bulimia	0	0	1	6.2	1	6.7	0	0	2	3.2	Not significant
Cases N	**18**		**16**		**15**		**9**		**58**		
Mental health issues such as depression	1	5.6	0	0	0	0	1	11.1	2	3.4	Not significant
Cases N	**18**		**16**		**15**		**9**		**58**		
Down's syndrome or other intellectual difficulty	0	0	0	0	0	0	1	11.1	1	1.7	Not significant
Cases N	**18**		**16**		**15**		**9**		**58**		
Other learning or behavioural difficulties	8	44.4	3	18.8	7	46.7	2	22.2	20	34.5	Not significant
Cases N	**18**		**16**		**15**		**9**		**58**		

Strengths and Difficulties in the Child

Table A6: Emotional symptoms scale in sample child population, by area					
Areas	**Mean Score**	**Median**	**Standard Deviation**	**Range Min-Max**	**Cases**
Northside Regeneration	3.15	2.00	2.99	0-10	**N=103**
Southside Regeneration Area	4.06	4.00	3.04	0-10	**N=78**
Disadvantaged Control Area	2.63	2.00	2.43	0-9	**N=88**
Average Area	2.47	2.00	2.42	0-9	**N=86**
All Areas	**3.05**	**3.00**	**2.79**	**0-10**	**N=355**

Statistical Tests: F= 5.619; p<0.01 (p=0.001)
Scale 0 (no problem) to 10 (severe problem)

Table A7: Conduct problems scale in sample child population by area					
Areas	**Mean Score**	**Median**	**Standard Deviation**	**Range Min-Max**	**Cases**
Northside Regeneration	2.45	2.00	2.40	0-10	**N=103**
Southside Regeneration Area	2.99	2.00	2.20	0-10	**N=78**
Disadvantaged Control Area	1.92	2.00	1.83	0-8	**N=88**
Average Area	1.17	1.00	1.27	0-5	**N=86**
All Areas	**2.13**	**2.00**	**2.09**	**0-10**	**N=355**

Statistical Tests: F=12.617; p<0.001
Scale 0 (no problem) to 10 (severe problem)

Table A8: Hyperactivity scale in sample child population by area					
Areas	**Mean Score**	**Median**	**Standard Deviation**	**Range Min-Max**	**Cases**
Northside Regeneration	3.99	3.00	3.29	0-10	**N=103**
Southside Regeneration Area	4.68	4.00	3.12	0-10	**N=78**
Disadvantaged Control Area	3.32	3.00	2.98	0-10	**N=88**
Average Area	3.12	2.00	2.71	0-10	**N=86**
All Areas	**3.76**	**3.00**	**3.09**	**0-10**	**N=355**

Statistical Tests: F=4.466; p<0.01 (p=0.004)
Scale 0 (no problem) to 10 (severe problem)

Table A9: Peer problems scale in sample child population by area					
Areas	**Mean Score**	**Median**	**Standard Deviation**	**Range Min-Max**	**Cases**
Northside Regeneration	1.73	1.00	1.77	0-8	**N=103**
Southside Regeneration Area	2.46	2.00	2.12	0-8	**N=78**
Disadvantaged Control Area	1.48	1.00	1.76	0-8	**N=88**
Average Area	1.08	1.00	1.67	0-8	**N=86**
All Areas	**1.67**	**1.00**	**1.88**	**0-8**	**N=355**

Statistical Tests: F=8.199; p<0.001
Scale 0 (no problem) to 10 (severe problem)

Table A10: Pro-social scale in sample child population by area					
Areas	**Mean Score**	**Median**	**Standard Deviation**	**Range Min-Max**	**Cases**
Northside Regeneration	8.68	10.00	1.99	2-10	**N=103**
Southside Regeneration Area	8.59	10.00	2.19	0-10	**N=78**
Disadvantaged Control Area	8.75	3.00	1.80	3-10	**N=88**
Average Area	9.16	10.00	1.15	4-10	**N=86**
All Areas	**8.79**	**10.00**	**1.83**	**0-10**	**N=355**

Statistical Tests: F=1.656; p=0.176 (not significant)
Scale 10 (no problem) to 0 (severe problem)

Table A11: Total difficulties scale in sample child population by area					
Areas	**Mean Score**	**Median**	**Standard Deviation**	**Range Min-Max**	**Cases**
Northside Regeneration	11.31	10.00	7.63	0-36	**N=103**
Southside Regeneration Area	14.19	13.00	7.69	1-35	**N=78**
Disadvantaged Control Area	9.34	8.00	6.53	0-27	**N=88**
Average Area	7.84	7.00	5.54	0-25	**N=86**
All Areas	**10.61**	**9.00**	**7.26**	**0-36**	**N=355**

Statistical Tests: F=12.908; p<0.001
Scale: 0 (no problems) to 40 (severe problems)

Difficulties with reference to "normality"

Table A12: Emotional symptoms scores and classification of normality of the child population, by area										
Categories	**N'side Regeneration Area**		**S'side Regeneration Area**		**Other Disadvantaged Area**		**Average Area**		**All Areas**	
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Normal (0-3)	63	61.2	36	46.2	60	68.2	64	74.4	223	62.8
Borderline (4)	10	9.7	11	14.1	7	8.0	7	8.1	35	9.9
Abnormal (5-10)	30	29.1	31	39.7	21	23.9	15	17.4	97	27.3
Total	**103**	**100**	**78**	**100**	**88**	**100**	**86**	**100**	**355**	**100**

Statistical Tests: Chi Sq = 15.73 (df=6), $p<0.05$ (p=0.02), Cramer's V = 0.15

Table A13: Conduct problems scores and classification of normality of the child population, by area										
Categories	**N'side Regeneration Area**		**S'side Regeneration Area**		**Other Disadvantaged Area**		**Average Area**		**All Areas**	
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Normal (0-2)	59	57.3	40	51.3	61	69.3	73	84.9	233	65.6
Borderline (3)	18	17.5	9	11.5	15	17.0	8	9.3	50	14.1
Abnormal (4-10)	26	25.2	29	37.2	12	13.6	5	5.8	72	20.3
Total	**103**	**100**	**78**	**100**	**88**	**100**	**86**	**100**	**355**	**100**

Statistical Tests: Chi Sq = 34.75 (df=6); Cramer's V=0.22, $p<0.001$

Table A14: Hyperactivity / inattentive problems scores and classification of normality of the child population, by area										
Categories	**N'side Regeneration Area**		**S'side Regeneration Area**		**Other Disadvantaged Area**		**Average Area**		**All Areas**	
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Normal (0-5)	69	67.0	46	59.0	65	73.9	69	80.2	249	70.1
Borderline (6)	6	5.8	9	11.5	6	6.8	7	8.1	28	7.9
Abnormal (7-10)	28	27.2	23	29.5	17	19.3	10	11.6	78	22.0
Total	**103**	**100**	**78**	**100**	**88**	**100**	**86**	**100**	**355**	**100**

Statistical Tests: Chi Sq = 12.71 (df=6); Cramer's V=0.13, p=0.05

Table A15: Peer problems scores and classification of normality of the child population, by area										
Categories	**N'side Regeneration Area**		**S'side Regeneration Area**		**Other Disadvantaged Area**		**Average Area**		**All Areas**	
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Normal (0-2)	73	70.9	47	60.3	66	75.0	77	89.5	263	74.1
Borderline (3)	14	13.6	10	12.8	9	10.2	4	4.7	37	10.4
Abnormal (4-10)	16	15.5	21	26.9	13	14.8	5	5.8	55	15.5
Total	**103**	**100**	**78**	**100**	**88**	**100**	**86**	**100**	**355**	**100**

Statistical Tests: Chi Sq = 20.92 (df=6); Cramer's V=0.17, p<0.001

Table A16: Prosocial behaviour scores and classification of normality of the child population, by area										
Categories	**N'side Regeneration Area**		**S'side Regeneration Area**		**Other Disadvantaged Area**		**Average Area**		**All Areas**	
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Normal (6-10)	93	90.3	71	91.0	80	90.9	85	98.8	329	92.7
Borderline (5)	4	3.9	2	2.6	5	5.7	0	0	11	3.1
Abnormal (0-4)	6	5.8	5	6.4	3	3.4	1	1.2	15	4.2
Total	**103**	**100**	**78**	**100**	**88**	**100**	**86**	**100**	**355**	**100**

Statistical Tests: Chi Sq = 8.86 (df=6); Cramer's V=0.11, p=0.18, not significant

Table A17: Total difficulties scores and classification of normality of the child population, by area										
Categories	**N'side Regeneration Area**		**S'side Regeneration Area**		**Other Disadvantaged Area**		**Average Area**		**All Areas**	
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Normal (0-13)	67	65.0	41	52.0	67	76.1	74	86.0	249	70.0
Borderline (14-16)	6	5.8	11	14.1	8	9.1	6	7.0	31	8.7
Abnormal (17-40)	30	29.1	23	33.3	13	14.8	6	7.0	75	21.1
Total	**103**	**100**	**78**	**100**	**88**	**100**	**86**	**100**	**355**	**100**

Statistical Tests: Chi Sq = 29.76 (df=6); Cramer's V=0.20, p<0.001

Table A18: Scores on Health Scales and Summary Health Components by Area						
Health Scale	**Mean** ***Median*** **(SD)** **Cases (N)**	**Mean** ***Median*** **(SD)** **Cases (N)**	**Mean** ***Median*** **(SD)** **Cases (N)**	**Mean** ***Median*** **(SD)** **Cases (N)**	**Mean** ***Median*** **(SD)** **Cases (N)**	**Statistical tests: statistical significance**
	Northside Regeneration Area	**Southside Regeneration Area**	**Disadvantaged Control Area**	**Average Control Area**	**All Areas**	**ANOVA**
Physical functioning (PF)	83.61 ***100.00*** (31.46) N=119	91.94 ***100.00*** (20.12) N=90	90.63 ***100.00*** (22.36) N=104	91.43 ***100.00*** (21.60) N=105	89.12 ***100.00*** (24.87) N=418	F=2.795; p<0.05 (p=0.04)
Role – Physical (RP)	83.09 ***100.00*** (29.77) N=119	90.42 ***100.00*** (19.75) N=90	92.67 ***100.00*** (18.65) N=104	89.76 ***100.00*** (22.85) N=105	88.73 ***100.00*** (23.75) N=418	F=3.470; p<0.05 (p=0.016)
Bodily Pain (BP)	85.50 ***100.00*** (30.79) N=119	90.56 ***100.00*** (22.04) N=90	86.54 ***100.00*** (27.85) N=104	86.43 ***100.00*** (27.08) N=105	87.08 ***100.00*** (27.34) N=418	Not significant
General Health (GH)	65.67 ***60.00*** (28.68) N=119	67.06 ***60.00*** (26.35) N=90	74.14 ***85.00*** (24.39) N=104	78.14 ***85.00*** (22.95) N=105	71.21 ***85.00*** (26.19) N=418	F=5.592 p<0.01 (p=0.001)
Vitality (VT)	60.29 ***50.00*** (27.50) N=119	61.94 ***75.00*** (28.60) N=90	62.26 ***75.00*** (25.60) N=104	68.57 ***75.00*** (21.10) N=105	63.22 ***75.00*** (25.92) N=418	F=2.135; P=0.095, not significant
Social functioning (SF)	80.88 ***100.00*** (32.00) N=119	81.67 ***100.00*** (30.63) N=90	83.89 ***100.00*** (27.85) N=104	94.05 ***100.50*** (16.08) N=105	85.11 ***100.00*** (27.83) N=418	F=5.204; p<0.01 (p=0.002)
Role – Emotional (RE)	80.57 ***75.00*** (23.75) N=119	84.86 ***100.00*** (26.00) N=90	92.07 ***100.00*** (19.01) N=104	92.26 ***100.00*** (18.21) N=105	87.29 ***100.00*** (24.28) N=418	F=6.391; p<0.001 (p=0.000)

Table A18: Scores on Health Scales and Summary Health Components by Area

Health scale	**Mean** ***Median*** **(SD)** **Cases (N)**	**Mean** ***Median*** **(SD)** **Cases (N)**	**Mean** ***Median*** **(SD)** **Cases (N)**	**Mean** ***Median*** **(SD)** **Cases (N)**	**Mean** ***Median*** **(SD)** **Cases (N)**	**Statistical tests: statistical significance**
	Northside Regeneration Area	**Southside Regeneration Area**	**Disadvantaged Control Area**	**Average Control Area**	**All Areas**	**ANOVA**
Mental health (MH)	65.55 ***75.00*** (23.75) N=119	67.36 ***75.00*** (24.70) N=90	75.60 ***75.00*** (18.85) N=104	73.81 ***75.00*** (18.63) N=105	69.77 ***75.00*** (21.83) N=418	F=3.701; p<0.05 (p=0.012)
Physical Component Score (PCS)	51.54 ***55.57*** (11.39) N=119	53.95 ***55.86*** (6.83) N=90	53.11 ***56.15*** (8.83) N=104	53.16 ***56.15*** (9.28) N=105	52.86 ***56.15*** (9.39) N=418	Not significant
Mental Component Score (PCS)	47.49 ***51.14*** (6.73) N=119	47.79 ***51.92*** (12.82) N=90	50.82 ***54.20*** (9.38) N=104	52.89 ***54.37*** (8.13) N=105	49.74 ***53.40*** (11.08) N=418	F=5.917; p<0.01 (p=0.001)

CHILD RESPONDENTS: ABOUT YOU AND YOUR FRIENDS

Table A19: Child perception of himself / herself and relationship with friends, by area										
WHETHER THE FOLLOWING STATEMENTS ARE 'TRUE'	**N'side Regeneration Area**		**S'side Regeneration Area**		**Other Disadvantaged Area**		**Average Area**		**All Areas**	
I get angry easily	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Yes, True	24	57.1	15	65.2	14	35.9	7	29.2	60	46.9
Cases: N	**42**	**100.0**	**23**	**100.0**	**39**	**100.0**	**24**	**100.0**	**128**	**100.0**
Statistical Tests: Chi Sq = 9.80 (df=3), p<0.05 (p=0.02); Phi = 0.28										
I like to have my own way even if it gets me into trouble										
Yes, True	21	50.0	11	47.8	16	41.0	5	20.8	53	41.4
Cases: N	**42**	**100.0**	**23**	**100.0**	**39**	**100.0**	**24**	**100.0**	**128**	**100.0**
Statistical Tests: Chi Sq = 5.86 (df=3), p=0.12; Phi = 0.21; not significant										
I have some good friends (one or more)										
Yes, True	41	97.6	23	100.0	39	100.0	24	100.0	127	99.2
Cases: N	**42**	**100.0**	**23**	**100.0**	**39**	**100.0**	**24**	**100.0**	**128**	**100.0**
Statistical Tests: Chi Sq = 2.06 (df=3), p=0.56; Phi = 0.13; not significant										
Other kids like me, I'm popular										
Yes, True	36	85.7	20	87.0	35	89.7	22	91.7	113	88.3
Cases: N	**42**	**100.0**	**23**	**100.0**	**39**	**100.0**	**24**	**100.0**	**128**	**100.0**
Statistical Tests: Chi Sq = 0.65 (df=3); p=0.88; Phi = 0.07; not significant										
My friends think I'm bold / get into trouble										
Yes, True	1	2.4	3	13.0	4	10.3	3	12.5	11	8.7
Cases: N	**42**	**100.0**	**23**	**100.0**	**39**	**100.0**	**24**	**100.0**	**128**	**100.0**
Statistical Tests: Chi Sq = 3.14 (df=3), p=0.37; Phi = 0.16; not significant										
I like being with my friends										
Yes, True	40	97.6	23	100.0	39	100.0	24	100.0	126	99.2
Cases: N	**41**	**100.0**	**23**	**100.0**	**39**	**100.0**	**24**	**100.0**	**127**	**100.0**
Statistical Tests: not significant										

Child respondent: Awards and positive behaviours

Table A20: Child respondent: awards, helpful behaviour and interests, by area										
Tell me about yourself ...	**N'side Regeneration Area**		**S'side Regeneration Area**		**Other Disadvantaged Area**		**Average Area**		**All Areas**	
Have you been given a prize or award at school for being good in school work or good behaviour?	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Yes	35	83.3	21	91.3	35	89.7	21	87.5	112	87.5
Cases: N	**42**	**100.0**	**23**	**100.0**	**39**	**100.0**	**24**	**100.0**	**128**	**100.0**
Statistical Tests: Chi Sq = 1.15 (df=3), p=0.76; Phi = 0.09; not significant										
Have been given a prize or award at school for anything else like sport, music, art, singing / dancing?										
Yes	32	76.2	17	73.9	32	82.1	16	66.7	97	75.8
Cases: N	**42**	**100.0**	**23**	**100.0**	**39**	**100.0**	**24**	**100.0**	**128**	**100.0**
Statistical Tests: Chi Sq = 1.97 (df=3), p=0.58; Phi = 0.12; not significant										
Have you been helpful to other people – doing things to help them without being made do it										
Yes	38	90.5	22	95.7	37	94.9	24	100.0	121	94.5
Cases: N	**42**	**100.0**	**23**	**100.0**	**39**	**100.0**	**24**	**100.0**	**128**	**100.0**
Statistical Tests: Chi Sq = 2.79 (df=3), p=0.43; Phi = 0.15; not significant										
I like to read books for fun										
Yes	30	71.4	12	52.2	32	82.1	20	83.3	94	73.4
Cases: N	**42**	**100.0**	**23**	**100.0**	**39**	**100.0**	**24**	**100.0**	**128**	**100.0**
Statistical Tests: Chi Sq = 8.11 (df=3); p<0.05 (p=0.04); Phi = 0.25										

Peer Networks: Awards and behaviour of friends

Table A21: Child respondent and his/her best friends – awards and behaviour - by area ALL CHILD RESPONDENTS										
With your friends, have any of best friends ...	**N'side Regeneration Area**		**S'side Regeneration Area**		**Other Disadvantaged Area**		**Average Area**		**All Areas**	
Been given a prize or award at school for being good in school work or good behaviour?	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Yes	34	87.2	18	85.7	34	91.9	20	87.0	106	88.3
Cases: N	**39**	**100.0**	**21**	**100.0**	**37**	**100.0**	**23**	**100.0**	**120**	**100.0**
Statistical Tests: Chi Sq = 0.69 (df=3), p=0.88; Phi = 0.08; not significant										
Been sent home from school (suspended or expelled) because they were bold / for bad behaviour?										
Yes	15	35.7	7	30.4	9	23.1	1	4.3	32	25.2
Cases: N	**42**	**100.0**	**23**	**100.0**	**39**	**100.0**	**23**	**100.0**	**127**	**100.0**
Statistical Tests: Chi Sq = 8.20 (df=3), p < 0.05 (p=0.04); Phi = 0.25										
Smoked cigarettes?										
Yes	9	22.0	7	31.8	7	17.9	3	12.5	26	20.6
Cases: N	**41**	**100.0**	**22**	**100.0**	**39**	**100.0**	**24**	**100.0**	**126**	**100.0**
Statistical Tests: Chi Sq = 2.87 (df=3), p=0.41; Phi = 0.15; not significant										
Been helpful to other people										
Yes	33	80.5	22	95.7	33	91.7	21	95.5	109	89.3
Cases: N	**41**	**100.0**	**23**	**100.0**	**36**	**100.0**	**22**	**100.0**	**122**	**100.0**
Statistical Tests: Chi Sq = 5.41 (df=3); p=0.14; Phi = 0.21; not significant										
Tried to steal stuff										
Yes	10	23.8	5	23.8	4	10.8	0	0	19	15.3
Cases: N	**42**	**100.0**	**21**	**100.0**	**37**	**100.0**	**24**	**100.0**	**124**	**100.0**
Statistical Tests: Chi Sq = 8.42 (df=3); p<0.05 (p=0.04); Phi = 0.21;										

Table A21: Child respondent and his/her best friends – awards and behaviour - by area CHILD RESPONDENTS AGED 12 YEARS AND OVER										
With your friends, have (do) any of best friends ...	**N'side Regeneration Area**		**S'side Regeneration Area**		**Other Disadvantaged Area**		**Average Area**		**All Areas**	
Got into trouble with the guards	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Yes	4	21.1	2	25.0	3	27.3	1	14.3	10	22.2
Cases: N	**19**	**100.0**	**8**	**100.0**	**11**	**100.0**	**7**	**100.0**	**45**	**100.0**
Statistical Tests: Chi Sq = 0.47 (df=3), p=0.93; not significant										
Drinks alcohol										
Yes	5	26.3	3	37.5	3	27.3	2	28.6	13	28.9
Cases: N	**19**	**100.0**	**8**	**100.0**	**11**	**100.0**	**7**	**100.0**	**45**	**100.0**
Statistical Tests: Chi Sq = 0.36 (df=3), p=0.95; not significant										
Takes drugs										
Yes	2	10.5	0	0	2	18.2	1	14.3	5	11.1
Cases: N	**19**	**100.0**	**8**	**100.0**	**11**	**100.0**	**7**	**100.0**	**45**	**100.0**
Statistical Tests: Chi Sq = 1.63 (df=3), p=0.65; Phi = 0.19; not significant										

Table A22: Incidents of bad behaviour towards the child respondent by area and location of incidents													
	AREAS										Where did it happen? ALL Areas		
INCIDENTS	N'side Regeneration Area		S'side Regeneration Area		Other Disadvantaged Area		Average Area		All Areas		At school	Where I live	Somewhere else
(a) Tried to kick me / actually kicked me / hit / hurt me	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**No.**	**No.**
Yes, in the last few weeks	8	19.0	7	30.4	7	17.9	2	8.3	24	18.8			
Not in the last weeks, but has happened	2	4.8	1	4.3	1	2.6	0	0	4	3.1			
Total, Yes	**10**	**23.8**	**8**	**34.7**	**8**	**20.5**	**2**	**8.3**	**28**	**21.9**	**11**	**10**	**0**
Cases (N)	**42**		**23**		**39**		**24**		**128**		**19**	**19**	**19**
Statistical Tests: Chi Sq = 5.42 (df=6), p=0.49; Cramer's V = 0.15; Not significant											Note: 9 cases 'missing' – i.e. did not specify where incident happened		
	AREAS										Where did it happen? ALL Areas		
INCIDENTS	N'side Regeneration Area		S'side Regeneration Area		Other Disadvantaged Area		Average Area		All Areas		At school	Where I live	Somewhere else
(b) Said they'd beat me up	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**No.**	**No.**
Yes, in the last few weeks	8	19.0	5	21.7	4	10.3	1	4.2	18	14.1			
Not in the last weeks, but has happened	1	2.4	0	4.3	0	0	0	0	1	0.8			
Total, Yes	**9**	**21.4**	**5**	**21.7**	**4**	**10.3**	**1**	**4.2**	**19**	**14.9**	**5**	**7**	**2**
Cases (N)	**42**		**23**		**39**		**24**		**128**		**14**	**14**	**14**
Statistical Tests: Chi Sq = 6.59 (df=6), p=0.36; Cramer's V = 0.16; Not significant											Note: 5 cases 'missing' – i.e. did not specify where incident happened		

Table A22: Incidents of bad behaviour towards the child respondent by area and location of incidents (continued)													
	AREAS										Where did it happen? ALL Areas		
INCIDENTS	N'side Regeneration Area		S'side Regeneration Area		Other Disadvantaged Area		Average Area		All Areas		At school	Where I live	Somewhere else
(c) Tried to make me give them money or / things	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**No.**	**No.**
Yes, in the last few weeks	4	9.5	3	13.0	2	5.1	1	4.2	10	7.8			
Not in the last weeks, but has happened	0	0	0	0	0	0	0	0	0	0			
Total, Yes	**4**	**9.5**	**3**	**13.0**	**2**	**5.1**	**1**	**8.3**	**28**	**7.8**	**3**	**3**	**0**
Cases (N)	**42**		**23**		**39**		**24**		**128**		**10**	**10**	**10**
Statistical Tests: Chi Sq = 5.42 (df=6), p=0.49; Cramer's V = 0.15; Not significant											Note: 5 cases 'missing' – i.e. did not specify where incident happened		
	AREAS										Where did it happen? ALL Areas		
INCIDENTS	N'side Regeneration Area		S'side Regeneration Area		Other Disadvantaged Area		Average Area		All Areas		At school	Where I live	Somewhere else
(d) Tried to break / actually broke my things	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**No.**	**No.**
Yes, in the last few weeks	2	4.8	2	8.7	4	10.3	0	0	8	6.3			
Not in the last weeks, but has happened	1	2.4	0	0	0	0	0	0	1	0.8			
Total, Yes	**3**	**7.2**	**2**	**8.7**	**4**	**10.3**	**0**	**0**	**9**	**7.1**	**3**	**3**	**0**
Cases (N)	**42**		**23**		**39**		**24**		**128**		**6**	**6**	**6**
Statistical Tests: Chi Sq = 5.10 (df=6), p=0.53; Cramer's V = 0.14; Not significant											Note: 3 cases 'missing' – i.e. did not specify where incident happened		

Table A22: Incidents of bad behaviour towards the child respondent by area and location of incidents (continued)													
	AREAS										Where did it happen? ALL Areas		
INCIDENTS	N'side Regeneration Area		S'side Regeneration Area		Other Disadvantaged Area		Average Area		All Areas		At school	Where I live	Somewhere else
(e) Said mean things about me	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**No.**	**No.**
Yes, in the last few weeks	14	33.3	6	26.1	14	35.9	3	12.5	37	28.9			
Not in the last weeks, but has happened	0	0	0	0	0	0	1	4.2	1	0.8			
Total, Yes	**14**	**33.3**	**6**	**26.1**	**14**	**35.9**	**4**	**16.7**	**38**	**29.7**	**15**	**13**	**0**
Cases (N)	**42**		**23**		**39**		**24**		**128**		**38**	**38**	**38**
Statistical Tests: Chi Sq = 5.42 (df=6), p=0.49; Cramer's V = 0.15; Not significant											Note: 13 cases 'missing' – i.e. did not specify where incident happened		
	AREAS										Where did it happen? ALL Areas		
INCIDENTS	N'side Regeneration Area		S'side Regeneration Area		Other Disadvantaged Area		Average Area		All Areas		At school	Where I live	Somewhere else
(f) Sent mean texts to me	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**No.**	**No.**
Yes, in the last few weeks	2	4.8	1	4.3	1	2.6	0	0	4	3.1			
Not in the last weeks, but has happened	0	0	0	0	0	0	0	0	0	0			
Total, Yes	**2**	**4.8**	**1**	**4.3**	**1**	**2.6**	**0**	**0**	**4**	**3.1**	**2**	**0**	**1**
Cases (N)	**42**		**23**		**39**		**24**		**128**		**4**	**4**	**4**
Statistical Tests: Chi Sq = 1.30 (df=6), p=0.73; Cramer's V = 0.10; Not significant											Note: 1 case 'missing' – i.e. did not specify where incident happened		

Table A23: Factors explaining variations in child difficulties (Total Difficulties Scale)				
	Outcome Variable: Child Total Difficulties Score (0 no difficulties - 40 very severe difficulties)			
Predictor Variables	B	**Beta**	*T values*	Significance
Age of sample child (in years 0-17)	-0.23	**-0.17**	*-3.15*	0.00
Parent level of education (1,2,3 – lowest to highest)	-1.02	**-0.12**	*-2.15*	0.03
Low social class (parent)	1.45	**0.11**	*1.98*	0.05
Parent Mental Health (MCS 0 worst -100 best)	-0.09	**-0.15**	*-2.48*	0.01
Neighbourhood problem concentration score (0-4)	0.97	**0.16**	*2.57*	0.01
Social capital summary score -1 to +3 (trust – know)	0.24	**0.04**	*0.60*	0.55
Hostility & criticism scale (-2 worst to +2 best)	-2.22	**-0.36**	*-6.70*	0.00
Warmth & involvement scale (-2 worst to +2 best)	-2.57	**-0.13**	*-2.32*	0.02
Intercept / constant	22.98	**0.00**	*7.79*	0.08
R^2 / Adjusted R^2	0.30 / 0.28			
F-statistic	13.03, p<0.001			
N cases	348			

Note on variables: Age of sample child=age in years; Parental level of education 1=Junior Cert or lower and technical / vocational; 2=Leaving Cert or equivalent; 3=any third level from Cert / Diploma to post-graduate; Low social class parent=SC5&6=1; SC1 thru 4=0.