

Child *Mental & Emotional* Health: *A Review of Evidence*

December 2006

Prepared by:

Child Mental and Emotional Health Project Team
HSE Programme of Action for Children

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on behalf of the Child Emotional and Mental Health Project Team established by the former HSE Programme of Action for Children.

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Foreword

The wealth of a nation is the health of its children.

Psychological wellbeing and general health benefit from an early investment in child and adolescent development. There is a growing evidence base for beneficial and lasting effects of parent support and skills education on many child and adolescent health outcomes, recognising the important role of early childhood experiences in promoting positive mental health. Interventions designed to foster resilience by promoting self-esteem, coping and life skills are required not just for individuals at risk of mental health problems, but across entire populations. While recognising that some children and their families are at higher risk of emotional and mental ill health, requiring complex and substantial interventions, it is beyond the scope of this review to specifically address the needs of any such particular population group.

In recognition of the need to build capacity and expertise for the promotion of positive mental health and in line with the Programme of Action for Children's commitment to improving quality, standards and equity of service provision for children and young people, this review has been undertaken to inform the development of a Child Mental and Emotional Health Module for the National Training Programme in Child Health Screening, Surveillance and Health Promotion Training Programme for Public Health Nurses and Doctors, thereby facilitating implementation and translation of evidence into practice.

The WHO European Strategy for Child and Adolescent Health and Development outlines the need to develop national frameworks for evidence based review and improvement of child and adolescent health policies, programmes and action plans, from a life course perspective, to promote and coordinate multisectoral action to address the main health issues for children and young people.

We know what works to improve child and adolescent mental health. The national mental health strategy 'A Vision for Change' provides the context for progress in Ireland, underlining the need for capacity building through training, education and additional resources.

The authors endorse the UN Convention on the Rights of the Child, which emphasises that the provision of services in response to need and in line with good practice as outlined in this review is not optional, but a legal requirement.

Christine McMaster,
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Table of Contents

Foreword.....	2
Project Team Membership	5
Terms of Reference.....	6
Acknowledgements.....	7
Summary	8
1 Introduction	12
• Infant and child mental health	13
• Epidemiology.....	13
• Early identification and intervention	16
• Costs and benefits.....	17
2 Normal Development	20
• Attachment and temperament.....	21
• Child learning	26
• Play	27
• Emotional and moral development	30
• Social competence.....	31
• Sexual development	36
3 Risk & Protective Factors	38
4 Parenting Skills	42
• Anti-natal preparation	43
• Impact of parenthood on parent relationship.....	44
• Impact of parenthood on teenage parents	44
• Impact of socioeconomic status on parenting.....	45
• Good enough parenting.....	45
• Dysfunctional parenting.....	46
• Child harm	47
• Child protection.....	47
5 Education	48
• Childcare.....	49
• School readiness.....	50
• School environment.....	51

6	Observation & Assessment	52
	• Identification of problematic behaviour.....	53
	• Areas of observation	53
	• Observation and assessment skills	54
7	Behavioural Problems	55
	• Feeding	56
	• Sleeping and crying.....	58
	• Emotional regulation	61
	• Toilet training.....	61
	• Temper tantrums.....	62
8	ADHD & Autism.....	63
	• Attention Deficit Hyperactivity Disorder	64
	• Autism	66
9	Referral Criteria.....	68
10	Interventions	70
	• Child mental health teams.....	71
	• Tiered community based models of service provision.....	72
	• Medication	73
11	Recommendations	74
	Appendices.....	77
	Appendix 1.....	78
	Appendix 2.....	80
	Appendix 3.....	83
	Appendix 4.....	85
	Appendix 5.....	88
	Appendix 6.....	90
	References	92

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Terms of Reference

Background

The Programme of Action for Children endorses an evidence-based approach to all its activities. The core child health surveillance programme as set out in the original report Best Health for Children-Developing a Partnership with Families, 1999 was reviewed in 2004. Revised recommendations for an evidence based approach to delivering the statutory core child health programme were published in Best Health for Children Revisited, 2005 and have formed the basis for content of all training modules developed and delivered as part of the National Training Programme for Public Health Nurses and Doctors in Child Health Screening, Surveillance and Health Promotion. In addition to requirements under the existing national statutory core child health programme, childhood obesity and child emotional and mental health problems were identified as areas of particular concern and importance for the health of children and young people in the Ireland of today. Training for primary and community care staff was therefore recommended.

Any changes to service development and delivery recommended following the review have practical implications for managers and front line staff. A collaborative approach involving all key stakeholders is necessary to ensure quality, standardisation and thus equity in child health service delivery.

Rationale

At a meeting of the National Expert Group on Training in Child Health Screening, Surveillance and Health Promotion (9th March, 2005), it was agreed that a project team should be established to consider the evidence, regional best practice and the training implications for community health professionals, in relation to:

- the promotion of child (0-5 years) mental and emotional health and well-being,
- effective prevention and management of behavioural difficulties
- early identification of ADHD and autism.

Process

The project team met six times between May 2005 and April 2006 and now presents this report as the background for the development of a training module in child emotional and mental health for primary and community care practitioners.

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SUMMARY OF EVIDENCE

Introduction

- Child emotional and mental health problems are emerging as a main threat to the health and wellbeing of children, young people and populations. They are common and have a significant negative impact on the child, family and society at large. International studies suggest that up to 20% of children have psychological problems, half of whom have associated impairment and require intervention.
- Early years of development from conception onwards set the foundation for competence and coping skills that will affect capacity to learn, behaviour and ability to regulate emotions throughout life.
- Psychological disorders in childhood persist into adolescence and into adulthood. Early identification of these problems will have a significant impact on adolescent and adult well being and productivity.
- Economic analysis supports early identification and intervention in child emotional and mental health. Certain disorders, such as ADHD are eminently treatable and others, such as Autism require significant early educational and therapeutic input to optimise development and reduce secondary handicap.
- Early childhood care and education form the basis for achieving the national goal of lifelong learning.
- Efficiency in public spending is enhanced by directing human capital investment toward the young on a universal basis.
- There are demonstrated positive effects of universal family support on all areas of child development, including mental health.
- Antenatal health surveillance, including incorporation of psychological tasks of pregnancy in the preparation parenthood, can improve pregnancy outcomes and the social and emotional health of the mother and child.
- While Public Health Nursing Services are universally accessible, albeit inadequately resourced and available, Primary Care Services provided by General Practitioners are subject to restricted access resulting from the two tier health care system in Ireland.
- Training of primary care providers in child emotional and mental health has been shown not to reduce the number of referrals to secondary services, but to increase the appropriateness of such referrals and reduce the number of families opting not to attend when offered an appointment.
- In an increasingly multicultural society, service users and providers must be cognisant of ethnic and cultural differences.

Normal Development

- Parental physical care, attention and emotional availability are essential for a child's future psychological health, well-being, emotional, educational and social development.
- Brain development is most rapid during infancy and is dependant on experiencing appropriate stimulation and support in laying the foundation for life long learning.
- Successful, sensitive parenting can help the child reach his/her optimal development of social and emotional competence.
- Emotionally significant experiences are given meaningful expression through play, and some children need support in shaping and developing their play skills.
- Investing in parenthood to support parents in these developmental tasks is of the utmost importance.

Risk and Protective Factors

- Delayed development may be a consequence of biological and genetic factors such as a chromosomal disorder, and/or environmental influences such as maternal depression or poverty.
- Poor children confront widespread environmental inequities.
- Material disadvantage and economic hardship are distal variables in the causal pathway to adverse childhood outcomes with parenting a proximal variable.
- Protective factors at individual, family and community level can mitigate the adverse effects of risks to mental and emotional health.

Parenting Skills

- Good antenatal education is a way of giving parents and children a good start in life.
- Quality, provision and availability of parenting skills and support programmes are variable, poorly co-ordinated and inequitable.
- Universal programmes of home visiting and parent support are more acceptable to parents than targeted interventions as demonstrated recently (HSE South). Awareness of the need for parenting programmes can be raised amongst all socio-economic groups, improving attendance of parents from social economically disadvantaged groups.

Education

- Responsive, sensitive, reciprocal and consistent relationships are essential to well-being, learning and development of the young child.
- The importance of universal family support and preschool education is unequivocally supported by evidence.
- School readiness is a measure to benchmark effectiveness of early childhood policies, programmes and parental support at community and societal level.

Observation and Assessment

- Identification of problematic behaviour needs to be understood in the context of families, school and day care environment.
- Tools for early identification of parental and professional concern regarding the emotional and mental health development of young children are required for use by primary and community care professionals in Ireland.

Behavioural Issues

- Parental awareness and knowledge of normal child development needs to be strengthened through antenatal education, parent and community support.
- Negative and dysfunctional parent- child relationships during early childhood predict continued problems at school entry and beyond.
- Feeding not only fulfils a biological need, but also contributes to attachment and bonding, playing a key role in the emotional, social and communication development of the child.

ADHD and Autism

- ADHD is the most commonly diagnosed child psychiatry disorder occurring in 3-5% of the school aged population and eminently amenable to treatment.
- Autistic spectrum disorders affect up to 1% of the population and have significant and pervasive effects on the child's development. Early identification and intervention minimises secondary problems and is associated with better prognosis.

Interventions

- Childhood emotional developmental disorders, behavioural problems and mental illness are under recognised, often remain untreated and are associated with life long morbidity, disability and mortality.
- Mental health treatment services and facilities for children and young people are neither adequately resourced nor sufficiently available.
- Delays of unacceptable duration occur when referring children and young people for assessment, investigation and management due to the limited availability of secondary or tertiary services.
- There are ethical concerns and implications for identifying need without having the necessary resources to respond.
- Frameworks and resources for improved multidisciplinary working are inadequate.
- Interagency integration between health services, community development and education through multidisciplinary training, shared working and linkages is necessary to improve emotional and mental health outcomes for children and young people.
- Primary care based mental health workers and child development teams are effective in dealing with many child emotional and mental health problems but are currently not available to children and young people from all communities.
- Advocacy and a rights based approach are required to promote integrated service provision.



(1)

INTRODUCTION

Emotional, behaviour and mental health problems are now the most common cause of morbidity in childhood and as such constitute an important public health issue (Denyer, Pelly & Thornton, 1999).

Human development hinges on nature, the environment and life course experience of children growing up within families and communities. This is recognised in the WHO European strategy for child and adolescent health and development, which includes psychosocial development and mental health as one of seven global priority areas (WHO, 2005). It emphasises the need for action across sectors, based on information and evidence, including participation and a life course approach for equity.

Mental health problems in children and young people may be defined as abnormalities of emotion, behaviour or social relationships sufficiently marked or prolonged to cause suffering or risk to optimal development in the child or distress or disturbance in the family or community (Denyer, Pelly & Thornton, 1999). This reinforces the need to support parents in their role as caregivers (Investing in Parenthood, 2002).

Hall & Elliman (2003) define psychological, emotional, and behavioural problems as “behaviours or distressed emotions, which are common or normal in children at some stage of development, but become abnormal by virtue of their frequency or severity, or their inappropriateness for a particular child’s age compared with the majority of ordinary children.”

1.1 Infant and Child Mental Health

Infant Mental Health derives its basis in attachment theory. Its central aim is to promote the optimal social and emotional development of infant and children. It also aims to reduce social and emotional problems that arise in infancy, early childhood and early parenthood.

Infant Mental Health is defined by the World Association of Infant Mental Health (WAIMH, 2005) as a field “dedicated to understanding and treating children from 0 to 3 years of age within the context of family, care giving and community relationships”. Healthy social and emotional development provides the capacity to regulate and express emotions, form close and secure interpersonal relationships, explore the environment and learn.

1.2 Epidemiology

Childhood emotional developmental disorders, behavioural problems and mental illness are under recognised, often remain untreated and are associated with significant morbidity and mortality, leading to life long disability. This may adversely affect the child’s behaviour, emotional well being and educational attainments, as well as affecting family, friends and society at large. Certain childhood disorders, such as Attention Deficit and Hyperactivity disorder (ADHD) and conduct disorder, which have their origins in childhood, may continue into adulthood. Many adult psychiatric disorders also have their origins in childhood. A New Zealand birth cohort study, which followed children up until the age of 26, found 75% of adults with mental illness had been diagnosed before reaching 18 years of age (Kim-Cohen et al, 2003). Early identification of childhood problems and effective intervention can thus have a significant impact on the prevalence of child and adult mental illness and the psychological and economical cost to both the individual and society.

Types of disorders:

- Emotional disorders, e.g. depression, anxiety states, phobias and psychosomatic disorders
- Oppositional defiant and conduct disorders, e.g. non compliance, stealing, truancy, aggression, and more persistent delinquency
- Attention deficit disorder, with or without hyperactivity
- Major psychiatric disorders e.g. psychosis, which increasingly occur from puberty onwards
- Developmental delay and autism
- Eating disorders e.g. anorexia nervosa
- Elimination disorders, e.g. wetting and soiling

It is estimated that 20% of the child and adolescent population may suffer from psychological problems at any given time. Half of these suffer some impairment. Approximately 2% of children have a major psychiatric disorder with a much smaller percentage (0.5%) requiring inpatient admission (Irish College of Psychiatrists, 2005). Surveys conducted in high risk groups find much higher prevalence rates. Particularly vulnerable children include children from the traveller community, children whose parents have mental illness, children who themselves have a physical illness or a learning disability, as well as children in care. Rates are generally higher in urban settings.

Despite high prevalence rates in children only a small proportion of children, are known to professionals and attend child and adolescent mental health services (Costello et al, 2005). In a recent study of 10,000 5-15 year olds, carried out in Britain, only 25% of children with a psychiatric disorder had contact with specialist health services. However many of these children had contact with other community services such as social services (20%) and educational services (49%) with significant cost implication for other services (Vostanis et al, 2003). It seems unlikely that child and adolescent mental health services will ever be extensive enough in any country to treat all children with mental health problems. It is therefore necessary to identify disorders at a primary care level and to intervene early to prevent progression to disorders of marked severity or chronicity. Davis & Spurr (1997) showed how community health visitors trained in child mental health issues could reduce parental distress. Closer links with mental health services and primary care have been developed in the UK through the establishment of primary care mental health workers who provide consultation to and joint working with General Practitioners (Vostanis et al, 2003). Children with complex needs will need to be referred to appropriate child mental health services, but with the hope that early treatment may be associated with better outcomes.

TABLE 1: PREVALENCE OF CHILD EMOTIONAL AND MENTAL HEALTH PROBLEMS (0- 18 YEARS)
 from: 'A better future now- position paper on psychiatric services for children and adolescents in Ireland'. Irish College of Psychiatrists (2005), Dublin.

Disorder	Percentage	Ratio
Psychological problems	20%	1 in 5
Mental illness with some impairment	10%	1 in 10
Major psychiatric disorder	5%	1 in 20
Mental illness requiring inpatient admission	0.5%	1 in 200
ADHD	3-5%	1 in 20-30
Autism and related conditions	0.5-1%	1 in 100-200
Mental health problems among children in care	60-70%	> 1 in 2
Mental health problems among children in residential homes	90%	< 1 in 1

Hay et al. (1999) found moderate agreement between parents in terms of the total number of problem behaviours in their pre-school children, but that each parent reported different sorts of problems. Further inquiry established that fathers' ratings were most influenced by factors associated with children's cognitive ability while mothers' ratings were most influenced by their own mental state and view of their marriage. Similarly, Breton et al. (1999) found that parents underestimated depressive symptoms in 6-8 year old boys and reported less depression than the boys did themselves, unless such disorders were associated with functional impairment. These findings point to the importance of having multiple informants when developing an understanding of mental health problems both at the individual and population level.

Epidemiological data on pre-school children is only emerging and comparisons between studies are made difficult by differing methodologies. Richman et al. (1982), using the Behavioural Screening Questionnaire, reported a rate of 7.3% for moderate to severe problems in 3 year olds. Children in the 'problem behaviour' group showed

"Significantly more difficulties with feeding and sleeping. They were more active, concentrated less well, and were clinging and less independent. They were difficult and disobedient, flew into tempers more often, and were more often miserable and fearful. They got on less well with their siblings and with other children"

Richman et al., 1982 p.35-36

The control group children in this study also displayed these behaviours though significantly less frequently.

Epidemiology in Ireland

In Ireland only three major epidemiological studies of psychological disorders in children have been published to date. They were conducted in Dublin, Clare and Cork in the late 1980s. The prevalence rates of psychological problems were 17%, 11% and 15% for Dublin, Clare and Cork respectively. In all three studies the prevalence of disorders was higher in boys, but this pattern was particularly marked in Dublin, where 21% of boys had disorders compared to 12% of girls. In Dublin (the only area for which data on family circumstances were available) family adversity was associated with psychological disorder. Estimated prevalence rates of psychological disorders based on interview data were 16% for Dublin and 10% for Cork. Many of the results of these studies were consistent with results of similar epidemiological studies conducted in other countries (Carr, 1993).

Problems with these three Irish studies limit their usefulness for service planning purposes now. First, they were conducted over 15 years ago. Second, they only provided data on children aged 6-12 years, offering no information on preschoolers or adolescents. In view of the shortcomings of available research on planning child and adolescent mental health services, Health Service Executive (HSE) South (former South Eastern Health Board area) initiated a major epidemiological study of mental health problems in children in late 2004. Over 4,000 children from ages 2 – 18 years were screened in the town of Clonmel with the Child Behaviour Checklist (Achenbach & Rescorla, 2000, 2001) and related instruments. There was a markedly higher prevalence rate of mental health problems amongst children and young people from socio economically deprived areas on the study, compared to their socio- economically advantaged peers. Overall, 17% of 2- 6 year olds screened positive, 10% of 6 – 12 year olds and 26 % of 13 –18 year olds, but amongst children and young people from socio- economically deprived areas, prevalence figures rose to 16% for 6 – 12 year olds, and 34% for 13 – 18 year olds (Martin & Carr, 2005).

1.3 Early Identification and Intervention

“The early years of development from conception to age six, particularly the first three years set the base for the competence and coping skills that will affect capacity to learn, behaviour and ability to regulate emotions throughout life” (Investing in Parenthood, 2002).

Following a growing interest in concepts such as early intervention and prevention, health care systems have now begun to recognise the need for programmes, which will target early childhood development. Early childhood development has been recognised to be the most important contributor to long-term social and emotional development. Policy documents governing health care practice have taken important steps in beginning to promote these concepts into primary health care delivery.

Best Health for Children (Denyer, Pelly and Thornton, 1999) states that early intervention programmes will be necessary to improve educational, social, emotional and economic outcomes for children and adults. This is a view point supported by existing Infant Mental Health and other early intervention programmes throughout Britain, Europe, USA and Australia.

Early diagnosis is important because early intervention may be beneficial and parents are dissatisfied and lose confidence in professionals when delays occur in diagnosis (Hall & Elliman, 2003).

Following increased awareness of the significant role a child's early attachment experiences play in determining healthy psychological development, Fraiberg and her colleagues (Fraiberg et al, 1975) began to develop a model of intervention that involved working with the parent or caregiver and child together in the home environment. This enabled the clinician to observe parent and child interactions in the natural setting of the home, to understand and nurture the parent/child relationship and to provide a therapeutic framework of trust and support.

An Infant Mental Health model of intervention that has been empirically evaluated is the STEEP Programme (Erickson, Korfmacher & Egeland, 1992), a home visiting service, which was delivered to 74 women, during their pregnancy and continuing through the first 12 months of the infant's life. The model of intervention involved two components, individual home visits and partaking in a parent-infant group. The research findings revealed that women who participated in the treatment programme, when compared to the control group, demonstrated increased understanding of their infant's cries and cues at 24 months in addition to fewer depressive symptoms and a more positive sense of themselves (Erickson & Kurz-Riemer, 1999; Egeland & Erickson 1999).

Elements of supportive home visiting and parenting programmes are based on and include the following:

- Infants and young children can be understood and supported in the context of their family and care giving environment.
- The focus of Infant Mental Health intervention is to promote the optimal development of the infant within the context of at least one nurturing relationship.
- Interventions incorporate a parent- child relationship based approach, build on strengths and include case management information, concrete guidance, behavioural observations and reinforcement.
- Strategies include emotional support, concrete service support, developmental guidance, advocacy, infant and parent psychotherapy.

In recognition of the hierarchy of needs (Maslow 1954, 1968), it is important to acknowledge and support needs of parents in the context of priorities arising from their life circumstances. A framework outlining elements of this has been developed by Weatherston and Tableman, 2002 (see Appendix A).

1.4 Cost effectiveness of Early Childhood Care and Education

This has already been identified in the 2005 National Economic and Social Forum Report on Early Childhood Care and Education. Below is a summary of the Forum's findings.

International comparisons show that Ireland spends less than 0.2% of our GDP on early education and care, compared to the OECD average of 0.4%. Early childhood care and education form the indispensable foundations for achieving the national goal of lifelong learning. Among landmark initiatives and reports in this regard are Ireland's ratification of the UN Convention

on Children's Rights (1989), publication of the Childcare (Pre-School Services) Regulations (1996), Strengthening Families for Life (1998), Report on the National Forum for Early Childhood Education (1998), White Paper on Early Childhood Education (1999), National Childcare Strategy (1999), National Children's Strategy (2000), Children's Act (2001), Equal Opportunities Childcare Programme (2001), Children's Ombudsman (2003), National Council for Curriculum and Assessment's (NCCA) Towards a Framework for Early Learning (2003), OECD's Review of ECCE Policy in Ireland (2004), Centre for Early Childhood Development and Education's (CECDE) Insights on Quality (2004), and Making Connections (2004).

High quality pre-school programmes for young children living in poverty have been shown to contribute to their intellectual and social development in childhood and their school success, economic performance and reduced levels of crime in adulthood. The most recent findings show that these benefits extend to adults in midlife in relation to issues such as crime prevention, health, family and children. It confirms that "long-term effects are lifetime effects. The cost-benefit analysis showed a \$17 dollar return on each dollar invested" (Schweinhart, 2004). Outcomes include children being better prepared to make the transition to school (Howes, 1990), being less likely to drop out of school or repeat grades (Reynolds et al, 2001; Campbell, 2002), showing greater sociability and having better access to health care as well as improved physical health (McKey et al, 1985). In Ireland 15.7% of children live in relative poverty. The United Kingdom (UK) has experienced a substantial reduction in child poverty (-3.1%) since the 1990s concurrent with substantial investment in children during this period. A cost-benefit analysis setting out the net costs of providing a universal pre-school service in Ireland against the long-term benefits that would accrue has shown a predicted net benefit return of €4.60 to €7.10 for every euro invested (Annex 5 of NESF Report 31 on www.necf.ie).

Programmes like Perry Pre-school foster long-term improvements in the home environment that carry over long after programme related interventions have ceased. The evidence from the Perry Pre-school Programme and the evidence summarised in Carneiro and Heckman (2003) reveals that early intervention programmes are highly effective in reducing criminal activity, promoting social skills and integrating disadvantaged children into mainstream society (see Appendix 6). An important lesson from successful early interventions is that the social skills and motivation of the child are more easily altered than IQ. There also tends to be a substantial improvement in the children's social attachment. The social and emotional skills acquired in these types of programmes affect performance in school and in the workplace. This leads to the conclusion that investment in early childhood education result in long-term gains for individuals, government and society.

Human capital is not merely a function of the initial stock the individual is born with (genetic luck) but is produced over the life cycle by families, schools, and environmental influences. Efficiency in public spending would be enhanced if human capital investment were directed more toward the young on a universal basis. As advantaged children are more numerous, even small health gains in individuals can accumulate to substantial gains across the whole population. Administrative costs determining eligibility are avoided, as is the potential for stigma associated with participation in a targeted programme. No child who might benefit is excluded either because of not quite meeting eligibility criteria or because there is confusion regarding eligibility. Political support and the support of public opinion are often stronger for programmes available to all children.

Adequate investments need to be transferred to families with young children as this recognizes the high cost of raising young children. Positive educational outcomes for children are associated with extended maternity leave (Ruhm, 2002).

The Children's Centre programme in the UK is based on the concept that providing integrated education, care, family support and health services are key factors in determining good outcomes for children and their parents. It has been proposed that Child and Family Centres in Ireland are developed in a similar fashion and facilitated by cooperation of the HSE, Community Development Programmes, Family Resource Centres and others to provide the following:

- Early education and day care, including early identification of and provision for children with special educational needs and disabilities,
- Family and parent outreach support, including support for parents of children with special needs,
- Health services,
- Service hub within the community for parents and providers of childcare services,
- Effective links with local employment services, local training providers and further and higher education institutions,
- Effective links with children's information services, out of school and after school clubs,
- Management and workforce training.

The economic efficiency arguments for a policy of targeted early interventions are summarised in a Policy Briefing Paper by J.J. Heckman and published by the Geary Institute UCD, (2006):
See also Appendix 6

We summarise with the findings of a large literature. The economic return to early interventions is high. The return to later intervention is lower. The reason for this relationship is the technology of skill formation. Skill begets skill and early skill makes later skill acquisition easier. Remedial programs in the adolescent and young adult years are much more costly in producing the same level of skill attainment in adulthood. Most are economically inefficient. Children from advantaged environments by and large receive substantial early investment. Children from disadvantaged environments more often do not. There is a strong case for public support for funding interventions in early childhood for disadvantaged children.

The economic and equity argument for targeted interventions is strong. However, the right of every child to appropriate support indicates the need for universal family support services, within which the need for targeted interventions can be identified. The evidence indicates the positive effects of such universal support on all areas of child development, including mental health.

A stylized, light red graphic in the background depicts a hand holding a heart. The hand is positioned at the bottom left, with fingers curved upwards to cradle a heart shape. The heart is located in the upper left quadrant of the image. The entire graphic is rendered in a light red color that matches the background, creating a subtle watermark effect.

(2)

NORMAL
DEVELOPMENT

The developmental tasks of children change with age, and each stage of development presents unique challenges to children and parents. The ways in which significant adults help children through these periods can have implications for children's later development.

Individual differences in the rate of development are clearly apparent during the pre-school years, and these differences often persist into the school age years. Some of these inter- and intra-individual differences are primarily the result of genetic and biological factors; others seem to be more the result of environmental influences and parent child interactions.

Infant development (birth – 1 year)

Development during the first year of life is phenomenal, and by twelve months of age infants barely resemble the being they were at birth. The main tasks of the first year can be summarized as follows:

1. To gain physiological stability
2. To develop interpersonal attachments and strategies for maintaining them
3. To regulate arousal and affect
4. To develop and gain control over motor skills
5. To begin to communicate needs and desires
6. To explore and learn about the external world

Toddler development (1- 3 years)

The hallmark of development in the toddler years is the child's striving for autonomy and independence, at the same time that he or she still wants to be close to the primary attachment figure. Davies, 1999, summarises the primary tasks of the toddler period as:

1. To balance the need for closeness with exploration of the environment
2. To become increasingly independent
3. To begin to internalize parental standards
4. To gain the ability to control emotions, impulses and behaviours
5. To begin to use mental representation in play and communication

2.1 Attachments and Temperament

Research indicates that the quality of care a child receives in earlier life has important implications for future psychological health, well-being and personality development.

*“In a society where death rates are low, the rate of employment high, and social welfare schemes adequate, it is the emotional instability and the inability of parents to make effective family relationships which are the outstanding cause of children becoming deprived of a normal family life”.
(Bowlby, 1952)*

Development of attachment

Attachment behaviour is *“any form of behaviour that results in a person attaining or retaining proximity to some other differentiated and preferred individual. Whilst especially evident during childhood, attachment behaviour is held to characterise human beings from the cradle to the grave”*. (Bowlby, 1979, 126)

Features of an attachment relationship

- (a) Proximity seeking to a preferred figure: The small infant child has a deep desire to follow their attachment figure/ parent/ caregiver wherever they go.
- (b) A secure base: A trusted person/persons who will come to the aid of the child should difficulties arise.
- (c) Separation protest: Bowlby identified protest as the primary response produced in children by separation from their parents, e.g. crying, screaming, shouting, biting and kicking to ‘reprimand’ the parent/ caregiver for the separation and ‘prevent’ its reoccurrence.

Patterns of attachment

Ainsworth et al. (1978) performed a series of studies with one-year-old babies. Her three categories of attachment pattern classification are:

Insecure- avoidant attachment (A)

The insecure- avoidant (A) attachment behaviour shows rejection or “avoidant” response towards the mother on reunion only after a brief separation. These children show no distress when separated from their mother and ignore her on return. This insecure avoidant pattern was found in 21% of infants studied.

Secure attachment (B)

The secure baby becomes distressed when separated from its mother. When reunited the baby seeks contact, is calm and welcoming with its mother, greets her, exhibits joy and settles back to play. Secure attachment (B) was found in 67% of the study population.

Insecure- ambivalent attachment (C)

The remainder become distressed when separated from their mother. On her return, these babies are unable to obtain comfort from her.

Main et al, (1985) in further studies found a group that did not meet Ainsworth’s classification.

Disorganised-disorientated attachment (D)

These babies display a range of confused and contradictory behaviours on reunion with their mother. They have a glazed expression and odd postures and unpredictable crying episodes. Main et al proposed that this behaviour occurred because of the infants’ experience of frightened behavioural experiences with their caregiver or where maltreatment had occurred.

Disorganised disorientated attachment type is considered to reflect the greatest insecurity pattern and the highest predictor of psychological problems. Holmes (2005) elaborates further on this pattern as “fear without solution”. The caregiver, who ought to provide a safe haven, is unable to meet or protect the infant in distress.

Stages in attachment development

0-6 months

Attachment in the infant develops and forms gradually over time with interaction and proximity to the attachment figure/parent/caregiver. By the end of the first six months, the baby is beginning to show signs of proximity seeking, secure base and separation protest. (Winnicott, 1971) described this process further, perceiving the mother’s face as the mirror through which the child gets his or her first sense of self. It is the mother who guides the infant’s sense or perception of self.

Maternal attachment is a term coined by Daniel Stern (1985). Stern described how sensitive mothers, when interacting with their children, are able to tune into the cues and signals of their baby in such a way that enables them to modulate their infant’s rhythm. When the activity level between parent and infants falls, the mother stimulates her baby and when she observes that her infant appears over stimulated, she slows down sufficiently to restore the balance and regulate the interaction between them. In a healthy parent or other caregiver/ infant relationship, a parent will respond to these social emotional behavioural/ physical cues and signals, which the infant emits. This in turn leads to the establishment of the mutual and interactive feedback and balance in the parent and infant interaction.

In this interactive communicating environment, the hallmark of a secure mother-infant relationship is “mutual knowing”, where the mother responds to baby’s smile: “Oh! You’re having such a happy day.” Holmes suggests that the process of interaction between mother and baby has the potential to set the stage for the development of emotional regulation skills for the baby (Holmes, 2005).

6 months to 3 years

In this period many developmental changes are evident, which mark the definitive onset of the attachment period. A child who is securely attached will store an internal working model of a parent who is kind, loving, reliable, warm and responsive and a model of self that is worthy of that love, attention and warmth. As the child develops, he or she will bring this viewpoint into other relationships as they develop.

An infant/ child who experiences an unstable parental relationship, which is cold and unresponsive, comes to know the world as threatening and unpredictable and may consider himself unworthy of love, attention and warmth.

3 years onwards

By the end of the third year, Bowlby considered that the attachment system is fully developed and maintained to persist from then on throughout life (Holmes, 1993).

Disorders of attachment

These can be defined as deviations from the optimal pattern of relationships between a child under 3 years and his or her care giving figure (Lieberman and Zeanah, 1995). Interactions between a parent and child are usually reciprocal. Winnicott (1960) observed “there is no such thing as a baby”, there is only “a mother and child couple”. Thus, it is sadly the case that many of the distortions in the child-caregiver relationship that we see arise initially out of the caregiver’s disrupted capacity to care and provide security for the child” (Slade & Cohen 1996). Simultaneously, the role of primary caregiver’s/ paternal/ maternal sensitive responsiveness to the baby’s signal and cues has been identified as one of the main conditions, which influence the development of secure attachment.

SUMMARY TABLE: WARNING SIGNS IN ATTACHMENT DEVELOPMENT

	0–6 months	6 months - 3 years	3 years onwards
Inappropriate care giver response to child’s distress	x	x	x
Inadequate physical proximity	x	x	x
Insufficient emotional warmth	x	x	x
Unmet physical needs	x	x	x
Inappropriate levels of discipline	x	x	x
Lack of stimulation through play and social interaction	x	x	x
Interrupted child – care giver relationship	x	x	x
Poor eye contact	x	x	x
Difficulty in sustaining reciprocal interactions	x	x	x
Hyper vigilant behaviour observable in child	x	x	x
Poor care giver ability to and respond to child	x	x	x
Care giver depression or anxiety	x	x	x
Indiscriminate sociability in child		x	x
Child depression or anxiety		x	x
Inflexible, repetitive, aggressive play		x	x
Pseudo independence		x	x
Excessive or absent separation anxiety			x

The role of temperament

Children are born with a predetermined temperamental type. Temperament influences how the child may react or self regulate and can also be influenced or modified by the care-giving environment.

Thomas & Chess (1977), described three main types of temperament:

- Easy
- Slow to warm
- Difficult

Easy: Flexible child, regular and predictable, consistently in good mood, adapts easily to change and is mild to moderately intense in emotional responses.

Slow to warm: children who are slow to warm up tend to withdraw initially or take a longer time to adapt and adjust. They tend to express their emotions mildly but these can escalate up to intense expression if pushed or challenged. In new situations may also be shy or timid.

Difficult: These children tend to be fussy and inflexible, often withdrawn in new situations and have difficulty adapting. They may be hard pleased and have intense emotional reactions. They are often difficult to predict.

In addition to these three main types, there is also an entity of anxious children.

Anxious: Anxiety symptoms in children follow a normal developmental course, which changes over time. For example, separation anxiety is a normal phenomenon present in young babies and regarded to reach a peak between 9 and 18 months. This serves as an adaptive function and decreases as the child increases in autonomy and confidence.

Separation anxiety refers to extreme anxiety about actual or envisaged separation from a significant attachment figure leading to avoidance behaviour, for example school refusal and sleeping difficulties. Similarly, childhood fears such as fear of the dark, fear of dogs are common in early childhood, while in adolescence fear of heights, public speaking and self consciousness become more common.

These may serve as a protective function and generally minimise over time. However, at the other end of the spectrum children can experience severe overwhelming and incapacitating symptoms of anxiety, which interfere significantly with social, family and academic functioning. Some of these symptoms remit over time while others follow a relapsing course and may continue into adulthood. This latter group clearly needs to be identified and offered appropriate treatment.

Certain childhood temperamental characteristics act as risk factors to subsequently developing anxiety disorders. Kagan et al (1988) in a three year follow up was able to differentiate children suffering from anxiety disorders as those who exhibited a high degree of behavioural inhibition. This refers to a temperamental tendency to show fear and withdrawal in new, unfamiliar situations and was found to increase the risk of having more than two anxiety disorders (Rosenbaum et al, 1993). Capsi et al, 1996 similarly found that behavioural observations at age three could predict adult psychiatric disorders.

Temperament in parent or other caregiver/ child relationship

Temperamental style can influence attachment style and goodness of fit between parent or other caregiver and child.

- **Goodness of fit**

Parents too have temperamental styles. When there is a match between the temperament of parent and child, this goodness of fit promotes the establishment of a partnership, as parent and child have an understanding of each other's style of relating and expressing.

- **Parent and child collaboration**

In toddler hood, children develop greater independence and wish to assert their own agenda and goals. In doing so, they also come to realise that their agenda may not match those of their parents. When there is flexible give and take between the parent and child and their agendas or goals can be accommodated, a partnership develops.

2.2 Child Learning

Different parts of the brain contribute to learning. The frontal part of the brain is responsible for motor control and planning, also known as the executive functions. Other parts of the brain are responsible for other learning functions such as memory, language, hearing, vision and balance. Nervous impulses are sent from one part of the brain to other parts of the nervous system via nerve fibres. These pathways are not set down at birth but develop over time and in response to experience. At birth the infant possesses excess neurons which are immature, and many more random synaptic connections are made each second. The pathways that are utilised most often and are found to be effective persist and develop, those that are infrequently innervated die away. This is referred to as 'synaptic pruning' and highlights the importance of early stimulation in childhood in terms of generating the maximum number and most effective systems.

Brain development is most rapid during the first year of life, and this development makes all other functions (sensual, perceptual, emotional, regulatory, motor and cognitive) possible (Davies, 1999).

Development during infancy is inseparable from the child's relationship with his or her caregiver. Although the child is born with certain biological pre-requisites, and his or her capabilities unfold in a regular progression, simple maturation is not sufficient to ensure normal progress. The infant is born with a capacity to organise his or her experience, for example, but is dependent on adults to determine what these experiences will be and to provide appropriate stimulation and support so that the child can profit from these experiences. The type of experience, to which the infant is exposed, influences which neural pathways will be strengthened, which will remain available and which will atrophy (Davies, 1999). Thus issues of parenting are most critical during this early time of life.

The ability to pay attention and concentrate has been defined as the ability to select and focus on one aspect of the environment before processing the information.

Attention may be:

- **selective**, where one stimulus is attended to while others are ignored,
- **divided**, where multiple stimuli are attended to simultaneously e.g. visual, motor and auditory or
- **sustained**, which requires the persistent maintenance of responsiveness in spite of boredom or frustration.

The process of attending involves several tasks including perception, registration, volition, motivation and short-term memory. We develop the ability to perform these tasks as our brain matures, thus the attention span of children varies widely with developmental status. Very young infants can sustain their attention only for very short periods, are easily distractible and fail to filter out irrelevant details. With increasing age our attention becomes more flexible and more focused according to the task being carried out. We are thus able to develop organised and strategic plans.

Our ability to concentrate is affected by the type of information being presented and its mode of presentation, the sophistication of our perceptive skills and the availability of working and long-term memory.

With increasing age our memory develops in terms of basic capacity, variety of strategies used (e.g. role rehearsal, elaboration, categorisation) and world knowledge. The three abilities of perception, attention and memory combine to produce our ability to problem-solve, which is a pre-requisite for successful functioning in life.

Children pass through these developmental stages at different rates, which are not solely biologically pre-determined but are influenced by experience. The child is not merely a tabula rasa but plays an active role in creating his or her own experiences. Our society has set expectations regarding attention and concentration yet many children do not reach these expectations. Some will catch up in time and simply experience a developmental delay while others have a specific attention disorder requiring intervention.

2.3 Play

Children do not need to be taught how to play, nor must be made to play, but some children need support in shaping and developing their play skills.

*‘Unlike adults, whose natural medium of communication is verbalisation, the natural medium of communication for children is play and activity’
(Landreth, 1991).*

Play is:

- Children's natural medium of communication,
- The singular central activity of childhood, occurring at all times, in all places,
- Spontaneous,
- Enjoyable,
- Voluntary,
- Non-goal directed.

Play provides:

- Children's need for physical activity,
- Preparation for life tasks,
- Natural expression of frustration and aggression,
- Development of interpersonal skills,
- Imaginative self-expression,
- Personality exploration and development.

Spontaneous play occurs when children play because they want to and for no other reason. The play is child-directed, adults often being superfluous. Spontaneous play is considered to be part of normal childhood development.

Guided play is adult directed for purposes such as giving the child permission and freedom to be a child and play, encouraging the child to relax and have fun. Guided play can be used to encourage carers to interact more favourably with and enjoy their children.

According to Piaget play bridges the gap between concrete experience and abstract thought and it is this symbolic function of play that is so important. In play, the child is dealing in a sensory-motor way with concrete objects, which are symbols for something that the child has experienced directly or indirectly. Play represents the attempt of children to organise their experiences. Play gives concrete form and expression to children's inner world. Emotionally significant experiences are given meaningful expression through play. A major function of play is the changing of what may be unmanageable in reality to manageable situations through symbolic representation. A child's feelings are often inaccessible at a verbal level and developmentally can lack the cognitive, verbal facility to express what they feel – children are not able to engage fully in abstract reasoning or thinking until approximately age 11 years.

Symbolic play usually begins at 11 – 13 months of age. The earliest forms of pretend play are very simple acts in which infants pretend to engage in familiar activities such as eating, sleeping or drinking from a cup. Six important elements for symbolic play include:

1. Imitate role play – using speech, gestures.
2. Make believe with objects using real or imaginary objects to represent other things.
3. Make believe in regard to actions and situations.
4. Persistence – sticking with the play for a designated time period.
5. Interaction – working with another in shared pretend play.
6. Verbal communication – using words to elaborate on a story.

TABLE 2 DIFFERENCES IN PLAY OF WELL ADJUSTED & LESS WELL CHILDREN (ADAPTED FROM MOUSTAKAS,1955)

Issue	Well adjusted children	Less well adjusted children
Play materials and area	Varied toys, large area	Few toys, small area
Play strategies	Imaginative and varied	Wants to be told what to do
Problem solving	Symbolic	Concrete and unimaginative
Intensity of feelings	Engaged, but flexible	Overly involved, aggressive
Expression of negative attitudes	Infrequent	Common

Guidelines for supportive play

Lots of what children do is their own thing or play and parents, particularly those with difficult children, often take no notice of it. When a child is disruptive, a parent can spend a lot of time trying to curb the negative behaviour and spend less time when the child is playing quietly. But this is just the time when the child should be attended to positively by the parent, commenting on and acknowledging actions. Attending is “tuning in” or taking notice of the things a child is doing and making a child feel valued in their own right; it is not teaching. It helps to build a positive self- concept and a positive relationship. If a caregiver shows that what their child is doing is important to them, this can improve the relationship between them. Children notice this attention and respond more positively to it. The pattern of attending can often change once the child starts to talk, and parents can easily turn into teachers or instructors. But as well as being teachers, the caregiver’s job is to support and encourage the child in their chosen activity. The following are useful guidelines to help parents get better at attending.

- Set out to use the episode to build a positive relationship with your child.
- Try to use the episode to give your child the message that she is in control of what happens and that you like being with her.
- Set a specific time for 20 minutes supportive play per day.
- Ask the child to decide what she wants to do.
- Agree on an activity.
- Participate wholeheartedly.
- Avoid using commands, instructions or teaching.
- Run a commentary on what the child is doing or saying, to show your child that you are paying attention to what she finds interesting.
- Describe and reflect what your child is doing- ‘I like it when you ...’ statements, to show your child you feel good about being there.
- Praise your child repeatedly.
- Laugh and make physical contact through hugs or rough and tumble.
- Notice how much you enjoy being with your child
- Cease the activity in a planned fashion by giving timely notice, offering to transit to another activity and managing protest, either by ignoring or distraction.
- Finish the episode by summarising what you did together and how much you enjoyed it.

Suggested toys and play activities

A mix of everyday household items in combination with commercial toys can be useful to help your child's development.

6 months old babies enjoy exploratory and manipulative play. They respond to toys, which can make sounds and involve grasping and reaching movement.

1 to 2 year olds are developing their motor coordination skills. They enjoy pouring and emptying sand and water and building blocks. They enjoy threading beads and using crayons and paint as their fine motor skills are developing.

Between 3 and 4 years, pretend play becomes an important activity. The child may engage in role play by dressing up, will play with a doctor's set or use an object in a symbolic fashion, e.g. a box for a car.

By 5 years of age the young child engages in more sophisticated forms of play activities such as following patterns using lego and jigsaws. The child discovers shapes, sizes, textures and colours. Social play becomes important and includes turn taking and an understanding of rules, e.g. 'Tag' (catch and run) and Blindman's Buff. Activities such as drawing using pencils, paint and crayons help to create clear identifiable persons and objects.

There are many sources to advise parents on age appropriate toys for children. (Child Health Information Service for Parents Project, 2005; Webster Stratton, 1990).

2.4 Emotional & Moral Development

Play is a major arena, in which children learn to express, process, modulate and regulate emotion to use in adaptive ways. Parental physical care, attention and emotional availability are essential for the child to start off optimistically on life's journey.

0 - 2 years

Erikson (1965) believes that from birth to 2 years of age the infant learns whether the world is a good and secure place. If the basic needs are met the infant will develop a 'basic trust' in the world and subsequently start to trust his- or herself. Trust shows itself in the young infant's behaviour through feeding with ease, sleeping comfortably and closely nurtured in a warm and supportive environment. When older, the infant will let his or her parent out of sight without undue anxiety. Therefore, if the parent meets the needs of the infant, the child will develop a stronger sense of trust rather than mistrust.

2 – 4 years

Between the ages of 2 and 4 years autonomy develops. If the parents reward the child's successful actions and do not shame him or her, the child's sense of autonomy will outweigh the sense of shame and doubt. The young child can build up his or her confidence by being allowed to experiment with autonomy.

4 – 6 years

From 4 to 6 years a sense of initiative develops and if parents accept the child's curiosity and do not put down the need to know and to question, the child's sense of initiative will outweigh the sense of guilt.

Range of emotions a child can express:

- **Pleasure** – smiling in response to the human voice appears at 4 weeks
- **Sadness and Anger** – evident at 4 months when a teething toy is removed
- **Fear** – facial expression following separation apparent at 9 months

The peak for fears of threatening objects, e.g. animals is about 3 years (fears in childhood). Age related fears are often transitory and of short duration.

Warning signs in emotional and moral development:

- Insecure attachment
- Emotional lacking environment
- Mistrust
- Shame and doubt
- Guilt
- Parental indifference
- Denial of emotional warmth, love, discipline
- Negative parental attitudes, including ridicule and denigration
- Overprotection
- Neglect and abuse

2.5 Social Competence

The development of appropriate social skills in a child is an important foundation for adequate peer relationships.

Social skills include:

- Communicating effectively
- Coping with peer provocation
- Resolving conflicts
- Group entry skills
- Good sportsmanship

“Social competence” is the general term used to describe the overall effectiveness of one's social skills and behaviours.

Parenting practices associated with positive social skills development

- **Authoritative discipline.** Socially competent behaviour with peers is predicted by an authoritative parenting style. The three main components of authoritative parenting are (1) parental acceptance or warmth, (2) behavioural supervision and strictness, and (3) granting psychological autonomy. Conversely, harsh, restrictive, authoritarian discipline has been found to be associated with children's aggression, which in turn is associated with peer rejection.
- **Attachment.** Children who establish secure attachment relationships with their parents during infancy are reported to be more likely to be competent with their peers than infants who were insecurely attached.
- **Arranged peer contact.** Young children of parents who provide them with many opportunities to mingle with other children (e.g. play dates, enrolment in organised activities) tend to have a large number of playmates and be better liked by their peers.
- **Modelling.** Parents who model positive social behaviours at home (effective conflict resolution strategies) tend to have more socially competent children.
- **Coaching.** Children whose parents actively instruct them to manage challenging peer situations (resolving peer disputes, initiating contact with unacquainted peers) are more competent in peer interactions. Shaffer (1989), showed that preschool girls benefit from their mothers' social coaching, whereas boys demonstrate elevated levels of social competence following their fathers' involvement in play and coaching.
- **Verbal interaction.** Frequent verbal interaction between parents and child correlates positively with peer popularity. Parents who provide verbal support and direction while they stimulate their children to think and problem solve tend to have children who are more socially competent. When parents are generally agreeable in interactions with their children, their children are less disagreeable during play with their peers. Preschool boys whose fathers were physically playful while allowing their sons to regulate the pace of the interaction were found to be popular with their classmates.
- **Harmonious interaction.** The way in which a parent and child interact is related to social competence in later life. Harmonious interaction refers to reciprocal, mutually responsive interactions whereby a child or a parent adjusts her behaviour in response to another's actions. Parents and children low in harmonious interaction tend to be unresponsive to one another (ignoring each other or responding with a contrary opinion), change the topic frequently, or show affect that is counter to the prevailing mood of the other person (e.g. mother appears excited, child responds glumly).
- **Stress.** Stressful family events, such as divorce, death of a relative, and relocation, tend to trigger negative emotional states in children, which in turn can adversely affect their relationship with peers (Shaffer, 1989).

Sociability

Sociability describes the child's willingness to engage others in social interaction and to seek their attention or approval. Researchers who study infants and toddlers have found that some youngsters are simply more sociable than others, regardless of environmental influences (see attachment and temperament).

Who raises sociable children?

Although data are limited, it appears that parents who are warm and supportive and who require their children to follow certain rules of social etiquette (for example, 'be nice', 'play quietly', 'don't hit') are likely to raise well adjusted sons and daughters who relate well to both adults and peers. By contrast, permissive parents who set few standards and exert little control over their children often raise youngsters who are aggressive and unpopular with their peers and who may resist or rebel against rules set by other adults (e.g. teachers).

There is evidence that children of overprotective mothers (particularly boys) are quite sociable when interacting with adults but are often anxious and inhibited around their peers. This finding might be explained by the fact that a highly protective mother frequently encourages her children to remain near her side. As a result, an overprotected son may be rejected as a sissy by other children, an experience that may prompt him to seek the company of friendly adults and to avoid peers.

The finding that securely attached youngsters are generally outgoing and even popular with other children suggests that sensitive, responsive care giving contributes to the development of sociability. It is believed that the character of playful interactions between parents and their children is especially significant in this regard. Parents' conduct while serving as 'playmates' will undoubtedly influence the ways in which the child reacts to other playmates, such as siblings and peers. Nine month old infants whose mothers provide many opportunities for playful turn taking are already more responsive to playmates than are peers who have experienced less turn taking with their mothers. Studies of playful interactions between 3 to 5 year olds and their parents finds that if parents are directive and controlling, their children tend to have poor social skills and non harmonious peer interactions. Perhaps a controlling parent who is always barking orders will inhibit sociability by simply taking all the fun out of play activities. Or alternatively, these parents may be teaching their children to be bossy and dictatorial, a style that is likely to elicit negative reactions from playmates and convince the child that contacts with peers are not all that pleasant.

Warning signs in emotional and moral development:

- Highly protective parenting
- Over controlling parenting
- Insecure attachment
- Limited social opportunities
- Paternal history of antisocial behaviour
- Poor paternal social skills
- Indiscriminate over familiarity

TABLE 3 NORMAL ATTACHMENT, COGNITIVE, PLAY, EMOTIONAL, SOCIAL AND BEHAVIOURAL DEVELOPMENT OF PRESCHOOL CHILDREN

Age	Attachment	Cognitive development	Play	Emotional, social, behavioural development
0-6 months	<ul style="list-style-type: none"> • Face to face arouses intense interest • Onset of smiling at 4 weeks marks start of child-caregiver relationship • Baby mirrors caregiver facial expression 	Sensory motor development: <ul style="list-style-type: none"> • Touch • Smell • Hearing • Seeing 	Undifferentiated, random play: <ul style="list-style-type: none"> • Sucking • Biting • Grasping • Dropping 	<ul style="list-style-type: none"> • Smiling in response to sense of pleasure from 4 weeks • Sadness and anger in response to removal of toy from 4 months • Object centred: Touching other infants from 3 to 4 months • Reciprocal social smiling by 4 weeks of age • Recognition of mother
6-12 months	<ul style="list-style-type: none"> • Baby moves towards caregiver in times of distress • Baby signals distress on separation from caregiver • Baby looks to care giver in new situations to receive direction through direct eye contact • Reciprocal relationships 	Cause and effect: <ul style="list-style-type: none"> • Action evokes response, e.g. kicking mobile or rattle results in movement or sound • Object permanence develops 	<ul style="list-style-type: none"> • Recognition of faces and pictures in books • Manipulation of objects (stacking of blocks etc) • Imitation of others' activities and models of play 	<ul style="list-style-type: none"> • Expression of fear in response to separation and things that did not bother child before like heights or bath • Shows feelings of happiness by laughing, feelings of anger by screaming and feelings of hurt by crying • Crying to seek attention • Shy with less familiar faces • Might cry in response to other child crying • Smiles at other infant, vocalises, offers toys, gestures in imitation • Pays more attention to toy than to one another child
12-18 months	<ul style="list-style-type: none"> • Development of multiple attachments and affirmation of existing ones • Ongoing development of a continuous concept of security and continuity of care • Settled patterns of care and daily routine 	<ul style="list-style-type: none"> • Experimenting to find novel solutions to problems and reproduce interesting results • Imitation of others' actions becomes more precise 	<ul style="list-style-type: none"> • Consolidation of play skills • Increasingly creative play (building skills) • Concrete and increasingly interactive play alongside other children • Enjoyment of books, stories and songs 	<ul style="list-style-type: none"> • Frightened and startled by sudden sound • Upset and angry when refused a wish • Interactive stage: React to behaviour of others • Looking for attention and approval • Unwilling to share toys

18-24 months	<ul style="list-style-type: none"> Development of patterns and concepts of attachments which shape relationships throughout life 	<ul style="list-style-type: none"> Developing sense of self by recognising face in mirror Ability to comprehend and use language emerges and allows behavioural regulation to achieve goals Capability of solving problems mentally without resorting to trial and error activities (inner experimentation) 	<ul style="list-style-type: none"> Representational use of toys, taking one thing to stand for another Early interactive and co operative play, returning of favours, begins to take turns 	<ul style="list-style-type: none"> Able to deal with short separations from caregiver Might show resentment when attention given to others Temper tantrums and testing limits Complementary interactive stage: true social interaction and exchanges with others, tries to influence others through smiling or talking Emergence of self conscious emotions such as shame, guilt and embarrassment, as well as true empathy and morality
2-3 years	<ul style="list-style-type: none"> Sense of autonomy emerging against a background of previously established trust and security; dependence on primary care givers remains 	<ul style="list-style-type: none"> Preoperational thinking: capacity to imagine but unable to discriminate fantasy from reality Use of symbols 	<ul style="list-style-type: none"> Development of symbolic, imitative and pretend play 	<ul style="list-style-type: none"> Outbursts of anger and temper tantrums reach a peak at 2 years Egocentric perspective emerges
3-5 years	<ul style="list-style-type: none"> Attachment complete Child develops separate identity Begins to use language instead of behaviours to express wishes 	<ul style="list-style-type: none"> Conceptual thinking emerges (numbers, categories, words, size) 	<ul style="list-style-type: none"> Imaginative play (role and pretend play) Play with peers begins to evolve 	<ul style="list-style-type: none"> Peak of fears in childhood of specific things like dogs or spiders or darkness- many transitional and short lived Becomes more sociable with strange adults, might be comforted by less familiar adult
5 years onwards		<ul style="list-style-type: none"> Concrete and logical operational thinking 	<ul style="list-style-type: none"> Abstract reasoning in play (building models and patterns, e.g. lego), reading and writing Formation of peer groups 	

2.6 Sexual Development

Sex play

Children have a natural curiosity about their bodies and often include it in their play. Children play 'doctors and nurses' as a way of exploring their own bodies and other children's bodies. Sex play is usually only part of their overall playtime, limited and infrequent. It is usually voluntary and involves another child of the same age, usually a friend. It might help to ask your child how he thought up the game and to explain that there are lots of ways to learn about bodies, by touching, by books and to invite the child to look at some picture books.

Parents' reactions

How comfortable are parents with their own sexuality? Many children end up confused and frightened and this can be due to parent's reaction. A parent's reaction can send an early message about sexuality to a child. If a parent says 'No' in a stern way to a young baby and takes his hand away, this teaches the child that touching his genitals is bad. It might be better to say 'I know that feels good' and continue changing his nappy and maybe leave the nappy off for a while.

Masturbation

Some reports in the literature say that at least half of children between the ages of one and two discover masturbation while exploring their bodies. Masturbation can occur several times a day to once a week. Preschoolers who masturbate can feel good and comforted when they are upset or worried. Some children will twirl their hair or suck their thumb, others will rub their genitals for comfort. With very young children it is difficult to find out what is worrying them and parents have to try and work this out (a new baby in the family, moving house, fear or anxiety about a person or situation). Children need to learn over time that touching should be done in a private place. A good time to introduce this might be during potty training.

Some preschoolers touch their penis constantly, at naptime, at playschool, in the shop and in the grandparent's house. Parents can become frustrated and ask themselves 'How can I stop this?' Adults need to take off adult lenses and realise that the child is not masturbating for erotic purposes, it just feels good and it is comforting.

Advice to parents

- Do not scold your child for masturbating.
- Tell your child that touching needs to be done in a private place.
- Try to work out what if anything might be worrying your child.
- Offer your child a hug and some reassurance.
- Think before you speak.
- Try to convey the above messages without shame.

Stages in Sexual Development	
Babies	Have sexual feelings from birth, i.e. boys can have an erection and boys and girls get good feelings from touching the sexual parts of their bodies. Their nervous system allows sexual reflexes and responses.
Very young babies	Usually do not explore their genitals until late into their first year. It is harder for them to see their genitals. They play with their hands or feet and are not yet sure that they are parts of their body.
At around six months	Babies discover their bodies, i.e. their hands, toes, feet, penis and vulva. It is a natural discovery and feels good.
At around one year of age	Children might play with their genitals more often and feel comforted when they are upset and worried.
Two year olds	Are still trying to work out how all the parts of their body are connected to the rest of them and sometimes are unsure about their relationship to one another.
Preschoolers usually	<p>Are modest about their bodies. Like being naked.</p> <p>Are interested in looking at own body and other children's bodies. Like to be nude, playing doctors and nurses, inspecting others' bodies, including those of their parents.</p> <p>Want to know where babies come from but don't understand sexual intercourse.</p> <p>Are interested in toilets and bathroom functions. Might use swear words.</p> <p>Enjoy touching their own genitals when being changed, going to sleep, when tense, excited or afraid.</p> <p>Want to explore differences between males and females. Like to touch the genitals, breasts of familiar adults and children.</p> <p>Ask about genitals, breasts, intercourse, babies, erections.</p> <p>Might put something in genitals or rectum of self or other for curiosity or exploration.</p> <p>Like to play house, act out roles of Mammy and Daddy.</p>

The background is a solid red color. A large, white, stylized number '(3)' is positioned in the upper left quadrant. A thick, red, brushstroke-like line starts from the left, curves around the '(3)', and extends towards the right side of the slide.

(3)

RISK & PROTECTIVE FACTORS

Delayed development may result primarily from a biological factor such as a chromosomal disorder, or an environmental factor such as maternal depression.

Risk factors of minor psychological problems (Hall & Elliman, 2003):

- Poor parenting
- Socially deprived families
- Boys rather than girls
- Children with learning or cognitive difficulties and, in young children, delayed language development
- Children with other problems of health or development, including chronic illness and disability
- Adolescence rather than earlier childhood
- Being 'looked after'.
- Associated family relationship problems are common but not universal

Coie et al (1993) grouped risk factors for child mental health problems into seven domains.

Area	Issue	Association
1 Constitutional handicaps	Prenatal maternal smoking	ADHD
	Prenatal maternal alcohol consumption	Fetal alcohol syndrome
	Stress during pregnancy	Behavioural problems, disability, child harm
	Prematurity	Developmental delay, ADHD, child psychiatric disorders
	Disability	Various
2 Skills development delays and 3 Emotional problems	Low IQ	Attention deficits
	Aggression	Shyness, lack of social skills
	Specific learning disability	Lack of social competence
	Poor problem solving skills	
4 Family circumstances	Early economic disadvantage	Criminality
	Parental mental ill health	Child mental ill health
	Large family size, marital discord	ADHD
	Teenage mothers	Behavioural, emotional and cognitive problems; increased incidence of illness and non intentional injury
	Maternal history of abuse, disrupted care, insecure attachment to mother, substance misuse and emotional problems	Child harm
	Home chaos and disorganisation	Social incompetence, poor attention skills
	Criticism and intrusion	Disorganised attachment
	Marital violence	
5 Interpersonal problems	Peer rejection, alienation and isolation	Conduct disorder, criminality, substance misuse, depression, early school leaving
6 Schooling difficulties	Class size	Academic achievement
7 Ecological risks	Child poverty	Accumulation of risk factors and adverse outcomes
	Neighbourhood and TV violence	Aggression and violent behaviour

Evans (2004) has reviewed the environment of childhood poverty.

“Poor children confront widespread environmental inequities. Compared to their economically advantaged counterparts, they are exposed to more family turmoil, violence, separation from their families, instability, and chaotic households. Poor children experience less social support, and their parents are less responsive and more authoritarian. Low income children are read to relatively infrequently, watch more TV, and have less access to books and computers. ... The air and the water poor children consume are more polluted. Their homes are more crowded, noisier and of lower quality. Low income neighbourhoods are more dangerous ...”

The relationship between risk factors and clinical disorders is complex. The overall risk of an individual is a reflection of the interaction between aspects of the individual and aspects of their environment. Stressors operate directly and indirectly e.g. extreme poverty reduces life opportunities and impacts on the quality of parenting. Recent research suggests the effect of multiple risk factors is cumulative (Appleyard et al. 2005) and therefore reducing the impact of even one is of help to the child. Some stressors seem to have a significant effect only above a threshold e.g. minor hypoxia after birth is weakly associated with behavioural and cognitive difficulties while the number of days in which a newborn is hypoglycaemic predicts developmental delay at 3 years (Taylor and Rogers, 2005). Finally, as Webster-Stratton (2001) note, it is best to reduce risk factors while simultaneously promoting resilience.

Protective factors

There has been much less research on the protective factors that enable a child to “bounce back” or show resilience in the face of challenges and threats. Protective factors can operate in a variety of ways:

- directly to reduce a risk
- buffer an individual against the effects of a risk
- disrupt the mediating factors associated with the risk
- prevent the initial occurrence of the risk factor

Place et al (2002) has described protective factors under three main headings:

Individual factors	Good problem solving Good social skills Self reliance Positive outlook on life High cognitive ability Emotional resilience
Family factors	Quality of attachment Socioeconomic status
Community factors	Parental satisfaction with social support

A stylized background graphic in a lighter shade of red. It depicts a hand with fingers spread, holding a heart shape. The graphic is positioned behind the main text.

(4)

PARENTING
SKILLS

The parent-child relationship is a critical factor in determining both vulnerability and resilience among children. It is influenced by child characteristics (such as gender, intelligence, temperament), which interact with parental, familial and environmental characteristics to predict the path of development for individual children. The child-rearing practices of parents are an important part of this dynamic. Parent behaviour therefore can set the stage for children to develop and use coping skills that make them more resilient, or conversely can place children at risk for problems (Blout, 1989).

Regardless of age, socio-economic status, cultural background or geographic location, parents generally share similar wishes for their children and have similar questions about how to fulfill those wishes. There are many forces at work in children's lives, and although parental influences are powerful, they are mitigated by many other variables beyond parental control. Nevertheless there are things that parents can do from the first day of a child's life, and even before, to promote good outcomes.

4.1 Antenatal Preparation

Good ante-natal preparation is a way of giving parent and child a good start in life. Encouraging mother to take good care of her physical and mental health during pregnancy through attending ante-natal classes is. When preparing for the birth of a child, the expectant mother should also be made aware of the possible psychological impact of having a child, such as baby blues, post-natal depression and effects on the relationship with a partner.

Preparation for the transition to motherhood and parenthood is often perceived and heralded as a medical event, culminating in the birth of a baby. Much medical and scientific advancement has been made in obstetric care. This has greatly advanced the quality maternal and infant care at maternity hospitals both at inpatient and outpatient level. However, the antenatal care focus is most often centred on the medical events of labour, delivery and the post-natal period. There is often little acknowledgement of the psychological processes, which take place in the antenatal period or the need for development of a new attachment relationship between parent and infant.

Much has been written on the psychology of pregnancy, the psychological tasks inherent in pregnancy and their effect on mother-baby relationships. Solchany et al (2002) define the stages as follows:

- Acceptance of the pregnancy
- Development of the fantasy baby
- Development of mothering behaviours
- Redefinition of maternal self
- Developing mother- baby relationship

While significant theoretical knowledge has been documented on the psychological tasks of pregnancy, this component of pregnancy has not been incorporated into current antenatal care programmes within the Irish health services (Maguire & Matacz, 2005).

The National Council for Professional Development of Nurses and Midwives is currently conducting a review of Antenatal Education (Haghney, 2005, personal communication), which focuses on core competencies involved with a view to enhancing antenatal and parenting

education, based on a review of current practice and identification of antenatal educators' training needs. There is an acknowledgement of the specialised nature of this work and the need for specific knowledge and expertise, while Public Health Nurses are already overburdened by the extent of their generic workload.

There is a recognised need for facilitation and research to establish learning outcomes of antenatal education to date, especially in the format in which it is currently been conducted. To date, the effectiveness of existing antenatal education has not been assessed nor have the skills required for its delivery been defined. Furthermore, there appears to be little documented evidence of the benefits of antenatal care in the literature.

4.2 Impact of Parenthood on Parent Relationship

Knauth (2000) found a significant decline in both parents' satisfaction with family functioning in the transition to parenthood. Ahlborg et al (2005) suggest that while new parents can be satisfied with their emotional relationship they can be dissatisfied with their sex lives.

Women are more likely to experience distress because of disagreements with their partners or because of unmet expectations concerning the division of responsibility for child care rather than the division of responsibility for housework (Goldberg & Perry-Jenkins, 2004). The transition to motherhood is associated with significant changes in a women's life, which may include reduced income, role restriction, task overload, physical exhaustion, social isolation and depressive symptoms (Webster-Stratton, 1990). This can be an especially stressful time for teenage mothers who may be less prepared interpersonally and financially to cope with the transition. Condon et al. (2004) established that the most significant lifestyle, psychological and relationship changes for first time fathers happen relatively early in the pregnancy. Young men who experienced a stressful rearing environment and who have a history of conduct problems are more likely to become fathers early but to spend less time with their children (Jaffee et al. 2001). Reichman et al (2004) showed that having a child with poor health increased the probability that [1] the parents' relationship status moved in the direction of less involvement and [2] that the parents were separated by 18 months.

4.3 Impact of Parenthood on Teenage Parents

There are typically no systems in place to ensure that teenage mothers return to full time education or get additional or supplementary training following their child's birth (Moffitt et al., 2002). The type of social isolation which may follow, together with the typically lower levels of maternal self confidence and higher level of weight and shape concerns of teenage mothers have been shown to vary systematically with postpartum depression in this group (Birkeland et al. 2005).

Young mothers often report that their parenting skills are criticised and that they receive unwanted advice about child rearing (Pasley et al. 1993). They also seem more likely than older mothers to have experienced abusive relationships with partners in the past but rate communication, trust and affection in their current relationship, where there is such a relationship, as positively as do older mothers (Moffitt et al. 2002).

Lavers & Sonuga-Barke (1997) suggest that the helpfulness of maternal grandmother involvement in the care and support of the mother and her own child is likely to be significantly influenced by the attachment history between the mother and the grandmother.

4.4 Impact of Socioeconomic Status on Parenting

Social factors play an important role in parenting and may place certain families at risk for suboptimal parenting, leading to an increased risk of emotional and behavioural problems in children. Material disadvantage and economic hardship are viewed as distal variables in the causal pathway to adverse childhood outcomes with parenting a proximal variable. (Conger et al., 1992)

Longitudinal studies in the US have found a direct link between economic hardship and paternal punitive and rejecting parenting (Elder et al., 1985), as well as reduced parental nurturing and inconsistent discipline in both parents (Lempers et al., 1989). Another study found that low income parents who also perceived that they had low social support were found to be more punitive towards their child (Hashima & Amato, 1994). Economic hardship also affects the psychological well being of parents and their marital relationships (Rosenblatt & Keller, 1983), which in turn affects a child's well being and psychosocial functioning.

There is evidence of a dose response relationship: the longer children are in poverty, the more they are at risk of behavioural problems when compared to children from families in short term poverty or affluence. (Duncan et al. 1994) The prevalence of significant emotional and behavioural problems was found to be 6% higher for children from lower socio-economic groups than the average of 10% for children at primary school level in a recent study in the South East of Ireland (Martin & Carr, 2005). For children in secondary school education in the same study, the prevalence was 10% higher for those from lower socio economic classes than the average of 26%. Intergenerational cycles of poverty are also associated with poorer outcomes (Rutter, 1989).

Thus parents who experience economic hardship face additional stressors that make effective or 'good enough' parenting difficult. Earlier intervention and reduction of economic hardship will have a beneficial effect on parenting and consequently childhood outcomes.

4.5 Good Enough Parenting

A central issue in the early years of a child's life is the establishment of a sense of basic trust. Through experiences with caregivers, babies are receiving important messages about the world around them. This sense of basic trust is influenced by many experiences in the young child's life, but is most closely tied to the child's relationship or attachment to his primary caregiver. But as a famous paediatrician and psychotherapist said 'Parents do not have to be perfect – they just have to be "good enough" to produce healthy and well balanced children'.

Current research in the area of parenting has focused on the determinants of parenting and not surprisingly, they are numerous. The three main areas are:

1. Characteristics of parents themselves including their genetic and environmental origins and personal psychological make-up such as sensitivity,
2. Characteristics of the child, especially his unique temperamental profile,
3. Characteristics in the environment, including sources of stress and support.

It is the combination of the interaction of these three characteristics that determine parenting practices (Belsky, 1996).

Research has investigated the components of optimal parenting (Kendziora & O'Leary, 1993):

- Enforces rules consistently
- Has age – appropriate expectations
- Reinforces appropriate behaviour
- Accepts and nurtures the Child
- Models appropriate behaviour
- Assigns age – appropriate responsibilities
- Provides developmentally appropriate stimulation
- Monitors child's activities
- Provides reasons for rules and limits

Belsky (1994) describes the kinds of parenting at different ages that are thought to promote optimal child functioning as follows:

Infancy: Cognitive and motivational competence and healthy socio-emotional development are promoted by parents' attentive, affectionate, stimulating and non-restrictive parenting.

Pre-schoolers: High levels of nurturing and affection, accompanied by firm control, foster the development of good social skills, resourcefulness and achievement motivation.

School age: Consistent discipline, explaining reasons for things and expressions of affection are positively related to self-esteem, internalized controls and intellectual achievement.

Recent work has examined the role that fathers play in their children's development. This work indicates that the involvement of fathers and father figures with children is increasing as more mothers join the work force.

In conclusion, research on changing lifestyles and parenting styles, as well as that focused on risk and protective factors suggest the need to plan early intervention or prevention programmes for families to enhance children's development. These programmes are based on the assumption that if children are reached early enough, their life course can be significantly changed for the better (Barlow & Parsons, 2003).

4.6 Dysfunctional Parenting

- Studies show that parents who were mistreated during childhood are more likely than non-mistreated parents to mistreat their own children (Belsky, 1984). All or some of the following factors can result in a dysfunctional parenting style, which can result in child harm:
- Poor social supports networks
- Poor marital relationships
- Psychological factors such as maternal depression.

Components of dysfunctional parenting that health professionals should look out for include:

- Not responding to child with sufficient warmth and stimulation
- Overly harsh and controlling
- Unable to set reasonable expectations and limits
- Attending to and reinforcing inappropriate behavior while not attending to appropriate behaviour
- Attacking communication with child
- Not listening to child
- Inconsistent and inept handling of situations that require punishment.

4.7 Child Harm

The role of parenting is to facilitate the child's development within a safe and secure environment. Child maltreatment will impact on parent-child relationships and the child's social and emotional development. There is consensus that child maltreatment is the end result of parent /caregiver engagement in conflictual relationship patterns, either with their partners or resulting from unresolved issues in their own early life, which are carried into their current relationships with their children (Quinton & Rutter, 1988; Reider & Lucey, 1995).

Early indicators of child neglect and harm

Children First (DoHC, 1999), contains national guidelines in relation to child abuse, which are intended to assist people in identifying and reporting child neglect and harm. These should guide all practice in relation to the identification and reporting of children at risk.

For **Signs and symptoms of abuse** see Appendix 4.

4.8 Child Protection

Observational studies of children, who had been reared in care and/or had frequent changes of primary caregiver during infancy, revealed that the absence of nurturing relationships during these early years resulted in adverse effects on child development (Bowlby, 1988). Children reared without a nurturing relationship become regressed, significantly delayed in their development and in some cases fail to thrive (Bowlby, 1953). They are also at increased risk of emotional, behavioural and mental health problems.

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(5)

PRESCHOOL
EDUCATION

5.1 Childcare

Early childcare and development

Does the nursery school experience have any noticeable effect on children's sociability? The National Institute of Child Health and Development (1997) Early Child Care Network has investigated the effects of childcare on infant mother attachment, finding that "there were no significant main effects on child care experiences (quality, amount, age of entry, stability or type of care on attachment security". Maternal sensitivity and responsiveness are important characteristics in determining how quality and quantity of childcare affect a child's emotional development and security. Where low maternal sensitivity and responsiveness are combined with poor quality childcare, infants are less likely to be secure.

Characteristics of high quality child care provision

The National Quality Framework in Early Childhood Care and Education (NQF/ECCE) forms vision for quality child care in the Republic of Ireland.

All work with children should take into account the principles that:

- Early childhood is a significant and distinct time in life that must be nurtured, respected, valued and supported in its own right.
- The child's individuality, strengths, rights and needs are central in the provision of quality early childhood experiences.
- Parents are the primary educators of the child and have a pre-eminent role in promoting her/his well-being, learning and development.
- Care and education are inseparable in nature.
- The child is an active learner.
- Responsive, sensitive and reciprocal relationships, which are consistent over time, are essential to the well-being, learning and development of the young child.
- The role of the adult in providing quality early childhood experiences is fundamental.
- The provision of quality early childhood experiences requires cooperation, communication and mutual respect.

The standards include:

- Ensuring that each child's rights are met,
- Promoting the health and welfare of the child,
- Promoting play,
- Providing enriching environments,
- Ensuring inclusive decision-making,
- Valuing and involving parents and families,
- Fostering constructive interactions,
- Promoting identity and belonging,
- Ensuring community involvement.

The standards and principles will formally apply in four settings where care and early education occur, i.e.:

- Full day care,
- Infant classes of primary schools,
- Sessional services,
- Family day care (child minding).

It is worth noting that while the principles and standards will formally apply in these settings, they present a challenge as to how families may be equitably supported so that each child can experience these standards in his/her own family setting.

Please see Appendices 2 and 3 for detailed principles and standards with explanatory notes.

5.2 School Readiness

Until recently interest in 'school readiness' has been at the level of the individual, focusing mainly on whether a particular child is ready for school and how the child's parents and the school might make the transition process as smooth as possible. More recently, particularly in Canada, the United States and England, children's readiness for school has been examined within a broader context. Preparation has related not only to specific pre-literacy and pre-numeracy skills, but has been expanded to include physical health, social and emotional adjustment, the child's approach to learning and level of language, cognition and general knowledge.

A more radical change in broadening the definition recognises that the task of preparing children for school is a community responsibility. 'Readiness for school' is starting to be used as a benchmark to measure the degree to which early childhood policies, programmes and parental support have been effective at a community, as well as a societal level (Janus & Offord, 2000).

Shift in criteria for starting school

Historically and currently, the main criterion for assessing school readiness has been age. The results of research has led to a wider acceptance that children learn at an earlier age and that people caring for them are educating rather than just 'minding' them. This has led to criteria other than age being considered when assessing school readiness:

- **Social competence:** adequacy with which the child gets along with other children
- **Emotional adjustment:** being able to socialise and mingle with their peer group
- **Cognitive skills:** intellectually inquisitive and able to use language to communicate
- **Language:** ability to communicate effectively and unambiguously with peers and teachers
- **General knowledge:** ideas, facts or concepts, e.g. knowing the alphabet and numbering
- **Practical skills:** independent action, e.g. toileting, dressing, tying shoelaces, unwrapping lunch
- **Rules:** implicit and explicit expectations, such as sitting up straight, putting rubbish in bin, hanging bag on hook, not running on asphalt, wearing a hat and recognising that bells signal class times

Age and school readiness

Despite the complexity in defining individual readiness, age is still the most used single criterion for starting school (de Lemos & Mellor, 1994), but levels of school readiness may differ from one community to another. There are several reasons for this. Because high achievement and social

confidence are becoming more prized in our society, some children are starting school later. Only more financially secure families can afford to delay school entry, as this can mean another year of child care fees or another year with the loss of the only or second income.

Assessing school readiness

One way of assessing how well a community has served its youngest members is to check their progress against a wider societal norm. A logical time for this is when children start school.

By assessing the school readiness of all children, at best nationally and at least in some communities, it may be possible to monitor or 'keep score' of children's progress and to direct resources where they are most needed. In this sense, readiness for school is far removed from a knowledge race. Rather, it is a time when the community evaluates itself and ensures that it is doing the best it can for its young children.

Early development index (EDI)

It is now clear that high quality child care, parenting programs and early intervention can significantly improve children's life chances at an individual and community level.

In order to assess the level of school readiness at community level in Canada, the Early Development Index (EDI) has been developed (Janus et al, 2001), based on indicators of children's readiness to learn, of which five domains are deemed most relevant:

- physical health and well-being
- social knowledge and competence
- emotional maturity
- language and cognitive development
- communication skills and general knowledge

The aim of this instrument is to assess strengths and deficits in groups of children, evaluate the effectiveness of early childhood intervention and provide a predictor of how well this group might do in primary school. The overall results are made available to communities and can be used to assist in deciding which services might be required to overcome any gaps that are apparent. Service providers can work on strategies, which are likely to improve outcomes.

Assessing school readiness needs to be universally applied. Where programmes are aimed at only the most vulnerable (such as lower socio-economic families, single parents, parents suffering depression) the numerically larger number of middle class children, whose life chances have also been compromised by a 'bad start' for less demographically obvious reasons, will miss out on the benefits offered. Many children from apparently advantaged backgrounds have multiple, changing and not necessarily high quality child care provision. There is no quality control on nannies employed by families where both parents work long hours.

School Environment

Emotional, behavioural and mental health problems of children are often apparent to teachers in the early days of schooling, lasting throughout their school career and impairing their ability to succeed educationally. There are no systems in place to identify such children other than opportunistically. Resources to meet their needs are limited. While establishing the National Educational Psychology Service is a step in the right direction, many children, parents and teachers in need of support, advice and management of child emotional, behavioural and mental health problems are unable to avail of services appropriate to their needs.



(6)

OBSERVATION AND ASSESSMENT

There is evidence that early identification and intervention improves outcomes both for the child and for the family. Intervention is more likely to be successful when it focuses as much on supporting and training parents as it does on directly working with the child. There is evidence that the earlier an intervention takes place, the better the outcomes (Centre for Community Child Health, 2002).

The child's age, range and severity of psychological difficulties present should be taken into account when deciding whether to intervene. The most important distinction to be made is between a single problem, requiring a direct approach; or multiple problems needing a complex approach (Hall & Elliman, 2003).

6.1 Identification of Problematic Development

The identification and understanding of problematic behaviour can not occur in isolation. Identification of problematic behaviour must be understood within the context of the family or primary caregiver and within other significant contexts such as extended family, school, and day care environment.

Areas of Observation

Child	<ul style="list-style-type: none"> • Communication and language • Hearing and speech • Affect and emotion • Cognition 	<ul style="list-style-type: none"> • Physical well-being • Physical development • Self help skills • Relationships
Parents	<ul style="list-style-type: none"> • Parental characteristics • Parental relationships • Parental response to parenting • Parents' relationship to child • Emotional warmth • Child safety 	<ul style="list-style-type: none"> • Stimulation and play • Guidance and boundaries • Stability • Basic care • Parents' interactions with others • Stressful events
Environment	<ul style="list-style-type: none"> • Housing • Financial situation • Educational opportunities 	<ul style="list-style-type: none"> • Employment • Family functioning
Supports	<ul style="list-style-type: none"> • Family connectedness • Friends 	<ul style="list-style-type: none"> • Community connections

From: Assessing needs & risks in work with children & families. A multi-disciplinary assessment framework (2000), Western Area Child Protection Committee, NHS, Northern Ireland.

6.2 Observation and Assessment Skills

Assessment Skills	A therapeutic alliance with parents facilitates their capacity to provide a history of presenting issues and telling of their story. Often primary care workers are a first point of contact where parents present with concerns about their child's problems. The initial building of trust is vital and sets the stage for how further interventions may be received.
Clinical Observations	Capacity to interpret the range of clues and signals that may be displayed by parents and child or during parent – child interactions. Affective behaviour that occurs between child and caregiver is not easily assessed nor is there an array of standardized assessment scales to measure these interactions. The role of close clinical observation is vital.
Understanding Attachment Behaviour	Presence of age appropriate signs of secure attachment. Observation of child interacting with parents – quality of parent-child behavioural and emotional interactions.
Family Relationship History	Parent's perceptions, attitudes, understanding of problematic development, distortions and expectations should be explored.
Developmental History	Includes developmental aspects relating to biological, temperamental style, cognitive and emotional history. Information on child strengths and weakness / vulnerabilities and response to a previous stressor.
Clinical Interviewing Skills	Allow caregiver to tell their story wherever they choose to begin. Use open ended questions as they convey a non judgemental attitude. Listen for emotions as well as content.
Development of Therapeutic Alliance between Clinician and Caregiver	Provide support for parents as their fears about coming to see you may be as great as the presenting problem they are coming to talk about. Parents may be worried about what the professional has to say e.g. fear that their infant/toddler is developmentally delayed, fears about how they are viewed as parents.
Reflective Practice	Reflection concerns personal growth and capacity of the health professional to be aware of self (thinking, feeling and responding to situations) and of how the environment influences this - with the intention of realising desirable practice. Within the complex and often indeterminate world of clinical practice, the ability to make good judgements is significant, together with compassion and empathy for experiences of others, e.g. the child and family.



(7)

BEHAVIOURAL PROBLEMS

Inappropriate parental responses to children's non-compliance or defiance can exacerbate problems. Negative and complicated parent-child relationships during the toddler period predict continued problems at school entry and beyond.

Whether the child's defiance represents the self-assertion necessary to achieve independence or reflects anger and disturbance is the primary question for health professionals (Campbell, 1998). Unfortunately many parents have trouble making this distinction. They may interpret all toddler defiance as a threat to their authority, resulting in excessive punishment (authoritarian style) or conversely they may have trouble setting limits on the child's initiative (permissive style).

However, toddlers have limited internal control over their behaviour and impulses. This ability develops gradually during the pre-school years and is driven in part by the development of cognitive and language skills. The primary parental task is to provide external control that ensures children's safety, while they are busy exploring their environment (authoritative style).

Main presenting problem in early infancy and childhood	
Infancy	Early Childhood
<ul style="list-style-type: none"> • Difficulties in the formation of an attachment relationship • Parent child interactional problems • Separation anxiety • Child failing to thrive in the absence of any physical problem • Feeding and eating difficulties during infancy and early childhood • Sleeping difficulties • Persistent crying • Emotional regulation problems • Pervasive developmental delay • Delay in language development • Exposure to traumatic events 	<ul style="list-style-type: none"> • Sleeping problems • Toileting problems • Learning and communication difficulties • Intellectual disability • Speech and language disorder • Pervasive developmental delay • Autistic spectrum disorder • Attachment problems • Anxiety problems • Delay or poor capacity for emotional regulation • Attention Deficit Hyperactivity Disorder • Depression • Post- traumatic stress

7.1 Feeding

Feeding problems in early childhood impact on later social emotional development. DeGangi et al., (1996) in a follow up of children with feeding problems noted: "The only diagnosis at 3 years that was related to feeding problems was social – emotional problems. The fact that we are finding long term emotional problems in children who initially had feeding disorders points to the importance of addressing the parent – child interactive component in treatment when the feeding problem is first identified."

Feeding disorders are common in infancy and childhood and can be difficult to identify and treat. Certain children are at risk, such as those with developmental delay, medical illness or prematurity. Most are self limiting but up to 3-10% may be severe (Lindberg et al., 1991). Various

factors are involved in the aetiology of feeding disorders, including infant temperament, parental attributes, medical illness and environmental factors.

The feeding of infants and toddlers plays an important role in the developing relationship between a child and its caregiver (usually mother). Feeding not only fulfils a biological need in the infant or toddler, but also contributes to the attachment and bonding process. It also plays a key role in the emotional and communication development of the child.

Feeding disorders

Chatoor et al., 2002 propose the following classification system for feeding disorders:

Feeding disorder of state regulation: These feeding difficulties start in the newborn period and the infant fails to gain adequate weight or shows loss of weight. The infant is unable to maintain a state of calm alertness for feeding. The parent requires sensitive advice regarding feeding in a calm environment and responding to the infant's cues appropriately.

Feeding disorder of reciprocity: This disorder has previously been called 'Failure To Thrive' (FTT) and is thought to be heavily influenced by the relationship between the child and parent. Apparent often by 6 months, children become difficult to feed and malnourished. Treatment involves encouraging a positive relationship between mother and child whilst monitoring nourishment and development.

Infantile anorexia: This disorder is characterised by food refusal occurring at an age (1-3 years) when toddlers otherwise develop increasing autonomy and separation from parents. The infant is learning to differentiate between states of hunger, fullness and various emotions. If the mother is unable to interpret these cues and constantly offers food, the infant becomes confused. Hunger is then linked with emotion, and the infant learns to eat or refuses to eat when angry, upset etc. These infants eat small amounts and rarely show signs of hunger. Parents become concerned and try various techniques to improve food intake with little success, which results in frustration and conflict during feeding. Infants fail to gain weight. This exacerbates parental concern and frustration leading to increased conflict and distress, and a vicious cycle ensues. Behavioural techniques are the mainstay of treatment and need to address the parent-infant conflict.

Sensory food aversions: Children with this disorder refuse to eat certain foods based on their appearance, smell, taste and texture to the extent that they have specific nutritional deficiencies or oral motor delay or both. It is helpful to introduce a variety of foods early on in a neutral fashion to allow infants to become accustomed to them and for the family to model good eating habits.

Feeding disorder associated with a concurrent medical condition: This may result from gastroesophageal reflux, food allergies to respiratory distress. Treatment of the medical cause along with advice and reassurance to parents is essential.

Posttraumatic feeding disorder: This feeding disorder develops following a frightening incident e.g. choking, gagging, severe vomiting or a medical procedure such as intubation. The child may refuse solid foods or drinks and become distressed when attempts are made at feeding. This disorder is difficult to treat and can be life threatening. A gradual desensitisation approach, usually by specialised therapists, can take months to years to achieve.

The role of primary and community care practitioners

Primary care practitioners play an early important role in the diagnosis and treatment of feeding disorders. This consists of growth monitoring as well as providing parents with appropriate advice and support. This entails encouraging a positive relationship between mother and child by using behavioural techniques around feeding, as well as ensuring support from the wider family and community. At the more severe end of the spectrum, a multi-disciplinary team approach may be required.

During infancy, there are periods of time during which children are more receptive to the introduction of food tastes and textures. If these windows of opportunity pass without being made use of, restricted dietary pattern might evolve, which are difficult to correct later (Gill Harris, personal communication, 2005)

- 3-5 months:** Acquisition of varied tastes
- 8-12 months:** Introduction of solids, finger foods, self feeding
- by 1 year:** Recognition of food by appearance and shape ("gestalt")
- by 5 years:** Acceptance of food categories, establishment of preferences, occasional food refusal

7.2 Sleeping and Crying

Among the many developmental tasks to be achieved in infancy is the regulation of sleeping patterns, in particular the organisation of waking and sleeping states or cycles (Anders, Halpern & Hua, 1993). Sleep plays many important roles in infancy and early childhood. It restores the body, providing nutrients to body cells and tissues and stimulates brain protein synthesis (Adams, 1980).

The regulation and maintenance of sleep states are controlled by biological mechanisms and maturational processes. Depending on the age of the child, falling and staying asleep involves several developmental tasks for the infant (De Gangi, 2000):

- Regulating basic sleep, wake cycles and arousal states
- Internalising daily routines and schedules
- Transitioning from active and quiet alert states to sleep
- Screening out noises from the environment when falling asleep
- Self calming when distressed or when awakened in the night
- Feeling attached to caregiver while feeling secure in separating from them to sleep.

To support this process, parents and caregivers offer a role in supporting sleep routines or hygiene. This term describes the habits children develop, often in conjunction with their caregivers, for example, going to and remaining asleep (Minde, 2002). They may include bedtime rituals such as bedtime stories, bath time, helping the infant use soothing devices such as a play mobile over the cot and "by providing experiences that both support attachment and separateness" (De Gangi, 2000).

Additional developmental tasks for falling and staying asleep for the second and third year of a child's life include (De Gangi, 2000):

- Calming down after a stimulating day of activities
- Receiving a balanced sensory diet of movement stimulation and calming activities
- Negotiating fears of dark places and of being alone
- Tolerating limits set by caregivers around bedtime rituals
- Developing autonomy.

Problems may arise in falling and staying asleep even when they were not previously an issue. Caregivers have an important role in facilitating the toddler to negotiate different levels of sensory stimulation without becoming over stimulated. "The toddler needs to internalize and follow routines that caregivers have established while becoming comfortable with tolerating rules and learning to assert their autonomy" (De Gangi, 2000).

Sleep problems in children

Sleep problems often occur during childhood and their management frequently presents quite a challenge to distressed parents. Sleep problems are often associated with maternal and/ or paternal sleep disturbance. They can cause disruption in the parent- child relationship and family life in general. Families may vary in how they manage children's sleeping habits. What may be problematic for one family may be manageable for the another. Sleep patterns that occur at different developmental stages of infancy and toddlerhood make the definition of disordered sleep patterns difficult. For example, a 2 month old baby waking frequently during the night is not considered abnormal. However, a 2 year old child also waking frequently is considered to have an abnormal sleep pattern.

The Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: Revised Edition (DC: 0-3R, 2005) notes that sleep problems are a frequent feature during the first year of a child's life. These problems may be associated with disorders of affect, relationship problems or transient adjustment problems. Therefore, sleep behaviour disorders can be appropriately classified only after the age of 12 months when there is a more typical sleep pattern.

Causes of sleep problems in children

Child Factors	Parental Factors	Environmental Factors
Bedwetting Physical illness Sleep disorders Habit reinforcement Separation anxiety Fears Drug misuse Psychiatric illness incl. depression and mania	Failure to establish bedtime routine Emotional over involvement	Cold Dampness Darkness Noise Overcrowding

Types of sleep disorders and disorders of the sleep – wake cycle

- Sleep / Night terrors
- Sleep walking
- Nightmares
- Disorders of initiating sleep
- Disorders of maintaining sleep
- Breathing related sleep disorders

Night time waking

- A problem if parents say so!
- One in four 1 year olds wake most nights.
- One in three 3 year olds wake every night and one in five 5 year olds do.
- Parental depression
- Feeding problems
- First born

For **suggested questions to ask parents about their child's sleeping pattern** (Thiedke, 2001)- see Appendix 5, also 'Caring for your child 0-6 months' and 'Caring for your child 6 months to 2 years' (Child Health Information Service for Parents (CHISP), HSE South, 2005).

How much sleep do children need?	
By about 6 months	<ul style="list-style-type: none">• about 10–11 hours' sleep a night,• 2 naps during daytime of about 2–3 hours each, and• less inclined to sleep during a feed.
By about 9 months	<ul style="list-style-type: none">• about 10–12 hours' sleep a night,• may go the whole night without a feed, and• two naps during the daytime of about 1–2 hours each.
By about 1 year	<ul style="list-style-type: none">• about 10–12 hours' sleep a night,• 2 naps during the daytime of about 1–2 hours each, and• may begin to wake again during the night, especially if teething.
By about 18 months	<ul style="list-style-type: none">• about 11–12 hours' sleep a night, and• 1 nap during the daytime of about 1–2 hours.
By about 2 years	<ul style="list-style-type: none">• about 11–12 hours' sleep a night, and• 1 nap during the daytime of about a half an hour.

7.3 Emotional Regulation

The accomplishment of social and emotional development is a major developmental task during the first three years of life and especially in the first year. Central to this is emotional regulation, which is “the keystone of emotional development during infancy” (Crockenberg & Leerkers, 2000). “Emotional regulation can be defined as individual’s attempt to monitor, evaluate and modify their emotional reactions, particularly in pursuit of a goal” (Thompson, 1994).

An important factor, which influences the development of emotional regulation, is the parent/ caregiver - child relationship. “Parents influence how infants interpret situations as well as how and when infants regulate their emotions”. (Crockenberg & Leerkers, 2000).

“Parents assist their infants in reinforcing positive emotions, and structure the environment in which infants experience emotions” (Thompson, 1994).

De Gangi (2000) outlines five main areas, which are related to emotional regulation in children:

1. Cognitive appraisal
 - Reading and understanding social cues
 - Perception, facial recognition and discrimination of affect
 - Predicting one’s own behaviour and that of others
2. Physical aspects of emotions, e.g. physiological processes to facilitate a response
3. Expression of emotions
4. Socialisation of emotions
5. Modulation of emotion and mood states

De Gangi states that understanding the importance of these various elements of emotional regulation is necessary when intervening with children with regulatory disorders.

For commonly asked questions and how to respond to them, please see ‘Caring for your child 0-6 months’ (CHISP), HSE South, 2005.

7.4 Toilet Training

An important development task for the toddler is the achievement of continence in toilet functions. Elimination of bodily fluids is initially an involuntary process. The baby’s muscles must mature until they are strong and coordinated enough to hold back the waste products that are trying to emerge from his body. Of all the muscles in the trunk region, those that control the organs of elimination are the slowest to come under voluntary control. It is usually the case that bowel control comes after the child can walk somewhere between the ages of one and two. Bladder control comes somewhat later. Many babies acquire the dry habit during the day somewhere between the ages of 17 months and three years of age, although they have frequent lapses when they are excited or tired. A year may pass before the child is dry at night and lapses can occur during this time.

For commonly asked questions about toilet training, please see ‘Caring for your child 2 to 5 years’ (Child Health Information Service for Parents (CHISP), HSE South, 2006).

7.5 Temper Tantrums

During toddlerhood, children strive towards developing autonomy and a sense of mastery. Temper tantrums form part of healthy development and are the extreme manifestation of non-compliance.

Toddlers tend to live on an emotional seesaw with anxiety and tears on one end and frustration and tantrums on the other. Their feelings, both positive and negative, are as powerful at this age as they will ever be. Although temper tantrums are particularly common with toddlers, they are not unusual in babies as young as nine months and in young children up to the age of 4 years.

Not every show of anger or defiance is a tantrum. A full blown tantrum is something special, the emotional equivalent of a blown fuse. Once a tantrum is underway, it is not something that an adult can interrupt or a child can stop to order. A tantrum is most likely when there is a build up of frustration, anger or anxiety inside the toddler until he or she is so full of tension that only an explosion can release it. While the tantrum lasts, the toddler is overwhelmed by his or her own internal rage, lost to the world, and terrified by the violent feelings, which he or she cannot control. However unpleasant the toddler's tantrum might be for the parent, they are much worse for the child.

Children's behaviour during a full blown tantrum varies between rushing around the room screaming, flinging themselves on the floor kicking or even holding their breath until loss of consciousness in extreme cases.

For commonly asked questions and advice to parents, please see 'Caring for your child 2 to 5 years' (CHISP), HSE South, 2006.



(8)

ATTENTION DEFICIT
HYPERACTIVITY
DISORDER (ADHD)
& AUTISM
(PERVASIVE
DEVELOPMENTAL
DISORDER)

8.1 Attention Deficit Hyperactivity Disorder

This is a syndrome which is usually diagnosed in childhood, characterised by persistent over activity, impulsivity and difficulties in sustaining attention. These core difficulties can often lead to a wide range of secondary academic and occupational problems, including early school or college drop out and under performance at work. Psychiatric co morbidity includes depression, antisocial behaviours and an increase in substance misuse. Family dysfunction and relationship difficulties are more common as are teen pregnancies, sexually transmitted diseases, increased physical injuries and road traffic accidents.

In light of the fact that ADHD is one of the most commonly diagnosed childhood mental health disorders, with an estimated prevalence worldwide and in Ireland of between 1% and 5% of school age children, it is not surprising that responding to the needs of this client population can place huge demands on Child and Adolescent Psychiatric Services, and indeed that many remain unrecognised and untreated. Given that ADHD symptoms are frequently evident by early childhood, early intervention is both feasible and sensible.

Early identification

Early detection and intervention for targeted groups of children with ADHD may reduce impairment for the affected child and the burden of suffering for the families and communities. However, the modest results achieved in research to date indicate that these interventions will have to be very intensive, comprehensive (involve the child, parents and schools) and multidimensional.

Key questions for early identification of ADHD

Compared with other children of the same age,

- Do you think this child is overly active, i.e. “on the go all the time”?
- Do you think that this child is unusually impulsive?
- Do you think that this child has significant difficulties in concentration, paying attention and following through on instruction?

In a child with ADHD, the answer to these questions is likely to be ‘yes’.

If you have concerns about the possibility ADHD it would be helpful to discuss these concerns with the parent and with their permission with the Community Medical Officer of the child’s GP. This will then allow a referral to be made to the most appropriate service, dealing with the assessment and treatment of these conditions.

Aetiology

There is growing evidence from genetic, neuro-imaging and epidemiological studies as to the validity of ADHD as a diagnosis. Abnormalities have been found in the parts of the brain involved with dopamine neuro-transmission. Methylphenidate acts by inhibiting the dopamine transport mechanism and is the treatment of choice in ADHD, with up to 70% response rate.

Assessment

The corner stone of any assessment is a comprehensive interview with the parent, individual interview with the child and information from relevant teachers. On occasions medical investigations uncover underlying medical illnesses. Co-morbid learning problems are assessed using appropriate psychometric assessment tools.

Treatment

ADHD is a life long disorder for which children and families require ongoing treatment, usually in the form of intensive clinical contact at critical points in the child's life cycle, interspersed with periods of less intensive monitoring and support.

The evidence base to support medication as an essential component of ADHD management is overwhelming. One of the largest and best conducted studies of treatment for ADHD to be carried out is known as the Multimodal Treatment Study of Children with ADHD (MTA). Results from the MTA trials suggest that medication is as effective as the combined treatment for core ADHD symptoms but that combined treatment (i.e. medication and behavioural intervention) is superior in effecting change in secondary areas of psychological functioning (emotional, social, academic and family problems).

Chang et al (2004) reported parent reported improved child behaviour after an eight week social skills training programme for boys aged 4-6 years. The programme has not yet been applied to children under 4 years. The Incredible Years Dinosaur Social Skills and Problem Solving Curriculum has been shown to improve behaviour and reduce aggressive and noncompliant behaviour in children with early-onset conduct problems aged 4-8 years (Webster-Stratton et al., 2001).

Stimulant medications can be prescribed to children from 3 years of age. However, most clinical trials have been carried out in children aged 6 years and older. Only six controlled trials with a total enrolment of less than 200 children have been conducted using stimulant drugs in preschool children (Kratochvil et al., 2004). These small studies show evidence of benefit from using methylphenidate in preschoolers with ADHD. The ongoing preschool ADHD Treatment Study (PATs) funded by the National Institute of Mental Health in the US will provide important clinical guidelines for diagnostic considerations and intervention strategies for children with ADHD aged 3-5 years.

Preliminary evidence from controlled trials suggests that dietary supplementation with long-chain polyunsaturated fatty acids might help in the management of a range of childhood developmental disorders including ADHD, dyslexia and dyspraxia (Richardson, 2004).

8.2 Autism

Autism is defined on the basis of characteristic problems in three areas:

- social interaction
- communication and play
- restricted patterns of interest

By definition, symptoms of autism must be present by the age of 3 years.

Prevalence

Over 20 epidemiological studies of autism have been conducted with a median value of prevalence estimates of 4-5 per 10,000 (Fombonne, 1998). Several recent studies have reported somewhat higher rates of the condition, in the order of 1 per 1000. It remains unclear whether the condition has actually increased or whether the apparent increase relates to broader definitions of autism or other factors. Epidemiological studies have clarified that there is no association of autism with upper socio economic status. Early impressions of such associations were the result of referral bias. A number of studies, including both epidemiological and clinically referral samples, report higher rates of autism in boys than in girls, especially in normal IQ ranges (approximately 3.5-4:1). The explanation for this sex difference remains unclear.

Childhood autism is a chronic disability; about two-thirds of individuals continue to require significant supervision and support as adults. Perhaps one in ten has a reasonably good outcome and can live independently. Jarbrink & Knapp (2001) estimated with an assumed prevalence of 5 per 100,000, the lifetime cost for a person in the U.K. with autism exceeded 12.4 million. The main costs were for living support and day activities.

Aetiology

The importance of biological factors in the pathogenesis of autism is suggested by its association with intellectual disability, seizure disorders and other medical disorders e.g. tuberous sclerosis. Twin studies suggest very high heritability, with 90% concordance in monozygotic twins and a risk of 2-4% in siblings. Specific modes of inheritance are unclear and it is likely that several interacting genes are involved.

Assessment

Assessment requires a full history, observation and physical examination to exclude medical causes of autism (e.g. Fragile X, Tuberous Sclerosis, Phenylketonuria). Karyotyping may assist in the diagnosis of conditions such as Fragile X syndrome. Assessment should utilise standardised interview tools for parents (e.g. Childhood Autism Rating scale, CARS) and standardised assessment schedules for the child (e.g. Autistic Diagnostic Observation Schedule, ADOS). If the child is attending a school setting, liaison with the child's pre-school or crèche is essential.

Early identification

Key questions for early identification of autism

Compared with other children of the same age,

- Has this child from an early age on appeared less interested in interacting socially or responding in an affectionate and playful way to his or her parents and carers?
- Have there been significant difficulties with speech and language development, i.e. no single words by age 2 years, no phrases by age 3 years?
- Has this child difficulty with communicating needs rather than just waiting for them to be met?
- Has this child shown delay in developing imaginative and pretend play?
- Does this child show repetitive types of behaviours?
- Does this child fail to smile in response to interaction from you?
- Does this child appear disinterested in what you are doing when you are trying to engage him or her in a playful manner?

In a child with autism, the answer to these questions is likely to be 'yes'.

If you have concerns about the possibility Autism Spectrum Disorder it would be helpful to discuss these concerns with the parent and with their permission with the Community Medical Officer of the child's GP. This will then allow a referral to be made to the most appropriate service, dealing with the assessment and treatment of these conditions.

Questionnaires such as the Checklist for Autism in Toddlers (CHAT) have been found useful in screening children at risk, particularly in conjunction with ascertaining parental concerns, but they are not currently recommended for universal population based screening.

Trillingsgaard et al. (2005) studied a group of thirty 2-3 year old children in order to identify behavioural patterns that distinguish autistic spectrum disorder from other developmental disorders in children aged less than 4 years. Professional observations in a semi-structured play interaction identified several distinguishing signs between 24 and 36 months, namely reciprocal smiling, responding to name, following pointing, looking to "read" faces, requesting verbal and nonverbal behaviours and functional play.

Early detection of children with autistic spectrum disorder is essential in order to facilitate early intervention, which has been shown to lead to considerable improvement in outcome. The National Autistic Society Early Bird Programme, which is an autism-specific three-month parent package was shown to be an effective short-term, affordable and popular package in pilot studies. Further evaluation of the programme is under way (Shields, 2001).

Eikesth et al. (2002) carried out a one year comparative controlled study of an intensive behavioural treatment at school for 4-7 year old children with autism. Children in the behavioural treatment group made significantly larger gains using the school-based programme.

The Scottish Centre for Autism has developed an early intervention programme aimed at improving early social communication and social interaction skills. Salt et al. (2002) carried out a controlled treatment outcome study and found that children in the treatment group improved significantly on measures of joint attention, social interaction, imitation, daily living skills, motor skills and adaptive behaviour as well as showing reduced stress in their parents.



(9)

REFERRAL CRITERIA

It is difficult and in many instances inappropriate to be prescriptive about referral criteria and thresholds, as many behavioural problems in childhood occur at the extreme end of normal development. The decision to refer therefore depends on professional judgement, based on the following:

- Parental concern
- Timing, duration and severity of the condition
- Parental ability to cope
- Impact on child and environment
- Level of impairment and child's distress
- Availability of support and treatment services
- Options for effective interventions



(10)

INTERVENTIONS

In many cases, children identified by primary and community based practitioners as requiring further assessment and management will not have speedy, easy or equitable access to appropriate services. The aim of this document is to support practitioners in identifying need, appropriately use existing services and contribute to the development of skills, services and other resources in response to such need.

Currently, service provision for children with emotional, behavioural and mental health problems in regional Irish health services is delivered by multidisciplinary and early intervention teams constituted from a variety of disciplines, including community based clinical psychologists, social workers, public health nurses, therapists for speech and language development, physiotherapists and occupational therapist, as well as paediatricians and child and family service support workers. While the concepts underlying these services are designed to respond holistically to identified need, the actually available resources and capacity are in many instances inadequate to meet demand.

10.1 Child Mental Health Teams

Multidisciplinary mental health teams may include a broad range of professionals e.g. Child and Adolescent Psychiatrists, Clinical Psychologists, Social Workers, Speech and Language Therapists, Occupational Therapists and Clinical Nurse Specialists. Not all teams are fully resourced and many have some unfilled posts. Some geographical areas lack provision altogether.

Referral pathways differ. Many teams require a referral from the family GP or a Community Medical Officer. Supporting letters from other involved professionals e.g. teachers, PHNs and indeed from families are generally welcome and helpful.

Waiting lists are often long and it is worth checking this out before making a routine referral. Alternative sources of service may be better options. Where there is concern about a serious mental health issue children and families are seen very much more quickly and most teams welcome informal discussion about the need for and appropriateness of a referral anyway.

Generally teams expect the family or referring GP to review children and families if their difficulties become more acute while they are on the waiting list. Assessment appointments can then be brought forward in discussion with the Mental Health Team.

Assessment precedes treatment and intervention. Assessment may involve one or more members of the team and one or more sessions. It is helpful for clients to have some prior knowledge of what they will face locally in this regard. Clinicians tend to gather very broad information from children and families and then narrow down the area of focus. Families can expect to be asked lots of questions and may be asked to complete standard forms or a questionnaire. Those with literacy difficulties can be helped as necessary. Teams differ in how they handle requests from parents to discuss their child in the child's absence. Clinicians are generally happy to defer a particular line of questioning if parents request this until the child is otherwise engaged. However, the child may be seen separately for a check on their mental health status. Teams often request parents' permission to get further information e.g. from the child's teacher, and may also wish to visit a school or preschool setting to observe the child.

At the end of the assessment process families and children are given feedback – an idea what if anything the clinicians think is amiss and what if anything can be done to help. Generally, the family GP is sent a summary report. Under FOI, if not more informally, the families can normally access all reports and files held on their child and family by the clinical team.

Interventions offered follow from assessed need. Intervention may focus on the individual child e.g. anxiety management training; the parents e.g. group parent training or the family as a whole e.g. family therapy. There are useful medications for some conditions such as depression and ADHD and these, where considered appropriate, should be carefully explained and monitored by members of the team. Speech therapy and occupational therapy are often provided in blocks of sessions with review appointments. Frequently parents and children are given 'homework' to complete between sessions. Many children and families have an involvement with more than one of the team's clinicians.

Increasingly clinicians are using evidenced based standard assessment and treatment guidelines. This helps ensure the quality of the contact with the team.

While there are useful websites for every conceivable difficulty, children and families should take guidance from clinicians about what to access, as there are many unhelpful sites, too.

Children and families may attend for only one, a few or for very many sessions. They should be encouraged to take a key role in deciding what is necessary and sufficient to meet their own needs.

10.2 Tiered Community Based Models of Service Provision

Modern Child and Adolescent Mental Health thinking recommends a tiered service with locally based, flexible and easily accessible services as a first access point for straightforward problems and identification of those children and young people who require more specialised services. Models developed and evaluated in the UK recommend a four-tier model of conceptualising service provision (Appleton and Hammond- Rowley, 2000):

- **Tier 1:**
Primary and community care and non-specialist services for identification and early intervention, management of many cases and referral of those requiring more specialised service provision.
- **Tier 2:**
Specialist CAMHS staff working individually
- **Tier 3:**
Specialist CAMHS staff working as an outpatient multidisciplinary team
- **Tier 4:**
Day- and in-patient units, and other highly-specialised services such as forensic and neuropsychiatric services.

As one goes up through the tiers, the numbers seen decrease, and severity and complexity increase. For maximum effectiveness, the tiers should work closely together and share information, with referrals going in both directions as required to manage the resources most effectively. Usually someone from CAMHS is identified as the liaison specialist to facilitate the exchange of information and referrals for a specific area, and regular interagency meetings are held to co-ordinate the work.

Specialist and multidisciplinary services are always expensive and in short supply, and are not always appropriate or necessary for straightforward or self-limiting problems (e.g. uncomplicated bereavement or separation anxiety). Non-specialist help from sources in primary care, school, church, youth and voluntary work may be just as effective, but more responsive, convenient and acceptable.

These sources are often underused or undervalued because of:

- lack of training and support;
- lack of communication and referral networks to underpin them;
- lack of consultation, liaison and advice from specialist services;
- lack of confidence that rapid referral to specialist services can take place when required.

The four-tier model contends that these Tier 1 services can work very effectively, taking a lot of pressure off the specialist services, if adequately supported. Experience has shown that the overall number of referrals to secondary services does not increase, while their appropriateness does. Tier 1 services are also able to accept the ongoing care of some vulnerable young people, thus enabling their earlier discharge from specialist services. Joint work may also take place, particularly in areas such as groups, parent training, anti-bullying, anger and anxiety management, alcohol and drug counselling and bereavement, thereby reducing duplication and inefficient use of limited resources.

10.3 Medication

Medication is rarely used in preschool children and when it is it is usually part of a more comprehensive treatment pack including behavioural work and working with the family and wider environment.

The use of medication has been found to be effective in a number of childhood psychiatric disorders, such as ADHD, behavioural disturbances associated with autism, obsessive compulsive disorder, and other severe anxiety disorders, childhood depression, mania and psychotic disorders. The main disorders presenting in young children (under 5 years) are ADHD and autism.

Dexamphetamine is a psychostimulant licensed for use in children over the age of 3. Methylphenidate, although licensed for use in children over 6, may also be used. Both these medications act by increasing the amount of available dopamine in the parts of the brain responsible for paying attention and inhibiting impulsive behaviour. These medications are very effective in older children and the main stay of treatment in ADHD, but are slightly less effective in younger children, who may also be more prone to adverse side effects. Height and weight monitoring is recommended on account of the side effects of anorexia and abdominal pain. They may also cause sleeping problems. The half-life of the shorter acting preparations is 3-4 hours. The short acting variety is often preferred to longer acting formulations in this age group, and are given either once or twice a day, depending on the duration of action required.

Antipsychotic medications, such as Risperidone, have been shown to be effective in reducing behavioural problems associated with autism. Although their side effect profile is much better than older drugs such as Haloperidol, they do have side effects or movement disorders or weight gain.

(11)

RECOMMENDATIONS

“What needs
to be done for
under 5s?”

Antenatal Period

- Translate core competencies identified in a recent national review for enhancing antenatal and parenting skills education into training and skills development programmes for practitioners.
- Realise the specialised nature of this work without further overburdening generic universal core child health service providers, i.e. public health nurses.
- Endorse the incorporation of the psychological tasks of pregnancy into the antenatal care education

Preschool Children

- Resource existing universal statutory child health services to respond to the need for parenting skills development through antenatal education and parent support.
- Evaluate and validate psychosocial assessment tools for use with Irish children to identify child emotional and mental health difficulties for early intervention.
- Establish training and education programmes for service providers and users in evidence based promotion of positive mental health.
- Invest in capacity building for prevention and management of emotional and mental health problems during the formative early years.

School Environment

- Incorporate parenting skills in primary and post primary curriculum, e.g. SPHE programme.

Primary and Community Services

- Develop standardised, multidisciplinary and accredited training programme for primary and community service providers in the provision of ante-, peri- and postnatal parent support and parenting skills education.
- Increase primary and community service capacity to provide universal, standardised and equitable parent support and child health promotion programmes.
- Early intervention in postnatal depression.

Secondary and Tertiary Services

- Strengthen and support primary and community services capability to identify problems and refer appropriately.
- Increase service capacity to respond to identified need.
- Improve access for parents, families, community and primary service providers.
- Develop multidisciplinary interagency teams.

Policy Makers

- Increase resources for community, primary, secondary and tertiary services to support promotion of positive mental health.
- Resource community based mental health workers and teams (four tier model, community networks, primary care teams).
- Strengthen early intervention child development teams, child and adolescent mental health services.
- Include antenatal PHN visit in statutory child health screening, surveillance and health promotion programme.
- Facilitate training of preschool service providers in promoting positive mental health.
- Support outcome focussed development of indicator “school readiness” to measure effectiveness of communities in supporting child emotional and mental health.
- Integrate working of the Office of the Minister for Children, HSE, education agencies, community and voluntary organisations to develop interagency models of intervention to address social exclusion, disadvantage and poverty.

Research

- Develop guidance for practitioners on quality characteristics for parent support and skills education programmes.
- Develop antenatal education programmes to promote positive parent- child interaction.
- Provide guidance for practitioners on ethnic and cultural differences.
- Validate tools for primary and community service providers to identify post natal depression.
- Support evaluation of effectiveness and monitoring of programmes.



APPENDICES

Appendix 1

1. Building an alliance with the parent/ caregiver

This offers the experience of a stable and consistent relationship with someone who is dependable and reasonable. It enables parents to enter and support a healthier attachment relationship with their child. This alliance provides the experience of a secure and safe base.

- Regular visits in the home
- Telephone support
- Observation, listening, accepting use of non verbal cues as well as verbal interaction- “She needed to talk, I needed to listen” Weatherston (1997)
- Provides stable, consistent relationship
- Identifies and helps to meet material needs

2. Meeting material needs

- Facilitates access to Community Agencies
- Helps to arrange transportation to services
- Discusses safety issues
- Helps to meet basic needs

3. Supportive counselling (home visits)

- Observes, listens, feels, responds
“Tell me about your baby, tell me how the first few weeks have been”
- Identifies and reinforces feelings
- Sets limits for behaviour
- Establishes expectation for change

4. Developing life coping skills and social support

Help parent/ caregiver to:

- Resolve conflict with family members
- Understand the need for social support and the obligations involved
- Identify possible friends community groups and services
- Use of anticipatory role play to rehearse use of social support
- Models and teaches problem solving and decision making skills
- Supports parents in using skills

5. Developmental guidance

- Provides information about infant growth and development
- Use of formal assessment to show infants capabilities and next steps
- Shares literature if relevant
- Encourages parent to positively interact with infant:
- Encourages observation and interaction (Use of videotaping)
- Speaks for infant
- Models reinforces or shapes appropriate intervention
- Provides toys /books

6. Infant – parent psychotherapy

- Observes patterns of interactions
- Defines issues of clinical concern
- Assists Parent to:
- Identify feelings and put them into words
- Understand reactions, defences and coping strategies
- Find words to understand, grieve, forgive and heal
- Develop new, healthier patterns of interactions

Adapted from: Overview of Intervention Strategies and Tasks for the Infant Mental Health Specialist. (Weatherston & Tableman, 2002)

Appendix 2

Principles of The National Quality Framework for Early Childhood Education (NQF) and Explanatory Notes

Early childhood is a significant and distinct time in life that must be nurtured, respected, valued and supported in its own right.

Early childhood, the period from birth to six years, is a significant and unique time in the life of every individual. Every child needs and has the right to positive experiences in early childhood. As with every other phase in life, positive supports and adequate resources are necessary to make the most of this period. Provision of such supports and resources should not be conditional on the expectations of the economy, society or other interests.

The child's individuality, strengths, rights and needs are central in the provision of quality early childhood experiences.

The child is an active agent in her/his own development through her/his interactions with the world. These interactions are motivated by the individual child's abilities, interests, previous experiences and desire for independence. Each child is a competent learner from birth and quality early years experiences can support each child to realise their full potential. Provision of these experiences must reflect and support the child's strengths, needs and interests. Children have the right to be listened to and have their views on issues that affect them heard, valued and responded to.

Parents are the primary educators of the child and have a pre-eminent role in promoting her/his well-being, learning and development.

Quality early childhood care and education must value and support the role of parents. Open, honest and respectful partnership with parents is essential in promoting the best interests of the child. Mutual partnership contributes to establishing harmony and continuity between the diverse environments the child experiences in the early years. The development of connections and interactions between the early childhood setting, parents, the extended family and the wider community also adds to the enrichment of early childhood experiences by reflecting the environment in which the child lives and grows.

Responsive, sensitive and reciprocal relationships, which are consistent over time, are essential to the well-being, learning and development of the young child.

The relationships that the child forms within her/his immediate and extended environment from birth will significantly influence her/his well-being, development and learning. These relationships are two-way and include adults, peers, family and the extended community. Positive relationships, which are secure, responsive and respectful and which provide consistency and continuity over time, are the cornerstone of the child's well-being.

Equality is an essential characteristic of quality early childhood care and education.

Equality, as articulated in Article 2 of the UN Convention on the Rights of the Child (1989) and in the Equal Status Acts 2000 to 2004, is a fundamental characteristic of quality early childhood care and education provision. It is a critical prerequisite for supporting the optimal development of all children in Ireland. It requires that the individual needs and abilities of each child are recognised and supported from birth towards the realisation of her/his unique potential. This means that all children should be able to gain access to, participate in, and benefit from early years services on an equal basis.

Quality early childhood settings acknowledge and respect diversity and ensure that all children and families have their individual, personal, cultural and linguistic identity validated.

Diversity is a term which is generally used to describe differences in individuals by virtue of gender, age, skin colour, language, sexual orientation, ethnicity, ability, religion, race or other background factors such as family structure, economic circumstances, etc. Quality early childhood environments should demonstrate respect for diversity through promoting a sense of belonging for all children within the cultural heritage of Ireland. They should also provide rich and varied experiences which will support children's ability to value social and cultural diversity.

The physical environment of the young child has a direct impact on her/his well-being, learning and development.

The child's experiences in early childhood are positively enhanced by interactions with a broad range of environments. These include the indoor and outdoor, built and natural, home and out-of-home environments. The environment should be high quality and should extend and enrich the child's development and learning. These experiences stimulate curiosity, foster independence and promote a sense of belonging. The development of respect for the environment will also result from such experiences.

The safety, welfare and well-being of all children must be protected and promoted in all early childhood environments.

The promotion of child well-being is a characteristic of a quality environment. This involves the protection of each child from harmful experiences and the promotion of child welfare. Additionally, the opportunity to form trusting relationships with adults and other children is a key characteristic of quality. Promotion of safety should not prevent the child from having a rich and varied array of experiences in line with her/his age and stage of development.

The role of the adult in providing quality early childhood experiences is fundamental.

Quality early childhood practice is built upon the unique role of the adult. The competencies, qualifications, dispositions and experience of adults, in addition to their capacity to reflect upon their role, are essential in supporting and ensuring quality experiences for each child. This demanding and central role in the life of the young child needs to be appropriately resourced, supported and valued.

The provision of quality early childhood experiences requires cooperation, communication and mutual respect.

Teamwork is a vital component of quality in early childhood care and education. It is the expression of cooperative, coordinated practice in any setting. Shared knowledge and understanding, clearly communicated among the team within the setting; with and among other professionals involved with the child; and with the parents is a prerequisite of quality practice and reflects a “whole-child perspective”. This also ensures the promotion of respectful working relationships among all adults supporting the well-being, learning and development of the child. Such teamwork, coordination and communication must be valued, supported and resourced by an appropriate infrastructure at local, regional and national levels.

Pedagogy in early childhood is expressed by curricula or programmes of activities which take a holistic approach to the development and learning of the child and reflect the inseparable nature of care and education.

Pedagogy is a term that is used to refer to the whole range of interactions which support the child’s development. It takes a holistic approach by embracing both care and education. It acknowledges the wide range of relationships and experiences within which development takes place and recognises the connections between them. It also supports the concept of the child as an active learner. Such pedagogy must be supported within a flexible and dynamic framework that addresses the learning potential of the ‘whole child.’ Furthermore, it requires that early childhood practitioners are adequately prepared and supported for its implementation.

Play is central to the well-being, development and learning of the young child.

Play is an important medium through which the child interacts with, explores and makes sense of the world around her/him. These interactions with, for example, other children, adults, materials, events and ideas, are key to the child’s well-being, development and learning. Play is a source of joy and fulfilment for the child. It provides an important context and opportunity to enhance and optimise quality early childhood experiences. As such, play will be a primary focus in quality early childhood settings.

Appendix 3

Standards for The National Framework for Quality in ECCE (NFQ/ECCE)

1. The Rights of the Child

Ensuring that each child's rights are met requires that she/he is enabled to exercise choice and to use initiative as an active participant and partner in her/his own development and learning.

2. Environments

Enriching environments, both indoor and outdoor (including materials and equipment) are well-maintained, safe, available, accessible, adaptable, developmentally appropriate, and offer a variety of challenging and stimulating experiences.

3. Parents and Families

Valuing and involving parents and families requires a proactive partnership approach evidenced by a range of clearly stated, accessible and implemented processes, policies and procedures.

4. Consultation

Ensuring inclusive decision-making requires consultation that promotes participation, and seeks out, listens to and acts upon the views and opinions of children, parents and staff, and other stakeholders as appropriate.

5. Interactions

Fostering constructive interactions (child/child, child/adult and adult/adult) requires explicit policies, procedures and practice that emphasise the value of process and are based on mutual respect, equal partnership and sensitivity.

6. Play

Promoting play requires that each child has ample time to engage in freely available and accessible, developmentally appropriate and well-resourced opportunities for exploration, creativity and meaning making in the company of other children, with participating and supportive adults and alone, where appropriate.

7. Curriculum

Encouraging each child's holistic development and learning requires the implementation of a verifiable, broad-based, documented and flexible curriculum or programme.

8. Planning and Evaluation

Enriching and informing all aspects of practice within the setting requires cycles of observation, planning, action and evaluation undertaken on a regular basis.

9. Health and Welfare

Promoting the health and welfare of the child requires protection from harm, provision of nutritious food, appropriate opportunities for rest, and secure relationships characterised by trust and respect.

10. Organisation

Organising and managing resources effectively requires an agreed written philosophy, supported by clearly communicated policies and procedures to guide and determine practice.

11. Professional Practice

Practising in a professional manner requires that individuals have skills, knowledge, values and attitudes appropriate to their role and responsibility within the setting. In addition, it requires regular reflection upon practice and engagement in supported ongoing professional development.

12. Communication

Communicating effectively in the best interests of the child requires policies, procedures and actions that promote the proactive sharing of knowledge and information among appropriate stakeholders, with respect and confidentiality.

13. Transitions

Ensuring continuity of experiences for each child requires policies, procedures and practice that promote sensitive management of transitions, consistency in key relationships, liaison within and between settings, the keeping and transfer of relevant information (with parental consent), and the close involvement of parents and, where appropriate, relevant professionals.

14. Identity and Belonging

Promoting positive identities and a strong sense of belonging requires clearly defined policies, procedures and practice that empower every child and adult to develop a confident self- and group-identity, and have a positive understanding and regard for the identity and rights of others.

15. Legislation & Regulation

Being compliant requires that all relevant regulations and legislative requirements are met or exceeded.

16. Community Involvement

Promoting community involvement requires the establishment of networks and connections evidenced by policies, procedures and actions which extend and support all adults' and children's engagement with the wider community.

Principles and Standards developed by the
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Appendix 4

SIGNS AND SYMPTOMS OF ABUSE

(Extract from *Children First*, DOHC, 1999)

Signs and Symptoms of Child Neglect

This category of abuse is the most common. A distinction can be made between “wilful” neglect and “circumstantial” neglect. For instance, “wilful” neglect would generally incorporate a direct and deliberate deprivation by a parent/carer of a child’s most basic needs e.g. withdrawal of food, shelter, warmth, clothing, contact with others, whereas “circumstantial” neglect more often may be due to stress and inability to cope by parents or carers. Neglect is closely correlated with low socio-economic factors and corresponding physical deprivations. It is also related to parental incapacity due to learning disability or psychological. The neglect of children is “usually a passive form of abuse involving omission rather than acts of commission”. It comprises “both a lack of physical caretaking and supervision and a failure to fulfil the developmental needs of the child in terms of cognitive stimulation”

Child neglect should be suspected in cases of:

- Abandonment or desertion
- Children persistently being left alone without adequate care and supervision
- Malnourishment, lacking food, inappropriate food or erratic feeding
- Lack of warmth
- Lack of adequate clothing
- Lack of protection and exposure to danger including moral danger or lack of supervision appropriate to the child’s age
- Persistent failure to attend school
- Non-organic failure to thrive i.e. child not gaining weight not alone due to malnutrition but also due to emotional deprivation
- Failure to provide adequate care for the child’s medical problems
- Exploited, overworked

Signs and Symptoms of Emotional Child Abuse

Emotional abuse occurs when adults responsible for taking care of children are unable to be aware of and meet their children’s emotional and developmental needs. Emotional abuse is not easy to recognise because the effects are not easily observable. Emotional abuse refers to the habitual verbal harassment of a child by disparagement, criticism, threat and ridicule and the inversion of love, whereby verbal and nonverbal means of rejection and withdrawal are substituted. Emotional abuse can be defined in reference to the following indices. However, it should be noted that no one indicator is conclusive of emotional abuse.

- Rejection
- Lack of praise and encouragement
- Lack of comfort and love
- Lack of attachment
- Lack of proper stimulation (e.g. fun and play)
- Lack of continuity of care (e.g. frequent moves)
- Serious over-protectiveness
- Inappropriate non-physical punishment (e.g. locking in bedrooms)
- Family conflicts and/or violence
- Every child who is abused sexually, physically or neglected is also emotionally abused
- Inappropriate expectations of a child's behaviour - relative to his/her age and stage of development

3. Signs and Symptoms of Physical Abuse

Unsatisfactory explanations or varying explanations for the following events are highly suspicious:

- Bruises (see below for more detail)
- Fractures
- Swollen joints
- Burns/Scalds(see below for more detail)
- Abrasions/Lacerations
- Haemorrhages (retinal, subdural)
- Damage to body organs
- Poisonings - repeated (prescribed drugs, alcohol)
- Failure to thrive
- Coma/Unconsciousness
- Death.

There are many different forms of physical abuse but skin, mouth and bone injuries are the most common.

4. Signs and Symptoms of Child Sexual Abuse

Child sexual abuse often covers a wide spectrum of abusive activities. It rarely involves just a single incident and usually occurs over a number of years. Child sexual abuse frequently happens within the family. Intra-familial abuse is particularly complex and difficult to deal with.

Cases of sexual abuse principally come to light through:

- (a) disclosure by the child or its siblings/friends,
- (b) suspicions of an adult,
- (c) due to physical symptoms.

The sexual abuses described above may be found in combination with other abuses, such as physical abuse and urination and defecation on the victim. In some cases physical abuse is an integral part of the sexual abuse; in others drugs and alcohol may be given to the victim. It is important to note that physical signs may not be evident in cases of sexual abuse due to the nature of the abuse and/or the fact that the disclosure was made some time after the abuse took place.

Particular behavioural signs and emotional problems suggestive of child abuse in young children (0-10 yrs):

- Mood change, e.g. child becomes withdrawn, fearful, acting out;
- Lack of concentration (change in school performance)
- Bed wetting, soiling
- Psychosomatic complaints; pains, headaches
- Skin disorders
- Nightmares, changes in sleep patterns
- School refusal
- Separation anxiety
- Loss of appetite
- Isolation

Particular behavioural signs and emotional problems suggestive of child abuse in older children (10 yrs +):

- Mood change, e.g. depression, failure to communicate
- Running away
- Drug, alcohol, solvent abuse
- Self mutilation
- Suicide attempts
- Delinquency
- Truancy
- Eating disorders
- Isolation

All signs/indicators need careful assessment relative to the child's circumstances.

Appendix 5

Suggested Questions to ask Parents about their Child's Sleeping Pattern (Thiedke, 2001):

To bring up the topic as part of a well-child visit:

- How has your child been sleeping recently?

If the parent indicates a problem:

- What time do you put your child to bed?
- What is the usual routine in your household between dinner and bedtime?
- What is your routine in the 30 to 60 minutes before bedtime?
- What happens when the lights are turned off?
- When your child cries, how do you respond? How quickly?
- Does your child get a bottle or get nursed at bedtime?
- Does your child get a bottle or get nursed in the middle of the night?
- How many times a night does your child awaken?
- How do you or your partner respond?
- How long does it take your child to go back to sleep?
- What time does your child get out of bed to start the day?
- Will your child play quietly in bed if he or she is awake before others come to get him or her?
- Does your child sleep in a crib or a bed?
- Is the environment in your child's room conducive to sleep (e.g., dark, quiet)?
- Does your child ever sleep in your bed with you?
- Does your child sleep with a toy, stuffed animal or favourite blanket?
- Does your child nap during the day? How often? How long?

Questions about sleep patterns should be part of every well child's visit. "Physicians should use these moments as a time to let parents know that the development of healthy sleep patterns is as important as good nutritional and dental habits".

Intervention:

- Obtain a good and thorough history from parents/caregivers.
- What strategies have been used to date to address the problem?
- Exploration of physical illness and role of medications where relevant
- Ask parents to keep a sleep diary for the week.
- Parents should help to develop consistent bed time routine and rituals and patterns of night time intervention.
- Allow parents to express any misgiving they may have regarding this initial intervention plan, so as they are not sent out with treatment plan they are not willing to try.
- Referral for additional assessment and intervention e.g. Child and Adolescent Community Psychology Team, Child & Adolescent Mental Health Team when a sleep disorder or disorder of the sleep-wake cycle is evident.

Appendix 6

US NATIONAL BUREAU OF ECONOMIC RESEARCH WORKING PAPER SERIES

HUMAN CAPITAL POLICY

Pedro Carneiro

James Heckman

Working Paper 9495

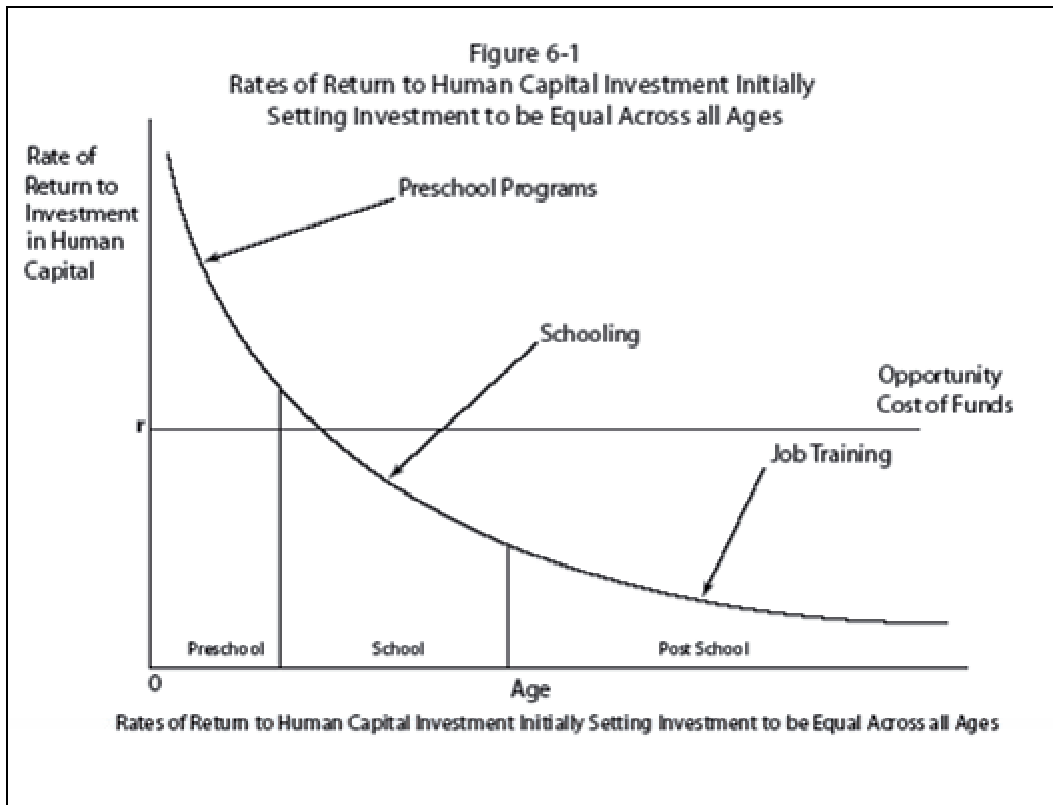
ABSTRACT

This paper considers alternative policies for promoting skill formation that are targetted to different stages of the life cycle. We demonstrate the importance of both cognitive and noncognitive skills that are formed early in the life cycle in accounting for racial, ethnic and family background gaps in schooling and other dimensions of socioeconomic success. Most of the gaps in college attendance and delay are determined by early family factors. Children from better families and with high ability earn higher returns to schooling. We find only a limited role for tuition policy or family income supplements in eliminating schooling and college attendance gaps. At most 8% of American youth are credit constrained in the traditional usage of that term. The evidence points to a high return to early interventions and a low return to remedial or compensatory interventions later in the life cycle.

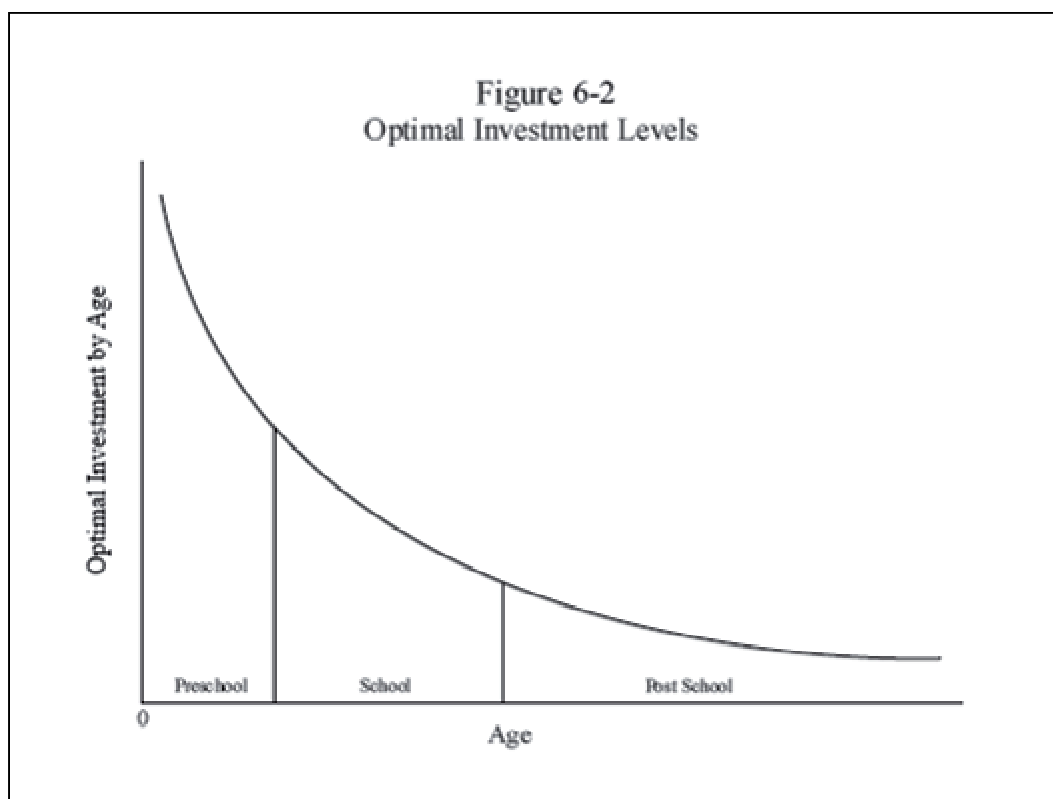
Skill and ability beget future skill and ability. At current levels of funding, traditional policies like tuition subsidies, improvements in school quality, job training and tax rebates are unlikely to be effective in closing gaps.

Figures 6-1 and 6- 2 below taken from this article summarise the argument made by Heckman and Carneiro for the effectiveness and efficiency of investment in preschool programmes. The full document can be accessed at <http://ideas.repec.org/p/nbr/nberwo/9495.html>

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