

# **Promoting Mental Health in Primary School:**

**Evaluation of a Mental Health  
Intervention in a Disadvantaged  
Primary School in Dublin**

## **A Report**

by

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<sup>1</sup> NYFP is an acronym for Neighbourhood Youth and Family Project.

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## Chapter One

### Context

#### 1.1 Introduction

Mounttown NYFP<sup>2</sup> is a mental health programme which supports vulnerable children aged 8-13 who are having difficulties at primary school. These difficulties, which are often referred to as mental health problems, typically present themselves as behaviour and emotional difficulties, and have the effect of diminishing the child's capacity to benefit from school, can interfere with other pupils learning, and increase the risk of early school-leaving.

In the UK and US, the school is increasingly being used as the setting for interventions to address the needs of children who find it difficult to learn because of behavioural or emotional problems<sup>3</sup>. Many of these initiatives are relatively new and have not been rigorously evaluated with the result that their effectiveness is usually described as 'promising' rather than 'proven'<sup>4</sup>. This promise offers an important incentive to evaluate initiatives such as Mounttown NYFP and led the Expert Group on Mental Health Policy to suggest that "for children aged between 5 and 12, the school setting provides an ideal setting for the promotion of positive mental health"<sup>5</sup>.

Within the spectrum of mental health interventions - comprising prevention, early intervention, and treatment<sup>6</sup> - Mounttown NYFP could be characterised as a form of early intervention for at-risk children because it addresses difficulties at a relatively early stage in the life of the child, as well as in the life of the problem. Mounttown NYFP is also involved in prevention by providing an input into the Early Start Programme over and above the existing curriculum. Prevention and early intervention is one of the key recommendations of the Expert Group on Mental Health Policy in the area of child and adolescent mental health services: "programmes addressing mental health promotion and primary prevention early in life should be targeted at child populations at risk"<sup>7</sup>. Prevention and early intervention is also consistent with evidence on the cost effectiveness of intervening early, particularly in the area of conduct disorder, where it has been estimated that interventions with children under the age of 10 have a 75% success rate compared to a 25% success rate for adolescents<sup>8</sup>. The importance of early

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2 NYFP is an acronym for Neighbourhood Youth and Family Project.

3 Pugh and Statham, 2006; Dryfoos and Nissani, 2006.

4 Lister-Sharp, Chapman, Stewart-Brown, and Sowden, 1999; Pugh and Statham, 2006; Dryfoos and Nissani, 2006.

5 Expert Group on Mental Health Policy, 2006:86.

6 Health and social services are sometimes referred to as forms of intervention which vary according to the time at which they intervene in the life of a problem. Some interventions are made before the problem is allowed to emerge (prevention), others occur after the problem has emerged but are made early in order to stop the problem getting worse (early intervention), while yet others take place when the problem is fully developed in order to address the consequences which have evolved (treatment).

7 Expert Group on Mental Health Policy, 2006:87

8 Patterson, Dishion, and Chamberlain, 1993; see also Bullis and Walker, 1994; Francis, Shaywitz, Stuebing, Shaywitz, and Fletcher, 1991; Eron, 1990.

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intervention is also highlighted by the challenge facing some secondary schools from children with behaviour problems, as highlighted in the recent report of the Task Force on Student Behaviour in Secondary Schools<sup>9</sup>.

Mounttown NYFP is funded by the Health Services Executive with a small amount of additional funding from the Local Drugs Task Force. It is based in the school campus of the Holy Family Primary School and is represented on the board of management; the school has disadvantaged status and is part of the School Completion Programme<sup>10</sup>. The programme run by Mounttown NYFP has 30 places and works closely with the school, from which all referrals originate. The programme, which is run by three full-time staff and a number sessional staff, is an integral part of the school setting and there is no stigma for children in being referred to the NYFP. In general, the number of referrals exceeds the number of places, resulting in a waiting list for admission to the programme.

The work of Mounttown NYFP has a significance beyond the confines of the project and school because of the relatively high prevalence of mental health problems among children in Ireland and the importance of finding interventions which address these problems. For this reason, it is appropriate to set the context for this study by reviewing the prevalence of mental health problems among children in Ireland and elsewhere (Section 1.2) while also describing the objectives of the intervention provided by Mounttown NYFP (Section 1.3) and its theoretical orientation in the Marte Meo Method (Section 1.4). Mounttown NYFP also has a significance within the wider local community by virtue of its contribution to a number of organisations and services which address the needs of families and communities affected by socio-economic disadvantage and other adversities, and we briefly review its role and influence in that context (Section 1.5). The chapter concludes with a brief summary (Section 1.6).

## **1.2 Prevalence of Mental Health Difficulties Among Children**

Mental health difficulties are manifested in many different ways and may be included under a variety of labels such as emotional and behavioural disorder, mental illness, psychological disturbance, and psychiatric disorder. These difficulties involve an enduring disturbance in emotions, behaviour or relationships, whose severity requires professional intervention. The term 'psychiatric disorder' is used when these difficulties meet the diagnostic criteria of the World Health Organisation (ICD-10 Criteria)<sup>11</sup>, or the American Psychiatric Association (DSM-IV Criteria)<sup>12</sup>. According to the Irish College of Psychiatrists, psychiatric disorders in children "encompass abnormalities of behaviour, emotions or social relationships that are sufficiently marked or prolonged to cause suffering or hardship to the child or distress or disturbance in the family or community"<sup>13</sup>.

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<sup>9</sup> Task Force on Student Behaviour in Secondary Schools, 2006.

<sup>10</sup> The School Completion Programme was introduced by the Department of Education & Science in 2003 in order to promote the retention of pupils in primary and second level schools. The School Completion Programme subsumes the "8 to 15 Early School Leaver Initiative" and the "Stay in School Retention Initiative" and is a key component of the Department's strategy to discriminate positively in favour of children and young people who are at risk of, or who are experiencing, educational disadvantage. The programme is funded on a multi-annual basis under the National Development Plan with assistance from the European Social Fund (ESF).

<sup>11</sup> World Health Organisation, 2004

<sup>12</sup> American Psychiatric Association, 1994

<sup>13</sup> Irish College of Psychiatrists, 2005: Appendix Three.

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A synthesis of international studies has found that “the prevalence of psychiatric disorders in community surveys is reported to be around 20-30% of school-age children, but this figure drops to 12-15% when only moderate to severe (clinically significant) diagnoses are considered. ... Overall, persistence of moderate or severe disorders at any age is about 50%”<sup>14</sup>. In line with this, the Irish College of Psychiatrists estimate that 8% of Irish children have a mental health difficulty that is “moderate to severe”<sup>15</sup>.

In the US, the estimated prevalence of mental health problems among children, defined as anyone under the age of 18, is 4%-13%<sup>16</sup>. Prevalence varies not only according to the method used to measure it but also by the characteristics of the population; the most striking source of variation among children is socio-economic status with children in lower socio-economic groups having much higher rates of emotional and behaviour problems.

In the UK, a national survey based on multiple report sources and diagnostic interview indicated that 10% of children aged 5-15 years have had a mental disorder and half of these presented with clinically significant conduct disorders<sup>17</sup>. The findings indicate a much higher proportion of boys (7.4%) showing evidence of a conduct related disorder compared to girls (3.2%). Another UK study, based on children living in a disadvantaged neighbourhood in London, found that nearly 20% had conduct disorders<sup>18</sup>.

In Ireland, there has been no national study on the prevalence of mental health difficulties. However a number of local studies have been undertaken and these provide some indication of the likely prevalence, particularly among children in disadvantaged areas. The most recent study involved a survey of 3,374 children in Clonmel, County Tipperary, equivalent to 75% of all children in the town<sup>19</sup>. Mental health problems were measured using the Child Behaviour Checklist (CBCL)<sup>20</sup> and the results indicated that “the overall prevalence of mental health problems was 17.5%”<sup>21</sup>. Of the children aged 6-18 with mental health problems, the three most frequent difficulties were rule-breaking, aggressive behaviour and attention problems. Another large study of mental health problems was carried out with a sample of over 2,000 ten-year old children at schools in west Dublin. This study, based on teachers’ reports using the Rutter Scale<sup>22</sup>, found that “the rate of behavioural deviance ... was 19 per cent for children in disadvantaged schools as defined by the Department of Education and 8 per cent for advantaged schools. Twice as many males had behaviour problems as females”<sup>23</sup>. In-depth interviews with a sub-sample of nearly 200 of these children revealed that “16.3 per cent showed evidence of formal child psychiatric disorder”<sup>24</sup> and these were more likely to be boys with reading difficulties and low IQ. Interviews with the mothers of these children also revealed that their marital and parental satisfaction was a strong predictor

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14 Fonagy, Target, Cottrell, Phillips and Kurtz, 2002:64

15 Irish College of Psychiatrists, 2005:23

16 For more details see Simpson, Bloom, Cohen, Blumberg and Bourdon, 2005:4.

17 Office for National Statistics, 1999

18 Attridge-Sterling, Davis, Day, and Sclare, 2000.

19 Martin, Carr, Carroll and Byrne, 2005

20 Achenbach and Rescorla, 2000; 2001.

21 Martin, Carr, Carroll and Byrne, 2005:4

22 The Rutter Scale is a 26-item screening questionnaire created by Michael Rutter which can be completed by either parents or teachers for the purpose of detecting psychological disorders among children (Rutter, 1967).

23 Fitzgerald and Jeffers, 1994:289

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of depression as well as being “major influences on child mental health”<sup>25</sup>.

Another large study surveyed 1,361 primary school children in the former Mid-Western Health Board Region (comprising Limerick, Clare and North Tipperary) using the Rutter Scale and found that “the estimated rate of psychological disorder among the children of the study is 14%”<sup>26</sup>. However the prevalence among children attending schools officially designated as disadvantaged by the Department of Education and Science was 28%, indicating the influence of socio-economic status on psychological problems<sup>27</sup>. The most common form of psychological disorder was conduct disorder which was present in three quarters of all cases; boys were significantly more likely than girls to exhibit signs of conduct disorder.<sup>28</sup>

Other studies in Ireland, though based on smaller samples, are in line with these prevalence rates and confirm the high levels of mental health problems among children in disadvantaged areas and among boys. For example, a study of 542 primary school children aged 7-11 years in Dublin using teacher reports based on the Bristol Social Adjustment Guides, found that 17.3% of all children showed marked conduct disorders<sup>29</sup>. Boys had considerably higher rates than girls (21% compared to 12.1%) but the greatest variation in rates of conduct disorder was found when comparing children from schools described as ‘socially deprived’ (19.4%), ‘working class’ (18.9%), and ‘upper middle class’ (8.8%)<sup>30</sup>. In Cork, a study of 733 primary school children aged 9-10 years used parent and teacher reports on the Rutter Scale to find that between 11% (based on parent reports) and 15% (based on teachers reports) showed clinical signs of behavioural maladjustment although there is no analysis by gender or socio-economic status<sup>31</sup>. In Ballymun, Dublin, a representative sample of 128 mothers completed the Strengths and Difficulties Questionnaire<sup>32</sup> on one of their children aged four or over; where the mother had more than one child she was invited to focus on the child who may have caused her the most concern during the past six months<sup>33</sup>. The results indicate that the total difficulties score for 30% of the children was in the abnormal range, indicating that the mental health difficulties of these children were likely to be confirmed by independent clinical assessment<sup>34</sup>.

A number of other smaller scale Irish studies of children from disadvantaged areas in Dublin also found consistently high rates of behaviour problems. For example, a study of 55 boys in primary schools estimated that the prevalence of behavioural deviance was between 40% (on Rutter’s parent scale) and 36% (on Rutter’s

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24 Fitzgerald and Jeffers, 1994:289

25 Fitzgerald and Jeffers, 1994:295

26 O’Connor, Ruddle and O’Gallagher, 1988:55

27 O’Connor, Ruddle and O’Gallagher, 1988:55

28 O’Connor, Ruddle and O’Gallagher, 1988:59

29 McCarthy and O’Boyle, 1986:128

30 McCarthy and O’Boyle, 1986

31 Porteus, 1991:Table 3, p.310

32 The Strengths and Difficulties Questionnaire (SDQ) is used for screening children who may have mental health or psychiatric needs, and is a validated and reliable instrument for assessing whether a child falls within internationally agreed mental health categories of normal, borderline or abnormal. It is suitable for 3-16 year olds and can be completed by the child (if over 11), the parent (for children aged 3+), and the teacher (for children aged 3+). For more information, see [www.sdqinfo.com](http://www.sdqinfo.com).

33 McKeown and Haase, 2006

34 McKeown and Haase, 2006: Chapter Three

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teacher scale)<sup>35</sup> while a similar study of 45 boys aged 10-11 years found that behavioural deviance ranged from 42% (on Rutter's parent scale) to 36% (on Rutter's teacher scale)<sup>36</sup>. The latter study also undertook a clinical diagnosis of each child and found that 19% had a psychiatric disorder, significantly lower than the rates indicated by Rutter's screening scales, and leading the authors to suggest that these scales are "over inclusive and tend to select large numbers of children who are not disturbed"<sup>37</sup>. A study of 55 girls aged 10-11 years found that behavioural deviance ranged from 20% (on Rutter's parent scale) to 33% (on Rutter's teacher scale)<sup>38</sup>. In a study involving 33 mothers and their 70 children in Dublin, the authors calculated the prevalence of behaviour problems at 32% using the Child Behaviour Checklist<sup>39</sup>. Another study of 95 children aged 11-12 years from an area of high unemployment in Dublin found that 31% were rated anti-social (on Rutter's teacher scale)<sup>40</sup> while a small non-random sample of 65 mothers in a Dublin working class suburb, found that 14% of the children had a diagnosed behavioural problem<sup>41</sup>. It is clear from this range of studies that the proportion of Irish children living in disadvantaged areas who exhibit some form of behaviour problems is substantial, particularly among boys, even if not all of these children fall within a clinically defined range.

As might be expected, studies of children involved in social services tend to show high levels of conduct disorder. One study of over 300 children in receipt of Springboard family support services in different parts of Ireland found that about half were in the clinical range for both 'conduct problems' and 'total difficulties' as measured by mother's report on the Strengths and Difficulties Questionnaire (SDQ)<sup>42</sup>. Another study of children using a child and family centre in west Dublin found that over half were in the clinical range according to the mothers' reports on the Child Behaviour Checklist<sup>43</sup>.

One aspect of behavioural difficulties is the extent of bullying and physical fighting by children. Standardised data on this issue was collected from school children aged 11, 13 and 15 years in 35 countries, including Ireland, during 2001/2 as part of a World Health Organisation collaborative cross-national study entitled the Health Behaviour in School-aged Children Study (HBSC)<sup>44</sup>. The results reveal that between a quarter and a third of Irish boys reported bullying others at least once during the previous couple of months with less than 10% bullying others at least two or three times a month<sup>45</sup>. These rates are at least twice those for Irish school girls<sup>46</sup> but are lower than the overall level of bullying in 30 of the other countries surveyed, including the US and the UK. Somewhat similar results were found for involvement in physical fighting. These findings indicate that the

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35 O'Rourke and Fitzgerald, 1985

36 Lynch, Fitzgerald and Kinsella, 1987

37 Lynch, Fitzgerald and Kinsella, 1987:23

38 Barton and Fitzgerald, 1986

39 Cody and Fitzgerald, 1989

40 Stone, Fitzgerald and Kinsella, 1990

41 Mohan, Fitzgerald and Collins, 1998

42 McKeown, Haase and Pratschke, 2001; the SDQ comprises a core scale of 25 items with six sub-scales: (i) conduct problems (ii) emotional symptoms (iii) hyperactivity (iv) peer problems (v) prosocial behaviour (vi) total difficulties (see [www.sdqinfo.com](http://www.sdqinfo.com)).

43 Moukaddem, Fitzgerald and Barry, 1998

44 Currie, Roberts, Morgan, Smith, Settertobulte, Samdal, and Rasmussen, 2004. For more details, visit [www.hbsc.org](http://www.hbsc.org) or [www.who.int](http://www.who.int)

45 Craig and Harel, 2004:133-144

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level of bullying and physical fighting as well as the resulting victimisation is considerable and, according to the authors, "highlight the importance of addressing these behaviours as a significant mental and health issue ... [since] ... the more frequently young people engage in these behaviours, the more likely they are to be at risk of developing emotional, physical, psychological and academic problems"<sup>47</sup>.

Overall, it has been estimated that around 8% of Irish children have a moderate to severe mental health problems, but this rises to around 20% of children who live in disadvantaged homes and communities. In view of this, it is clear that a substantial need exists for interventions such as the Mounttown NYFP to prevent and treat mental health problems in school-going children.

### **1.3 Objectives of the Intervention**

The programme at Mounttown NYFP has a number of therapeutic objectives which include:

- Increasing the pupil's self-esteem, self-awareness, and self-confidence through positive social interactions with staff and other children.
- Improving peer relationships and peer acceptance by cultivating the skills of listening, empathy, respect, and working together.
- Promoting attachment and developmental catch-up by helping the children feel safe, secure and cared-for within the project, while taking account of the fact that some children are at a developmental stage which is behind their chronological age.
- Improving educational attainment and reducing the fear of failure by helping the children to be attentive and focused, while developing their capacity to sit still and complete tasks.

These objectives are pursued through interventions which involve both group sessions and one-to-one sessions. Each pupil on the project attends a weekly group session. Each group comprises up to six boys and girls and is held after school throughout the school year. The typical format for each group begins with a snack and a chat followed by homework; a range of activities are then undertaken, depending on the preferences of the children, such as arts/crafts, games, cookery, watching a video, drama, outings; finally, the group concludes with dinner.

The group format is facilitated by two staff and is used to teach basic skills such as listening to each other, showing respect, concentrating, working as part of a team, etc. Each group is involved in planning activities for the month, including the dinner menu. Breakfast is provided each Friday before school, on days-off during the school year, and twice a week during the summer holidays. Outings are provided occasionally and, during the summer, there are trips involving overnight stays away from home. Special occasions, such as each child's birthday, are celebrated. In addition to the group sessions, all children have a monthly one-to-one session to

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46 However the authors caution that "this finding does not necessarily indicate that boys are more aggressive than girls, but rather that they are more likely to engage in this overt form of aggression, while girls are more likely to engage in subtler, more covert forms of indirect aggression, not assessed in the questionnaire" (Craig and Harel, 2004:142).

47 Craig and Harel, 2004:143

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discuss their experience in the group; some children with more serious difficulties receive more frequent one-to-one sessions.

Interventions with parents are not a significant part of the programme run by Mounttown NYFP. This is partly because it was set up with a brief to focus on children, and partly because other agencies are involved with the parents. Nevertheless, an increasing number of parents are approaching the project for help, and staff are responding to these requests.

The theoretical approach which informs all interventions in Mounttown NYFP is the Marte Meo Method. All staff are trained in this method and two are certified Marte Meo therapists<sup>48</sup>. For this reason, it is appropriate to outline the core principles of the Marte Meo Method.

#### **1.4 Theoretical Orientation of Intervention: The Marte Meo Method**

The Marte Meo Method was created by Maria Aarts in Holland and developed over a period of years beginning in 1978. It was first developed to treat children with severe developmental problems at the Orion Day Treatment Centre in Holland, a residential centre for children. Gradually and with Government support its application was extended to become a home-based programme for parents and children in other parts of Holland; it was called the Orion Home Training Programme but later became known as Video Home Training. In 1987, Maria Aarts established an independent organisation in order to develop the programme in different care settings and apply it in different countries, and this became known as the Marte Meo Method. It is now used in over 30 countries to address problems experienced by different target groups such as children in care and school settings, parents who are experiencing difficulties, drug users, elderly, persons with depression or intellectual disabilities; it is also used as a general training in communication and management skills<sup>49</sup>. In Ireland, the first Marte Meo therapists were trained in 1990. Since 1992, the HSE (and its predecessor, the Eastern Health Board) has provided training in the Marte Meo Method on an on-going basis<sup>50</sup>.

The name Marte Meo Method (One One's Own Strength) was chosen in order to "highlight the central focus of the programme, which is to identify, activate and develop skills to enable and enhance constructive interaction and development"<sup>51</sup>. The developmental process, as described in the Marte Meo Manual, is cultivated through three separate stages: (i) identifying opportunities for development such as the initiatives and actions of a child (ii) finding the natural supportive behaviours which are required to assist development such as naming, confirming, supporting, selecting and structuring the child's initiatives (iii) incorporating this knowledge into

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48 There are three main levels of training in the Marte Meo method: (i) Communications Skills Training Course (ii) Therapist Training Course and (iii) Supervisor Training Course. The Communications Skills Training Course involves six sessions, each lasting a half-day or, for some groups, a full-day. The Therapist Training Course is delivered over a period of 18 months and involves 18 monthly training days, three blocks of training each lasting four days each, and a four day accreditation process. The Supervisor Training Course involves delivering the Therapist Training Course under the supervision of a Licensed Marte Meo Supervisor; this accepted on this course must have spent at least one year as a trained therapist under the supervision of a Licensed Marte Meo Supervisor.

49 [www.martemeo.com](http://www.martemeo.com)

50 O'Donovan, 1998; 2004

51 Aarts, 2000:42

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the natural system of the individual so that they can learn the new skills in the most efficient way possible<sup>52</sup>. Seen from this perspective, the Marte Meo Method regards problems and difficulties as ways of identifying skills that need to be learned: “Problems show what kind of skills have been inadequately developed to enable people to cope with their own situation”<sup>53</sup>. Elsewhere in the Marte Meo Manual, Maria Aarts observes: “The message behind problem behaviour is that the child has not yet developed something important and might need help doing so”<sup>54</sup>.

Video analysis of interactions is a key tool of the method and has a number of specific functions including gathering information about interactions in naturalistic settings, giving clients a picture of their reality including a perspective on their strengths as well as weaknesses, offering step-by-step guidance on specific behaviours, checking if a new behaviour is working, and providing opportunities to see positive results. In order to make a diagnosis, professionals typically make a five-minute video of an unstructured situation such as free play and another five-minute video of a structured situation such as a family meal. These are then analysed from the perspective of: (i) developmental needs of the child / client and (ii) supportive behaviour of the parents or caregivers accompanying them<sup>55</sup>. This can be illustrated by the example of a child with problems in language development: “If a child is behind in his language development, check to see whether the parents are sufficiently able to put the child’s focus and activities into words”<sup>56</sup>.

In orientation, the Marte Meo Method emphasises actions and behaviours over thoughts and cognitions. According to Maria Aarts, “In my opinion, changes take place at action moments, and not in the mind. This is why I feel too much therapy is based on talking rather than doing”<sup>57</sup>. Similarly, the method emphasises the practical over the theoretical, the specific over the general. For this reason, “it is not enough to be ‘solution-oriented’, you also have to provide caregivers with concrete steps they can take to arrive at a solution. It is necessary to know exactly what kind of supportive behaviour is needed to make the desired developments possible”<sup>58</sup>.

The emphasis on behaviours and skills also implies an emphasis on learning through practice: “Helping a child with developmental problems with counselling one or more hours a week does not entail enough practice moments of the same nature and composition. In a normal developmental process, the child does not learn things in one interaction moment, but by repeating in infinite numbers of interaction moments of the same sort with the same support of parents and caregivers”<sup>59</sup>. At the same time, the Marte Meo Method also acknowledges the key role of insight and understanding, such as when a parent sees the link between their supportive behaviours and the development of their child. This is called ‘the Ultimate Marte Meo Moment’ when “the parents or other caregivers arrive at the right conclusion, draw the right link, or experience a moment

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52 Aarts, 2000: Chapter Three

53 Aarts, 2000:45

54 Aarts, 2000:90

55 Aarts, 2000:59

56 Aarts, 2000:62

57 Aarts, 2000:44

58 Aarts, 2000:46

59 Aarts, 2000:90

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of enlightenment or clear perception”<sup>60</sup>. A key role for the therapist therefore is to reinforce and build on those moments.

The Marte Meo Manual offers specific guidance on how to treat babies who cry constantly as well as children who are hyperactive by virtue of a specific disorder (such as ADHD – Attention Deficit Hyperactivity Disorder) or being reared in ‘an unstructured situation’<sup>61</sup>. In relation to the latter, the overall approach is to create a structure for the child which facilitates the development of normal behaviour. This structure has both an internal and an external dimension, whether applied in a family or group context. The internal structure includes helping the child develop a positive self-image, selecting initiatives that are appropriate, structuring and expanding initiatives with proper closure, registering and coping with feelings, and becoming aware of the initiatives of others. The external context refers to clear openings and closings, helping the child to gain insight into social situations, looking around and taking turns, providing positive alternatives to actions that are not allowed, as well as developing models of acting cooperatively.

The Marte Meo Method may be used as the main intervention with a target group or as a supplement to other interventions. A key requirement for its success is that professionals must be familiar with the particular needs and demands of their target group and the skill deficits which are impeding development. For example, the Marte Meo Method has been used successfully to improve the parenting and communication skills of drug users, but only where the professionals are knowledgeable in working with this target group.

It is recognised that some target groups may not be able to benefit from the Marte Meo Method such as those who not willing or able to develop because they are “too damaged or who live in too complicated a situation to have any energy left to be able to develop. ... Another group that is hard to reach consists of parents with weak child-raising skills and in combination with children with special needs, such as ADHD or autistic children”<sup>62</sup>.

Research on the effectiveness of the Marte Meo Method shows promising results although much of the published results fall short of a full scientific evaluation. This is because of weak research design in many of the studies such as lack of both pre-test and post-test data, use of measurement instruments that have not been independently tested or which measure client perceptions rather than client behaviours, application of the programme to relatively small samples and often without a comparison group. No evaluation meets the gold standard of a randomised control trial which involves offering the programme to an experimental group and comparing outcomes with a matched control group which has not been offered the programme. Despite these limitations, one of the more robust evaluations was carried out in Israel based on the Orion Home Training Programme – a predecessor of Marte Meo - and involved comparing 52 families who received the programme with 64 control families; this evaluation concluded that “the Orion families showed significant gains in all the eight areas of positive parent-child communication that are the focus of the program. ... these gains were

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60 Aarts, 2000:84

61 Aarts, 2000:127

62 Aarts, 2000:47-8

generally sustained 6 months after program completion<sup>63</sup>. A much smaller pre-test / post-test study of the Marte Meo Method in Denmark, based on 11 families, found that 10 of the families experienced significant improvements in the parent-child relationship<sup>64</sup>. Preliminary results from an evaluation of the Marte Meo programme in Sweden involving 33 children, their parents and teachers based on pre-test / post-test data and standardised measures for child symptoms found “as statistical as well as a clinically significant decrease in the children’s symptoms”<sup>65</sup>.

## **1.5 Contribution to the Wider Community**

Mounttown NYFP is located in a neighbourhood characterised by significant socio-economic disadvantage and emerged in response to the needs of children and families living in that community. The underlying concept of a Neighbourhood Youth Project (NYP) was first recommended in the Interim Report of the Task Force on Child Care Services in 1975<sup>66</sup> and, since then, 14 projects have been established throughout the country<sup>67</sup>. From the outset, the vision for NYPs was to be a community service for more vulnerable children since, according to the Task Force on Child Care Services, “this should enable children who require intensive and skilled care to receive it while remaining at home or in the community”<sup>68</sup>. This rationale continues to inform the work of NYPs, including Mounttown NYFP.

Mounttown NYFP was established in 1996. The need for the project was identified by the Community Development Project (CDP) of Mountwood / Fitzgerald Park and financial support was received from the Eastern Health Board (since incorporated into the Health Services Executive in 2005). The CDP has remained involved in Mounttown NYFP and its Coordinator is a member of the Management Committee.

In keeping with its commitment to the needs of disadvantaged children and families, Mounttown NYFP participates in a wide range of organisations and services which also have this remit. These are listed in Table 1.1 and Mounttown NYFP is mainly represented on them by its Coordinator, Mary Cullen.

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63 Weiner, Kuppermintz and Guttman, 1994

64 Kristensen, 2003

65 Wirtberg and Axberg, 2005:20.

66 Task Force on Child Care Services, 1975

67 The 14 NYPs are located in different parts of the country, including: Dublin (4), Cork (2), Galway (2), Mayo (2), Leitrim (1), Monaghan (1), Roscommon (1) and Tipperary (1). Eleven of the 14 NYPs are managed by Foróige.

68 Task Force on Child Care Services, 1980:12

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**Table 1.1 Membership by Mounttown NYFP in Selected Organizations and Services**

<ul style="list-style-type: none"> <li>• Holy Family Primary School</li> <li>• Mounttown Consortium</li> <li>• School Completion Committee</li> <li>• Management Committee of the Oasis project</li> <li>• Youth at Risk Network</li> <li>• HSE Placement Committee</li> <li>• Children’s Rights Alliance</li> <li>• The Wheel</li> </ul>	<ul style="list-style-type: none"> <li>• Southside Partnership, chair (2006 onwards), vice-chair (2000-2005)</li> <li>• County Development Board (CDB) representing Southside Partnership from 2000-2005</li> <li>• Social Inclusion Measures Sub-Committee of CDB, co-chair</li> <li>• Social Development Sub-Committee of CDB</li> </ul>
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The Coordinator and staff in Mounttown NYFP are also involved in a range of teaching and consultancy services. These include:

- Teaching a course entitled ‘In Touch with Children’ to community childcare providers, HSE and Springboard staff.
- Consultancy to HSE Social Work Fostering Team and Springboard staff.
- Guest lectures on TCD Diploma in Child Protection & Welfare Course, and Dun Laoghaire Youth Services.
- Presentation to national conferences in 2005 on the Marte Meo Method and the TCD Addiction Studies Conference.

It is difficult to assess the impact of such a diverse range of activities, in part because any impact is typically caused by a multiplicity of influences which cannot easily be identified separately. In addition, even if the impacts of Mounttown NYFP could be separately identified, it is not clear if these have been influenced by the characteristics of the project, or the person representing the project, or both. Bearing these limitations in mind, we nevertheless consulted a number of organisations and services – listed in the Acknowledgements - which have detailed knowledge of Mounttown NYFP with a view to estimating its impact in the two key areas of practice and policy, as follows:

- (i) impacts on practice through sharing knowledge and skills on effective interventions
- (ii) impacts on policy, particularly for children affected by social exclusion and educational disadvantage.

A clear consensus among those consulted is that Mounttown NYFP has had a significant impact on the quality of services for children in the entire locality. This has mainly come about through teaching and consultancy to a range of child and family services in the voluntary, community and statutory services. Mounttown NYFP is widely regarded as a centre of excellence by other services because of the quality of its work with children, as well as the qualifications and experience of its staff. The project has particular expertise in psychoanalytic approaches which bring a depth of understanding to the relationships and attachments at the heart of human problems. At the same time, project staff are qualified in the Marte Meo Method which has a more direct focus

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on the skills needed by parents and professionals to identify, activate and develop the competencies needed to promote child development. These twin competencies, through the teaching and consultancy work of Mounttown NYFP, have been experienced by many practitioners as highly influential in terms of cultivating insightfulness and skillfulness in working with children and families as well as setting a standard for this work that practitioners could aspire to. One example of this is the two-day course entitled 'In Touch With Children' which is always well received whenever it is delivered and provides a safe environment where participants can reflect on their own childhood and use this to build awareness of the assumptions which they may bring to working with children. Another example is the benefits of its consultancy on issues such as domestic violence and sexual abuse where services have been helped to understand the processes underlying these behaviours in order to draw up plans which simultaneously responds to the needs of victims and their perpetrators. In its own work, Mounttown NYFP lays great stress on the need to reflect on practice in light of developments in theory and research, and for staff to receive regular professional supervision on all aspects of their work. This, in turn, has set a standard which other services seek to match.

In the area of policy, Mounttown NYFP is perceived to be at the forefront in a range of fora – Southside Partnership, County Development Board and its Social Inclusion Measures Sub-committee, County Childcare Committee, Southside Childcare Action Network, etc. – with the aim of promoting better understanding of the needs of vulnerable children and families, and helping to put appropriate and realistic strategies in place to address those needs. The policy interventions of Mounttown NYFP have sought to increase the quantum of services for children and families in areas such as childcare, family support, education, community facilities, as well as responding to the dearth of specialist services for children in areas such as speech and language, child psychiatry, etc. In tandem with this, the project has been involved in initiatives to build dialogue and cooperation between agencies so that children and families can receive a more holistic and integrated service. It has also emphasised the need to raise service standards by encouraging staff training, particularly among providers of community-based childcare. Mounttown NYFP has assisted in disseminating information to other organisations about policy developments affecting children and families, such as the implications of the new Office of the Minister for Children established in 2005, and the ongoing implementation of Children First, the national child protection guidelines. In her roles as chair of the Southside Partnership and the Social Inclusion Sub-Committee of the County Development Board, the Coordinator of Mounttown NYFP is universally regarded as highly skilled in creating a space to 'think outside the box' while also keeping focused on the task at hand, and is also noted for enabling conflicts to be resolved and dissolved by linking and integrating different viewpoints.

It is clear from this that Mounttown NYFP is highly regarded within the local community and has an influence on policy and practice which is probably disproportionate to its size or resources. Its reputation as a centre of excellence illustrates the contribution which a relatively small project can make by virtue of the skills and commitment of staff and a willingness to share those with the wider community. Many of those consulted spoke of the project's generosity in sharing its premises and offering staff time without remuneration. In keeping with this, the project is also committed to an in-depth evaluation of its services which we detail in the subsequent chapters of this report.

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## **1.6 Summary and Conclusion**

In this chapter we have seen that Mounttown NYFP<sup>69</sup> is a mental health programme to support vulnerable children aged 8-13 who present with behaviour and / or emotional problems at school. It is based in the school campus of the Holy Family School Primary School, a school which has disadvantaged status and runs the School Completion Programme<sup>70</sup>. School-based programmes like Mounttown NYFP are increasingly popular in the UK<sup>71</sup> and US<sup>72</sup> and their potential contribution of school-based programmes to the mental health of children was highlighted by the Expert Group on Mental Health Policy<sup>73</sup>.

The work of Mounttown NYFP has a significance beyond the confines of the project and school because of the relatively high prevalence of mental health problems among children in Ireland and the importance of finding effective interventions to address those problems. Our review of the evidence indicates that around 8% of Irish children have moderate to severe mental health problems, but this rises to around 20% of the children who live in disadvantaged homes and communities, depending on how it is measured. In view of this, it is clear that a substantial need exists for interventions such as the Mounttown NYFP to prevent and treat mental health problems in school-going children.

Interventions at Mounttown NYFP have a number of therapeutic objectives which include: (i) increasing the pupil's self-esteem, self-awareness, and self-confidence; (ii) improving peer relationships and peer acceptance; (iii) promoting attachment and developmental catch-up; and (iv) improving educational attainment and reducing the fear of failure.

These objectives are pursued through interventions which involve weekly group sessions and monthly one-to-one sessions. The group format is facilitated by two staff and is used to teach basic skills such as listening to each other, showing respect, concentrating, working as part of a team, etc. The theoretical approach which informs all interventions is the Marte Meo Method. All staff are trained in this method and two are certified Marte Meo therapists<sup>74</sup>.

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69 NYFP Is an acronym for Neighbourhood Youth and Family Project.

70 The School Completion Programme was introduced by the Department of Education & Science in 2003 in order to promote the retention of pupils in primary and second level schools. The School Completion Programme subsumes the "8 to 15 Early School Leaver Initiative" and the "Stay in School Retention Initiative" and is a key component of the Department's strategy to discriminate positively in favour of children and young people who are at risk of, or who are experiencing, educational disadvantage. The programme is funded on a multi-annual basis under the National Development Plan with assistance from the European Social Fund (ESF).

71 Pugh and Statham, 2006.

72 Dryfoos and Nissani, 2006.

73 Expert Group on Mental Health Policy, 2006:86.

74 There are three main levels of training in the Marte Meo method: (i) Communications Skills Training Course (ii) Therapist Training Course and (iii) Supervisor Training Course. The Communications Skills Training Course involves six sessions, each lasting a half-day or, for some groups, a full-day. The Therapist Training Course is delivered over a period of 18 months and involves 18 monthly training days, three blocks of training each lasting four days each, and a four day accreditation process. The Supervisor Training Course involves delivering the Therapist Training Course under the supervision of a Licensed Marte Meo Supervisor; this accepted on this course must have spent at least one year as a trained therapist under the supervision of a Licensed Marte Meo Supervisor.

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The Marte Meo Method was created by Maria Aarts in Holland and developed over a period of years beginning in 1978. It was first developed to treat children with severe developmental problems but is now used in over 30 countries to address problems experienced by different target groups such as children in care and school settings, parents who are experiencing difficulties, drug users, elderly, persons with depression or intellectual disabilities; it is also used as a general training in communication and management skills<sup>75</sup>.

The name Marte Meo Method (meaning ‘one one’s own strength’) was chosen in order to “highlight the central focus of the programme, which is to identify, activate and develop skills to enable and enhance constructive interaction and development”<sup>76</sup>. The developmental process, as described in the Marte Meo Manual, is cultivated through three separate stages: (i) identifying opportunities for development such as the initiatives and actions of a child (ii) finding the natural supportive behaviours which are required to assist development such as naming, confirming, supporting, selecting and structuring the child’s initiatives (iii) incorporating this knowledge into the natural system of the individual so that they can learn the new skills in the most efficient way possible<sup>77</sup>.

Video analysis of interactions is a key tool of the Marte Meo Method and has a number of specific functions including gathering information about interactions in naturalistic settings, giving clients a picture of their reality including a perspective on their strengths as well as weaknesses, offering step-by-step guidance on specific behaviours, checking if a new behaviour is working, and providing opportunities to see positive results. In orientation, the Marte Meo Method emphasises actions and behaviours over thoughts and cognitions, and stresses the importance of learning through practice. At the same time, the Marte Meo Method also acknowledges the key role of insight and understanding, such as when a parent sees the link between their supportive behaviours and the development of their child.

Research on the effectiveness of the Marte Meo Method shows promising results although much of the published results fall short of a full scientific evaluation. This is because of weak research design in many of the studies such as lack of both pre-test and post-test data, use of measurement instruments that have not been independently tested or which measure client perceptions rather than client behaviours, application of the programme to relatively small samples and often without a comparison group. No evaluation meets the gold standard of a randomised control trial which involves offering the programme to an experimental group and comparing outcomes with a matched control group which has not been offered the programme.

In addition to its direct work with children at the Holy Family School, Mounttown NYFP also participates in a wide range of organisations and services whose remit includes children and families, especially those experiencing some form of adversity associated with socio-economic circumstances, disability, parenting difficulties, etc. Staff in Mounttown NYFP also offer teaching and consultancy inputs to other services in the community, voluntary and statutory sectors. We consulted a range of professionals to assess the impact of this

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75 [www.martemeo.com](http://www.martemeo.com)

76 Aarts, 2000:42

77 Aarts, 2000: Chapter Three

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work and found that Mounttown NYFP is widely regarded as a centre of excellence by other services which have, in turn, benefited from this expertise. The project has particular expertise in psychoanalytic approaches to the family which bring a depth of understanding to the relationships and attachments at the heart of human problems. In addition, project staff are qualified in the Marte Meo Method which has a more direct focus on the skills needed by parents and professionals to identify, activate and develop the competencies needed to promote child development. In its own work, Mounttown NYFP lays great stress on the need to reflect on practice in light of developments in theory and research, and for staff to receive regular professional supervision on all aspects of their work. This, in turn, has set a standard which other services seek to match. In the area of policy, Mounttown NYFP is represented by its Coordinator, Mary Cullen, on a range of fora with the aim of promoting better understanding of the needs of vulnerable children and families, and helping to put appropriate and realistic strategies in place to address those needs. The project has highlighted the need to increase the quantum of services in areas such as childcare, family support, education, community facilities, while also drawing attention to the dearth of specialist services for children in areas such as speech and language, child psychiatry, etc. Overall, our consultations revealed that Mounttown NYFP is highly regarded within the local community and has an influence on policy and practice which is probably disproportionate to its size or resources. Many of those consulted spoke of the project's generosity in sharing its premises and staff, and giving their time without remuneration. In keeping with the ethos of finding new ways to improve services, Mounttown NYFP is also committed to the evaluation of its services which we detail in the subsequent chapters of this report.

## **Chapter Two**

### **Methodology**

#### **2.1 Introduction**

This chapter describes the methodology used to evaluate the effectiveness of Mounttown NYFP, a school-based mental health programme for children aged 8-13 who present with behaviour and / or emotional problems at school. The evaluation is timely in view of the growing use of school-based programmes to address the mental health difficulties of children and the application of the Marte Meo Method in this particular programme.

The methodology involves a pre-test / post-test comparison, which means that the impact of the programme is measured by comparing the well-being of children at the beginning of the programme (pre-test) and end of the programme (post-test); in addition, the group of children who receive the programme (the 'experimental' group) is compared to a similar group of children who have not received the programme or any similar programmes (the 'comparison' group). This methodology is usually referred to as a 'quasi-experimental design'<sup>78</sup>, or a 'pre-post evaluation with a comparison group'<sup>79</sup>, and offers a reliable way of assessing the scale and direction of impacts produced by Mounttown NYFP.

The chapter begins by describing the instruments used to measure the behaviours, emotions and relationships which are the specific targets of this intervention (Section 2.2). We then describe the samples used, both the 'experimental group' who receive the programme and the 'comparison group' who, although similar to the experimental group, do not receive the programme (Section 2.3). We explain how the data was processed and analysed, including the effect sizes which will be used to measure impact in a standardised way (Section 2.4). Finally, we give an overview of the structure of the report (Section 2.5).

#### **2.2 Instruments for Measuring Child Outcomes**

We measured a wide range of behaviours and emotions that are recognised to be key dimensions in the mental health of children. We also measured the child's performance at school notably reading as well as the child's

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<sup>78</sup> This contrasts with an 'experimental design', usually referred to as a randomised control trial (RCT), which involves setting up two matched groups using a random process of selecting participants and then offering the programme to one group (the experimental group) while the other group is either placed on a waiting list or offered an alternative programme (the control group). Since both groups are matched prior to the intervention, it is reasonable to infer that any differences which emerge at the end of the programme can be attributed to the programme. RCTs are now regarded as the gold standard among researchers for measuring the efficacy of programmes (Chambless and Hollon, 1998) essentially because the process of randomly allocating subjects to either an experimental or control group ensures that both groups are as perfectly matched as possible and therefore controls for all possible differences – both known and unknown – between the groups, other than the fact that one (the experimental group) receives the programme and the other (the control group) does not. In the absence of random allocation, only the known differences can be controlled in setting up the experimental and comparison group and it is this which accounts for the superiority of experimental designs over quasi-experimental designs. It is for this reason that RCTs provide a level of certainty about the efficacy of an intervention which is not achievable through any other research design. At the same time, a quasi-experimental design, which we use here for practical reasons, provides a reliable though not definitive guide to the likely impacts of a programme.

<sup>79</sup> See Chinman, Imm and Wandersman, 2004.

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punctuality at school. These dimensions of well-being, and the instruments used to measure them, are summarised in Table 2.1. All of these instruments are in widespread use and have been tested for validity and reliability. Some of the instruments have been used in other Irish studies, providing a useful source of comparative data<sup>80</sup>.

It is well known that any rounded assessment of the mental health needs of children requires an input from the child and others who are familiar with the child in different settings. In this evaluation, most of the data was collected from the child during an interview with staff. Each child was also assessed by his / her teacher in terms of mental health (using the Strength and Difficulties Questionnaire), cognitive development (using the Micra T Reading Attainment Test), and school punctuality. Staff in Mounttown NYFP also completed a questionnaire on the family and household characteristics of each child.

**Table 2.1 Instruments for Measuring the Well-Being of Children**

<b>Dimensions of Need Among Children</b>	<b>Scale for Measuring Well-Being</b>
Physical Well-Being	1. Health and Daily Living Scales <sup>81</sup> . The ‘physical health’ subscale has 10 items which is reduced to 5 items in this study.
Smoking, Drinking and Drugs	2. Smoking, Drinking and Drugs questions from NACD’s Drug Prevalence Survey <sup>82</sup> 3. National Health and Lifestyle Surveys <sup>83</sup> .
Strengths and Difficulties	4. Strengths and Difficulties Questionnaire (SDQ) <sup>84</sup> comprising 25 items on its core scale which has six sub-scales: (i) conduct problems (ii) emotional symptoms (iii) hyperactivity (iv) peer problems (v) prosocial behaviour (vi) total difficulties. Separate versions of the SDQ were completed by the child and the child’s teacher.
Psychological Distress	5. Beck Youth Inventories of Emotional and Social Impairment <sup>85</sup> comprising 100 items and five scales: (i) self-concept (ii) anxiety (iii) depression (iv) anger (v) disruptive behaviour. Each scale has 20 items.
Attachment to Parents and Peers	6. Inventory of Parent and Peer Attachment <sup>86</sup> , comprising three sub-scales of 25 items each: (i) attachment to mother (ii) attachment to father (iii) attachment to friends.
Life Satisfaction	7. Multidimensional Students’ Life Satisfaction Scale <sup>87</sup> , comprising 41 items and five sub-scales: (i) family (ii) friends (iii) school (iv) living environment (v) self. In this study we have reduced the number of items to 21.

80 See notably McKeown, K., Haase, T., and Pratschke, J., 2001; McKeown, K., Pratschke, J., and Haase, T., 2003.

81 Adapted from Moos, Cronkite, Billings, and Finney, 1986.

82 National Advisory Council on Drugs, 2005.

83 See Centre for Health Promotion Studies, 2003.

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

85 Adapted from Beck, Beck & Jolly, 2001.

86 Armsden and Greenberg, 1987

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Relationship with Parents	8. Parenting Style Scale <sup>88</sup> comprising 14 items and three sub-scales: (i) father supportiveness (ii) mother supportiveness (iii) parental supervision.
Conflict with Parents	9. New scale for measuring unresolved problems with parents comprising 18 areas of potential conflict which are rated on a scale from 1 (not a problem) to 7 ( a severe problem).
School Performance	10. Micra T Reading Attainment Test <sup>89</sup> 11. Sigma T Numeracy Test <sup>90</sup>
School Attendance	12. Official school records
Experiences at school	13. Health and Daily Living Scales <sup>91</sup>

### 2.3 Samples of Children

The evaluation is based on data collected from 19 children in the ‘experimental’ group (those who received the NYFP programme at The Holy Family Primary School) and 18 children in the ‘comparison’ group (those who did not receive the NYFP programme and attended St. Kevin’s Primary School). The experimental group contains two sub-groups of children: (i) those who started the programme at the same time as this evaluation and whose pre-test scores were collected when they started Mounttown NYFP (6 children whom we call the ‘first year group’); and (ii) those who were already on the programme when the evaluation started and whose pre-test scores were collected more than a year after they started Mounttown NYFP (13 children whom we call the ‘second year group’). In view of this, we undertake a separate analysis of the changes in both these experimental groups.

The schools attended by both groups of children have disadvantaged status and are part of the School Completion Programme. The same set of questionnaires, compiled from the instruments listed in Table 2.1, was used to collect data from both groups of children. Data on the experimental group was collected at the beginning of the school year (September / October 2005) and at the end (May / June 2006, with some additional data collected in September 2006); data on the comparison group was collected in February / March 2006 and again in June 2006.

### 2.4 Analysis

The analysis addresses two basic questions that are at the heart of this evaluation: (i) how much change occurred to the children following their participation in Mounttown NYFP? (ii) what level of need remained among the children following participation in the Mounttown NYFP?

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87 Adapted from Huebner, 2001; 1994; Huebner and Gilman, 2002.

88 Lamborn, Mounts, Steinberg and Dornbusch, 1991.

89 Available at [www.micra-t.ie](http://www.micra-t.ie) and [www.cjfallon.ie](http://www.cjfallon.ie)

90 Available at [www.micra-t.ie](http://www.micra-t.ie) and [www.cjfallon.ie](http://www.cjfallon.ie)

91 Adapted from Moos, Cronkite, Billings, and Finney, 1986.

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In order to answer the first question, we measured the difference in pre-test and post-test scores using the statistical concept of effect size. The concept of effect size is a simple way of standardising the measurement of change and allows impacts to be compared across different instruments as well as between the experimental and comparison groups. The formula involves subtracting the mean post-test scores from the mean pre-test scores and dividing by their pooled standard deviation. Thus, the effect size is measured in standard deviation units and the score varies from 0.0 to 3.0. The convention established by Jacob Cohen<sup>92</sup>, and referred to as 'Cohen's d', is that a coefficient between 0.2 and 0.5 indicates a small effect, between 0.5 and 0.8 indicates a moderate effect, and above 0.8 indicates a large effect<sup>93</sup>.

An important advantage of using effect sizes is that it allows the results to be compared with previous research on the outcomes of similar programmes. In this study, we use three points of comparison to assess the performance of Mounttown NYFP. The first is the impact which is normally achieved by family support programmes in the area of children's socio-emotional development (which range from 0.22<sup>94</sup> to 0.27<sup>95</sup>), as summarised in Table 2.2 below. The second is the standard used by one agency for identifying programmes of 'proven' effectiveness which require an effect size of 0.25 or higher for at least outcome<sup>96</sup>. The third is the standard used by another agency for identifying 'blueprint' programmes which require an effect size of 0.5 or higher for at least outcome variable<sup>97</sup>.

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92 Cohen, 1988

93 The interpretation of effect sizes should be done with care however and even small effect sizes can have enormous practical significance. The medical example used to illustrate this is the effect size of aspirin in reducing heart disease, which is 0.03, yet is widely prescribed by doctors because the cost of the intervention is cheap and the potential benefits are very large (cited in McCartney and Dearing, 2002). In the social field, the effect size of the High / Scope Perry Pre-School Programme in the US when participants reached the age of 23 was 0.36 (Schweinhart and Weikhart, 1997) but the economic return at age 27 is estimated to be \$8 for every \$1 invested (Barnett, 1996), rising to \$17 for every \$1 invested by age 40 (Schweinhart, 2004). This is similar to the results of a meta-analytic review of the effect sizes associated with family support programmes (Layzer, Goodson, Bernstein and Price, 2001) and other pre-school prevention programmes (see Nelson, Westhues and MacLeod, 2003). A guide to the interpretation of effect sizes is summarised in the table below and shows, for each effect size, the proportion of the experimental group (EG) whose scores exceed the average score of the control group (CG), based on the assumption that scores are normally distributed.

Effect Size	0.0	0.1	0.2	0.3	0.4	0.5	0.6	0.7	0.8	0.9	1.0	1.2	1.4	1.6	1.8	2.0	2.5	3.0
% exceeds CG	50	54	58	62	66	69	73	76	79	82	84	88	92	95	96	98	99	99.9

Source: Carr, 2002:12

94 Layzer, Goodson, Bernstein and Price, 2001.

95 Nelson, Westhues and MacLeod, 2003

96 The Promising Practices Network run by the Rand Corporation defines a programme as 'proven' where, inter alia, 'at least one outcome is changed by 20%, 0.25 standard deviations or more' (<http://www.promisingpractices.net>) (see also Shonkoff and Phillips, 2000:342-343).

97 The Centre for the Study and Prevention of Violence at University of Colorado in Boulder, USA selects 'Blueprint Model Programs' on the basis of 'the most rigorous tests of effectiveness in the field', and requires that all Blueprint programmes have 'at least moderate effect sizes', which imply effect sizes of 0.5 or higher (<http://www.colorado.edu/cspv/blueprints>).

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**Table 2.2 Effect sizes for family support programmes and pre-school prevention programmes**

Outcome Domain	Average Effect Size:	
	Short-term (end of treatment)	Longer-term (follow-up)
<b>1. Meta-Analysis of 665 experimental and quasi-experimental studies of family support programmes</b>		
Child cognitive development	0.293	0.345
Child social-emotional development	0.223	0.150
Child physical health and development	0.123	0.112
Child injury, abuse, neglect	0.213	0.152
Parenting attitudes and knowledge	0.230	0.273
Parenting behaviour	0.257	0.204
Family functioning / family resources	0.169	0.002
Parent mental health / health risks	0.137	0.226
Family economic self-sufficiency	0.099	0.464
<b>2. Meta-Analysis of 34 experimental and quasi-experimental studies of pre-school prevention programmes for children</b>		
Cognitive impacts on children	0.52	0.30
Socio-emotional impacts on children	0.27	0.27
Parent / family wellness impacts	0.33	0.30
<b>3. Meta-Analysis of 2,513 experimental and quasi-experimental studies of psychotherapy</b>		
Psychotherapy	0.82	

Sources: 1. Layzer, Goodson, Bernstein and Price, 2001.  
2. Nelson, Westhues and MacLeod, 2003  
3. Asay and Lambert, 1999

In order to answer the second question – what level of need remains after the programme? - we compare the post-test scores of children in the experimental group, on each dimension of well-being, with the corresponding scores of a nationally representative of Irish children<sup>98</sup>; in the case of the Strengths and Difficulties Questionnaire, the comparison is with a nationally representative of British children<sup>99</sup> since there is no comparable Irish data; similarly, in the case of the Inventory of Parent and Peer Attachment, the comparison is with a nationally representative of Dutch children<sup>100</sup> since there is no comparable Irish data. In this context, need is measured by how far the post-test scores of children in the experimental groups are from the norms experienced by the average Irish, British or Dutch child, and are expressed in terms of an effect size. Given that the baseline figure for Ireland is 0.0, and the fact that most programmes in the area of family support tend to achieve effect sizes in the range 0.2 to 0.5, it follows that effect sizes in this range tend to indicate a significant level of need while effect sizes in excess of 0.5 can be regarded as quite large relative to the capacity of programmes to meet that need. These considerations will be used as a guide in the interpretation of results.

<sup>98</sup> McKeown, Pratschke and Haase, 2003

<sup>99</sup> Meltzer, Gatward, Goodman, and Ford, 2000

Our study also used a comparison group. The rationale for this quasi-experimental method is that, by estimating the difference between children in the experimental and the comparison group, we can estimate the true impact of the intervention since it controls for the fact that some children in each group may show an improvement even without intervention – a phenomenon that is variously referred to as regression to the mean, or a regression effect / artifact - either because of random error in their scores, or because some children show spontaneous improvement. However, as we shall see in subsequent chapters, the comparison group was not a useful point of comparison since their pre-test scores are not well matched with the pre-test scores of children in either of the experimental groups.

## **2.5 Structure of the Report**

The report is divided into nine chapters as follows:

Chapter One	Context
Chapter Two	Methodology
Chapter Three	Background Characteristics of Children
Chapter Four	Changes in Strengths and Difficulties
Chapter Five	Changes in Social and Emotional Impairment
Chapter Six	Changes in Life Satisfaction and Physical Symptoms
Chapter Seven	Changes in Relationship with Parents
Chapter Eight	Changes in School Outcomes
Chapter Nine	Summary, Conclusions and Implications

## **Chapter Three**

### **Background Characteristics of Children**

#### **3.1 Introduction**

This chapter describes the family characteristics of children attending Mounttown NYFP. We refer to these children as the ‘experimental group’ because they attend the programme in Mounttown NYFP, unlike the ‘comparison group’ who do not. In fact the experimental group contains two sub-groups of children – those who started the programme at the same time as this evaluation and whose pre-test scores were collected when they started Mounttown NYFP (6 children whom we call the ‘first year group’) and those who were already on the programme when the evaluation started and whose pre-test scores were collected more than a year after they started Mounttown NYFP (13 children whom we call the ‘second year group’). Our analysis begins by describing the age and gender of children (Section 3.2), and the family type in which they live (Section 3.3). This is followed by a description of household size (Section 3.4), housing status (Section 3.5), and main source of family income (Section 3.6). We conclude with a brief summary of the findings (Section 3.7).

#### **3.2 Age and Gender**

Table 3.1 gives a detailed breakdown of the age and gender of children. This reveals significant contrasts between the first year and the second year group. Children in the first year group started Mounttown NYFP at a significantly older age (10.8 years) compared to the second year group (8.5 years), a difference of over two years. The second year group has also spent more than twice the amount of time attending Mounttown NYFP (2.3 years) compared to the first year group (1.0 year). As a result, the average age of children now (in June 2006 when the post-test data was collected at follow-up) is also different in the two groups: the average age of children in the first year group (11.8 years) is a year older than the average age of children in the second year group (10.8 years). The average age of the comparison group now is 12 years which is closer to the first year group. The significant difference between the two groups in terms of the amount of time spent in Mounttown NYFP provides an opportunity to test whether there is any relationship - direct or inverse - between programme duration and programme outcomes; at the same time it is also an opportunity to test whether the age on starting the programme affects the outcome.

Table 3.1 also shows that there is a similar number of boys (7) and girls (6) in the second year group but more girls (4) than boys (2) in the first year group. In the comparison group, there are considerably more girls (13) than boys (5).

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**Table 3.1 Age and Gender of Children in the Experimental Groups Before and After Participation in Mounttown NYFP, including data on the Comparison Group**

Category	First Year Group			Second Year Group			Comparison Group		
	Boys (2)	Girls (4)	Total (6)	Boys (7)	Girls (6)	Total (13)	Boys (5)	Girls (13)	Total (18)
Mean age on starting NYFP	12.5	10.0	10.8	8.6	8.6	8.5	11	11	11
Age range on starting NYFP	12-13	8-12	8-13	7-10	7-10	7-10	9-13	9-13	9-13
Mean duration on NYFP	1	1	1	2.4	2.9	2.3	-	-	-
Mean age at follow-up, Jun 06	13.5	11.0	11.8	11.0	11.5	10.8	12.0	12.0	12
Age range at follow-up	13-14	9-13	9-13	9-12	8-12	8-12	10-13	10-13	10-13

### 3.3 Family Type

The family structure in which children live is summarised in Table 3.2 with comparative data for Ireland. This reveals nearly six out of ten of all the children in the study live in a two parent household, compared to eight out of ten in Ireland. Conversely, four out of ten children live in a one parent household compared to two in ten in Ireland. Of the children attending Mounttown NYFP who are not living with both parents (10), most see the non-resident parent a few times a week (6), or once a month (2), and two never see the non-resident parent. As in other countries, poverty is strongly associated with lone parenthood as both its cause and its consequence<sup>101</sup>. Public policy in Ireland, as in other EU countries, is committed to reducing poverty but is neutral regarding family type, in part because the effects of family type on the well-being of children is often mediated by factors such as household income combined with the stability of family relationships and the absence of conflict.

**Table 3.2 Family Types (%)**

Variable	First Year Group (6)	Second Year Group (13)	Comparison Group (18)	Ireland*
Two parents – married	33	8	56	68
Two parents – cohabiting	0	46	11	11
One parent – single	33	23	22	12
One parent – separated/divorced / etc	34	8	11	9
Other, eg foster / residential care	0	15	0	-
<b>Total</b>	<b>100</b>	<b>100</b>	<b>100</b>	<b>100</b>

\*McKeown, Pratschke and Haase, 2003. Note: At some time in the past, three children have lived away from the family home; of these, one has returned to the family, one lives with friends of the family, and one is in foster care.

<sup>101</sup> See McLanahan, Donahue and Haskins, 2005.

### 3.4 Household Size

Information on household size is summarised in Tables 3.4, with comparative data on the household size of family units in Ireland. This reveals that children in the study live in households containing a larger number of persons compared to Ireland.

**Table 3.4 Household Characteristics**

Persons Per Household	First Year Group (6)	Second Year Group (13)	Comparison Group (18)	Ireland*
Mean	4.3	4.8	5.6	3.6

\*Source: Census of Population 2002, Household Composition and Family Units, Volume 3.

### 3.5 Housing Status

The housing status of the family home is summarised in Tables 3.5, with comparative data for Ireland. This reveals that most of the homes (75%) are rented from the local authority with about a fifth (20%) in owner-occupation. This contrasts strongly with the pattern in Ireland where the vast majority of people (81%) live in owner-occupied housing. Given that owner-occupation is a reliable predictor of economic well-being, it follows that most of the children live in families who are not well-off.

**Table 3.5 Housing status of Families (%)**

Variable	First Year Group (6)	Second Year Group (13)	Comparison Group (18)	Ireland*
Owner occupied	20	23	24	81
Renting from private landlord	0	8	0	12
Renting from Local Authority	<b>80</b>	<b>69</b>	<b>76</b>	7
<b>Total</b>	<b>100</b>	<b>100</b>	<b>100</b>	<b>100</b>

\*Source: Census of Population 2002, Housing, Volume 13.

**Table 3.6 Length of Time Living in Area (%)**

Variable	First Year Group (6)	Second Year Group (13)	Comparison Group (18)
Up to five years	0	15	6
Five to ten years	0	0	11
Eleven to twenty years	<b>20</b>	<b>8</b>	<b>17</b>
Over twenty years	<b>80</b>	<b>77</b>	<b>67</b>
<b>Total</b>	<b>100</b>	<b>100</b>	<b>100</b>

### 3.6 Main Source of family Income

The main source of family income is summarised in Tables 3.5. This reveals that about six out of ten households are dependent on social welfare for all or part of their income. This is much higher than in Ireland and suggests that most of the families are not well-off.

**Table 3.6 Main Source of Family Income (%)**

Family Type	First Year Group (6)	Second Year Group (13)	Comparison Group (18)	Ireland*
Mainly social welfare	40	62	44	81
Mainly employment	40	38	50	12
Combination of both	20	0	6	7
<b>Total</b>	<b>100</b>	<b>100</b>	<b>100</b>	<b>100</b>

\*Source: Census of Population 2002, Housing, Volume 13.

### 3.7 Summary and Conclusion

This chapter described the background characteristics of children in the study. These comprise 19 children who attend Mounttown NYFP, the ‘experimental group’, and 18 children in a ‘comparison group’. In fact the children attending Mounttown NYFP comprises two sub-groups: those who started the programme at the same time as this evaluation and whose pre-test scores were collected when they started Mounttown NYFP (6 children whom we call the ‘first year group’), and those who were already on the programme when the evaluation started and whose pre-test scores were collected more than a year after they started Mounttown NYFP (13 children whom we call the ‘second year group’). In order to assess the impact of Mounttown NYFP it is necessary to analyse these two groups separately.

Our analysis revealed that children in the first year group started Mounttown NYFP at a significantly older age (10.8 years) compared to children in the second year group (8.5 years), a difference of over two years. The second year group has also spent more than twice the amount of time attending Mounttown NYFP (2.3 years) compared to the first year group (1.0 year). As a result, when the post-test data was collected in June 2006, the average age of children in the first year group (11.8 years) was a year older than the average age of children in the second year group (10.8 years), but similar to the average age of the comparison group (12.0 years). A similar number of boys (9) and girls (10) attend Mounttown NYFP whereas the comparison group contains considerably more girls (13) than boys (5).

The majority of children in the study, about six out of ten, live in a two parent household, compared to eight out of ten in Ireland. Conversely, the rate of lone parenthood is much higher in the study group with four out of ten children living in a one parent household compared to two in ten in Ireland. Of the children attending

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Mounttown NYFP who are not living with both parents (10), most see the non-resident parent a few times a week (6), or once a month (2), and two never see their non-resident parent. Children in the study live in households containing a larger number of persons compared to Ireland.

Most of the homes (75%) in which the children live are rented from the local authority with about a fifth (20%) in owner-occupation. This contrasts with the pattern in Ireland where the vast majority of people (81%) live in owner-occupied housing while less than a tenth rent from the local authority. Given that owner-occupation is a reliable predictor of economic well-being, it follows that most of the children live in families who are not well-off. This is also indicated by the fact that about six out of ten households are dependent on social welfare for all or part of their income.

These background characteristics indicate that children in the experimental groups are broadly similar to children in the comparison group. However there are significant differences within the experimental group, particularly due to the fact that those in the first year group are older, were older when they started Mounttown NYFP, and spent a much shorter amount of time on the programme compared to the second year group. This provides an important opportunity to test if differences between these groups have any influence on the outcomes of Mounttown NYFP.

## **Chapter Four**

### **Changes in Strengths and Difficulties**

#### **4.1 Introduction**

This chapter describes changes in the strengths and difficulties of children during their time at Mounttown NYFP, as measured by the Strengths and Difficulties Questionnaire (SDQ). It is based on data collected from children and their teachers in the experimental group (those who received the NYFP programme) and the comparison group (those who did not receive the NYFP programme). Change is measured by comparing the scores of children at baseline (pre-test scores) and follow-up (post-test scores). Given that the experimental group contains two sub-groups of children – those whose pre-test scores were collected when they started the programme (6 children whom we call the ‘first year group’) and those whose pre-test scores were collected more than a year after they started the programme (13 children whom we call the ‘second year group’) – our analysis assesses the impact on both groups.

The SDQ has been extensively tested for validity and reliability<sup>102</sup>, and is a recognised screening instrument for identifying children with mental health difficulties which meet DSM-IV diagnostic status<sup>103</sup>, sometimes referred to as ‘child psychiatric caseness’<sup>104</sup>. The SDQ contains four different measures of strengths and difficulties:

- (i) ‘SDQ Symptoms’ which refer to 25 symptom statements about the child from which a total difficulties score is computed as well as scores for five sub-scales: emotional symptoms, behaviour problems, hyperactivity, peer problems and pro-social behaviour;
- (ii) ‘SDQ Perceived Difficulties’ which comprises one question to the child and teacher which asks if the child has difficulties in one or more of the following areas: emotions, concentration, behaviour or being able to get on with other people;
- (iii) ‘SDQ Impact’ which is based on two questions to assess the impact of difficulties in terms of the distress caused to the child, and the interference caused to home life, friendships, classroom learning and leisure activities.
- (iv) ‘SDQ Burden’ which is based on a question to assess the burden imposed by the child’s difficulties on others such as family, friends, teachers, etc.

The SDQ has been ‘normed’ meaning that its results can be used reliably to classify children as ‘normal’, ‘borderline’ or ‘abnormal’ in terms of their difficulties. In addition, there is data on the mean scores of a

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102 For more information, see [www.sdqinfo.com](http://www.sdqinfo.com); see also Goodman, 1997; Goodman, Meltzer and Bailey, 1998; Goodman and Scott, 1999; Goodman, 1999; Smedje, Broman, Hetta and von Knorring, 1999.

103 DSM-IV refers to Diagnostic and Statistical Manual of Mental Disorders which sets out the diagnostic criteria developed by the American Psychiatric Association (1994).

104 Goodman, 1999.

nationally representative sample of over 10,000 children in Britain, which provides a useful point of comparison with children in this study, and this allows us to estimate the level of need, based on the effect size statistic<sup>105</sup>.

In this chapter we measure changes in each of aspect of the SDQ following the children's participation in Mounttown NYFP based on the reports of children and their teachers. These aspects include changes in SDQ Symptoms (Sections 4.2 and 4.3 respectively), clinical status (Section 4.4), SDQ Perceived Difficulties (Section 4.5), SDQ Impact (Section 4.6), and SDQ Burden (Section 4.7). We conclude by summarising the key changes (Section 4.8). Detailed tables of findings pertaining to this chapter are in the Appendix to Chapter Four.

## **4.2 Change in SDQ Symptoms: Child's Perspective**

'SDQ Symptoms' refer to 25 symptom statements about the child. For each of the five areas covered - emotional symptoms, behaviour problems, hyperactivity, peer problems and pro-social behaviour - there are five statements. Examples of the statements used to measure each concept indicate that this is a child-friendly instrument: emotional symptoms ('I worry a lot', 'I am often unhappy, down-hearted or tearful', etc); behaviour problems ('I get very angry and often lose my temper', 'I fight a lot', 'I can make other people do what I want', etc); hyperactivity ('I am restless, I cannot stay still for long', 'I am easily distracted, I find it hard to concentrate', etc); peer problems ('I am usually on my own. I generally play alone or keep to myself', 'Other children or young people pick on me or bully me', etc); and pro-social behaviour ('I try to be nice to other people. I care about their feelings', 'I am helpful if someone is hurt, upset or feeling ill', etc).

Table 4.1 summarises the changes in SDQ Symptoms, expressed in terms of effect sizes, for children who have spent one year on the programme (the first year group), and children who have spent one or more additional years on the programme (the second year group). This reveals that there was a significant reduction in the total difficulties of the first year group (an effect size of -0.26), indicating a significant impact during the first year of the programme. Closer inspection reveals that the main area of improvement for the first year group was hyperactivity (effect size of -0.53), with smaller improvements in peer problems (effect size of -0.20), and emotional problems (effect size of -0.15).

There was almost no change in the total difficulties of the second year group (an effect size of -0.07). However there were improvements in terms of peer problems (effect size of -0.28), prosocial behaviour (+0.23), and emotional problems (effect size of -0.17), but there was also a disimprovement in hyperactivity (effect size of +0.16).

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<sup>105</sup> The effect size is a simple way of standardising and comparing the difference between two groups on a range of test scores. It is typically used in randomised control trials (RCTs) to compare the difference between an experimental and a control group. The formula involves subtracting the mean of the experimental group from the mean of the control group and dividing by their pooled standard deviation. Thus, the effect size is measured in standard deviation units and the score varies from 0.0 to 3.0. The convention established by Jacob Cohen (1988) and referred to as 'Cohen's d', is that a coefficient between 0.2 and 0.5 indicates a small effect, between 0.5 and 0.8 indicates a moderate effect, and above 0.8 indicates a large effect.

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These results show that emotional problems and peer problems improved for both groups – and therefore over each year of the programme – while the impact on hyperactivity was confined to the first year and the impact on prosocial behaviour was confined to the second and subsequent years. Significantly, conduct problems were not impacted in either group. The deterioration in hyperactivity in the second year group suggests that improvements made in the first year may be difficult to sustain in the second and subsequent years.

These results suggest that Mounttown NYFP has its biggest impact during the first year, with a reduced impact during the second and subsequent years. The impact produced during both years is similar to what is normally achieved by family support programmes in the area of children’s socio-emotional development (which range from 0.22<sup>106</sup> to 0.27<sup>107</sup>). This impact also meets the standard used by one agency for identifying programmes of ‘proven’ effectiveness which is an effect size of 0.25 or higher for any outcome<sup>108</sup>. However the level of impact in Mounttown NYFP is below the standard set by another agency for the identification of ‘blueprint programmes’ which require an effect size of 0.5 for one outcome variable<sup>109</sup>.

**Table 4.1 Estimated Changes in SDQ Symptoms of Children in the Experimental and Comparison Groups following Participation in Mounttown NYFP. Based on the Children’s Self-Report of ‘SDQ Symptoms’.**

Categories	First Year Group (6)		Second Year Group (13)		Comparison Group (18)	
	Change*	Need**	Change*	Need**	Change*	Need**
Conduct problems	+0.07	+0.66	+0.07	+0.29	-0.06	-0.65
Hyperactivity	-0.53	+0.02	+0.16	+0.34	-0.15	-0.59
Emotional problems	-0.15	+1.21	-0.17	+0.64	0.00	-0.71
Peer problems	-0.20	+1.07	-0.28	+0.74	+0.04	-0.24
Prosocial behaviour	-0.61	-0.20	+0.23	+0.14	-0.18	+0.16
<b>Total Difficulties</b>	<b>-0.26</b>	<b>+1.00</b>	<b>-0.07</b>	<b>+0.69</b>	<b>-0.07</b>	<b>-0.81</b>

\*Change refers to the difference in pre-test and post-test scores of the experimental groups divided by the pooled standard deviation of the combined experimental groups; for the comparison group, change refers to the difference in pre-test and post-test scores divided by the standard deviation of the comparison group.

\*\*Need refers to the difference between the post-test scores of the experimental group and a representative sample of over 10,000 British children who completed the SDQ (Meltzer, Gatward, Goodman, and Ford, 2000; see also [www.sdqinfo.com](http://www.sdqinfo.com)).

Table 4.1 also reveals that children in Mounttown NYFP have a substantial level of need after the intervention, when compared with a representative sample of British children. The level of need in the first year group, as

106 Layzer, Goodson, Bernstein and Price, 2001.

107 Nelson, Westhues and MacLeod, 2003

108 The Promising Practices Network run by the Rand Corporation defines a programme as 'proven' where, inter alia, 'at least one outcome is changed by 20%, 0.25 standard deviations or more' (<http://www.promisingpractices.net>) (see also Shonkoff and Phillips, 2000:342-343).

109 The Centre for the Study and Prevention of Violence at University of Colorado in Boulder, USA selects 'Blueprints Model Programs' on the basis of 'the most rigorous tests of effectiveness in the field', and requires that all Blueprint

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measured by total difficulties, exceeds the level of need in the second year group, at 1.0 and 0.69 respectively. Emotional problems and peer problems are significant areas of need for both groups, but conduct problems are an additional area of need for the first year group. Overall, the level of need in both groups is substantially greater than the changes which occurred while participating in Mounttown NYFP, and this gives an indication of the challenge involved in reducing this level of need.

We found that the comparison group was not a useful source of comparison since their pre-test scores are significantly below those of the experimental group, indicating a much lower level of need (see Table A4.1). In addition, this group does not have significant needs in the area of SDQ Symptom, as we have defined need.

### **4.3 Change in SDQ Symptoms: Teacher's Perspective**

The changes in SDQ Symptoms, as reported by teachers, are summarised in Table 4.2. This reveals that there was a significant reduction in the total difficulties of the first year group (an effect size of -0.31), indicating a clear impact during the first year of the programme. Closer inspection reveals that improvements took place in all areas except hyperactivity.

There was no impact on the total difficulties of the second year group (an effect size of +0.10). However there were improvements in terms of peer problems (effect size of -0.19) and prosocial behaviour (+0.38), but these were largely outweighed by disimprovements in emotional problems (effect size of +0.23) and hyperactivity (effect size of +0.13).

These results suggest that Mounttown NYFP has its biggest impact during the first year, with a reduced impact during the second and subsequent years. As indicated in the previous section, the impact produced during the first year is similar to what is normally achieved by family support programmes in the area of children's socio-emotional development (which range from 0.22<sup>110</sup> to 0.27<sup>111</sup>) and is also similar the standard used by one agency for identifying programmes of 'proven' effectiveness which is an effect size of 0.25 or higher for any outcome<sup>112</sup>. However the level of impact in Mounttown NYFP is below the standard set by another agency for the identification of 'blueprint' programmes which require an effect size of 0.5 for one outcome variable<sup>113</sup>.

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programmes have 'at least moderate effect sizes', which imply effect sizes of 0.5 or higher (<http://www.colorado.edu/cspv/blueprints>).

110 Layzer, Goodson, Bernstein and Price, 2001.

111 Nelson, Westhues and MacLeod, 2003

112 The Promising Practices Network run by the Rand Corporation defines a programme as 'proven' where, inter alia, 'at least one outcome is changed by 20%, 0.25 standard deviations or more' (<http://www.promisingpractices.net>) (see also Shonkoff and Phillips, 2000:342-343).

113 The Centre for the Study and Prevention of Violence at University of Colorado in Boulder, USA selects 'Blueprint Model Programs' on the basis of 'the most rigorous tests of effectiveness in the field', and requires that all Blueprint programmes have 'at least moderate effect sizes', which imply effect sizes of 0.5 or higher (<http://www.colorado.edu/cspv/blueprints>).

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**Table 4.2 Estimated Changes in SDQ Symptoms of Children in the Experimental and Comparison Groups following Participation in Mounttown NYFP. Based on Teacher’s Report of ‘SDQ Symptoms’.**

	First Year Group (6)		Second Year Group (13)	
	Change*	Need**	Change*	Need**
Conduct problems	-0.30	+1.31	+0.05	+1.22
Hyperactivity	+0.05	+0.15	+0.13	+1.00
Emotional problems	-0.44	-0.21	+0.23	+0.92
Peer problems	-0.28	-0.13	-0.19	+0.29
Prosocial behaviour	+0.60	+0.13	+0.38	+0.40
<b>Total Difficulties</b>	<b>-0.31</b>	<b>+0.32</b>	<b>+0.10</b>	<b>+1.17</b>

\*Change refers to the difference in pre-test and post-test scores of the experimental groups divided by the pooled standard deviation of the combined experimental groups; for the comparison group, change refers to the difference in pre-test and post-test scores divided by the standard deviation of the comparison group.

\*\*Need refers to the difference between the post-test scores of the experimental group and a representative sample of over 10,000 British children who completed the SDQ (Meltzer, Gatward, Goodman, and Ford, 2000; see also [www.sdqinfo.com](http://www.sdqinfo.com)).

Table 4.2 also reveals that children in Mounttown NYFP have a substantial level of need after the intervention, when compared with a representative sample of British children, particularly the children in the second year group (+1.17). The main area of need for both groups, according to their teachers, is conduct problems, and this level of need is greater than the changes which occurred while participating in Mounttown NYFP, a finding which illustrates the challenge involved in reducing this level of need.

There is no data from teachers on the comparison group. However, as indicated in the previous section, the comparison group is not an appropriate match for the experimental group in terms of needs and, for this reason, there is little benefit in comparing both groups.

A comparison of the responses of teachers and children to SDQ Symptoms reveals some consistent findings about the impact of Mounttown NYFP: (i) the impact is consistently greater in the first year group than in the second year group which implies that the programme creates a greater impact in its first year than in subsequent years; (ii) the impact tends to be felt in a larger number of domains in the first year group (notably emotional and peer problems as well as problems associated with either conduct or hyperactivity) compared to the second year group (notably peer problems and prosocial behaviour with no impact in the areas of conduct or hyperactivity); (iii) the level of need at the end of the intervention is greater than the size of the impact created during the intervention, but teachers identify different areas of need (mainly conduct and hyperactivity problems) compared to children (mainly emotional and peer problems).

## 4.4 Change in Clinical Status

SDQ Symptoms can be classified into the clinical categories of normal, borderline, and abnormal and these can be used to assess changes in the clinical status of children following their participation in Mounttown NYFP. Table 4.3 gives a breakdown of the children whose clinical status improved, disimproved or showed no change. This shows that a majority of children, whether based on the responses of teachers or children, showed no change in clinical status. In addition, there is a broadly similar tendency for children to both improve as well as disimprove; the one exception to this is children in the first year group where, in the opinion of teachers, half improved and the other half stayed the same. The main reason for the overall stability in the clinical categories of children is that change in mean SDQ scores described in the previous sections, though significant, was not sufficient to create significant movement across the clinical categories. This also illustrates why the measurement of changes in mean scores is a more sensitive indicator of impact than changes in clinical status.

**Table 4.3 Estimated Changes in Clinical Status of Children in the Experimental Groups following Participation in Mounttown NYFP. Based on Children’s and Teacher’s Responses to ‘SDQ Symptoms’.**

Category	Based on Children’s Self-report				Based on Teacher’s Report			
	First Year Group (6)		Second Year Group (13)		First Year Group (6)		Second Year Group (13)	
	N	%	N	%	N	%	N	%
Improve	1	17	1	8	3	50	2	16
Disimprove	1	17	2	16	0	0	3	24
No change	4	66	10	76	3	50	8	60
<b>Total</b>	<b>6</b>	<b>100</b>	<b>13</b>	<b>100</b>	<b>6</b>	<b>100</b>	<b>13</b>	

Another influence on the stability of children’s clinical status, as summarised in Table 4.4, lies in the fact that the pre-test scores of a significant proportion of children, particularly in the second year group, were in the normal clinical range, thereby making change unlikely. It should also be noted that screening instruments, such as the SDQ, do not provide a definitive assessment of clinical status, a point emphasised in the Manual for the Beck Youth Inventories: “It is important to note that self-report measures, including the Beck Youth Inventories, should not be used in isolation to make a diagnosis”<sup>114</sup>.

114 Beck, Beck & Jolly, 2001:16

**Table 4.4 Clinical Status of Children’s Pre-test Scores in the Experimental Groups. Based on Children’s and Teacher’s Responses to ‘SDQ Symptoms’.**

Variable	First Year Group (6)	Second Year Group (13)
	Normal Clinical Status (%)	Normal Clinical Status (%)
SDQ Perceived Difficulties: Children’s Report	33	70
SDQ Perceived Difficulties: Teacher’s Report	33	46

#### **4.5 Change in SDQ Perceived Difficulties: Child’s and Teacher’s Perspective**

‘SDQ Perceived Difficulties’ refer to the child’s response to one question: ‘overall, do you think that you have difficulties with any of the following areas: feelings, concentration, behaviour or getting on with others?’ The same question, with appropriate adjustments, is also addressed to the teacher: ‘overall, do you think that the child has difficulties in one or more of the following areas: emotions, concentration, behaviour or being able to get on with people?’ Both the child and the teacher are offered the same four response options comprising ‘no difficulties’, ‘minor difficulties’, ‘definite difficulties’ and ‘severe difficulties’.

Pre-test and post-test responses to this question were used to measure changes in SDQ Perceived Difficulties, as reported by the child and the teacher, and the results are summarised in Table 4.5. This reveals that, after participating in Mounttown NYFP, the effect perceived by both children and teachers is close to zero, indicating no change.

**Table 4.5 Estimated Change in the Experimental Groups, Based on Children’s and Teacher’s Report of ‘SDQ Perceived Difficulties’.**

Variable	First Year Group (6)	Second Year Group (13)
	Change*	Change*
SDQ Perceived Difficulties: Children’s Report	-0.09	-0.04
SDQ Perceived Difficulties: Teacher’s Report	0.00	+0.08

\*Change is measured in terms of the effect size and refers to the difference in pre-test and post-test scores of the experimental groups divided by the pooled standard deviation of the combined experimental groups.

#### **4.6 Change in SDQ Impact: Child’s and Teacher’s Perspective**

‘SDQ Impact’ is based on two questions addressed to the child: (i) do the difficulties upset or distress you? and (ii) do the difficulties interfere with your everyday life in the following areas - home life, friendships, classroom learning and leisure activities? The same two questions, with appropriate adjustments, are addressed to the teacher: (i) do the difficulties upset or distress the child? and (ii) do the difficulties interfere with the child’s

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everyday life in the following areas – peer relationships and classroom learning? The same response options are offered to both the child and the teacher: ‘not at all’, ‘only a little’, ‘quite a lot’ and ‘a great deal’.

The results are summarised in Table 4.6. These show significant differences in how children and their teachers perceive the impact of participating in Mounttown NYFP. In the first year group, children report a significant reduction in the impairments caused by their difficulties (effect size of -0.84) but their teachers report an increase in their impairments (an effect size of +0.27). Conversely, in the second year group, children report no change in the impairments caused by their difficulties (effect size of -0.06) but their teachers report a decrease in their impairments (an effect size of +0.27). These results underline the different perspectives of both children and teachers and the importance of using both perspectives in assessing the needs of children. These different perspectives also need to be seen in the context of the other SDQ results which we summarise at the end of this chapter.

**Table 4.6 Estimated Change in the Experimental Groups, Based on Children’s and Teacher’s Report of ‘SDQ Impact’.**

Variable	First Year Group	Second Year Group
	(6)	(13)
	Change*	Change*
SDQ Impact: Children’s Report	-0.84	-0.06
SDQ Impact: Teacher’s Report	+0.27	-0.32

\*Change is measured in terms of the effect size and refers to the difference in pre-test and post-test scores of the experimental groups divided by the pooled standard deviation of the combined experimental groups.

#### **4.7 Change in SDQ Burden: Child’s Perspective and Teacher’s Perspective**

‘SDQ Burden’ is measured by the following question addressed to the child: do your difficulties make it harder for those around you (family, friends, teachers, etc)? For teachers, the SDQ Burden is measured by a similar question: do the difficulties put a burden on you or the class as a whole? The response options to both questions involve a four-point scale comprising: ‘not at all’, ‘only a little’, ‘quite a lot’ and ‘a great deal’.

Pre-test and post-test responses to this questions were compared to give a measure of change in SDQ Burden, as reported by the child and the teacher, and the results are summarised in Table 4.7. The results show divergent views between children and teachers. In the first year group, children report a significant reduction in the burden which their difficulties impose on others (effect size of -0.82) but their teachers perceive that the burden on others is significantly increased (an effect size of +0.65). Similarly, in the second year group, children report a reduction in the burden which their difficulties impose on others (effect size of -0.30) but their teachers perceive that the burden on others is significantly increased (an effect size of +0.22). As indicated in the previous section, these results illustrate the different perspectives of children and teachers and the importance of using both perspectives in assessing the needs of children. At the end of this chapter, we summarise these different perspectives in the context of the other SDQ results.

**Table 4.7 Estimated Change in the Experimental Groups, Based on Child’s and Teacher’s Report of ‘SDQ Burden’.**

Variable	First Year Group (6)	Second Year Group (13)
	Change*	Change*
SDQ Burden: Children’s Report	-0.82	-0.30
SDQ Burden: Teacher’s Report	+0.65	+0.22

\*Change is measured in terms of the effect size and refers to the difference in pre-test and post-test scores of the experimental groups divided by the pooled standard deviation of the combined experimental groups.

## 4.8 Summary and Conclusion

This chapter described changes in the strengths and difficulties of children during their time at Mounttown NYFP, as measured by the Strengths and Difficulties Questionnaire (SDQ). It is based on data collected from children and their teachers in the experimental group (those who received the NYFP programme) and the comparison group (those who did not receive the NYFP programme). Change is measured by comparing the scores of children at baseline (pre-test scores) and follow-up (post-test scores). Given that the experimental group contains two sub-groups of children – those whose pre-test scores were collected when they started the programme (6 children whom we call the ‘first year group’) and those whose pre-test scores were collected more than a year after they started the programme (13 children whom we call the ‘second year group’) – our analysis assesses the impact on both groups.

The SDQ provides four measures of change: (i) SDQ Symptoms (ii) SDQ Perceived Difficulties (iii) SDQ Impact, and (iv) SDQ Burden. Given that each of these is measured using different numerical scales, the concept of effect size is used in order to provide a common measurement of impact. The formula involves subtracting the pre-test scores from the post-test scores and dividing by the pooled standard deviation. Thus, the effect size is measured in standard deviation units and the score varies from 0.0 to 3.0. The convention established by Jacob Cohen<sup>115</sup>, and referred to as ‘Cohen’s d’, is that a coefficient between 0.2 and 0.5 indicates a small effect, between 0.5 and 0.8 indicates a moderate effect, and above 0.8 indicates a large effect. The results of previous research, based on experimental or quasi-experimental design, indicate that effective programmes for children and families tend to achieve effect sizes in the range 0.2 to 0.5; for example, the impact achieved by family support programmes in the area of children’s socio-emotional development tends to

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<sup>115</sup> Cohen, 1988. The interpretation of effect sizes should be done with care however and even small effect sizes can have enormous practical significance. The medical example used to illustrate this is the effect size of aspirin in reducing heart disease, which is 0.03, yet is widely prescribed by doctors because the cost of the intervention is cheap and the potential benefits are very large (cited in McCartney and Dearing, 2002). In the social field, the effect size of the High / Scope Perry Pre-School Programme in the US when participants reached the age of 23 was 0.36 (Schweinhart and Weikhart, 1997) but the economic return at age 27 is estimated to be \$8 for every \$1 invested (Barnett, 1996), rising to \$17 for every \$1 invested by age 40 (Schweinhart, 2004). This is similar to the results of a meta-analytic review of the effect sizes associated with family support programmes (Layzer, Goodson, Bernstein and Price, 2001) and other pre-school prevention programmes (see Nelson, Westhues and MacLeod, 2003).

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range from 0.22<sup>116</sup> to 0.27<sup>117</sup>. The standard used by one agency for identifying programmes of 'proven' effectiveness is an effect size of 0.25 or higher for any outcome<sup>118</sup> while the standard set by another agency for the identification of 'blueprint' programmes is an effect size of 0.5 for any outcome variable<sup>119</sup>. These benchmarks will be used in our assessment of the impacts of Mounttown NYFP; however they are used only as a guide since this study does not meet the standard of an experimental or quasi-experimental design given that the pre-test scores of the comparison group were significantly different to those of the experimental group with the result that the comparison group is not a useful source of comparison.

Table 4.8 provides a summary of the main impacts, based on the different SDQ measures, as perceived by children and their teachers. The table also estimates the level of need at the end of the programme. The key results are:

- (i) the programme produced benefits for both groups of children.
- (ii) the size of the benefits is considerably greater for the first year group, and covers a much wider range of domains, compared to the second year group.
- (iii) the size of the benefits is considerably greater when measured through the perceptions of children than through the perceptions of teachers.
- (iv) the key domains which benefited in the first year group, and where the perceptions of children and teachers coincide, are hyperactivity / behaviour problems as well as emotional and peer problems; in the second year group, there is agreement between children and teachers that the key domain which benefited was peer problems.
- (v) there was relatively little movement of children between the clinical categories of normal, borderline and abnormal essentially because most of the change was within clinical categories.
- (vi) the level of need which exists at the end of the programme, as defined by the difference in mean scores between children in Mounttown NYFP and a representative sample of British children, is substantial and greater than the benefits generated during the programme. The areas of need vary according to the perceptions of children and teachers; for children, the main areas of need are emotional and peer problems; for teachers the main areas of need are conduct and hyperactivity problems.

These findings have a number of implications. First, the programme's impact on the first year group is substantial and, for a number of outcomes, it exceeds an effect size of 0.5 which is the standard used to identify 'blueprint' programmes. For the second year group, the effect size exceeds 0.25 on a number of outcome variables which is a threshold of effectiveness used to identify 'proven' programmes. This however does not prove that Mounttown NYFP is either a 'blueprint' or 'proven' programme since, as explained above, our study

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116 Layzer, Goodson, Bernstein and Price, 2001.

117 Nelson, Westhues and MacLeod, 2003

118 The Promising Practices Network run by the Rand Corporation defines a programme as 'proven' where, inter alia, 'at least one outcome is changed by 20%, 0.25 standard deviations or more' (<http://www.promisingpractices.net>) (see also Shonkoff and Phillips, 2000:342-343).

119 The Centre for the Study and Prevention of Violence at University of Colorado in Boulder, USA selects 'Blueprints Model Programs' on the basis of 'the most rigorous tests of effectiveness in the field', and requires that all Blueprint programmes have 'at least moderate effect sizes', which imply effect sizes of 0.5 or higher (<http://www.colorado.edu/cspv/blueprints>).

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does not meet the standards of an experimental or quasi experimental design. Nevertheless the results are promising and generally exceed the impacts produced by family support programmes on children's socio-emotional development, which range from 0.22<sup>120</sup> to 0.27<sup>121</sup>. Significantly, the Springboard family support programme in Ireland also used SDQ Symptoms as one of its outcome measures and, based on the total difficulties score, found impacts equivalent to effect sizes of 0.27 (based on children's responses) and 0.16 (based on teacher's responses), which is less than the outcome of Mounttown NYFP for the first year group<sup>122</sup>.

**Table 4.8 Estimated Changes and Needs in the Experimental Groups Following Participation in Mounttown NYFP, Based on Different SDQ Measures as reported by Children and their Teachers**

SDQ Measure	First Year Group (6)				Second Year Group (13)			
	Children's responses		Teachers' responses		Children's responses		Teachers' responses	
	Change*	Need**	Change*	Need**	Change*	Need**	Change*	Need**
SDQ Symptoms: Total Difficulties	-0.26	+1.0	-0.31	+0.32	-0.07	+0.69	+0.10	+1.17
SDQ Symptoms: Conduct problems	+0.07	+0.66	-0.30	+1.31	+0.07	+0.29	+0.05	+1.22
SDQ Symptoms: Hyperactivity	-0.53	+0.2	+0.05	+0.15	+0.16	+0.34	+0.13	+1.00
SDQ Symptoms: Emotional problems	-0.15	+1.21	-0.44	-0.21	-0.17	+0.64	+0.23	+0.92
SDQ Symptoms: Peer problems	-0.20	+1.07	-0.28	-0.13	-0.28	+0.74	-0.19	+0.29
SDQ Symptoms: Prosocial behaviour	-0.61	-0.20	+0.60	+0.13	+0.23	+0.14	+0.38	+0.40
SDQ Perceived Difficulties	-0.09	-	0.00	-	-0.04	-	+0.08	-
SDQ Impact	-0.84	-	+0.27	-	-0.06	-	-0.32	-
SDQ Burden	-0.82	-	+0.65	-	-0.30	-	+0.22	-

\*Change is measured in terms of the effect size and refers to the difference in pre-test and post-test scores of the experimental groups divided by the pooled standard deviation of the combined experimental groups.

Second, it is significant that children and teachers display quite different perspectives in their responses to the SDQ. This is to be expected given that adults and children tend to see the world differently, and these differences may be heightened in a classroom setting where children are having difficulties in meeting the demands being made of them. Given that Mounttown NYFP is there to serve the needs of both children and teachers, it is important that both perspectives are taken into account. In practice the findings create a challenge

120 Layzer, Goodson, Bernstein and Price, 2001.

121 Nelson, Westhues and MacLeod, 2003

122 McKeown, Haase and Pratschke, 2006:21

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for Mounttown NYFP given that teachers perceive that the areas of greatest need among the second year group are behaviour and hyperactivity problems, which are also the areas in which the programme has least impact on the second year group.

Third, the fact that the first year group experienced significantly greater benefits than the second year group poses the more general challenge as to whether the impacts of the programme tend to diminish over time. We are not in a position to answer this since we do not know how the first year group will perform in the second year, nor do we know how the second year group performed in their first year. Tracking children at the end of each year would be necessary to establish how the general pattern of impact varies over time. At face value, the evidence suggests that the programme could produce a larger range of benefits by offering a first year programme to all children who need it, rather than a second year to those who have already received a first year. At the same time, the children in the second year group have a significant level of need – and a much higher level of need than the first year group in the opinion of teachers – and this suggests that a variation in the programme during the second year might be appropriate with a greater focus on addressing problems of behaviour and hyperactivity. Programmes such as The Incredible Years have a demonstrated effectiveness in terms of improving these problems among children as well as improving the capacity of teachers to deal with such children<sup>123</sup>.

Fourth, this study is limited by the small number of children involved, particularly in the first year group, but also by the absence of a credible comparison group. The small number of cases makes the results vulnerable to the possibility that these may not be representative of other children in the school who have similar difficulties, while the absence of a credible comparison group makes it difficult to prove that the changes observed are attributable solely to the intervention of Mounttown NYFP. For these reasons, the results reported here should be regarded as indicative rather than definitive. At the same time, these limitations also provide compelling grounds for continuing to monitor the outcomes of Mounttown NYFP on an ongoing basis, possibly using this study as a template for the evaluation.

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123 see [www.incredibleyears.com](http://www.incredibleyears.com)

## **Chapter Five**

### **Changes in Social and Emotional Impairment**

#### **5.1 Introduction**

This chapter describes changes in the well-being of children, following their participation in Mounttown NYFP, using the Beck Youth Inventories of Emotional and Social Impairment<sup>124</sup>. This instrument measures the child's self-concept as well as mental health difficulties such as depression, anxiety, disruptive behaviour, and anger. In addition, we use the instrument to assess the level of need among these children using the normative standards set out in the Manual for the Beck Youth Inventories.

The Beck Youth Inventories were created to measure mental health difficulties among children aged 7-14 years. The inventories measure five concepts covering depression, anxiety, disruptive behaviour, anger, and self-concept. Each concept is measured by 20 self-report statements with four response options: never, sometimes, often and always. Examples of the statements used to measure each concept indicate that this is a child-friendly instrument: self-concept ('I work hard', 'I like myself', 'I am a good person', 'I like my body', etc); depression ('I think that I am a bad person', 'I feel lonely', 'I hate myself', 'I feel sad', etc); anxiety ('I worry when I am at school', 'I get nervous', 'My hands shake', 'I have problems sleeping', etc); disruptive behaviour ('I steal', 'I do mean things', 'I hate listening to other people', 'I break the rules', etc); and anger ('I feel like screaming', 'I get mad at other people', 'I hate people', 'I get angry', etc).

We measure the change which occurred while the children were attending Mounttown NYFP in two ways. First, we compare the difference in pre-test and post-test scores and standardise the amount of change using the effect size statistic (Section 5.2). Second, we estimate the extent of clinical change by calculating the number of children who move from one clinical category to another (Section 5.3). Given that the experimental group contains two sub-groups of children – those whose pre-test scores were collected when they started the programme (6 children whom we call the 'first year group') and those whose pre-test scores were collected more than a year after they started the programme (13 children whom we call the 'second year group') – our analysis estimates the extent of change in both groups. We conclude by summarising the key results (Section 5.4). Detailed tables of findings pertaining to this chapter are in the Appendix to Chapter Five.

#### **5.2 Change in Mean Scores**

The amount of change in the first year and second year groups, after participating in Mounttown NYFP, is summarised in Table 5.1. This reveals that the first year group showed significant and substantial improvement as a result of reductions in the four areas of depression (effect size of -0.74), anxiety (effect size of -0.86), disruptive behaviour (effect size of -0.15), and anger (effect size of -0.54); the overall reduction in these four

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areas combined was an effect size of -0.69. By contrast, the second year group showed no change in these domains while the level of anxiety increased (effect size of +0.49). The main reason for the difference in both groups is that the pre-test scores of the first year group were much higher than the second year group, indicating a much higher level of need among the first year group and a much greater scope for improvement.

The changes in the first year group exceed what is normally achieved by family support programmes in the area of children's socio-emotional development (which range from 0.22<sup>125</sup> to 0.27<sup>126</sup>) as well as the standard used by one agency for identifying programmes of 'proven' effectiveness which is an effect size of 0.25 or higher for any outcome<sup>127</sup>. In addition, it exceeds the standard set by another agency for the identification of 'blueprint' programmes which require an effect size of 0.5 for one outcome variable<sup>128</sup>.

The one domain which exhibited unusual results in both the first year and second year groups is self-concept. At pre-test, both groups had self-concept scores which were well in excess of the average Irish child and there was little room for improvement. As a consequence, the first year group showed a decrease in self-concept scores while the second year group showed no change. It is difficult to explain why the scores of both groups of children seem to be so at variance with both Irish norms and with the children's other scores.

The comparison group, as Table 5.1 reveals, is not a useful source of comparison since their pre-test scores are significantly below those of the experimental group, but are also below the scores of a representative sample of Irish children. This implies that the comparison group does not present as having any needs, as measured by the Beck Youth Inventories of Emotional and Social Impairment. It is challenging to explain why the scores of the comparison group should be so at variance with the expected pattern of responses to this scale.

At the end of the programme, as illustrated in Table 5.1, children in both groups still have a substantial level of need, when compared with a representative sample of Irish children. The level of need is higher in the first year group (an effect size of +0.89) than in the second year group (an effect size of +0.52), and exceeds the impact achieved during the first year of the programme (-0.69). This illustrates the challenge involved in reducing the level of need, particularly in view of the reduced impacts associated with the second and subsequent years of the programme.

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124 Adapted from Beck, Beck & Jolly, 2001.

125 Layzer, Goodson, Bernstein and Price, 2001.

126 Nelson, Westhues and MacLeod, 2003

127 The Promising Practices Network run by the Rand Corporation defines a programme as 'proven' where, inter alia, 'at least one outcome is changed by 20%, 0.25 standard deviations or more' (<http://www.promisingpractices.net>) (see also Shonkoff and Phillips, 2000:342-343).

128 The Centre for the Study and Prevention of Violence at University of Colorado in Boulder, USA selects 'Blueprints Model Programs' on the basis of 'the most rigorous tests of effectiveness in the field', and requires that all Blueprint programmes have 'at least moderate effect sizes', which imply effect sizes of 0.5 or higher (<http://www.colorado.edu/cspv/blueprints>).

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**Table 5.1 Estimated Changes in the Experimental and Comparison Groups following Participation in Mounttown NYFP. Based on Children’s Self-Report to the Beck Youth Inventories of Emotional and Social Impairment.**

Category	First Year Group (6)		Second Year Group (13)		Comparison Group (18)	
	Change*	Need**	Change*	Need**	Change*	Need**
Self-concept	-1.05	+2.44	+0.06	+2.72	-0.07	+2.36
Depression	-0.74	+0.92	+0.04	+0.55	0.00	-0.56
Anxiety	-0.86	+0.87	+0.49	+0.76	-0.37	-1.05
Disruptive behaviour	-0.15	+0.43	+0.02	+0.05	-0.16	-1.03
Anger	-0.54	+0.79	+0.01	+0.36	-0.21	-0.70
<b>Total</b>	<b>-0.69</b>	<b>+0.89</b>	<b>+0.16</b>	<b>+0.52</b>	<b>-0.23</b>	<b>-0.95</b>

\*Change refers to the difference in pre-test and post-test scores of the experimental groups divided by the pooled standard deviation of the combined experimental groups; for the comparison group, change refers to the difference in pre-test and post-test scores divided by the standard deviation of the comparison group.

\*\*Need refers to the difference between the post-test scores of the experimental groups and a representative sample of 234 children in Ireland (McKeown, Pratschke and Haase, 2003).

### 5.3 Change in Clinical Status

The Manual for the Beck’s Youth Inventories provides guidelines on how to translate ‘raw scores’ into ‘t-scores’ and for re-classifying t-scores into clinical ranges. The terms used to classify the clinical ranges for depression, anxiety, disruptive behaviour, and anger are: average, mildly elevated, moderately elevated, extremely elevated. For self-concept, the clinical ranges are labelled: above average, average, lower than average, much lower than average. These clinical ranges are used to assess the extent of change which is detailed in Tables A5.2 to A5.6 in the Appendix to Chapter Five.

Table 5.2 summarises the changes in clinical status following participation in Mounttown NYFP. This shows that the four of the six children in the first year group (67%), and twelve of the thirteen children in the second year group (92%), showed no change in clinical status.

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**Table 5.2 Estimated Changes in Clinical Status of Children’s in the Experimental Groups following Participation in Mounttown NYFP. Based on Children’s Self-Report to the Beck Youth Inventories of Emotional and Social Impairment.**

Variable	First Year Group (6)			Second Year Group (13)		
	Improve %	Disimprove %	No change %	Improve %	Disimprove %	No change %
Self-Concept	-	33	67	15	23	62
Depression	17	-	83	8	-	92
Anxiety	33	-	67	8	8	84
Disruptive	17	-	83	-	-	100
Anger	33	17	50	8	-	92
Total	33*	0	67	8*	0	92

\*This refers to children who improved in three of the following four domains: depression, anxiety, disruptive behaviour and anger.

The reason for stability in clinical status is due to the fact, as summarised in Table 5.3, that the pre-test scores of most of children were in the normal clinical range, thereby making change unlikely. It should also be noted that screening instruments, such as the Beck Youth Inventories and the SDQ used in the previous chapter, do not provide a definitive assessment of clinical status, as the Manual for the Beck Youth Inventories points out: “It is important to note that self-report measures, including the Beck Youth Inventories, should not be used in isolation to make a diagnosis”<sup>129</sup>.

**Table 5.3 Clinical Status of Children’s Pre-test Scores in the Experimental Groups. Based on Children’s Self-Report to the Beck Youth Inventories of Emotional and Social Impairment.**

Variable	First Year Group (6)	Second Year Group (13)
	Normal Clinical Status (%)	Normal Clinical Status (%)
Self-Concept	100	100
Depression	83	92
Anxiety	83	92
Disruptive behaviour	83	100
Anger	67	92

129 Beck, Beck & Jolly, 2001:16

## **5.4 Summary and Conclusion**

This chapter described changes in the well-being of children, following their participation in Mounttown NYFP, using the Beck Youth Inventories of Emotional and Social Impairment<sup>130</sup>. This instrument measures the child's self-concept as well as mental health difficulties such as depression, anxiety, disruptive behaviour, and anger. We compared the children's pre-test and post-test scores on each concept and estimated the amount of change for both groups of children: those whose pre-test scores were collected when they started the programme (6 children whom we call the 'first year group'), and those whose pre-test scores were collected more than a year after they started the programme (13 children whom we call the 'second year group'). We also collected the same data from a comparison group but this turned out not to be a useful source of comparison since their pre-test scores are significantly below those of the experimental group, but are also below the scores of a representative sample of Irish children.

After participating in Mounttown NYFP, the first year group showed significant and substantial improvement as a result of reductions in the four areas of depression, anxiety, disruptive behaviour, and anger; the overall reduction in these four areas combined was an effect size of -0.69. By contrast, the second year group showed no change in these domains while their level of anxiety increased, although the pre-test and post-test scores of the second year group are much lower than those of the first year group thereby reducing the scope for change.

The changes in the first year group exceed what is normally achieved by family support programmes in the area of children's socio-emotional development (which range from 0.22<sup>131</sup> to 0.27<sup>132</sup>) as well as the standard used by one agency for identifying programmes of 'proven' effectiveness which is an effect size of 0.25 or higher for any outcome<sup>133</sup>. In addition, it exceeds the standard set by another agency for the identification of 'blueprint' programmes which require an effect size of 0.5 for one outcome variable<sup>134</sup>.

At the end of the programme, children in both groups still have a substantial level of need, when compared with a representative sample of Irish children. The level of need is higher in the first year group (an effect size of +0.89) than in the second year group (an effect size of +0.52), and exceeds the impact achieved during the first year of the programme (-0.69). This illustrates the challenge involved in reducing the level of need, particularly in view of the reduced impacts associated with the second and subsequent years of the programme.

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130 Adapted from Beck, Beck & Jolly, 2001.

131 Layzer, Goodson, Bernstein and Price, 2001.

132 Nelson, Westhues and MacLeod, 2003

133 The Promising Practices Network run by the Rand Corporation defines a programme as 'proven' where, inter alia, 'at least one outcome is changed by 20%, 0.25 standard deviations or more' (<http://www.promisingpractices.net>) (see also Shonkoff and Phillips, 2000:342-343).

134 The Centre for the Study and Prevention of Violence at University of Colorado in Boulder, USA selects 'Blueprints Model Programs' on the basis of 'the most rigorous tests of effectiveness in the field', and requires that all Blueprint programmes have 'at least moderate effect sizes', which imply effect sizes of 0.5 or higher (<http://www.colorado.edu/cspv/blueprints>).

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We also analysed changes in clinical status following participation in Mounttown NYFP and found that most of the children showed no change in clinical status. Further inspection revealed that the pre-test scores of most of children were in the normal clinical range, thereby making clinical change unlikely.

These findings draw attention to three implications. First, they reinforce the finding in the previous chapter that the largest amount of change in Mounttown NYFP takes place during the first year of the programme. To some extent, this is attributable to the fact that the pre-test scores of children in the first year group tend to indicate a higher level of need than the pre-test scores of children in the second year group - the exception being the teachers' pre-test SDQ scores which show a higher level of need in the second year group – which in itself generates a greater scope for change. This raises the question as to whether the reduced impact on the second year group is due to the fact that the level of need is less in this group – a view supported by the self-reports of the children but not of their teachers – or whether, due to familiarity and habituation, the programme loses some of its capacity for change in the second year. It is likely that both factors are involved and this poses a challenge to examine ways of sustaining the programme's impact during the second year.

Second, the needs which children present through their self-report to the Beck Youth Inventories tend to involve emotions such as depression, anxiety and anger. This is similar to the results of the SDQ in the previous chapter which also identified emotional and peer problems as the main areas of need which were revealed by the children's self-report. Consistent with this, children's self-reports present as having fewer needs in the area of disruptive behaviour (using the Beck Youth Inventories), or hyperactivity / conduct problems (using the SDQ). For teachers, however, as we have seen in the previous chapter, the main area of need among these children concerns behaviour problems, a finding which suggests that children may be more attuned to their own feelings than to the consequences of their behaviour on others, particularly in a classroom setting. It is significant that the domain of least impact for both the first year and second year groups, as measured by the Beck Youth Inventories in this chapter, was disruptive behaviour; while the domains of least impact for the second year group, as measured by the SDQ in the previous chapter, were hyperactivity / conduct problems. These considerations pose a challenge for Mounttown NYFP on how to match improvements in emotional well-being with improvements in the children's behaviour, particularly as it relates to the classroom setting. In order to create a more holistic picture of the needs of the child, it would also be useful to include the views of parents in making an assessment since the views of parents, teachers and children offer a picture of the child in different settings and from different perspectives.

Third, as in the previous chapter, we have used two methods to measure the extent of need among children and each yields quite different results. The first method involved comparing the mean scores of the children in Mounttown NYFP with the mean scores of a representative sample of Irish children and this indicated significant levels of need, based on the assumption that the mean scores of Irish children represent a useful statistical point of comparison. The second method involved classifying the children's pre-test and post-test scores into clinical categories, following the guidelines in The Manual for the Beck Youth Inventories and this indicated that most children were in normal clinical range. This is not dissimilar to the finding in the previous chapter using the SDQ and highlights the fact that clinical status cannot be based on the results of a screening

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instrument alone, as the Manual for the Beck Youth Inventories points out: “It is important to note that self-report measures, including the Beck Youth Inventories, should not be used in isolation to make a diagnosis”<sup>135</sup>. In view of this, we have tended to use the comparison of means as our main definition of need, while also using the Beck Youth Inventories as a more useful instrument for measuring change than need.

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135 Beck, Beck & Jolly, 2001:16

## Chapter Six

### Changes in Life Satisfaction and Physical Symptoms

#### 6.1 Introduction

The well-being of children, as of adults, is measured not just by the absence of symptoms but the presence of physical and mental health. To be healthy, according to the World Health Organisation, involves “a complete state of physical, mental and social well-being and not merely the absence of disease or infirmity”<sup>136</sup>. The importance of using positive indicators to measure well-being is increasingly recognised by psychologists and provides a necessary counterbalance to measurement based on negative symptoms. Equally, it is recognised that services to improve children’s lives have tended to focus on “the remediation of problems, ridding children of psychopathology, or reducing the potential for pathology to develop” but this needs to be complemented by a focus on “developing strengths, facilitating positive responses to adversity, and strengthening the important institutions in children’s lives”<sup>137</sup>.

Against this background, we measured changes in children’s life satisfaction using the Multi-Dimensional Students Life Satisfaction Scale<sup>138</sup> (Section 6.2). We also measured changes in physical symptoms (Section 6.3) and their use of substances such as smoking, drinking, or taking drugs (Section 6.4). As in the previous chapters, our analysis estimates the extent of change in both groups of children who comprise the experimental group: those whose pre-test scores were collected when they started the programme (6 children whom we call the ‘first year group’) and those whose pre-test scores were collected more than a year after they started the programme (13 children whom we call the ‘second year group’). Given that the scales used in this chapter do not have clinical thresholds, the measurement of change in clinical status does not apply; however we use comparative data to assess the extent of need among children after the intervention. We conclude the chapter by summarising the key results (Section 6.5). Detailed tables of findings pertaining to this chapter are in the Appendix to Chapter Six.

#### 6.2 Changes in Life Satisfaction

We measured the life satisfaction of children using the Multi-Dimensional Students Life Satisfaction Scale<sup>139</sup>. This scale measures the satisfaction which children experience in five key domains of their lives namely self, family, friends, school, and living environment. Each domain is measured using four statements with six response options varying from ‘strongly disagree’ to ‘strongly agree’. Examples of the statements used to measure each concept indicate that this is a child-friendly instrument: family (‘I enjoy being at home with my

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136 Quoted in Department of Health, 2001:15

137 Huebner, Suldo, Smith, and McKnight, 2004:81

138 Huebner, 2001.

139 Huebner, 2001.

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family', 'I like spending time with my parents'); friends ('My friends are nice to me', 'I have a lot of fun with my friends'), school ('I look forward to going to school', 'I wish I didn't have to go to school'); living environment ('I like where I live', 'I wish I lived in a different house'); self ('I am a nice person', 'Most people like me'). As with the other scales used, the psychometric properties of the Multi-Dimensional Students Life Satisfaction Scale have been well-tested for reliability and validity.

The amount of change in the first year and second year groups, after participating in Mounttown NYFP, is summarised in Table 6.1. This reveals that the second year group showed a significant and substantial improvement in overall life satisfaction (effect size of +0.57) compared to the first year group which experienced a slight reduction in life satisfaction (effect size of -0.17). However these results need to be seen in the context that the overall pre-test scores of both groups were the same as the scores of a representative sample of Irish children, suggesting that this is not a significant area of need for either group of children. By the same reasoning, neither group exhibited a significant level of need after participating in Mounttown NYFP. Nevertheless it is noteworthy that the second year group showed improvements in all of the domains measured (family, friends, living environment and self) with the exception of school (effect size of -0.09) while, conversely, school was the only domain of significant improvement for the first year group (effect size of +0.26).

The changes in the second year group exceed what is normally achieved by family support programmes in the area of children's socio-emotional development (which range from 0.22<sup>140</sup> to 0.27<sup>141</sup>) as well as the standard used by one agency for identifying programmes of 'proven' effectiveness which is an effect size of 0.25 or higher for any outcome<sup>142</sup>. In addition, it exceeds the standard set by another agency for the identification of 'blueprint' programmes which require an effect size of 0.5 for one outcome variable<sup>143</sup>.

The comparison group, as Table 6.1 reveals, is not a useful source of comparison since their pre-test scores are significantly above the experimental groups, but are also above the scores of a representative sample of Irish children. This implies that the comparison group does not present as having any needs in the area of life satisfaction. It is challenging to explain why the scores of the comparison group should be so at variance with the expected pattern of responses to this scale.

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140 Layzer, Goodson, Bernstein and Price, 2001.

141 Nelson, Westhues and MacLeod, 2003

142 The Promising Practices Network run by the Rand Corporation defines a programme as 'proven' where, inter alia, 'at least one outcome is changed by 20%, 0.25 standard deviations or more' (<http://www.promisingpractices.net>) (see also Shonkoff and Phillips, 2000:342-343).

143 The Centre for the Study and Prevention of Violence at University of Colorado in Boulder, USA selects 'Blueprints Model Programs' on the basis of 'the most rigorous tests of effectiveness in the field', and requires that all Blueprint programmes have 'at least moderate effect sizes', which imply effect sizes of 0.5 or higher (<http://www.colorado.edu/cspv/blueprints>).

**Table 6.1 Estimated Changes in the Experimental and Comparison Groups following Participation in Mounttown NYFP. Based on the Multidimensional Student’s Life Satisfaction Scale.**

Variable	First Year Group (6)		Second Year Group (13)		Comparison Group (18)	
	Change*	Need**	Change*	Need**	Change*	Need**
Family	-0.75	-0.17	+0.74	+0.91	+0.29	+2.18
Friends	0.00	-0.31	+0.84	+0.44	-0.08	+0.47
School	+0.26	+0.17	-0.09	-0.14	-0.19	+0.67
Living Environment	-0.14	+0.02	+0.21	+0.33	+0.16	+1.04
Self	-0.15	-0.50	+0.39	+0.51	+0.30	+0.78
<b>Total</b>	<b>-0.17</b>	<b>-0.17</b>	<b>+0.57</b>	<b>+0.56</b>	<b>+0.10</b>	<b>+1.44</b>

\*Change refers to the difference in pre-test and post-test scores of the experimental groups divided by the pooled standard deviation of the combined experimental groups; for the comparison group, change refers to the difference in pre-test and post-test scores divided by the standard deviation of the comparison group.

\*\*Need refers to the difference between the post-test scores of the experimental groups and a representative sample of 234 children in Ireland (McKeown, Pratschke and Haase, 2003).

### 6.3 Changes in Physical Symptoms

We measured the physical well-being of children using an abbreviated version of the Health and Daily Living Scales<sup>144</sup>. This scale measures the frequency with which the following symptoms were experienced in the previous 12 months: upset stomach, indigestion, headaches, nightmares, trouble going to sleep, had to miss school due to illness. The presence of physical symptoms can be a sign of either physical problems or psychological problems, or both. Where symptoms are based entirely on self-report, as here, they are a reliable indicator of psychological problems<sup>145</sup>. Indeed it has been found that subjective ratings of personal health – but not the objective ratings of a medical expert - are associated with levels of happiness and associated personality traits. In other words, a person’s self-reported symptoms may indicate more about their psychological than their physical state. Indeed, there is growing evidence that a person’s physical well-being is influenced by their psychological well-being since “the immune systems of happy people work more effectively than those of unhappy people ... [which] may account of the longevity of happy people”<sup>146</sup>.

Table 7.2 summarises the changes in physical symptoms, expressed in terms of effect sizes, for children who have spent one year on the programme (the first year group), and children who have spent one or more additional years on the programme (the second year group). This reveals that there was a significant increase in the total symptoms of the first year group (an effect size of +0.46), but no change in the second year group (an effect size of +0.03). These results should be seen in the context that the pre-test and post-test scores of both groups are well above the mean score of a representative sample of Irish children, which suggests a significant level of need in terms of physical symptoms. Closer inspection of Table 7.2 reveals that the symptoms of the

144 Adapted from Moos, Cronkite, Billings, and Finney, 1986.

145 Derogatis, 1992; see also [www.pearsonassessments.com](http://www.pearsonassessments.com)

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first year group increased in all but one of the domains measured (upset stomach, headaches, nightmares and too ill for school); the exception is a reduction in trouble going asleep (effect size of -0.36). For the second year group, there was no change in symptoms of upset stomach, a decrease in headaches and being too ill for school, but an increase in nightmares and trouble going to sleep.

These results suggest that Mounttown NYFP has no consistent impact on physical symptoms. This is somewhat surprising given that both groups have a significant level of need in this area which is indicated in Table 7.2 by effect sizes of +1.38 for the first year group and +1.11 for the second year group. The higher level of need in terms of physical symptoms is also somewhat inconsistent with the finding in the previous section which indicates that both groups of children enjoy a level of life satisfaction which is similar to that enjoyed by other Irish children. In addition, given the psychological improvements experienced by the first year group as described in Chapters Four and Five, and the acknowledged link between physical and psychological well-being, it is surprising that the first year group presents with an increase in physical symptoms after participating in Mounttown NYFP.

By contrast, we found that the comparison group had similar pre-test scores to a representative sample of Irish children indicating that this group does not have a significant level of need. As such, it is not a useful source of comparison since their pre-test scores are significantly below those of the experimental group.

**Table 6.2 Estimated Changes in the Experimental and Comparison Groups following Participation in Mounttown NYFP. Based on the Health and Daily Living Scale.**

Variable	First Year Group (6)		Second Year Group (13)		Comparison Group (18)	
	Change*	Need**	Change*	Need**	Change*	Need**
Upset stomach	+0.45	+0.28	0.00	+0.52	+0.55	-0.41
Headaches	+0.53	+0.93	-0.65	+0.09	+0.35	-0.42
Nightmares	+0.27	+1.12	+0.25	+0.99	0.00	+0.02
Trouble going asleep	-0.36	+0.59	+0.83	+0.78	0.00	-0.30
Too ill for school	+0.55	+0.24	-0.82	-0.14	+0.07	-0.34
<b>Total</b>	<b>+0.46</b>	<b>+1.27</b>	<b>+0.03</b>	<b>+1.00</b>	<b>+0.30</b>	<b>-0.44</b>

\*Change refers to the difference in pre-test and post-test scores of the experimental groups divided by the pooled standard deviation of the combined experimental groups; for the comparison group, change refers to the difference in pre-test and post-test scores divided by the standard deviation of the comparison group.

\*\*Need refers to the difference between the post-test scores of the experimental groups and a representative sample of 234 children in Ireland (McKeown, Pratschke and Haase, 2003).

## 6.4 Changes in Smoking and Drinking

We measured the prevalence of smoking by asking if the children had ever smoked and if they currently smoke. Similarly, we asked if they have ever tried alcohol and if they have taken alcohol during the past month. The results are summarised in Table 6.3 and show slight differences between the first year group and the second year group, possibly reflecting the age difference in the two groups. In the first year group, there was an increase in the number of children who have ever smoked (from 0 to 2), who currently smoke (from 0 to 1), but no change in the number who have ever tried alcohol (from 2 to 2), and an increase in the number who took alcohol in the past month (from 0 to 1). In the second year group, there was an increase in the number of children who have ever smoked (from 1 to 4), but no change in the number who currently smoke (from 1 to 1), an increase in the number who have ever tried alcohol (from 4 to 9), but a decrease in the number who took alcohol in the past month (from 3 to 1).

These findings, in conjunction with the fact that children in this age group are likely to experiment with smoking and drinking, suggest that the experience of Mounttown NYFP had no effect on the propensity to smoke or drink. However, it is worth noting that the prevalence of smoking and drinking among Mounttown children is considerably less than the prevalence rate among a nationally representative sample of 11, 13 and 15 year olds.

**Table 6.3 Estimated Changes in the Experimental and Comparison Groups following Participation in Mounttown NYFP.**

Variable	First Year Group (6)		Second Year Group (13)		Comparison Group (18)		Ireland*
	Pre	Post	Pre	Post	Pre	Post	
% ever smoked	0	33	8	31	6	6	41
% currently smoke	0	17	8	8	0	0	19
% ever tried alcohol	33	33	31	54	39	22	60
% alcohol in last month	0	17	23	8	0	0	25

\*Based on a representative sample of 5,712 children in Ireland aged 11, 13 and 15 (Centre for Health Promotion Studies, 2003:24; 31-32).

## 6.5 Summary and Conclusion

This chapter measured the life satisfaction of children using the Multi-Dimensional Students Life Satisfaction Scale<sup>147</sup>. This scale measures the satisfaction which children experience in five key domains of their lives namely self, family, friends, school, and living environment. The results show that, after participating in Mounttown NYFP, the second year group showed a significant and substantial improvement in overall life satisfaction (effect size of +0.57) compared to the first year group which experienced a slight reduction in life satisfaction (effect size of -0.17). However these results need to be seen in the context that the overall pre-test

<sup>147</sup> Huebner, 2001.

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scores of both groups were the same as the scores of a representative sample of Irish children, suggesting that this is not a significant area of need for either group of children. Similarly, neither group exhibited a significant level of need after participating in Mounttown NYFP. Nevertheless it is noteworthy that the second year group showed improvements in all of the domains measured (family, friends, living environment and self) with the exception of school (effect size of -0.09) while, conversely, school was the only domain of significant improvement for the first year group (effect size of +0.26).

We also measured changes in the physical well-being of children using an abbreviated version of the Health and Daily Living Scales<sup>148</sup>. This scale measures the frequency with which the following symptoms were experienced in the previous 12 months: upset stomach, indigestion, headaches, nightmares, trouble going to sleep, had to miss school due to illness. The results showed that there was a significant increase in the total symptoms of the first year group (an effect size of +0.46) – which implies a disimprovement in physical well-being - but no change in the second year group (an effect size of +0.03). This result suggest that Mounttown NYFP has no consistent impact on physical symptoms which is a little surprising in view of the fact that the pre-test and post-test scores of both groups are well above the mean scores of a representative sample of Irish children, thereby suggesting a significant level of need in terms of physical symptoms. It is also surprising that physical symptoms showed no improvement in light of the psychological impacts experienced by the first year group as described in Chapters Four and Five, and the acknowledged link between physical and psychological well-being.

We measured the prevalence of smoking and drinking and found that, during their time at Mounttown NYFP, there was a slight increase in the number of children who have ‘ever smoked’, who ‘currently smoke’, who have ‘ever tried alcohol’, but a small decrease in the number who ‘took alcohol in the past month’. This suggests that the experience of Mounttown NYFP had no effect on the propensity to smoke or drink although it is also worth noting that the prevalence of smoking and drinking among these children is considerably less than the prevalence rate among a nationally representative sample of 11, 13 and 15 year olds.

It is useful to put the results of this chapter in the broader context of results from the previous two chapters. Taken together, these results show that children in the first year and second year groups have significant psychological needs as measured by the Strengths and Difficulties Questionnaire (Chapter Four) and The Beck Youth Inventories of Social and Emotional Impairment (Chapter Five). These psychological needs are consistent with the fact, reported in this chapter, that children in both groups present with a significantly higher number of physical symptoms compared to the average Irish child. However it is noteworthy that these negative experiences do not seem to diminish the children’s life satisfaction, as reported in this chapter, which is similar to that enjoyed by other Irish children, both before and after their participation in Mounttown NYFP. These findings suggests that the domains of psychological problems and physical symptoms are quite separate from the domain of life satisfaction. In other words, having problems is not necessarily inconsistent with enjoying life, unless and until one translates those problems into a personal identify which generates internalised

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148 Adapted from Moos, Cronkite, Billings, and Finney, 1986.

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suffering. As a consequence, life satisfaction is not the opposite of having psychological problems and physical symptoms, but may indicate a capacity to cope with those difficulties. This interpretation is also supported by the fact that, although these children's emotional and behaviour patterns tend to deviate from accepted norms, and tend to create problems for themselves and others, the children seem to have relatively limited self-awareness of this situation, as evidenced by the findings in Chapter Four. As a result, it would seem that the children have not created a self-identity around the problems which others, notably teachers, have observed; unlike adults and, to a lesser extent, adolescents, these children seem to be free from the internalised burden of identifying with their problems. This is a significant asset for the children – the asset based on innocence rather than awareness - and clearly reflects their age but probably also reflects the non-stigmatising style of intervention offered by Mounttown NYFP. In terms of a strengths-based perspective, it is clear that the capacity of these children to enjoy life while also having problems is an important asset which is being used by Mounttown NYFP, mindful that this asset will tend to diminish as the child grows into adolescence, as part of normal psychological development. This reality also underlines the importance of early intervention where 'early' is understood as early in the life of the problem as well as early in the life of the child<sup>149</sup>.

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149 Health and social services are sometimes referred to as forms of intervention which vary according to the time at which they intervene in the life of a problem. Some interventions are made before the problem is allowed to emerge (prevention), others occur after the problem has emerged but are made early in order to stop the problem getting worse (early intervention), while yet others take place when the problem is fully developed in order to address the consequences which have evolved (treatment).

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## **Chapter Seven**

### **Changes in Relationship with Parents**

#### **7.1 Introduction**

This chapter describes changes in the relationship of children to their parents, following participation in Mounttown NYFP. We measured three aspects of this relationship. First, we measured the child's attachment to its parents using The Inventory of Parent and Peer Attachment (IPPA)<sup>150</sup>. Second, we measured the child's perception of parental supportiveness using the Parenting Style Scale<sup>151</sup>. Third, we measured the extent of conflict and unresolved problems which the child has with its parents, using a composite scale that has been used elsewhere<sup>152</sup>. As in the previous chapters, change is measured by comparing the scores of children at baseline (pre-test scores) and follow-up (post-test scores). Given that the experimental group contains two sub-groups of children – a 'first year group' comprising 6 children whose pre-test scores were collected when they started the programme, and a 'second year group' comprising 13 children whose pre-test scores were collected more than a year or more after they started the programme – our analysis assesses the impact on both groups.

We begin by reporting on changes in the attachment of children to their parents (Section 7.2). We then report on changes in the perceived supportiveness of parents (Section 7.3) and on the extent of unresolved problems between the child and its parents (Section 7.4). We conclude by summarising the key findings (Section 7.5). Detailed tables of findings pertaining to this chapter are in the Appendix to Chapter Seven.

#### **7.2 Changes in Attachment to Parents**

The concept of attachment, as it relates to children, refers to an enduring emotional bond between the child and significant others, notably the parents<sup>153</sup>. The quality of attachment between a child and its parent(s) varies on a continuum from secure attachment to insecure attachment and it has a life-long influence on the well-being of children and adults essentially because the experience of attachment during the early years of life seems to create an internal model for subsequent close relationships<sup>154</sup>. The internal model created during childhood is enduring and varies according to the attachment relationship between child and parent; secure attachment generates an internal model where the self is experienced as worthy and lovable, and others are expected to be trustworthy and responsive; conversely, insecure attachment creates a self that is experienced as unworthy and unlovable and who expects others to be untrustworthy and unresponsive.

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150 Armsden and Greenberg, 1987

151 Lamborn, Mounts, Steinberg and Dornbusch, 1991.

152 McKeown, Pratschke and Haase, 2003

153 Bowlby, 1979

154 Ainsworth, 1991

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Recent reviews of research on attachment found that adolescents who were securely attached to parents and peers had increased life satisfaction, school achievement, self esteem and psychological adjustment while, conversely, insecurely attached adolescents were more likely to exhibit emotional and behavioural problems with a greater risk of psychopathology in adulthood<sup>155</sup>. Despite some differences in attachment behaviours associated with mothers and fathers, the research suggests that “fathers and mothers seem to influence their children in similar rather than dissimilar ways ... parental warmth, nurturance, and closeness are associated with positive child outcomes regardless of whether the parent involved is a mother or a father”<sup>156</sup>.

Variations in the quality of attachment between a child and its parents have four main sources: (i) characteristics of the child, such as particular behaviour or perception patterns (ii) characteristics of the parent, such as the degree of responsiveness or sensitivity (iii) characteristics of the relationship itself, such as the way the child and parent adjust to each other’s unique characteristics and (iv) characteristics of the family, such as variations in education, income and other factors. This observation has practical implications for service providers since interventions to improve the quality of an attachment relationships need to be informed by a proper diagnosis before deciding whether interventions should focus on the child, the attachment figure, the attachment relationship, the family, or a particular combination of these factors<sup>157</sup>.

The Inventory of Parent and Peer Attachment (IPPA)<sup>158</sup> was used to assess the quality of children’s attachment to their parents; this scale also measures the child’s attachment to peers which we report on, although it is open to debate whether the ‘attachment’ which a child has to its parents is of the same order as the ‘attachment’ which a child has to its peers. The IPPA is a widely used instrument and is well-researched psychometrically. The scale measures positive and negative experiences – covering emotional, cognitive, and behavioural domains - associated with three attachment figures: mother, father, peers. The IPPA has not been developed for clinical purposes, with the result that the scale does not have a threshold separating normal levels of secure attachment from abnormal levels of insecure attachment. However we use data from a representative sample of 288 adolescents in Holland, each living in a two-parent family, as a benchmark against which to assess the attachment of children in Mounttown NYFP.

The changes in attachment to parents are summarised in Table 7.1. This shows that, following participation in Mounttown NYFP, the first year group experienced a significant decline in attachment to mothers (effect size of -0.61), and an even greater decline in attachment to fathers (effect size of -1.12). In the second year group, there

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155 Murray and Greenberg, 2006; Ridenour, Greenberg and Cook, 2006; Wilkinson and Walford, 2001; Wilkinson and Parry, 2004

156 Lamb and Tamis-Lemonda, 2004:10

157 In a study, based on a representative sample of 288 two-parent families with adolescent children (aged 11-15) in Holland, the authors tested the relative importance these four influences on the quality of attachment and found that the two strongest influences were characteristics of the child and the relationship, while the two weakest influences were characteristics of the parent and the family. Commenting on the implications of this, the authors observe that “if an adolescent reports a low quality of attachment to his or her parents, it might be important that intervention focus not only on the adolescent but also on the specific relationship. Characteristics of the attachment figure do not seem to be very important in causing differences between adolescents in quality of attachment to their parents, so, considering our results, it might not be very effective for the attachment figure to be the focus of the intervention (Buist, Dekovic, Meeus, and van Aken, 2004:845).

158 Armsden and Greenberg, 1987

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was no change in attachment to mothers but a decline in attachment to fathers (effect size of -0.22). One reason for the decline in attachment to parents may be that the pre-test scores of both groups were already above those of a representative sample of Dutch children which, since this is the only statistical norm we have available for this scale, would suggest that the children in Mounttown NYFP are already securely attached while also suggesting that there was little scope for improvement. Similarly, the children's post-test scores suggest that they are securely attached to their mothers although the first year group has a somewhat weaker attachment to fathers. If this interpretation is correct, then it would seem that neither group display significant attachment difficulties to their parents, as measured by the Inventory of Parent and Peer Attachment. It is also possible that, between the baseline and follow-up, there may be a growing awareness of how the children are relating to their parents, possibly because they are a year older, and that their attachment to parents is not as strong or secure as they may have originally thought at the baseline. Whatever the explanation, it seems safe to conclude that Mounttown NYFP has little effect on children's attachment to their parents.

Table 7.1 also summarises the changes in attachment to friends and this shows that the first year group experienced an increase in attachment (an effect size of +0.38) while the second year group experienced no change (an effect size of +0.06). This is in line with the broader pattern of results throughout the study which indicate that the first year group has a greater propensity to improve compared to the second year group.

As elsewhere in the report, the comparison group is not a useful source of comparison since their pre-test and post-test scores are significantly above those of the experimental groups, but are also well above the scores of a representative sample of Dutch children. For this reason, there is little to be gained from comparing the two groups.

**Table 7.1 Estimated Changes in the Experimental and Comparison Groups following Participation in Mounttown NYFP. Based on the Inventory of Parent and Peer Attachment.**

Variable	First Year Group (6)		Second Year Group (13)		Comparison Group (18)	
	Change*	Need**	Change*	Need**	Change*	Need**
Attachment to mother	-0.61	+0.35	-0.05	+0.19	+0.20	+2.09
Attachment to father	-1.12	-0.29	-0.22	+0.27	+0.09	+1.94
Attachment to friends	+0.38	-	+0.06	-	-0.28	-

\*Change refers to the difference in pre-test and post-test scores of the experimental groups divided by the pooled standard deviation of the combined experimental groups; for the comparison group, change refers to the difference in pre-test and post-test scores divided by the standard deviation of the comparison group.

\*\*Need refers to the difference between the post-test scores of the experimental groups and a representative sample of 288 adolescents in Holland, each living in a two-parent family (Buist, Dekovic, Meeus and van Aken, 2004).

### **7.3 Changes in Supportiveness of Parents**

We used the Parenting Style Scale<sup>159</sup> to measure how children perceive the parental supportiveness of their father and mother (using four identical items to measure the supportiveness of each parent) and the level of parental involvement in their lives (also using four items). Examples of the items used to measure parental supportiveness include 'he / she encourages me to do my best in whatever I do', ' he / she helps me with my school work if there is something I don't understand', 'when he she wants me to do something, he / she explains why'. Examples of the items used to measure parental involvement include 'my parents spend time just talking with me', 'my family do enjoyable things together at home'.

The amount of change in the first year and second year groups, after participating in Mounttown NYFP, is summarised in Table 7.2. This reveals that the first year group experienced an increase in the overall level of parental support and involvement (an effect size of +0.48), while the second year group experienced a decrease in the level of parental support and involvement (an effect size of -0.93). For the first year group, the main source of change was an increase in parental involvement (an effect size of +0.91) which is associated with encouraging and praising the child for work done at school. As a result, the post-test scores of first year group indicate a level of parental support and involvement which is higher than that experienced by a representative sample of Irish children (indicated by an effect size of +0.38). For the second year group, there was a decrease in the supportiveness of both parents as well as in parental involvement, and their post-test scores indicate a lower level of parental support and involvement than that experienced by a representative sample of Irish children (indicated by an effect size of -0.73).

The results for the comparison group, as summarised in Table 7.2, indicate a broad similarity in pre-test scores while their post-test scores show an increase in each aspect of parental supportiveness and involvement (an effect size of +0.22). However, given that the comparison group is not a good match for either the first year group or second year group on most of the measures used, it would be unwise to use this as a standard of comparison.

These findings are consistent with other results which show a tendency among the first year group to perceive things as getting better and a corresponding tendency among the second year group to perceive either no change or disimprovement. At the same time, the substantial decline in parental supportiveness and involvement which is reported by the second year group is somewhat difficult to interpret given that, as we have seen in the previous section, these children have a relatively high level of attachment to both parents which changed little while attending Mounttown NYFP while, as we shall see in the next section, they also have relatively few conflicts with their parents. Moreover the absence of any data on how parents perceive their relationship with the child - as well as data on the well-being of parents generally – is a significant gap which hinders us from forming a more complete picture of the child's family context.

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159 Lamborn, Mounts, Steinberg and Dornbusch, 1991.

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**Table 7.2 Estimated Changes in the Experimental and Comparison Groups following Participation in Mounttown NYFP. Based on the Parenting Style Scale.**

Variable	First Year Group (6)		Second Year Group (13)		Comparison Group (18)	
	Change*	Need**	Change*	Need**	Change*	Need**
Mother Supportiveness	+0.13	+0.52	-0.70	-0.25	+0.48	+1.34
Father Supportiveness	-0.22	+0.29	-0.74	-0.54	+0.23	+1.11
Parental Involvement	+0.91	+0.20	-0.41	-0.50	+0.57	0.00
Total Support & Involvement	+0.48	+0.38	-0.93	-0.73	+0.22	+0.51

\*Change refers to the difference in pre-test and post-test scores of the experimental groups divided by the pooled standard deviation of the combined experimental groups; for the comparison group, change refers to the difference in pre-test and post-test scores divided by the standard deviation of the comparison group.

\*\*Need refers to the difference between the post-test scores of the experimental groups and a representative sample of 234 children in Ireland (McKeown, Pratschke and Haase, 2003).

## 7.4 Changes in the Extent of Conflict with Parents

We measured the extent of conflict and unresolved problems which the child has with its parents, using a composite scale that has been used elsewhere<sup>160</sup>. This scale lists 18 different areas of potential conflict between a child and its parents (eg. helping out around the house, pocket money, behaviour, friends, progress at school, etc). The extent to which each area is a source of conflict is measured on a scale from 1 (not a problem) to 7 (a severe problem). The resulting mean scores provides an indication of the number and frequency of conflicts.

A comparison of the pre-test and post-test scores is summarised in Table 7.3 and reveals that the first year group experienced a reduction in conflict with parents (an effect size of -0.27) while the second group showed no change (an effect size of 0.0.3). This should be seen in the context that the pre-test and post-test scores of the first year group are significantly higher than the second year group but are also higher than the mean score of a representative sample of Irish children. Despite the change therefore, children in the first year group have slightly more conflicts with their parents (an effect size of +0.24) compared to other Irish children while the second year group have substantially less conflicts with their parents (an effect size of 0.74) compared to other Irish children.

The pre-test and post-test scores of the comparison group indicate a significantly lower level of conflict than either of the experimental groups or a representative sample of Irish children. For this reason they are not a useful source of comparison.

<sup>160</sup> McKeown, Pratschke and Haase, 2003

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**Table 7.3 Estimated Changes in the Experimental and Comparison Groups following Participation in Mounttown NYFP. Based on the Conflict Scale.**

Variable	First Year Group (6)		Second Year Group (13)		Comparison Group (18)	
	Change*	Need**	Change*	Need**	Change*	Need**
Conflict with parents	-0.27	+0.24	-0.03	-0.74	+0.19	-2.35

\*Change refers to the difference in pre-test and post-test scores of the experimental groups divided by the pooled standard deviation of the combined experimental groups; for the comparison group, change refers to the difference in pre-test and post-test scores divided by the standard deviation of the comparison group.

\*\*Need refers to the difference between the post-test scores of the experimental groups and a representative sample of 234 children in Ireland (McKeown, Pratschke and Haase, 2003).

## 7.5 Summary and Conclusion

This chapter described changes in the relationship of children to their parents, following participation in Mounttown NYFP. We measured three aspects of this relationship. First, we measured the child's attachment to its parents using The Inventory of Parent and Peer Attachment (IPPA)<sup>161</sup>. Second, we measured the child's perception of parental supportiveness and involvement using the Parenting Style Scale<sup>162</sup>. Third, we measured the extent of conflict which the child has with its parents, using a composite scale that has been used elsewhere<sup>163</sup>.

Beginning with attachment, we found that, following participation in Mounttown NYFP, the first year group experienced a significant decline in attachment to mothers (effect size of -0.61), and an even greater decline in attachment to fathers (effect size of -1.12). In the second year group, there was no change in attachment to mothers but a decline in attachment to fathers (effect size of -0.22). This may be due to the fact that the pre-test scores of both groups were already above those of a representative sample of Dutch children which, since this is the only statistical norm we have available for this scale, would suggest that the children in Mounttown NYFP are already securely attached while also suggesting that there was little scope for improvement. It is also possible that, between the baseline and follow-up, there may be a growing awareness that the children's attachment to their parents, particularly their fathers, is not as strong or secure as they originally thought at the baseline.

As regards attachment to friends, the results show that the first year group experienced an increase in attachment (an effect size of +0.38) while the second year group experienced no change (an effect size of +0.06).

We measured how children perceive the supportiveness and involvement of their parents and found that, after participating in Mounttown NYFP, the first year group experienced an increase in the overall level of parental support and involvement (an effect size of +0.48), while the second year group experienced a decrease in the

161 Armsden and Greenberg, 1987

162 Lamborn, Mounts, Steinberg and Dornbusch, 1991.

163 McKeown, Pratschke and Haase, 2003

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level of parental support and involvement (an effect size of -0.93). Both groups report a decline in the supportiveness of fathers. At the end of the intervention, the first year group feel more supported than the average Irish child (an effect size of +0.38) but the second year group feel significantly less supported (an effect size of -0.73).

The extent of conflict between the child and its parents fell among children in the first year group (an effect size of -0.27) while the second group showed no change (an effect size of 0.03). However, this should be seen in the context that the pre-test and post-test scores of the first year group were significantly higher than the second year group but were also higher than the mean score of a representative sample of Irish children. Despite the change therefore, children in the first year group have slightly more conflicts with their parents (an effect size of +0.24) compared to other Irish children while the second year group have substantially less conflicts with their parents (an effect size of -0.74) compared to other Irish children.

These findings throw some light on how the children attending Mounttown NYFP perceive the relationship with their parents. However it is limited by the fact that we do not have any data on how the parents perceive this relationship - or data on the well-being of parents generally – and this is a significant gap which hinders us from forming a more complete picture of the family context of each child. The extent of this limitation can be seen, analogously, by the value which the teachers' perspective brought to our analysis of the children's strengths and difficulties in Chapter Four.

The interpretation of data in this chapter is also made more difficult by the fact that the programme in Mounttown NYFP does not specifically address issues in the parent-child relationship, or the well-being of parents more generally. In view of this, it seems more likely that changes in how children perceive their parents may be the result of other changes emanating from the programme, or from the consequences of growing one year older between baseline and follow-up. As a result, it is necessary to exercise caution in using the data in this chapter as an indicator of programme effectiveness.

Despite these limitations, the results in this chapter seem to highlight a generally positive picture of the children's attachment to parents, but also reveal a growing sense, possibly associated with becoming one year older, that fathers are less central or supportive in their lives. The slippage between baseline and follow-up in the role of the father is quite clear in both groups of children although, as we have seen in Chapter Three above, the level of contact between children and their non-resident parents is relatively high. It is useful to remember that changes in the quality of attachment between a child and its parents can emanate from a number of sources including: (i) characteristics of the child, such as particular behaviour or perception patterns (ii) characteristics of the parent, such as the degree of responsiveness or sensitivity (iii) characteristics of the relationship itself, such as the way the child and parent adjust to each other's unique characteristics and (iv) characteristics of the

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family, such as variations in education and income<sup>164</sup>. Given that we have relatively little information on most of these factors, it is not possible to draw any definitive conclusions on the decline in attachment to fathers.

Finally, the acknowledged importance of parents in the lives of children also raises the more general question of whether the programme offered in Mounttown NYFP should explicitly include a module for parents. This clearly raises the issue of resources but, prior to that, it raises a more general strategic issue of whether the objective of improving the well-being of children can be achieved more effectively by offering supports to improve parental well-being and skills, or by working directly with the children only, or by a combination of both. Other research<sup>165</sup>, including research in Ireland<sup>166</sup> - and even research based on applying the same programme (The Incredible Years) to parents, children and teachers<sup>167</sup> - suggests that working with parents is one of the most effective ways of improving the well-being of children.

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164 In a study, based on a representative sample of 288 two-parent families with adolescent children (aged 11-15) in Holland, the authors tested the relative importance these four influences on the quality of attachment and found that the two strongest influences were characteristics of the child and the relationship, while the two weakest influences were characteristics of the parent and the family. Commenting on the implications of this, the authors observe that “if an adolescent reports a low quality of attachment to his or her parents, it might be important that intervention focus not only on the adolescent but also on the specific relationship. Characteristics of the attachment figure do not seem to be very important in causing differences between adolescents in quality of attachment to their parents, so, considering our results, it might not be very effective for the attachment figure to be the focus of the intervention (Buist, Dekovic, Meeus, and van Aken, 2004:845).

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

166 McKeown, Haase and Pratschke, 2001

167 Webster-Stratton, Reid, and Hammond, 2004:122

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## Chapter Eight

### Changes in School Outcomes

#### 8.1 Introduction

The objectives of Mounttown NYFP, as described in Chapter One above, focus mainly on improving the mental health of children but also aim to improve school outcomes by helping the children to be attentive and focused while developing their capacity to sit still and complete tasks. The improvement in school outcomes for children is also the main objective of the Government's programme to address educational disadvantage, particularly in the areas of literacy, numeracy and attendance; the Holy Family School is part of that programme by virtue of being designated as a disadvantaged school.

The Government's policy on educational disadvantage - referred to as DEIS: Delivering Equality of Opportunity in Schools<sup>168</sup> - comprises four school-based initiatives as follows: (i) Disadvantaged Areas Scheme, started in 1984; (ii) Home, School, Community Liaison Coordinators, started in 1990; (iii) Breaking the Cycle, started in 1996, which was subsumed into Giving Children and Even Break in 2001; (iv) School Completion Programme, started in 2002. The targets set for these initiatives in the National Action Plan Against Poverty and Social Exclusion in 2003 involve a halving of the number of pupils with serious literacy difficulties and a school retention rate to upper second level of 90% by 2006<sup>169</sup>. These targets are unlikely to be achieved by 2006. A National Assessment of English Reading carried out in 1998 and 2004 found that national standards of English reading had not changed in this period and "there has been no improvement in reading skills among pupils in designated schools"<sup>170</sup>; equally significant is the fact that the gap which emerges in first class lasts through till sixth class. In his review of the effectiveness of initiatives to address educational disadvantage, the Comptroller and Auditor General described the lack of progress in reading as 'disappointing' in view of the substantial resources - €1.8 million in 2003/4 - which are spent on these initiatives annually<sup>171</sup>. Data on changes in numeracy levels is not available but a study of numeracy in nine designated disadvantaged schools indicated that 64% of pupils were in the bottom 20% of primary school pupils<sup>172</sup>. The latest data on school retention indicate a retention rate to upper second level of 78%, which is well short of the target<sup>173</sup>. Data on absenteeism published by the National Educational Welfare Board for 2003/4 and 2004/5 indicate an annual attendance rate of 94% (91% in designated disadvantaged areas), while 10% of pupils are absent for 20 or more days (20% in designated disadvantaged areas)<sup>174</sup>. Overall therefore, the effectiveness of existing policies to address educational disadvantage, in terms of improved school outcomes for children, remains to be proven.

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168 Department of Education and Science, 2005a

169 Office for Social Inclusion, 2003:28

170 Eivers, Shiel, Perkins and Cosgrove, 2005:24

171 Comptroller and Auditor General, 2006:8

172 Cited in the report of the Comptroller and Auditor General, 2006:52

173 Department of Education and Science, 2005:4

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In this chapter we describe changes in a range of school outcomes, following the children's participation in Mounttown NYFP. From the child's perspective, we measure how well the child fits in at school in terms of getting on with teachers, and how their school marks compare with their classmates (Section 8.2). From the teacher's perspective, we measure changes in being late for school (Section 8.3), as well as changes in reading as measured by a standardised test (Section 8.4). Change is measured, as in the other chapters, by expressing the difference in pre-test and post-test scores in terms of their effect size, thereby providing a common standard of measurement across the outcome variables. Also, and as in the other chapters, we assess the extent of change in two sub-groups of children: a 'first year group' comprising 6 children whose pre-test scores were collected when they started the programme, and a 'second year group' comprising 13 children whose pre-test scores were collected more than a year or more after they started the programme. We conclude by summarising the key findings (Section 8.5). Detailed tables of findings pertaining to this chapter are in the Appendix to Chapter Eight.

## **8.2 Changes in Fitting in at School**

We asked the children two questions to determine how they fit in at school. The first is: 'in general, how well do you get on with your teachers?'. The answer to this question is on a four-point scale from 1 (not well) to 4 (very well). The second is: 'in general, how do your school marks / exam results compare to those of your classmates?'. The answer to this question is on a three-point scale comprising 1 (better), 2 (the same), and 3 (worse). These questions were taken from the Health and Daily Living Scales<sup>175</sup>, which we also used to measure the physical symptoms of children in Chapter Six.

Based on the first question, we see from Table 8.1 that there was a disimprovement in how children get on with their teachers in both the first year group (an effect size of -0.19) but especially in the second year group (an effect size of -0.41). The post-test scores of children in the first year group indicate that they get on better with their teachers than a representative sample of Irish children but the post-test scores of children in the second year group indicate that they get on worse with their teachers than a representative sample of Irish children.

Turning to the second question, we found that the first year group disimproved relative to other children in their class (an effect size of +0.53) while the second year group showed almost no change (an effect size of +0.08). Despite this, both groups perceive themselves as the same as their classmates (a mean post-test score of 2.0), which is marginally higher than the mean score of a representative sample of Irish children (mean score of 1.9).

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174 O'Briain, 2006

175 Adapted from Moos, Cronkite, Billings, and Finney, 1986

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**Table 8.1 Estimated Changes in the Experimental and Comparison Groups following Participation in Mounttown NYFP. Based on Health and Daily Living Scales**

Variable	First Year Group (6)		Second Year Group (13)		Comparison Group (18)	
	Change*	Need**	Change*	Need**	Change*	Need**
Get on well with teachers	-0.19	+0.4	-0.41	-0.17	+0.10	+1.58
School results are similar to classmates	+0.53	-0.16	+0.08	-0.11	+0.36	+0.38

\*Change refers to the difference in pre-test and post-test scores of the experimental groups divided by the pooled standard deviation of the combined experimental groups; for the comparison group, change refers to the difference in pre-test and post-test scores divided by the standard deviation of the comparison group.

\*\*Need refers to the difference between the post-test scores of the experimental groups and a representative sample of 234 children in Ireland (McKeown, Pratschke and Haase, 2003).

### 8.3 Changes in Lateness

We asked teachers the following question: ‘does the child arrive late for school, ie after the school’s official starting time?’ The responses are on a five-point scale comprising: 1 (always), 2 (never), 3 (sometimes), 4 (rarely), and 5 (never). The results, as summarised in Table 8.2, indicate that children in both the first year group and second year group are sometimes late for school and there was no significant change during the time they attended Mounttown NYFP.

**Table 8.2 Estimated Changes in the Experimental and Comparison Groups following Participation in Mounttown NYFP.**

Variable	First Year Group (6)			Second Year Group (13)			Comparison Group (18)		
	Pre	Post	Change*	Pre	Post	Change*	Pre	Post	Change*
Lateness rate	3.3	3.3	0.0	3.7	3.5	-0.14	4.2	-	-

\*Change refers to the difference in pre-test and post-test scores of the experimental groups divided by the pooled standard deviation of the combined experimental groups; for the comparison group, change refers to the difference in pre-test and post-test scores divided by the standard deviation of the comparison group.

### 8.4 Changes in Reading Ability

The children’s reading ability was measured by the class teacher who used the Micra T Reading Attainment Test<sup>176</sup>. This test has been ‘normed’ to allow the child’s ability to be rated in percentiles against age-appropriate national norms in Ireland. Percentiles range from 1-100 with each percentile rank indicating where the child stands *vis á vis* its peers. For example, a child whose percentile score is 20 on a given test implies that their performance is better than 20% of children who have taken that test, but worse than the remaining 80% who have also taken the test.

<sup>176</sup> Available at [www.micra-t.ie](http://www.micra-t.ie) and [www.cjfallon.ie](http://www.cjfallon.ie)

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The results are summarised in Tables 8.3a and 8.3b and show significant improvements in reading ability in both the first year group (where the mean percentile score moved from 13 to 37, an effect size of 1.2) and the second year group (where the mean percentile score moved from 12 to 32, an effect size of 1.0). All but one of the children in each of the groups showed an improvement. This is a very positive result and compares favourably with the results of national studies, as reported in the introduction to this chapter. However the result should be interpreted with caution given that it is based on only half the children in both groups; this is because half the children had left the school when the post-intervention assessment was carried out in September 2006.

**Table 8.3a Estimated Changes in the Experimental and Comparison Groups following Participation in Mounttown NYFP. Based on Micra T Reading Attainment Test and Sigma T Numeracy Test.**

Variable	First Year Group (3)			Second Year Group (6)			Comparison Group (18)		
	Pre	Post	Change*	Pre	Post	Change*	Pre	Post	Change*
Reading percentile	13	37	1.2	2	32	1.0	-	-	-

\*Change refers to the difference in pre-test and post-test scores of the experimental groups divided by the pooled standard deviation of the combined experimental groups; for the comparison group, change refers to the difference in pre-test and post-test scores divided by the standard deviation of the comparison group.

**Table 8.3b Change in Experimental and Control Groups, Based on Micra T Reading Attainment Test, Sigma T Numeracy Test, and School Attendance.**

Variable	Reading	
	First Year Group (3)	Second Year Group (6)
% improved	67	83
% no change	0	17
% disimproved	33	0
<b>Total</b>	<b>100</b>	<b>100</b>

## 8.5 Summary and Conclusion

This chapter described changes in school outcomes, following the children's participation in Mounttown NYFP. These outcomes were measured from the perspective of both children and teachers. From the child's perspective, we measured how well the child gets on with teachers and how their school marks compare with their classmates. From the teacher's perspective, we measured changes in school attendance and changes in being late for school, as well as changes in reading as measured by a standardised test.

The results show that there was a disimprovement in how children get on with their teachers in both the first year group (an effect size of -0.19) but especially in the second year group (an effect size of -0.41). The post-

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test scores of children in the first year group indicate that they get on better with their teachers than a representative sample of Irish children but the post-test scores of children in the second year group indicate that they get on worse with their teachers than a representative sample of Irish children.

There was a significant improvement in reading ability of both the first year group (where the mean percentile score moved from 13 to 37, an effect size of 1.2) and the second year group (where the mean percentile score moved from 12 to 32, an effect size of 1.0). This is a very positive result but should be interpreted with caution given that it is based on only half the children in both groups; this is because half the children had left the school when the post-intervention assessment was carried out in October 2006.

It is useful to place these results in the broader context of the Government's programme to address educational disadvantage since the Holy Family School where Mounttown NYFP is situated, is part of that programme by virtue of being designated as a disadvantaged school. The Government's policy on educational disadvantage - referred to as DEIS: Delivering Equality of Opportunity in Schools<sup>177</sup> - comprises four school-based initiatives as follows: (i) Disadvantaged Areas Scheme, started in 1984; (ii) Home, School, Community Liaison Coordinators, started in 1990; (iii) Breaking the Cycle, started in 1996, which was subsumed into Giving Children and Even Break in 2001; (iv) School Completion Programme, started in 2002. The targets set for these initiatives in the National Action Plan Against Poverty and Social Exclusion in 2003 involve a halving of the number of pupils with serious literacy difficulties and a school retention rate to upper second level of 90% by 2006<sup>178</sup>. These targets are unlikely to be achieved by 2006. A National Assessment of English Reading carried out in 1998 and 2004 found that national standards of English reading had not changed in this period and "there has been no improvement in reading skills among pupils in designated schools"<sup>179</sup>; equally significant is the fact that the gap which emerges in first class lasts through sixth class. In his review of the effectiveness of initiatives to address educational disadvantage, the Comptroller and Auditor General described the lack of progress in reading as 'disappointing' in view of the substantial resources - €61.8 million in 2003/4 - which are spent on these initiatives annually<sup>180</sup>. Data on changes in numeracy levels is not available but a study of numeracy in nine designated disadvantaged schools indicated that 64% of pupils were in the bottom 20% of primary school pupils<sup>181</sup>. The latest data on school retention indicate a retention rate to upper second level of 78%, which is well short of the target<sup>182</sup>. Data on absenteeism published by the National Educational Welfare Board for 2003/4 and 2004/5 indicate an annual attendance rate of 94% (91% in designated disadvantaged areas), while 10% of pupils are absent for 20 or more days (20% in designated disadvantaged areas)<sup>183</sup>. Overall therefore, the national effectiveness of existing policies to address educational disadvantage in terms of improved school outcomes for children remains to be proven.

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177 Department of Education and Science, 2005a

178 Office for Social Inclusion, 2003:28

179 Eivers, Shiel, Perkins and Cosgrove, 2005:24

180 Comptroller and Auditor General, 2006:8

181 Cited in the report of the Comptroller and Auditor General, 2006:52

182 Department of Education and Science, 2005:4

183 O'Briain, 2006

## **Chapter Nine**

### **Summary, Conclusion and Implications**

#### **9.1 Introduction**

Mounttown NYFP<sup>184</sup> is a mental health programme to support vulnerable children aged 8-13 who present with behaviour and / or emotional problems at school. It is based in the school campus of the Holy Family School Primary School, a school which has disadvantaged status and runs the School Completion Programme<sup>185</sup>. School-based programmes like Mounttown NYFP are increasingly popular in the UK<sup>186</sup> and US<sup>187</sup> and the potential contribution of school-based programmes to the mental health of children, which are widely regarded as ‘promising’ rather than ‘proven’<sup>188</sup>, was highlighted by the Expert Group on Mental Health Policy<sup>189</sup>.

The work of Mounttown NYFP has a significance beyond the confines of the project and school because of the relatively high prevalence of mental health problems among children in Ireland and the importance of finding effective interventions to address those problems. Our review of the evidence indicates that around 8% of Irish children have moderate to severe mental health problems, but this rises to around 20% of the children who live in disadvantaged homes and communities, depending on how it is measured. In view of this, it is clear that a substantial need exists for interventions such as the Mounttown NYFP to prevent and treat mental health problems in school-going children.

In this final chapter we summarise the key findings of the study and their implications. We begin by describing the programme at Mounttown NYFP (Section 9.2) and its activities within the wider community (Section 9.3). We describe the methodology we used to assess the effectiveness of its work with children (Section 9.4) and then present the key findings (Sections 9.5) and their implications (Section 9.6). The report ends with a concluding comment (Section 9.7).

#### **9.2 The Programme at Mounttown NYFP**

The programme at Mounttown NYFP has a number of therapeutic objectives which include:

- (i) increasing the pupil’s self-esteem, self-awareness, and self-confidence;

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184 NYFP Is an acronym for Neighbourhood Youth and Family Project.

185 The School Completion Programme was introduced by the Department of Education & Science in 2003 in order to promote the retention of pupils in primary and second level schools. The School Completion Programme subsumes the “8 to 15 Early School Leaver Initiative” and the “Stay in School Retention Initiative” and is a key component of the Department’s strategy to discriminate positively in favour of children and young people who are at risk of, or who are experiencing, educational disadvantage. The programme is funded on a multi-annual basis under the National Development Plan with assistance from the European Social Fund (ESF).

186 Pugh and Statham, 2006.

187 Dryfoos and Nissani, 2006.

188 Pugh and Statham, 2006; Dryfoos and Nissani, 2006.

189 Expert Group on Mental Health Policy, 2006:86.

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- (ii) improving peer relationships and peer acceptance;
- (iii) promoting attachment and developmental catch-up; and
- (iv) improving educational attainment and reducing the fear of failure.

These objectives are pursued through interventions which involve weekly group sessions and monthly one-to-one sessions. The group format is facilitated by two staff and is used to teach basic skills such as listening to each other, showing respect, concentrating, working as part of a team, etc. The theoretical approach which informs all interventions is the Marte Meo Method. All staff are trained in this method and two are certified Marte Meo therapists<sup>190</sup>.

The Marte Meo Method was created by Maria Aarts in Holland and developed over a period of years beginning in 1978. It was first developed to treat children with severe developmental problems but is now used in over 30 countries to address problems experienced by different target groups such as children in care and school settings, parents who are experiencing difficulties, drug users, elderly, persons with depression or intellectual disabilities; it is also used as a general training in communication and management skills<sup>191</sup>.

The name Marte Meo Method (meaning ‘one one’s own strength’) was chosen in order to “highlight the central focus of the programme, which is to identify, activate and develop skills to enable and enhance constructive interaction and development”<sup>192</sup>. The developmental process, as described in the Marte Meo Manual, is cultivated through three separate stages: (i) identifying opportunities for development such as the initiatives and actions of a child (ii) finding the natural supportive behaviours which are required to assist development such as naming, confirming, supporting, selecting and structuring the child’s initiatives (iii) incorporating this knowledge into the natural system of the individual so that they can learn the new skills in the most efficient way possible<sup>193</sup>.

Video analysis of interactions is a key tool of the Marte Meo Method and has a number of specific functions including gathering information about interactions in naturalistic settings, giving clients a picture of their reality including a perspective on their strengths as well as weaknesses, offering step-by-step guidance on specific behaviours, checking if a new behaviour is working, and providing opportunities to see positive results. In orientation, the Marte Meo Method emphasises actions and behaviours over thoughts and cognitions, and stresses the importance of learning through practice. At the same time, the Marte Meo Method also acknowledges the key role of insight and understanding, such as when a parent sees the link between their supportive behaviours and the development of their child.

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190 There are three main levels of training in the Marte Meo method: (i) Communications Skills Training Course (ii) Therapist Training Course and (iii) Supervisor Training Course. The Communications Skills Training Course involves six sessions, each lasting a half-day or, for some groups, a full-day. The Therapist Training Course is delivered over a period of 18 months and involves 18 monthly training days, three blocks of training each lasting four days each, and a four day accreditation process. The Supervisor Training Course involves delivering the Therapist Training Course under the supervision of a Licensed Marte Meo Supervisor; this accepted on this course must have spent at least one year as a trained therapist under the supervision of a Licensed Marte Meo Supervisor.

191 [www.martemeeo.com](http://www.martemeeo.com)

192 Aarts, 2000:42

193 Aarts, 2000: Chapter Three

Research on the effectiveness of the Marte Meo Method shows promising results although much of the published results fall short of a full scientific evaluation. This is because of weak research design in many of the studies such as lack of both pre-test and post-test data, use of measurement instruments that have not been independently tested or which measure client perceptions rather than client behaviours, application of the programme to relatively small samples and often without a comparison group. No evaluation meets the gold standard of a randomised control trial which involves offering the programme to an experimental group and comparing outcomes with a matched control group which has not been offered the programme.

### **9.3 Activities in the Wider Community**

In addition to its direct work with children at the Holy Family School, Mounttown NYFP also participates in a wide range of organisations and services whose remit includes children and families, especially those experiencing some form of adversity associated with socio-economic circumstances, disability, parenting difficulties, etc. Staff in Mounttown NYFP also offer teaching and consultancy inputs to other services in the community, voluntary and statutory sectors. We consulted a range of professionals to assess the impact of this work and found that Mounttown NYFP is widely regarded as a centre of excellence by other services which have, in turn, benefited from this expertise. The project has particular expertise in psychoanalytic approaches to the family which bring a depth of understanding to the relationships and attachments at the heart of human problems. In addition, project staff are qualified in the Marte Meo Method which has a more direct focus on the skills needed by parents and professionals to identify, activate and develop the competencies needed to promote child development. In its own work, Mounttown NYFP lays great stress on the need to reflect on practice in light of developments in theory and research, and for staff to receive regular professional supervision on all aspects of their work. This, in turn, has set a standard which other services seek to match. In the area of policy, Mounttown NYFP is represented by its Coordinator, Mary Cullen, on a range of fora with the aim of promoting better understanding of the needs of vulnerable children and families, and helping to put appropriate and realistic strategies in place to address those needs. The project has highlighted the need to increase the quantum of services in areas such as childcare, family support, education, community facilities, while also drawing attention to the dearth of specialist services for children in areas such as speech and language, child psychiatry, etc. Overall, our consultations revealed that Mounttown NYFP is highly regarded within the local community and has an influence on policy and practice which is probably disproportionate to its size or resources. Many of those consulted spoke of the project's generosity in sharing its premises and staff, and giving their time without remuneration. In keeping with the ethos of finding new ways to improve services, Mounttown NYFP is also committed to the evaluation of its services which we detail in the subsequent chapters of this report.

### **9.4 Methodology**

The methodology used in this study involves a 'pre-test / post-test comparison' which means that the impact of the programme is measured by comparing the well-being of children at the beginning of the programme (pre-test) and end of the programme (post-test); in addition, the group of children who receive the programme (the

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‘experimental’ group) is compared to a similar group of children who have not received the programme or any similar programmes (the ‘comparison’ group). This methodology is usually referred to as a ‘quasi-experimental design’<sup>194</sup> and offers a reliable way of assessing the scale and direction of impacts produced by Mounttown NYFP.

We measured a wide range of behaviours and emotions that are recognised to be key dimensions in the mental health of children. We also measured the child’s performance at school notably reading and punctuality. These dimensions of well-being, and the instruments used to measure them, are summarised above in Chapter Two (Table 2.1). All of these instruments are in widespread use and have been tested for validity and reliability.

The evaluation is based on data collected from 19 children in the ‘experimental’ group (those who received the NYFP programme at The Holy Family Primary School) and 18 children in the ‘comparison’ group (those who did not receive the NYFP programme and attended St. Kevin’s Primary School). The experimental group contains two sub-groups of children:

- (i) those who started the programme at the same time as this evaluation and whose pre-test scores were collected when they started Mounttown NYFP (6 children whom we call the ‘first year group’); and
- (ii) those who were already on the programme when the evaluation started and whose pre-test scores were collected more than a year after they started Mounttown NYFP (13 children whom we call the ‘second year group’).

In order to assess the effectiveness of Mounttown NYFP, it is necessary to undertake a separate analysis of changes in both these experimental groups.

The analysis addresses two basic questions that are at the heart of this evaluation. The first is: how much change occurred to the children following their participation in Mounttown NYFP? The second is: what level of need remained among the children following participation in the Mounttown NYFP?

In order to answer the first question, we measured the difference in pre-test and post-test scores using the statistical concept of effect size. The formula involves subtracting the mean post-test scores from the mean pre-test scores and dividing by the standard deviation. An important advantage of using effect sizes is that it allows the results from each instrument to be compared with each other as well as with previous research on the

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194 This contrasts with an ‘experimental design’, usually referred to as a randomised control trial (RCT), which involves setting up two matched groups using a random process of selection and then offering the programme to one group (the experimental group) while the other group is either placed on a waiting list or offered an alternative programme (the control group). Since both groups are matched prior to the intervention, it is reasonable to infer that any differences which emerge at the end of the programme can be attributed to the programme. RCTs are now regarded as the gold standard among researchers for measuring the efficacy of programmes (Chambless and Hollon, 1998) essentially because the process of randomly allocating subjects to either an experimental or control group ensures that both groups are as perfectly matched as possible and therefore controls for all possible differences – both known and unknown – between the groups, other than the fact that one (the experimental group) receives the programme and the other (the control group) does not. In the absence of random allocation, only the known differences can be controlled in setting up an experimental and comparison group and it is this which accounts for the superiority of experimental designs over quasi-experimental designs. It is for this reason that RCTs provide a level of certainty about the efficacy of an intervention which is not achievable through any other research design. At the same time, a quasi-experimental design, which we use here for practical reasons, provides a reliable though not definitive guide to the likely impacts of a programme.

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effectiveness of similar programmes. In this study, we use three points of comparison to assess the performance of Mounttown NYFP. The first is the impact which is normally achieved by family support programmes in the area of children's socio-emotional development, which range from 0.22<sup>195</sup> to 0.27<sup>196</sup>. The second is the standard used by one agency for identifying programmes of 'proven' effectiveness which require an effect size of 0.25 or higher for at least outcome<sup>197</sup>. The third is the standard used by another agency for identifying 'blueprint' programmes which require an effect size of 0.5 or higher for at least outcome variable<sup>198</sup>.

In order to answer the second question, we compare the post-test scores of children in the experimental group, on each dimension of well-being, with the corresponding scores of nationally representative samples of children, from Ireland<sup>199</sup>, Britain<sup>200</sup>, and Holland<sup>201</sup>. Given that most programmes in the area of family support tend to achieve effect sizes in the range 0.2 to 0.5, it follows that effect sizes in this range tend to indicate a significant level of need while effect sizes in excess of 0.5 can be regarded as quite large relative to the capacity of programmes to meet that need. These considerations will be used as a guide in the interpretation of results.

Our study also used a comparison group. The rationale for this quasi-experimental method is that, by estimating the difference between children in the experimental and the comparison group, we can estimate the true impact of the intervention since it controls for the fact that some children in each group may show an improvement even without intervention – a phenomenon that is variously referred to as regression to the mean, or a regression effect / artifact - either because of random error in their scores, or because some children show spontaneous improvement. Unfortunately, the comparison group turned out to be not a useful point of comparison in this study since their pre-test scores are not well matched with the pre-test scores of children in either of the experimental groups.

## **9.5 Key Findings**

In this section, we present the key findings of the study in the same sequence as they appear in the report.

### **9.5.1 Background Characteristics**

We found that children in the first year group started Mounttown NYFP at a significantly older age (10.8 years) compared to children in the second year group (8.5 years), a difference of over two years. The second year group also spent more than twice the amount of time attending Mounttown NYFP (2.3 years) compared to the first year group (1.0 year). As a result, when the post-test data was collected in June 2006, the average age of

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195 Layzer, Goodson, Bernstein and Price, 2001.

196 Nelson, Westhues and MacLeod, 2003

197 The Promising Practices Network run by the Rand Corporation defines a programme as 'proven' where, inter alia, 'at least one outcome is changed by 20%, 0.25 standard deviations or more' (<http://www.promisingpractices.net>) (see also Shonkoff and Phillips, 2000:342-343).

198 The Centre for the Study and Prevention of Violence at University of Colorado in Boulder, USA selects 'Blueprint Model Programs' on the basis of 'the most rigorous tests of effectiveness in the field', and requires that all Blueprint programmes have 'at least moderate effect sizes', which imply effect sizes of 0.5 or higher (<http://www.colorado.edu/cspv/blueprints>).

199 McKeown, Pratschke and Haase, 2003

200 Meltzer, Gatward, Goodman, and Ford, 2000

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children in the first year group (11.8 years) was a year older than the average age of children in the second year group (10.8 years), but similar to the average age of the comparison group (12.0 years). A similar number of boys (9) and girls (10) attend Mounttown NYFP whereas the comparison group contains considerably more girls (13) than boys (5).

The majority of children in the study, about six out of ten, live in a two parent household, compared to eight out of ten in Ireland. Conversely, the rate of lone parenthood is much higher in the study group with four out of ten children living in a one parent household compared to two in ten in Ireland. Of the children attending Mounttown NYFP and who are not living with both parents (10), most see the non-resident parent a few times a week (6), or once a month (2), and two never see their non-resident parent. Children in the study live in households containing a larger number of persons (4.3 to 5.6) compared to Ireland (3.6).

Most of the homes (75%) in which the children live are rented from the local authority with about a fifth (20%) in owner-occupation. This contrasts with the pattern in Ireland where the vast majority of people (81%) live in owner-occupied housing while less than a tenth rent from the local authority. Given that owner-occupation is a reliable predictor of economic well-being, it follows that most of the children live in families who are not well-off. This is also indicated by the fact that about six out of ten households are dependent on social welfare for all or part of their income.

These background characteristics indicate that children in the experimental groups are broadly similar to children in the comparison group. However there are significant differences within the experimental group, particularly due to the fact that those in the first year group are older, were older when they started Mounttown NYFP, and spent a much shorter amount of time on the programme compared to the second year group. This provides an important opportunity to test if differences between these groups have any influence on the outcomes of Mounttown NYFP.

### **9.5.2 Changes in Strengths and Difficulties**

We analysed changes in the strengths and difficulties of children using the Strengths and Difficulties Questionnaire (SDQ) which was completed by the children and their teachers. The SDQ measures the child's well-being in five areas: behaviour, hyperactivity, emotions, peer relations and pro-social attitudes. It has been extensively tested for validity and reliability<sup>202</sup>, and is a recognised screening instrument for identifying children with mental health difficulties which meet DSM-IV diagnostic status<sup>203</sup>, sometimes referred to as 'child psychiatric caseness'<sup>204</sup>. The SDQ was used to provide four estimates of change: (i) SDQ Symptoms (ii) SDQ Perceived Difficulties (iii) SDQ Impact, and (iv) SDQ Burden, as described in Chapter four above.

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201 Buist, Dekovic, Meeus, and van Aken, 2004

202 For more information, see [www.sdqinfo.com](http://www.sdqinfo.com); see also Goodman, 1997; Goodman, Meltzer and Bailey, 1998; Goodman and Scott, 1999; Goodman, 1999; Smedje, Broman, Hetta and von Knorring, 1999.

203 DSM-IV refers to Diagnostic and Statistical Manual of Mental Disorders which sets out the diagnostic criteria developed by the American Psychiatric Association (1994).

204 Goodman, 1999.

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The key results are:

- (i) the programme produced benefits for children in both the first year group and the second year group.
- (ii) the size of the benefits is considerably greater for the first year group, and covers a much wider range of domains, compared to the second year group.
- (iii) the size of the benefits is considerably greater when measured through the perceptions of children than through the perceptions of teachers.
- (iv) the key domains which benefited in the first year group, and where the perceptions of children and teachers coincide, are hyperactivity / behaviour problems as well as emotional and peer problems; in the second year group, there is agreement between children and teachers that the key domain which benefited was peer problems.
- (v) there was relatively little movement of children between the clinical categories of normal, borderline and abnormal essentially because most of the change was within these clinical categories.
- (vi) the level of need which exists at the end of the programme, as defined by the difference in mean scores between children in Mounttown NYFP and a representative sample of British children, is substantial and greater than the benefits generated during the programme. The areas of need vary according to the perceptions of children and teachers; for children, the main areas of need are emotional and peer problems; for teachers the main areas of need are conduct and hyperactivity problems.

The impact of Mounttown NYFP on the first year group is substantial and, for a number of outcomes, it exceeds an effect size of 0.5 which is the standard used to identify 'blueprint' programmes<sup>205</sup>. For the second year group, the effect size exceeds 0.25 on a number of outcome variables which is a threshold of effectiveness used to identify 'proven' programmes<sup>206</sup>. These results also exceed the impacts produced by family support programmes on children's socio-emotional development, which range from 0.22<sup>207</sup> to 0.27<sup>208</sup>. Significantly, the Springboard family support programme in Ireland also used SDQ Symptoms as one of its outcome measures and, based on the total difficulties score, found impacts equivalent to effect sizes of 0.27 (based on children's responses) and 0.16 (based on teacher's responses), which is less than the outcome of Mounttown NYFP for the first year group<sup>209</sup>.

### **9.5.3 Changes in Social and Emotional Impairment**

We measured changes in the well-being of children, following their participation in Mounttown NYFP, using the Beck Youth Inventories of Emotional and Social Impairment<sup>210</sup>. This instrument measures the child's self-concept as well as mental health difficulties such as depression, anxiety, disruptive behaviour, and anger. After

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205 The Centre for the Study and Prevention of Violence at University of Colorado in Boulder, USA selects 'Blueprints Model Programs' on the basis of 'the most rigorous tests of effectiveness in the field', and requires that all Blueprint programmes have 'at least moderate effect sizes', which imply effect sizes of 0.5 or higher (<http://www.colorado.edu/cspv/blueprints>).

206 The Promising Practices Network run by the Rand Corporation defines a programme as 'proven' where, inter alia, 'at least one outcome is changed by 20%, 0.25 standard deviations or more' (<http://www.promisingpractices.net>) (see also Shonkoff and Phillips, 2000:342-343).

207 Layzer, Goodson, Bernstein and Price, 2001.

208 Nelson, Westhues and MacLeod, 2003

209 McKeown, Haase and Pratschke, 2006:21

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participating in Mounttown NYFP, the first year group showed significant and substantial improvement as a result of reductions in the four areas of depression, anxiety, disruptive behaviour, and anger; the overall reduction in these four areas combined was an effect size of -0.69. By contrast, the second year group showed no change in these domains while their level of anxiety increased; however the pre-test and post-test scores of the second year group are much lower than those of the first year group thereby reducing the scope for change. Neither group showed any significant change in clinical status following participation in Mounttown NYFP essentially because the pre-test scores of most of children were in the normal clinical range, thereby making clinical change unlikely. The changes in the first year group exceed the standard set by one agency for the identification of 'blueprint' programmes which require an effect size of 0.5 for one outcome variable<sup>211</sup>.

At the end of the programme, children in both groups still have a substantial level of need, when compared with a representative sample of Irish children. The level of need is higher in the first year group (an effect size of +0.89) than in the second year group (an effect size of +0.52), and exceeds the impact achieved during the first year of the programme (-0.69). This illustrates the challenge involved in reducing the level of need, particularly in view of the reduced impacts associated with the second and subsequent years of the programme.

#### **9.5.4 Changes in Life Satisfaction and Physical Symptoms**

Changes in the life satisfaction of children were measured using the Multi-Dimensional Students Life Satisfaction Scale<sup>212</sup>. This scale measures the satisfaction which children experience in five key domains of their lives namely self, family, friends, school, and living environment. The results show that, after participating in Mounttown NYFP, the second year group showed a significant and substantial improvement in overall life satisfaction (effect size of +0.57) compared to the first year group which experienced a slight reduction in life satisfaction (effect size of -0.17). However these results need to be seen in the context that the overall pre-test scores of both groups were the same as the scores of a representative sample of Irish children, suggesting that this is not a significant area of need for either group of children. Similarly, neither group exhibited a significant level of need after participating in Mounttown NYFP. Nevertheless it is noteworthy that the second year group showed improvements in all of the domains measured (family, friends, living environment and self) with the exception of school (effect size of -0.09) while, conversely, school was the only domain of significant improvement for the first year group (effect size of +0.26).

We also measured changes in the physical well-being of children using an abbreviated version of the Health and Daily Living Scales<sup>213</sup>. This scale measures the frequency with which symptoms were experienced in the previous 12 months such as upset stomach, indigestion, headaches, nightmares, trouble going to sleep, had to miss school due to illness. The results showed that there was a significant increase in the total symptoms of the

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210 Adapted from Beck, Beck & Jolly, 2001.

211 The Centre for the Study and Prevention of Violence at University of Colorado in Boulder, USA selects 'Blueprints Model Programs' on the basis of 'the most rigorous tests of effectiveness in the field', and requires that all Blueprint programmes have 'at least moderate effect sizes', which imply effect sizes of 0.5 or higher (<http://www.colorado.edu/cspv/blueprints>).

212 Huebner, 2001.

213 Adapted from Moos, Cronkite, Billings, and Finney, 1986.

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first year group (an effect size of +0.46) – which implies a disimprovement in physical well-being - but no change in the second year group (an effect size of +0.03). This result suggest that Mounttown NYFP has no consistent impact on physical symptoms which is a little surprising in view of the fact that the pre-test and post-test scores of both groups are well above the mean score of a representative sample of Irish children, thereby suggesting a significant level of need in terms of physical symptoms. It is also surprising that physical symptoms showed no improvement in light of the psychological impacts experienced by the first year group as described in previous sections, and the acknowledged link between physical and psychological well-being.

We measured the prevalence of smoking and drinking and found that, during their time at Mounttown NYFP, there was a slight increase in the number of children who have ‘ever smoked’, who ‘currently smoke’, who have ‘ever tried alcohol’, but a small decrease in the number who ‘took alcohol in the past month’. This suggests that the experience of Mounttown NYFP had no effect on the propensity to smoke or drink although it is also worth noting that the prevalence of smoking and drinking among these children is considerably less than the prevalence rate among a nationally representative sample of 11, 13 and 15 year olds.

#### **9.5.5 Changes in Relationship with Parents**

We measured change in three aspects of the relationship between children and their parents. First, we measured the child’s attachment to its parents using The Inventory of Parent and Peer Attachment (IPPA)<sup>214</sup>. Second, we measured the child’s perception of parental supportiveness and involvement using the Parenting Style Scale<sup>215</sup>. Third, we measured the extent of conflict which the child has with its parents, using a composite scale that has been used elsewhere<sup>216</sup>.

Beginning with attachment, we found that, following participation in Mounttown NYFP, the first year group experienced a significant decline in attachment to mothers (effect size of -0.61), and an even greater decline in attachment to fathers (effect size of -1.12). In the second year group, there was no change in attachment to mothers but a decline in attachment to fathers (effect size of -0.22). This may be due to the fact that the pre-test scores of both groups were already above those of a representative sample of Dutch children which, since this is the only statistical norm we have available for this scale, would suggest that the children in Mounttown NYFP are already securely attached while also suggesting that there was little scope for improvement. It is also possible that, between the baseline and follow-up, there may be a growing awareness that the children’s attachment to their parents, particularly their fathers, is not as strong or secure as they originally thought at the baseline.

As regards attachment to friends, the results show that the first year group experienced an increase in attachment (an effect size of +0.38), while the second year group experienced no change (an effect size of +0.06).

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214 Armsden and Greenberg, 1987

215 Lamborn, Mounst, Steinberg and Dornbusch, 1991.

216 McKeown, Pratschke and Haase, 2003

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We measured how children perceive the supportiveness and involvement of their parents and found that, after participating in Mounstown NYFP, the first year group experienced an increase in the overall level of parental support and involvement (an effect size of +0.48), while the second year group experienced a decrease in the level of parental support and involvement (an effect size of -0.93). Both groups report a decline in the supportiveness of fathers. At the end of the intervention, the first year group feel more supported than the average Irish child (an effect size of +0.38) but the second year group feel significantly less supported (an effect size of -0.73).

The extent of conflict between the child and its parents fell among children in the first year group (an effect size of -0.27) while the second group showed no change (an effect size of 0.03). However, this should be seen in the context that the pre-test and post-test scores of the first year group were significantly higher than the second year group but were also higher than the mean score of a representative sample of Irish children. Despite the change therefore, children in the first year group have slightly more conflicts with their parents (an effect size of +0.24) compared to other Irish children while the second year group have substantially less conflicts with their parents (an effect size of -0.74) compared to other Irish children.

#### **9.5.6 Changes in School Outcomes**

Changes in school outcomes were measured from the perspective of both children and teachers. From the child's perspective, we measured how well the child gets on with teachers and how their school marks compare with their classmates. From the teacher's perspective, we measured changes in punctuality as well as changes in reading ability using the Micra T Reading Attainment Test<sup>217</sup>.

The results show that there was a disimprovement in how children get on with their teachers in both the first year group (an effect size of -0.19) but especially in the second year group (an effect size of -0.41). The post-test scores of children in the first year group indicate that they get on better with their teachers than a representative sample of Irish children but the post-test scores of children in the second year group indicate that they get on worse with their teachers than a representative sample of Irish children.

There was a significant improvement in reading ability of both the first year group (where the mean percentile score moved from 13 to 37, an effect size of 1.2) and the second year group (where the mean percentile score moved from 12 to 32, an effect size of 1.0). This is a very positive result but should be interpreted with caution given that it is based on only half the children in both groups; this is because half the children had left the school when the post-intervention assessment was carried out in September 2006.

#### **9.6 Issues and Implications**

The findings in this study highlight how the effectiveness of Mounstown NYFP varies according to the domains measured, the perceptions of children and teachers, and the length of time spent on the programme. It is now

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<sup>217</sup> Available at [www.micra-t.ie](http://www.micra-t.ie) and [www.cjfallon.ie](http://www.cjfallon.ie)

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necessary to draw out the implications which follow from the study. We do this in the form of four questions as follows:

- (i) Is the programme effective?
- (ii) What are the main areas of need among children?
- (iii) What are the main strengths in the lives of these children?
- (iv) What are the limitations of the study?

These questions are of direct relevance to the management and staff of both Mounttown NYFP and The Holy Family Primary School. Despite the relatively small scale of the study, these questions may also have more general applicability for agencies and professionals who are responding to the mental health needs of school-going children.

### **9.6.1 Is the programme effective?**

The work of Mounttown NYFP has a positive effect on children in a number of domains, particularly where there is a clearly identified need as measured by the Strengths and Difficulties Questionnaire and the Beck Youth Inventories of Social and Emotional Impairment. The size and number of domains is greatest for children in the first year group, particularly as measured by those two instruments, and generally exceeds an effect size of 0.5. By contrast, the second year group achieved more modest changes in a smaller number of domains of the SDQ, slightly above an effect size of 0.25, with no improvement in any of the domains measured by the Beck Youth Inventories. In other words, it would appear that the programme is nearly twice as effective in the first year group as in the second year group, although the level of need in the first year group was also greater than in the second year group, as perceived by the children.

The main improvements among children in the first year group involve reductions in conduct / hyperactivity problems, emotional problems such as depression, anxiety and anger, as well as reductions in peer problems. For children in the second year group, improvements were found in terms of emotional problems and peer problems.

The difference in impact between the two groups can be accounted for, in part, by the fact that children in the first year group tend to perceive themselves as having more needs than children in the second year group, as indicated by their pre-test scores on the SDQ and Beck Youth Inventories, and this in itself creates a greater scope for change. However the perceptions of children and teachers differ, and the responses of teachers to the SDQ suggest that children in the second year group have more needs and made less improvement than children in the first year group.

These findings pose the more general question as to whether the impacts of Mounttown NYFP tend to diminish over time. We are not in a position to answer this since we do not know how the second year group performed in their first year, or how the first year group will perform in the second year. Tracking children at the end of each year would be necessary to establish how the general pattern of impact varies over time. For example, it is

possible that the lower pre-test scores of the second year group, based on their own responses, may be the result of significant unmeasured improvements which took place in the year prior to the evaluation. Without systematic tracking of each child on an annual basis, it will not be possible to establish this with certainty.

At the same time, our findings also indicate that teachers regard children in the second year group as having substantial needs, particularly in the area of behaviour and hyperactivity. The findings also indicate that teachers found that children in the second year group showed no improvement in these two areas over the course of the evaluation. This raises the question as to whether the programme in Mounttown NYFP places sufficient emphasis on modifying problems in behaviour and hyperactivity given that the range of impacts, as measured by the SDQ and the Beck Youth Inventories, tend to be stronger in the emotional than in the behavioural area. In view of this, there may be a case for using a more behaviourally oriented programme, particularly during the second year, such as The Incredible Years programme, which has demonstrated effectiveness in terms of improving these problems among children as well as improving the capacity of teachers and parents to deal with such problems<sup>218</sup>.

It is clear that the answer to the question posed at the beginning of this section – is the programme effective? – that the work of Mounttown NYFP is effective, particularly in the first year of the programme and particularly in the area of emotional and relationship well-being. At the same time, there would seem to be scope to improve its effectiveness, particularly during the second year, and in areas of behaviour and hyperactivity.

#### **9.6.2 What are the main areas of need among children?**

It is well recognised that measuring the needs of children is a significant challenge, whether done from the perspective of clinical practice or research. The reason for this challenge is that the needs of children are often specific to particular settings (such as home, school, peer groups, etc) and to the person assessing the needs (the child, the parent, the teacher, etc). In addition, they are sensitive to the threshold used for defining what is normal, below which a child is said to be in need. In this study, we have used the results of representative national surveys as the threshold for our definition of what is normal while recognising that this is a statistical rather than a clinical concept of need. Significantly, the analysis found that many of the children in the study did not meet the clinical thresholds as defined by the SDQ and the Beck Youth Inventories. The reason for this is that clinical status cannot be based on the results of these screening instruments alone, as the Manual for the Beck Youth Inventories points out: “It is important to note that self-report measures, including the Beck Youth Inventories, should not be used in isolation to make a diagnosis”<sup>219</sup>.

An important finding of the study is that children perceive their needs quite differently from the way teachers perceive those needs. For example, the needs which children present through their self-report to the SDQ and the Beck Youth Inventories tend to focus on emotional and peer problems with fewer needs in the area of behaviour or hyperactivity. For teachers, by contrast, the main areas of need among these children are

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218 see [www.incredibleyears.com](http://www.incredibleyears.com)

219 Beck, Beck & Jolly, 2001:16

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behaviour and hyperactivity problems, with correspondingly less emphasis on emotional and relationship problems. Both perspectives are equally valid and underline the importance of seeing the child's needs in different settings and from different perspectives. They also underline how children may not be properly attuned to the demands of a classroom setting while, conversely, teachers may not be fully attuned to the emotional and behaviour problems which the children are experiencing.

These considerations underline the importance of developing a close working relationship between teachers and staff in Mounttown NYFP so that a fuller picture of the challenges facing the child can be formed. At the same time, they also point to a significant gap in our understanding of the needs of these children, due to the absence of the parents' perspective. In any subsequent evaluation, the needs of parents should be taken into account since the home is a core setting in the child's life. This, in turn, raises the more general question of whether the programme in Mounttown NYFP should explicitly include a module for parents. This clearly has resource implications but, prior to that, it raises a more general strategic issue of whether the objective of improving the well-being of children can be achieved more effectively by offering supports to improve the well-being and parenting skills of parents, or by working directly with the children only, or by a combination of both. Other research<sup>220</sup>, including research in Ireland<sup>221</sup> - and even research based on applying the same programme to parents, children and teachers<sup>222</sup> - suggests that working with parents is one of the most effective ways of improving the well-being of children<sup>223</sup>.

### **9.6.3 What are the main strengths in the lives of these children?**

The well-being of children, as of adults, is measured not just by the absence of symptoms but the presence of physical and mental health. To be healthy, according to the World Health Organisation, involves "a complete state of physical, mental and social well-being and not merely the absence of disease or infirmity"<sup>224</sup>. For this reason we used positive indicators to measure well-being (notably the child's satisfaction with life) as a necessary counterbalance to measurements based on negative symptoms (notably the SDQ and the Beck Youth Inventories). It is also recognised that services to improve children's lives need to focus not just on "the remediation of problems, ridding children of psychopathology, or reducing the potential for pathology to develop" but to complement this by a focus on "developing strengths, facilitating positive responses to adversity, and strengthening the important institutions in children's lives"<sup>225</sup>.

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

221 McKeown, Haase and Pratschke, 2001

222 This research is based on the impact of separately delivering The Incredible Years programme to parents, teachers and children; see Webster-Stratton, Reid, and Hammond, 2004:122

223 It is worth noting that the original vision for Neighbourhood Youth Projects, as outlined in the final report of the Task Force on Child Care Services (1980:151), also envisaged working with families, particularly where the children required intensive supports: "The essence of the Neighbourhood Youth Project is working with small groups of children in their own communities, using close adult/child/peer relationships, with a variety of activities, to encourage and facilitate personal growth and development in all spheres of the child's life. Where children who need intensive help are concerned ... work with the family and involvement of the family in the project is, we consider, an essential part of the exercise".

224 Quoted in Department of Health, 2001:15

225 Huebner, Suldo, Smith, and McKnight, 2004:81

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These observations are relevant in view of the findings that children attending Mounttown NYFP have significant psychological needs and a significantly higher number of physical symptoms compared to the average Irish child. At the same time, these negative experiences do not seem to diminish the children's life satisfaction, which is similar to that enjoyed by other Irish children, both before and after their participation in Mounttown NYFP.

Our interpretation of these apparently contradictory findings is that the domains of psychological problems and physical symptoms are quite separate from the domain of life satisfaction. In other words, having physical or psychological problems is not necessarily inconsistent with enjoying life, unless and until one translates those problems into a personal identify. This interpretation suggests that, for these children, life satisfaction is not the opposite of having psychological problems and physical symptoms, but may indicate a capacity to cope with those difficulties.

This interpretation is also supported by the fact that, although these children's behaviour patterns tend to deviate from accepted norms, and tend to create problems for themselves, their teachers and possibly their parents, the children do not seem to regard this as an area of significant need. As a result, it would seem that the children have not created a self-identify around the problems which others have observed; unlike adults and, to a lesser extent, adolescents, the children seem to be free from the internalised burden of identifying with their problems. This is a significant asset for the children – an asset based on innocence rather than awareness - and clearly reflects their age, but probably also reflects the non-stigmatising style of intervention offered by Mounttown NYFP. In terms of a strengths-based perspective, it is clear that the capacity of these children to enjoy life while also having problems is an important asset which is being used by Mounttown NYFP, mindful that this asset will tend to diminish as the child grows into adolescence, as part of normal psychological development. This reality also underlines the importance of early intervention where 'early' is understood as early in the life of the problem as well as early in the life of the child<sup>226</sup>.

#### **9.6.4 What are the limitations of the study?**

The study is limited by the small number of children involved, particularly in the first year group (6), but also by the absence of a credible comparison group. The small number of cases makes the results vulnerable to the possibility that these may not be representative of other children in the school who have similar difficulties, while the absence of a credible comparison group makes it difficult to prove that the changes observed are solely attributable to the interventions of Mounttown NYFP.

The study is also limited by the fact that we have no information on how the impact of Mounttown NYFP varies over time. As indicated above, we do not know how the second year group performed in their first year, or how

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<sup>226</sup> Health and social services are sometimes referred to as forms of intervention which vary according to the time at which they intervene in the life of a problem. Some interventions are made before the problem is allowed to emerge (prevention), others occur after the problem has emerged but are made early in order to stop the problem getting worse (early intervention), while yet others take place when the problem is fully developed in order to address the consequences which have evolved (treatment).

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the first year group will perform in the second year. The responses of teachers to the SDQ raise a concern that the impact of Mounttown NYFP may diminish in the second and subsequent years, particularly in the areas of behaviour and hyperactivity, but this could only be confirmed by setting up an evaluation system which tracks the children at the end of each year in order to establish how impact varies over time.

The study is also limited by the absence of an input from parents. This means that we do not know how children are perceived in the home setting and, equally important, we do not know about the well-being of parents or their parenting skills, since these are well recognised influences on the well-being of children. This absence makes it impossible to judge if the benefits of Mounttown NYFP are transferable to the home setting.

For these reasons, the results reported here should be regarded as indicative rather than definitive. At the same time, these limitations also provide compelling grounds for continuing to monitor the outcomes of Mounttown NYFP on an ongoing basis.

## **9.7 Concluding comment**

This study indicates that the programme offered at Mounttown NYFP is extremely promising and capable of producing significant benefits for children in a school setting, similar to those produced by other programmes which have been designated as 'proven'<sup>227</sup> or 'blueprint'<sup>228</sup>. The programme's main strength lies in its capacity to improve the emotional and relationship well-being of children. However Mounttown NYFP also faces the challenge of developing more effective responses to children with behaviour and hyperactivity problems, particularly those displayed in a classroom setting. The possibility that the programme's impact may diminish over time needs to be explored further since this is relevant to deciding on the optimum amount of time that a child should spend on this project. Given that there is a waiting list for the programme, the possibility needs to be considered that offering a child one year on the programme may be more beneficial than offering an additional year to a child who has already had one year. In responding to these challenges, it is essential that Mounttown NYFP continues to evaluate its work and to experiment with other programmes which may have greater impacts in key domains of need. This is an innovative project with enormous potential, particularly if Mounttown NYFP can develop a vision of itself as a laboratory for developing and testing effective programmes to meet the mental health needs of children in primary school. The evidence in this report clearly indicates that Mounttown NYFP is capable of responding to these challenges.

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227 The Promising Practices Network run by the Rand Corporation defines a programme as 'proven' where, inter alia, 'at least one outcome is changed by 20%, 0.25 standard deviations or more' (<http://www.promisingpractices.net>) (see also Shonkoff and Phillips, 2000:342-343).

228 The Centre for the Study and Prevention of Violence at University of Colorado in Boulder, USA selects 'Blueprints Model Programs' on the basis of 'the most rigorous tests of effectiveness in the field', and requires that all Blueprint programmes have 'at least moderate effect sizes', which imply effect sizes of 0.5 or higher (<http://www.colorado.edu/cspv/blueprints>).

## Appendix to Chapter Four: Changes in Strengths and Difficulties

**Table A4.1 Mean Pre-test and Post-test Scores, Estimated Change and Need in Experimental and Comparison Groups.  
Based on the Children’s Self-Report of ‘SDQ Symptoms’.**

Variable	First Year Group (6)				Second Year Group (13)				Comparison Group (18)				Britain***
	Pre	Post	Change*	Need**	Pre	Post	Change*	Need**	Pre	Post	Change*	Need**	
Conduct problems	3.2	3.3	+0.07	+0.66	2.5	2.7	+0.07	+0.29	1.2	1.1	-0.06	-0.65	2.2
Hyperactivity	4.8	3.8	-0.53	+0.02	4.2	4.5	+0.16	+0.34	2.8	2.5	-0.15	-0.59	3.8
Emotional problems	5.7	5.3	-0.15	+1.21	4.5	4.2	-0.17	+0.64	1.3	1.3	0.00	-0.71	2.8
Peer problems	3.3	3.0	-0.20	+1.07	3.0	2.5	-0.28	+0.74	1.1	1.2	+0.04	-0.24	1.5
Prosocial behaviour	8.7	7.7	-0.61	-0.20	7.8	8.2	+0.23	+0.14	8.6	8.3	-0.18	+1.16	8.0
<b>Total Difficulties</b>	<b>17.0</b>	<b>15.5</b>	<b>-0.26</b>	<b>+1.00</b>	<b>14.3</b>	<b>13.9</b>	<b>-0.07</b>	<b>+0.69</b>	<b>6.4</b>	<b>6.1</b>	<b>-0.07</b>	<b>-0.81</b>	<b>10.3</b>

\*\*Change is measured in terms of the effect size and refers to the difference in pre-test and post-test scores of the experimental groups divided by the pooled standard deviation of the combined experimental groups; for the comparison group, change refers to the difference in pre-test and post-test scores divided by the standard deviation of the comparison group.

\*\*Need refers to the difference between the post-test scores of the experimental group and a representative sample of over 10,000 British children who completed the SDQ (Meltzer, Gatward, Goodman, and Ford, 2000; see also [www.sdqinfo.com](http://www.sdqinfo.com)).

\*\*\*This refers to the mean scores of a representative sample of over 10,000 British children who completed the SDQ.

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**Table A4.2 Mean Pre-test and Post-test Scores, Estimated Change and Need in Experimental and Comparison Groups.**

**Based on Teacher's Report of 'SDQ Symptoms'.**

Variable	First Year Group (6)				Second Year Group (13)				Britain***
	Pre	Post	Change*	Need**	Pre	Post	Change*	Need**	
Conduct problems	3.8	3	-0.30	+1.31	2.7	2.8	+0.05	+1.22	0.9
Hyperactivity	3.2	3.3	+0.05	+0.15	5.2	5.7	+0.13	+1.00	2.9
Emotional problems	2.3	1	-0.44	-0.21	2.5	3.2	+0.23	+0.92	1.4
Peer problems	1.8	1.2	-0.28	-0.13	2.4	1.9	-0.19	+0.29	1.4
Prosocial behaviour	6.2	7.5	+0.60	+0.13	7.3	8.2	+0.38	+0.40	7.2
<b>Total Difficulties</b>	<b>11.2</b>	<b>8.5</b>	<b>-0.31</b>	<b>+0.32</b>	<b>12.8</b>	<b>13.6</b>	<b>+0.10</b>	<b>+1.17</b>	<b>6.6</b>

\*Change refers to the difference in pre-test and post-test scores of the experimental groups divided by the pooled standard deviation of the combined experimental groups; for the comparison group, change refers to the difference in pre-test and post-test scores divided by the standard deviation of the comparison group.

\*\*Need refers to the difference between the post-test scores of the experimental group and a representative sample of over 10,000 British children who completed the SDQ (Meltzer, Gatward, Goodman, and Ford, 2000; see also [www.sdqinfo.com](http://www.sdqinfo.com)).

\*\*\*This refers to the mean scores of a representative sample of 8,208 British children whose teachers completed the SDQ.

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**Table A4.3a Clinical Status of Children at Pre-test and Post-test in the Experimental Groups. Based on Children's Responses to 'SDQ Symptoms'.**

Category		First Year Group (6)				Second Year Group (13)			
		Pre-test				Pre-test			
		Normal	Borderline	Abnormal	Total	Normal	Borderline	Abnormal	Total
Post-test									
Normal	N	2	1	-	3	8	1	-	9
	%	33	17	-	50	62	8	-	69
Borderline	N	-	-	-	-	1	1	1	3
	%	-	-	-	-	8	8	8	24
Abnormal	N	-	1	2	3	-	-	1	1
	%	-	17	33	50	-	-	8	8
<b>Total</b>	N	<b>2</b>	<b>2</b>	<b>2</b>	<b>6</b>	<b>9</b>	<b>2</b>	<b>2</b>	<b>13</b>
	%	<b>33</b>	<b>34</b>	<b>33</b>	<b>100</b>	<b>70</b>	<b>16</b>	<b>16</b>	<b>100</b>

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**Table A4.3b Clinical Status of Children at Pre-test and Post-test in the Experimental Groups. Based on Teacher's Responses to 'SDQ Symptoms'.**

Category		First Year Group (6)				Second Year Group (13)			
		Pre-test				Pre-test			
		Normal	Borderline	Abnormal	Total	Normal	Borderline	Abnormal	Total
Post-test									
Normal	N	2	3	-	5	5	2	-	7
	%	33	50	-	83	38	15	-	54
Borderline	N	-	-	-	-	1	-	-	1
	%	-	-	-	-	8	-	-	8
Abnormal	N	-	-	1	1	-	2	3	5
	%	-	-	17	17	-	15	23	38
<b>Total</b>	N	<b>2</b>	<b>3</b>	<b>1</b>	<b>6</b>	<b>6</b>	<b>4</b>	<b>3</b>	<b>13</b>
	%	<b>33</b>	<b>50</b>	<b>17</b>	<b>100</b>	<b>46</b>	<b>31</b>	<b>23</b>	<b>100</b>

## Appendix to Chapter Five: Changes in Social and Emotional Impairment

**Table A5.1 Mean Pre-test and Post-test Scores, Estimated Change and Need in Experimental and Comparison Groups.  
Based on Children’s Self-Report to the Beck Youth Inventories of Emotional and Social Impairment.**

Variable	First Year Group (6)				Second Year Group (13)				Comparison Group (18)				Ireland***
	Pre	Post	Change*	Need**	Pre	Post	Change*	Need**	Pre	Post	Change*	Need**	
Self-concept	65.2	58.0	-1.05	+2.44	59.5	59.9	+0.06	+2.72	61.9	61.3	-0.07	+2.36	41.4
Depression	46.5	38.2	-0.74	+0.92	33.5	34.0	+0.04	+0.55	25.1	25.1	0.00	-0.56	27.8
Anxiety	54.2	44.5	-0.86	+0.87	37.9	43.3	+0.49	+0.76	30.4	28.0	-0.37	-1.05	34.8
Disruptive behaviour	34.8	33.3	-0.15	+0.43	29.3	29.5	+0.02	+0.05	24.7	23.9	-0.16	-1.03	29.0
Anger	49.2	42.7	-0.54	+0.79	37.5	37.5	+0.01	+0.36	29.5	27.9	-0.21	-0.70	33.2
<b>Total</b>	<b>184.7</b>	<b>158.6</b>	<b>-0.69</b>	<b>+0.89</b>	<b>138.2</b>	<b>144.4</b>	<b>+0.16</b>	<b>+0.52</b>	<b>109.7</b>	<b>104.9</b>	<b>-0.23</b>	<b>-0.95</b>	<b>124.8</b>

\*\*Change is measured in terms of the effect size and refers to the difference in pre-test and post-test scores of the experimental groups divided by the pooled standard deviation of the combined experimental groups; for the comparison group, change refers to the difference in pre-test and post-test scores divided by the standard deviation of the comparison group.

\*\*\*Need refers to the difference between the post-test scores of the experimental groups and a representative sample of 234 children in Ireland (McKeown, Pratschke and Haase, 2003).

\*\*\*This refers to the mean scores of a representative sample of 234 children in Ireland (McKeown, Pratschke and Haase, 2003).

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**Table A5.2 Changes in Self-Concept following Mounttown NYFP. Based on Children's Self-Report to the Beck Youth Inventories of Emotional and Social Impairment.**

Self-Concept		First Year Group (6)					Second Year Group (13)				
		Pre-test									
Post-test		Above average	Average	Below average	Much below average	Total	Above average	Average	Below average	Much below average	Total
Above average	N	4	-	-	-	4	8	2	-	-	10
	%	67				67	62	15			77
Average	N	2	-	-	-	2	3	-	-	-	3
	%	33				33	23				23
Below average	N	-	-	-	-	-	-	-	-	-	-
	%										
Much below average	N	-	-	-	-	-	-	-	-	-	-
	%										
<b>Total</b>	N	<b>6</b>	-	-	-	<b>6</b>	<b>11</b>	<b>2</b>	-	-	<b>13</b>
	%	<b>100</b>				<b>100</b>	<b>85</b>	<b>15</b>			<b>100</b>

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**Table A5.3 Changes in Depression following Mounttown NYFP. Based on Children's Self-Report to the Beck Youth Inventories of Emotional and Social Impairment.**

Depression		First Year Group (6)					Second Year Group (13)				
		Pre-test									
Post-test		Average	Mild	Moderate	Extreme	Total	Average	Mild	Moderate	Extreme	Total
Average	N	5	-	1	-	6	12	-	1	-	13
	%	83	-	17	-	100	92	-	8	-	100
Mild	N	-	-	-	-	-	-	-	-	-	-
	%	-	-	-	-	-	-	-	-	-	-
Moderate	N	-	-	-	-	-	-	-	-	-	-
	%	-	-	-	-	-	-	-	-	-	-
Extreme	N	-	-	-	-	-	-	-	-	-	-
	%	-	-	-	-	-	-	-	-	-	-
<b>Total</b>	N	<b>5</b>	<b>-</b>	<b>1</b>	<b>-</b>	<b>6</b>	<b>12</b>	<b>-</b>	<b>1</b>	<b>-</b>	<b>13</b>
	%	<b>83</b>	<b>-</b>	<b>17</b>	<b>-</b>	<b>100</b>	<b>92</b>	<b>-</b>	<b>8</b>	<b>-</b>	<b>100</b>

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**Table A5.4 Changes in Anxiety following Mounttown NYFP. Based on Children's Self-Report to the Beck Youth Inventories of Emotional and Social Impairment.**

Anxiety		First Year Group (6)					Second Year Group (13)				
		Pre-test									
Post-test		Average	Mild	Moderate	Extreme	Total	Average	Mild	Moderate	Extreme	Total
Average	N	4	1	-	1	6	11	-	1	-	12
	%	67	17	-	17	100	85	-	8	-	92
Mild	N	-	-	-	-	-	1	-	-	-	1
	%	-	-	-	-	-	8	-	-	-	8
Moderate	N	-	-	-	-	-	-	-	-	-	-
	%	-	-	-	-	-	-	-	-	-	-
Extreme	N	-	-	-	-	-	-	-	-	-	-
	%	-	-	-	-	-	-	-	-	-	-
<b>Total</b>	N	<b>4</b>	<b>1</b>	<b>-</b>	<b>1</b>	<b>6</b>	<b>12</b>	<b>-</b>	<b>1</b>	<b>-</b>	<b>13</b>
	%	<b>67</b>	<b>17</b>	<b>-</b>	<b>17</b>	<b>100</b>	<b>92</b>	<b>-</b>	<b>8</b>	<b>-</b>	<b>100</b>

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**Table A5.5 Changes in Disruptive Behaviour following Mounttown NYFP. Based on Children’s Self-Report to the Beck Youth Inventories of Emotional and Social Impairment.**

Disruptive Behaviour		First Year Group (6)					Second Year Group (13)				
		Pre-test									
		Average	Mild	Moderate	Extreme	Total	Average	Mild	Moderate	Extreme	Total
Post-test	N										
	%										
Average	N	5	-	-	-	5	13	-	-	-	13
	%	83	-	-	-	83	100	-	-	-	100
Mild	N	-	-	1	-	1	-	-	-	-	-
	%	-	-	17	-	17	-	-	-	-	-
Moderate	N	-	-	-	-	-	-	-	-	-	-
	%	-	-	-	-	-	-	-	-	-	-
Extreme	N	-	-	-	-	-	-	-	-	-	-
	%	-	-	-	-	-	-	-	-	-	-
<b>Total</b>	N	<b>5</b>	<b>-</b>	<b>1</b>	<b>1</b>	<b>6</b>	<b>13</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>13</b>
	%	<b>83</b>	<b>-</b>	<b>17</b>	<b>1</b>	<b>100</b>	<b>100</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>100</b>

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**Table A5.6 Changes in Anger following Mounttown NYFP. Based on Children's Self-Report to the Beck Youth Inventories of Emotional and Social Impairment.**

Anger		First Year Group (6)					Second Year Group (13)				
		Pre-test									
Post-test		Average	Mild	Moderate	Extreme	Total	Average	Mild	Moderate	Extreme	Total
Average	N	3			1	4	12		1		13
	%	50	-	-	17	67	92	-	8	-	100
Mild	N			1		1					
	%	-	-	17	-	17	-	-	-	-	-
Moderate	N	1				1					
	%	17	-	-	-	17	-	-	-	-	-
Extreme	N										
	%	-	-	-	-	-	-	-	-	-	-
<b>Total</b>	N	<b>4</b>		<b>1</b>	<b>1</b>	<b>6</b>	<b>12</b>		<b>1</b>		<b>13</b>
	%	<b>67</b>	-	<b>17</b>	<b>17</b>	<b>100</b>	<b>92</b>	-	<b>8</b>	-	<b>100</b>

## Appendix to Chapter Six: Changes in Life Satisfaction and Physical Symptoms

**Table A6.1 Mean Pre-test and Post-test Scores, Estimated Change and Need in Experimental and Comparison Groups.  
Based on the Multidimensional Student's Life Satisfaction Scale.**

Variable	First Year Group (6)				Second Year Group (13)				Comparison Group (18)				Ireland***
	Pre	Post	Change*	Need**	Pre	Post	Change*	Need**	Pre	Post	Change*	Need**	
Family	17.5	15.2	-0.75	-0.17	16.2	18.5	+0.74	+0.91	18.6	19.0	+0.29	+2.18	15.7
Friends	15.2	15.2	0.00	-0.31	14.8	17.9	+0.84	+0.44	17.8	17.6	-0.08	+0.47	16.3
School	9.7	11.2	+0.26	+0.17	9.9	9.4	-0.09	-0.14	13.7	12.9	-0.19	+0.67	10.2
Living Environment	20.2	19.3	-0.14	+0.02	19.9	21.2	+0.21	+0.33	22.7	23.3	+0.16	+1.04	19.2
Self	13.8	13.3	-0.15	-0.50	15.4	16.7	+0.39	+0.51	16.3	17.2	+0.30	+0.78	15.0
<b>Total</b>	<b>76.3</b>	<b>74.2</b>	<b>-0.17</b>	<b>-0.17</b>	<b>76.3</b>	<b>83.7</b>	<b>+0.57</b>	<b>+0.56</b>	<b>89.0</b>	<b>89.9</b>	<b>+0.10</b>	<b>+1.44</b>	<b>76.4</b>

\*\*Change is measured in terms of the effect size and refers to the difference in pre-test and post-test scores of the experimental groups divided by the pooled standard deviation of the combined experimental groups; for the comparison group, change refers to the difference in pre-test and post-test scores divided by the standard deviation of the comparison group.

\*\*\*Need refers to the difference between the post-test scores of the experimental groups and a representative sample of 234 children in Ireland (McKeown, Pratschke and Haase, 2003).

\*\*\*This refers to the mean scores of a representative sample of 234 children in Ireland (McKeown, Pratschke and Haase, 2003).

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**Table 6.2 Mean Pre-test and Post-test Scores, Estimated Change and Need in Experimental and Comparison Groups. Based on the Health and Daily Living Scale.**

Variable	First Year Group (6)				Second Year Group (13)				Comparison Group (18)				Ireland***
	Pre	Post	Change*	Need**	Pre	Post	Change*	Need**	Pre	Post	Change*	Need**	
Upset stomach	2.0	2.5	+0.45	+0.28	2.8	2.8	0.00	+0.52	2.3	1.7	-0.55	-0.41	2.2
Headaches	2.8	3.3	+0.53	+0.93	3.2	2.5	-0.65	+0.09	2.4	2.1	-0.35	-0.42	2.4
Nightmares	2.8	3.2	+0.27	+1.12	2.7	3.0	+0.25	+0.99	1.8	1.8	0.00	+0.02	1.8
Trouble going asleep	3.2	2.7	-0.36	+0.59	1.8	2.9	+0.83	+0.78	1.6	1.6	0.00	-0.30	1.8
Too ill for school	2.0	2.5	+0.55	+0.24	2.9	2.2	-0.82	-0.14	2.1	2.0	-0.07	-0.34	2.3
<b>Total</b>	<b>12.8</b>	<b>14.2</b>	<b>+0.46</b>	<b>+1.27</b>	<b>13.3</b>	<b>13.4</b>	<b>+0.03</b>	<b>+1.00</b>	<b>10.1</b>	<b>9.2</b>	<b>-0.30</b>	<b>-0.44</b>	<b>10.5</b>

\*\*Change is measured in terms of the effect size and refers to the difference in pre-test and post-test scores of the experimental groups divided by the pooled standard deviation of the combined experimental groups; for the comparison group, change refers to the difference in pre-test and post-test scores divided by the standard deviation of the comparison group.

\*\*\*Need refers to the difference between the post-test scores of the experimental groups and a representative sample of 234 children in Ireland (McKeown, Pratschke and Haase, 2003).

\*\*\*This refers to the mean scores of a representative sample of 234 children in Ireland (McKeown, Pratschke and Haase, 2003).

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**Table A6.3 Pre-test and Post-test Scores in Experimental and Control Groups, with Comparative Data from a Representative Sample of Irish Children.**

Variable	First Year Group (6)		Second Year Group (13)		Comparison Group (18)		Ireland*
	Pre	Post	Pre	Post	Pre	Post	
% ever smoked	0	33	8	31	6	6	41
% currently smoke	0	17	8	8	0	0	19
% ever tried alcohol	33	33	31	54	39	22	60
% took alcohol in last month	0	17	23	8	0	0	25

\*Based on a representative sample of 5,712 children in Ireland aged 11, 13 and 15 (Centre for Health Promotion Studies, 2003:24; 31-32).

## Appendix to Chapter Seven: Changes in Relationship with Parents

**Table A7.1 Mean Pre-test and Post-test Scores, Estimated Change and Need in Experimental and Comparison Groups.  
Based on the Inventory of Parent and Peer Attachment.**

Variable	First Year Group (6)				Second Year Group (13)				Comparison Group (18)				Holland***
	Pre	Post	Change*	Need**	Pre	Post	Change*	Need**	Pre	Post	Change*	Need**	
Attachment to mother	4.5	4.3	-0.61	+0.35	4.2	4.2	-0.05	+0.19	4.7	4.7	+0.20	+2.09	4.1
Attachment to father	4.3	3.6	-1.12	-0.29	4.1	4.0	-0.22	+0.27	4.6	4.6	+0.09	+1.94	3.8
Attachment to friends	3.8	4.0	+0.38	-	3.8	3.8	+0.06	-	4.4	4.2	-0.28	-4.	-

\*\*Change is measured in terms of the effect size and refers to the difference in pre-test and post-test scores of the experimental groups divided by the pooled standard deviation of the combined experimental groups; for the comparison group, change refers to the difference in pre-test and post-test scores divided by the standard deviation of the comparison group.

\*\*\*Need refers to the difference between the post-test scores of the experimental groups and a representative sample of 288 adolescents in Holland, each living in a two-parent family (Buist, Dekovic, Meeus and van Aken, 2004).

\*\*\*Based on a representative sample of 288 adolescents in Holland, each living in a two-parent family (Buist, Dekovic, Meeus and van Aken, 2004).

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**Table A7.2 Mean Pre-test and Post-test Scores, Estimated Change and Need in Experimental and Comparison Groups.**

**Based on the Parenting Style Scale.**

Variable	First Year Group (6)				Second Year Group (13)				Comparison Group (18)				Ireland***
	Pre	Post	Change*	Need**	Pre	Post	Change*	Need**	Pre	Post	Change*	Need**	
Mother Supportiveness	4.4	4.5	+0.13	+0.52	4.5	3.9	-0.70	-0.25	4.5	4.7	+0.48	+1.34	4.1
Father Supportiveness	4.3	4.1	-0.22	+0.29	4.0	3.3	-0.74	-0.54	4.4	4.5	+0.23	+1.11	3.8
Parental Involvement	2.1	2.7	+0.91	+0.20	2.5	2.2	-0.41	-0.50	2.3	2.6	+0.57	0.00	2.55
Total Parent Support	6.4	6.9	+0.48	+0.38	6.7	5.8	-0.93	-0.73	6.7	6.9	+0.22	+0.51	6.47

\*\*Change is measured in terms of the effect size and refers to the difference in pre-test and post-test scores of the experimental groups divided by the pooled standard deviation of the combined experimental groups; for the comparison group, change refers to the difference in pre-test and post-test scores divided by the standard deviation of the comparison group.

\*\*\*Need refers to the difference between the post-test scores of the experimental groups and a representative sample of 234 children in Ireland (McKeown, Pratschke and Haase, 2003).

\*\*\*Based on a representative sample of 234 children in Ireland (McKeown, Pratschke and Haase, 2003).

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**Table A7.3 Mean Pre-test and Post-test Scores, Estimated Change and Need in Experimental and Comparison Groups.**

**Based on the Conflict Scale.**

Variable	First Year Group (6)				Second Year Group (13)				Comparison Group (18)				Ireland***
	Pre	Post	Change*	Need**	Pre	Post	Change*	Need**	Pre	Post	Change*	Need**	
Conflict with parents	2.8	2.5	-0.27	+0.24	1.6	1.6	-0.03	-0.74	1.3	1.4	+0.19	-2.35	2.3

\*\*Change is measured in terms of the effect size and refers to the difference in pre-test and post-test scores of the experimental groups divided by the pooled standard deviation of the combined experimental groups; for the comparison group, change refers to the difference in pre-test and post-test scores divided by the standard deviation of the comparison group.

\*\*\*Need refers to the difference between the post-test scores of the experimental groups and a representative sample of 234 children in Ireland (McKeown, Pratschke and Haase, 2003).

\*\*\*Based on a representative sample of 234 children in Ireland (McKeown, Pratschke and Haase, 2003).

## Appendix to Chapter Eight: Changes in School Outcomes

**Table A8.1 Mean Pre-test and Post-test Scores, Estimated Change and Need in Experimental and Comparison Groups.**

**Based on the Multidimensional Student's Life Satisfaction Scale.**

Variable	First Year Group (6)				Second Year Group (13)				Comparison Group (18)				Ireland ***
	Pre	Post	Change*	Need**	Pre	Post	Change*	Need**	Pre	Post	Change*	Need**	
Get on well with teachers	3.0	2.8	-0.19	+0.4	3.1	2.6	-0.41	-0.17	3.6	3.7	+0.10	+1.58	2.8
School results are similar to classmates	2.3	2.0	+0.53	-0.16	2.1	2.0	+0.08	-0.11	1.9	1.7	+0.36	+0.38	1.9

\*\*Change is measured in terms of the effect size and refers to the difference in pre-test and post-test scores of the experimental groups divided by the pooled standard deviation of the combined experimental groups; for the comparison group, change refers to the difference in pre-test and post-test scores divided by the standard deviation of the comparison group.

\*\*\*Need refers to the difference between the post-test scores of the experimental groups and a representative sample of 234 children in Ireland (McKeown, Pratschke and Haase, 2003).

\*\*\*This refers to the mean scores of a representative sample of 234 children in Ireland (McKeown, Pratschke and Haase, 2003).

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**Table A8.2a Mean Pre-test and Post-test Scores, Estimated Change and Need in Experimental and Comparison Groups.**

**Based on Children's Attendance and Lateness for School.**

Variable	First Year Group (6)			Second Year Group (13)			Comparison Group (18)			Ireland**
	Pre	Post	Change*	Pre	Post	Change*	Pre	Post	Change*	
Mean attendance rate (%)	90.6	-	-	88.8	-	-	94.7	-	-	94.1
% absent for 20 days or more	33.3	-	-	38.5	-	-	11.0	-	-	10.7
Mean lateness score	3.3	3.3	0.0	3.7	3.5	-0.14	4.2	-	-	-

\*Change is measured in terms of the effect size and refers to the difference in pre-test and post-test scores of the experimental groups divided by the pooled standard deviation of the combined experimental groups; for the comparison group, change refers to the difference in pre-test and post-test scores divided by the standard deviation of the comparison group.

\*\*Based on data in the Analysis of School Attendance Data at Primary and Post-Primary Levels for 2004/2005 (O'Briain, 2006:10).

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**Table A8.3a Mean Pre-test and Post-test Scores, Estimated Change and Need in Experimental and Comparison Groups.  
Based on Micra T Reading Attainment Test, Sigma T Numeracy Test.**

Variable	First Year Group (3)			Second Year Group (6)			Comparison Group (18)		
	Pre	Post	Change*	Pre	Post	Change*	Pre	Post	Change*
Mean reading percentile	13	37	1.2	12	32	1.0	-	-	-
Mean numeracy percentile	-	-	-	-	-	-	-	-	-

\*Change is measured in terms of the effect size and refers to the difference in pre-test and post-test scores of the experimental groups divided by the pooled standard deviation of the combined experimental groups; for the comparison group, change refers to the difference in pre-test and post-test scores divided by the standard deviation of the comparison group.

**Table A8.3b Change in Experimental and Control Groups, Based on Micra T Reading Attainment Test and Sigma T Numeracy Test.**

Variable		Reading		Numeracy	
		First Year Group (3)	Second Year Group (6)	First Year Group (3)	Second Year Group (6)
Improved	N	2	5	-	-
	%	67	83	-	-
No change	N	0	1	-	-
	%	0	17	-	-
Disimproved	N	1	0	-	-
	%	33	0	-	-
<b>Total</b>	N	<b>100</b>	<b>100</b>	<b>100</b>	<b>100</b>
	%				

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