



## GROWING UP IN IRELAND – the national longitudinal study of children

### STRICTLY CONFIDENTIAL

#### FATHER / PARTNER QUESTIONNAIRE – SUPPLEMENTARY SECTION

GROUP   HHOLD     RESPONDENT

Interviewer Name \_\_\_\_\_ Interviewer Number

Time Section Started     (24 hour clock) Date \_\_\_\_ \_\_\_\_ \_\_\_\_  
day mth year

We have a few final questions which we would like to discuss with you. As some of these may be considered slightly sensitive we have included them in a section for you to complete by yourself. We would ask you to complete this section and return it to the interviewer.

Once again, we would like to assure you that **ALL THE INFORMATION PROVIDED IS TREATED IN THE STRICTEST CONFIDENCE.**

A1. What is your date of birth? \_\_\_\_\_ day \_\_\_\_\_ month \_\_\_\_\_ year

A2. Are you male or female? Male ..... <sub>1</sub> Female ..... <sub>2</sub>

S1. Are you the biological parent of <baby>?

Yes..... <sub>1</sub> → Go to S12 No..... <sub>2</sub> → Go to S2

S2. Are you the adoptive parent of <baby>?

Yes..... <sub>1</sub> No..... <sub>2</sub> → Go to S7

S3. Was that a domestic or an inter-country adoption?

Domestic ..... <sub>1</sub>

Inter-country ..... <sub>2</sub>

S4. Was this a within family adoption?

Yes ..... <sub>1</sub> No ..... <sub>2</sub>

S5. From which country?

\_\_\_\_\_

S6. What age was <baby> when you adopted him/ her? \_\_\_\_\_ years

**NOW PLEASE GO TO S12**

S7. Are you the foster parent of <baby>?

Yes..... <sub>1</sub> No..... <sub>2</sub> → Go to S12

S8. How long has <baby> been with your family? \_\_\_\_\_ months \_\_\_\_\_ weeks

S9. Do you anticipate that this will be a long-term foster placement? Yes ..... <sub>1</sub> No ..... <sub>2</sub>

S10. How many previous foster placements has <baby> been in? \_\_\_\_\_ previous placements DK... <sub>99</sub>

S11. Immediately before coming to live with you was <baby> living with another foster family, his/her family or in institutional care?

Another foster family..... <sub>1</sub> Own family ..... <sub>2</sub> Institutional care ..... <sub>3</sub>

**NOW PLEASE GO TO S12**

Because the issue of family life is so important we would now like to ask some questions about your family and marital history.

**S12. Can you tell me which of these best describes your current marital status?**

- Married and living with husband / wife ..... 1 **Go to S16**
- Married and separated from husband / wife ..... 2 **Go to S13**
- Divorced ..... 3 **Go to S13**
- Widowed ..... 4 **Go to S13**
- Never married ..... 5 **Go to S15**

**S13. In what year did you marry your (former) spouse?** \_\_\_\_\_(year)

**S14. Since when have you been living apart / spouse deceased?** \_\_\_\_\_(year)

**S15. May I just check whether you are currently living with someone in the household as a couple?**

- Yes ..... 1      No ..... 2 **Go to S25**

**S16. Since when have you and your spouse or partner been living together?** \_\_\_\_\_ (mth) \_\_\_\_\_(year)

**S17. Many couples argue from time to time. Roughly how often would you and your spouse / partner argue?**

- Most days ..... 1 **→Go to S18**
- At least once a week ..... 2 **→Go to S18**
- Less than once a week ..... 3 **→Go to S18**
- Hardly ever ..... 4 **→Go to S18**
- Never ..... 5 **→Go to S21**

**S18. How often would you argue about the child(ren)?**

- Most days ..... 1
- At least once a week ..... 2
- Less than once a week ..... 3
- Hardly ever ..... 4
- Never ..... 5

**S19. When you and your partner argue, how often do you ....**

- |                                     | Never                      | Not very often             | Sometimes                  | Often                      | Almost always/always       |
|-------------------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| Shout or yell at each other.....    | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| Throw something at each other ..... | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| Push, hit or slap each other.....   | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |

**S20. And to end an argument, how often would you ....**

- |   | Never                      | Not very often             | Sometimes                  | Often                      | Almost always/always       |
|---|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| Compromise .....  | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| Apologise .....   | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| Change the subject.....   | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| Agree to discuss the issue later.....   | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| Agree to disagree .....   | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| Use affection (hug) or make a joke about it.....                                      | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| Ignore or refuse to speak any more, walk away, leave the room or leave the house..... | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |

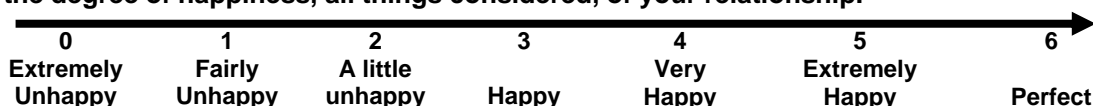
**S21. Most people have disagreements in their relationships. Please indicate below the approximate extent of agreement or disagreement between you and your partner for each item on the following list.**

- |   | Always Agree               | Almost Always Agree        | Occasionally Disagree      | Frequently Disagree        | Almost Always Disagree     | Always Disagree            |
|---|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| Philosophy of life.....                         | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> 6 |
| Aims, goals and things believed important ..... | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> 6 |
| Amount of time spent together .....             | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> 6 |

**S22. How often would you say the following events occur between you and your partner?**

- |   | Never                      | Less than once a month     | Once or twice a month      | Once or twice a week       | Once a week                | More often                 |
|---|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| Have a stimulating exchange of ideas..... | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> 6 |
| Calmly discuss something together .....   | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> 6 |
| Work together on a project .....          | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> 6 |

**S23. The numbers below represent different degrees of happiness in your relationship. The middle point, "happy," represents the degree of happiness of most relationships. Please circle the number which best describes the degree of happiness, all things considered, of your relationship.**



**S24. Do you feel that having <baby> has...**

Brought you and your spouse/partner closer together,

1

Made you less close than before,

2

Made no difference to your relationship,

3

**S25. Apart from your current partner (if relevant) have you had any other partners since <baby> was born who had a close relationship with or influence on <baby>?**

Yes.....1

No.....2 →Go to S27a

**S26. How many?**

One .....1

Two .....2

Three or more.....3

**Only answer questions S27a to S35a if you are the BIOLOGICAL MOTHER of <BABY>, If not please skip to S35b**

**S27a. Did you have any medical fertility treatment for this pregnancy?**

Yes.....1

No.....2

**S27b. What treatment did you receive?**

- Clomiphene citrate alone .....1
- GIFT: Gamete Intrafallopian Transfer.....2
- IVF: In Vitro Fertilisation .....3
- ICSI: IVF with intra cytoplasmic sperm injection .....4
- Frozen embryo transfer .....5
- Surgery involving the womb, tubes or ovaries.....6
- Donor sperm .....7
- Donor egg .....8
- Other (please specify) .....9

**S28a. What age were you when you became pregnant for the first time? \_\_\_\_\_ Age in years**

**S28b. Are you currently pregnant?** Yes .....1 No .....2

**S28c. What age were you when you had your first period? \_\_\_\_\_ years of age. Can't remember ....2**

**S29. Did you intend to become pregnant before <baby> was conceived?**

- Yes, at that time .....1
- Yes, but much later.....2
- Yes, but somewhat later .....3
- Yes, but earlier.....4
- No intention of ever becoming pregnant.....5
- Other (specify) .....6
- Unsure/Didn't mind .....7

**S30a. At any time during the pregnancy did you feel under any stress?**

A great deal

1

Some

2

Not much

3

None at all

4

**S30b. Was that during:**

- |  | Yes                        | No                         |
|--|----------------------------|----------------------------|
| First Trimester [1 <sup>st</sup> , 2 <sup>nd</sup> or 3 <sup>rd</sup> month] ..... | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 |
| Second Trimester [4th, 5th or 6th month] .....                                     | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 |
| Third Trimester [7th, 8th or 9th month] .....                                      | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 |

**S30c. Was this stress due to: (tick yes or not for each)**

- |   | Yes                        | No                         |
|---|----------------------------|----------------------------|
| (i) the pregnancy itself                                  | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 |
| (ii) other factor, such as bereavement, work related etc. | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 |

**S31. Did you smoke at all during the pregnancy?**

Yes.....<sub>1</sub> No.....<sub>2</sub>

**S32. Did you smoke during the first, second and third trimester of the pregnancy?**

[Tick one box on each line]

	Yes	No	How many per day?
First Trimester [1 <sup>st</sup> , 2 <sup>nd</sup> or 3 <sup>rd</sup> month].....	<input type="checkbox"/> <sub>1</sub> .....	<input type="checkbox"/> <sub>2</sub> .....	_____ N
Second Trimester [4 <sup>th</sup> , 5 <sup>th</sup> or 6 <sup>th</sup> month].....	<input type="checkbox"/> <sub>1</sub> .....	<input type="checkbox"/> <sub>2</sub> .....	_____ N
Third Trimester [7 <sup>th</sup> , 8 <sup>th</sup> or 9 <sup>th</sup> month].....	<input type="checkbox"/> <sub>1</sub> .....	<input type="checkbox"/> <sub>2</sub> .....	_____ N

**S33. Did you consume alcohol during your pregnancy?**

Yes.....<sub>1</sub> No.....<sub>2</sub>

**S34. Did you drink during the first, second and third trimester of the pregnancy? For each trimester that you drank, about how much on average did you drink per week?**

	Yes	No	Pints of beer/cider	Glasses of wine	Measures of spirits	Bottles of alcopops
First Trimester [1 <sup>st</sup> , 2 <sup>nd</sup> or 3 <sup>rd</sup> month].....	<input type="checkbox"/> <sub>1</sub> .....	<input type="checkbox"/> <sub>2</sub> .....	_____	_____	_____	_____
Second Trimester [4 <sup>th</sup> , 5 <sup>th</sup> or 6 <sup>th</sup> month].....	<input type="checkbox"/> <sub>1</sub> .....	<input type="checkbox"/> <sub>2</sub> .....	_____	_____	_____	_____
Third Trimester [7 <sup>th</sup> , 8 <sup>th</sup> or 9 <sup>th</sup> month].....	<input type="checkbox"/> <sub>1</sub> .....	<input type="checkbox"/> <sub>2</sub> .....	_____	_____	_____	_____

**S35a. How often did you take any of the following during your pregnancy with <baby>?**

	Often	Most days	Sometimes	Once or twice	Not at all
a. Sleeping pills.....	<input type="checkbox"/> <sub>1</sub> .....	<input type="checkbox"/> <sub>2</sub> .....	<input type="checkbox"/> <sub>3</sub> .....	<input type="checkbox"/> <sub>4</sub> .....	<input type="checkbox"/> <sub>5</sub>
b. Tranquillisers.....	<input type="checkbox"/> <sub>1</sub> .....	<input type="checkbox"/> <sub>2</sub> .....	<input type="checkbox"/> <sub>3</sub> .....	<input type="checkbox"/> <sub>4</sub> .....	<input type="checkbox"/> <sub>5</sub>
c. Pills for depression.....	<input type="checkbox"/> <sub>1</sub> .....	<input type="checkbox"/> <sub>2</sub> .....	<input type="checkbox"/> <sub>3</sub> .....	<input type="checkbox"/> <sub>4</sub> .....	<input type="checkbox"/> <sub>5</sub>
d. Cannabis / Marijuana.....	<input type="checkbox"/> <sub>1</sub> .....	<input type="checkbox"/> <sub>2</sub> .....	<input type="checkbox"/> <sub>3</sub> .....	<input type="checkbox"/> <sub>4</sub> .....	<input type="checkbox"/> <sub>5</sub>
e. Painkillers (aspirin, paracetamol, etc.).....	<input type="checkbox"/> <sub>1</sub> .....	<input type="checkbox"/> <sub>2</sub> .....	<input type="checkbox"/> <sub>3</sub> .....	<input type="checkbox"/> <sub>4</sub> .....	<input type="checkbox"/> <sub>5</sub>
f. Amphetamines or other stimulants.....	<input type="checkbox"/> <sub>1</sub> .....	<input type="checkbox"/> <sub>2</sub> .....	<input type="checkbox"/> <sub>3</sub> .....	<input type="checkbox"/> <sub>4</sub> .....	<input type="checkbox"/> <sub>5</sub>
g. Heroin, Methadone, Crack, Cocaine.....	<input type="checkbox"/> <sub>1</sub> .....	<input type="checkbox"/> <sub>2</sub> .....	<input type="checkbox"/> <sub>3</sub> .....	<input type="checkbox"/> <sub>4</sub> .....	<input type="checkbox"/> <sub>5</sub>
h. Anticonvulsants.....	<input type="checkbox"/> <sub>1</sub> .....	<input type="checkbox"/> <sub>2</sub> .....	<input type="checkbox"/> <sub>3</sub> .....	<input type="checkbox"/> <sub>4</sub> .....	<input type="checkbox"/> <sub>5</sub>
i. Steroids.....	<input type="checkbox"/> <sub>1</sub> .....	<input type="checkbox"/> <sub>2</sub> .....	<input type="checkbox"/> <sub>3</sub> .....	<input type="checkbox"/> <sub>4</sub> .....	<input type="checkbox"/> <sub>5</sub>

**S35b. How often do you take any of the following currently?**

	Often	Most days	Sometimes	Once or twice	Not at all
a. Sleeping pills.....	<input type="checkbox"/> <sub>1</sub> .....	<input type="checkbox"/> <sub>2</sub> .....	<input type="checkbox"/> <sub>3</sub> .....	<input type="checkbox"/> <sub>4</sub> .....	<input type="checkbox"/> <sub>5</sub>
b. Tranquillisers.....	<input type="checkbox"/> <sub>1</sub> .....	<input type="checkbox"/> <sub>2</sub> .....	<input type="checkbox"/> <sub>3</sub> .....	<input type="checkbox"/> <sub>4</sub> .....	<input type="checkbox"/> <sub>5</sub>
c. Pills for depression.....	<input type="checkbox"/> <sub>1</sub> .....	<input type="checkbox"/> <sub>2</sub> .....	<input type="checkbox"/> <sub>3</sub> .....	<input type="checkbox"/> <sub>4</sub> .....	<input type="checkbox"/> <sub>5</sub>
d. Cannabis / Marijuana.....	<input type="checkbox"/> <sub>1</sub> .....	<input type="checkbox"/> <sub>2</sub> .....	<input type="checkbox"/> <sub>3</sub> .....	<input type="checkbox"/> <sub>4</sub> .....	<input type="checkbox"/> <sub>5</sub>
e. Painkillers (aspirin, paracetamol, etc.).....	<input type="checkbox"/> <sub>1</sub> .....	<input type="checkbox"/> <sub>2</sub> .....	<input type="checkbox"/> <sub>3</sub> .....	<input type="checkbox"/> <sub>4</sub> .....	<input type="checkbox"/> <sub>5</sub>
f. Amphetamines or other stimulants.....	<input type="checkbox"/> <sub>1</sub> .....	<input type="checkbox"/> <sub>2</sub> .....	<input type="checkbox"/> <sub>3</sub> .....	<input type="checkbox"/> <sub>4</sub> .....	<input type="checkbox"/> <sub>5</sub>
g. Heroin, Methadone, Crack, Cocaine.....	<input type="checkbox"/> <sub>1</sub> .....	<input type="checkbox"/> <sub>2</sub> .....	<input type="checkbox"/> <sub>3</sub> .....	<input type="checkbox"/> <sub>4</sub> .....	<input type="checkbox"/> <sub>5</sub>
h. Anticonvulsants.....	<input type="checkbox"/> <sub>1</sub> .....	<input type="checkbox"/> <sub>2</sub> .....	<input type="checkbox"/> <sub>3</sub> .....	<input type="checkbox"/> <sub>4</sub> .....	<input type="checkbox"/> <sub>5</sub>
i. Steroids.....	<input type="checkbox"/> <sub>1</sub> .....	<input type="checkbox"/> <sub>2</sub> .....	<input type="checkbox"/> <sub>3</sub> .....	<input type="checkbox"/> <sub>4</sub> .....	<input type="checkbox"/> <sub>5</sub>

**S36. During the last year have you failed to do what was normally expected from you because of drinking?**

Yes.....<sub>1</sub> No.....<sub>2</sub>

**S37. How often do you have 6 or more drinks on one occasion?**

Every day	5-6 times a week	2-4 times a week	Once a week	1-3 times a month	Less often	Never
<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>	<input type="checkbox"/> <sub>7</sub>

**S38. Does anyone smoke in the same room as <baby>?**

Yes, on a regular basis.....<sub>1</sub> Yes, on an occasional basis.....<sub>2</sub> Never.....<sub>3</sub>

**S39. Have you ever been treated by a medical professional for clinical depression, anxiety or 'nerves'?**

Yes.....1

No.....2 → **Go to S41**

**[Ask S40 if biological mother, otherwise ask S40a.]**

**S40. Was this: [Tick all that apply]**

- Before being pregnant with <baby>.....1
- In the 1<sup>st</sup> trimester of the pregnancy.....2
- In the 2<sup>nd</sup> trimester of the pregnancy.....3
- In the 3<sup>rd</sup> trimester of the pregnancy.....4
- When <baby> was 0-2 months of age.....5
- When <baby> was 2-6 months of age.....6
- Since <baby> was 6 months of age.....7

**S40a. Was this: [Tick all that apply]**

- Before <baby> was born.....1
- When <baby> was 0-2 months of age.....2
- When <baby> was 2-6 months of age.....3
- Since <baby> was 6 months of age.....4

**S41. Listed below are 8 statements about some of the ways you may have felt or behaved. Please indicate how often you have felt this way during the past week.**

Rarely or none of the time (less than 1 day)      Some or a little of the time (1-2 days)      Occasionally or a moderate amount of the time (3-4 days)      Most or all of the time (5-7 days)

- a. I felt I could not shake off the blues even with help from my family or friends .....1.....2.....3.....4
- b. I felt depressed .....1.....2.....3.....4
- c. I thought my life had been a failure.....1.....2.....3.....4
- d. I felt fearful.....1.....2.....3.....4
- e. My sleep was restless.....1.....2.....3.....4
- f. I felt lonely.....1.....2.....3.....4
- g. I had crying spells.....1.....2.....3.....4
- h. I felt sad.....1.....2.....3.....4

**S42. Have you ever been in trouble with the Gardai (other than for traffic offences)?**

Yes.....1

No.....2 → **Go to S44**

**S43. Have you ever been to prison?**      Yes.....1      No.....2

**S44. Can we check, does <baby's> biological father/ mother live here with you or elsewhere?**

- Lives here.....1 → **Go to S60**
- Deceased.....2 → **Go to S60**
- Temporarily lives elsewhere.....3 → **Go to S60**
- Lives elsewhere.....4 → **Go to S45**

**S45. Were you ever married to or did you ever live with <baby's> biological father / mother?**

Yes, married to...1      Yes, lived with...2      No 3 **Go to S47**      Adoptive / Foster parent 4 **Go to S60**

**S46. When did you separate or split up with <baby's> biological father / mother?**

- Before child was born.....1
- Before child was six months old.....2
- In the last three months.....3

**S47. What was the nature of your relationship with <baby's> biological father / mother when you became pregnant with <baby>? (Please tick one box only).**

- Married and living together.....1      Going out but not living together.....5
- Cohabiting / living as married.....2      Just friends.....6
- Separated.....3      No relationship.....7
- Divorced.....4

**S48. Do you have a formal or informal custody arrangement regarding <baby> and where he / she lives?**

Formal.....1

Informal.....2

No custody arrangement.....3

**S49. Briefly describe that arrangement**

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**S50. Do you and <baby's> biological father / mother have shared parenting of <baby> on a regular basis?**

Yes ..... \_1 No..... \_2 →Go to S52

**S51. Please describe the nature of this shared parenting**

**S52. How far does <baby's> biological father / mother live from here?**

Within ½ hour's drive from here..... \_1 More than 1 hour's drive from here ..... \_3  
Between ½ and 1 hour's drive from here.. \_2 Outside the country ..... \_4

**S53. How often does <baby> have contact with his / her biological father / mother?**

Daily ..... \_1 Monthly ..... \_5  
Once or twice a week ..... \_2 Less than once a month ..... \_6  
Weekly ..... \_3 No contact ..... \_7  
Every second week / weekend ..... \_4

**S54. Does <baby's> biological father / mother make ANY financial contribution to your household and the maintenance of <baby>? Include any form of financial support such as rent, mortgage, direct maintenance payment etc.**

No, he/she never makes any payment..... \_1  
Yes, he/she makes a regular payment..... \_2  
Yes, he/she makes payments as required ..... \_3

**S55. How often do you talk to <baby's> biological father/ mother about <baby>?**

Every day \_1 Several times a week \_2 About once a week \_3 A few times a month \_4 Several times a year \_5 Never \_6

**S56. How well do you get on with <baby's> biological father/ mother? Would you say your relationship is?**

Very positive \_1 Positive \_2 Neither positive nor negative \_3 Somewhat negative \_4 Very negative \_5

**S57. We would like to send a short questionnaire to <baby's> biological father/ mother. We would be happy to show you the content of this questionnaire before we send it. Would you be able to provide us with contact details for <baby's> biological father/ mother?**

Yes ..... \_1  
No, I do not wish other parent to be contacted ..... \_2  
No, I do not have contact details for other parent ..... \_3

**Please give contact details to interviewer**

**Time Section Ended**     (24 hour clock)

**S60. THANK YOU VERY MUCH FOR TAKING PART IN THE *GROWING UP IN IRELAND* PROJECT.**

**YOUR ASSISTANCE IS GREATLY APPRECIATED.**