ESRI
RESEARCH
BULLETIN
DECEMBER
2021

HEALTH AND WELLBEING IN CHILDHOOD AND ADOLESCENCE

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Health and Wellbeing in Childhood and Adolescence[1]

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ESRI Research Bulletins provide short summaries of work published by ESRI researchers and overviews of thematic areas covered by ESRI programmes of research. Bulletins are designed to be easily accessible to a wide readership.

OVERVIEW

This research bulletin summarises the results from a series of ESRI research reports on the health and wellbeing of children and young people in Ireland, undertaken as part of a research programme funded by the HSE Health and Wellbeing Division. We used data from two cohorts of the Growing Up in Ireland survey, covering children born in 1998 and 2008, to examine issues of policy relevance to children and young people in three key domains of health and wellbeing: health behaviours, sexual health, and mental health and wellbeing. In the following sections, we summarise the findings from each of the three reports, before concluding with overarching themes and some implications for policy and practice with respect to children and young people.

HEALTH BEHAVIOURS

The World Health Organization (WHO) estimates that about a third of the burden of disease in developed countries is directly attributable to four modifiable health behaviours: smoking, excessive consumption of alcohol, poor diet and low levels of physical activity. While there is a large literature on these health behaviours in isolation, little is known about how these behaviours cluster together. For example, do those who smoke also have poor levels of physical activity? Using data from the ’98 Cohort at 17 years of age, this research examined how these four key risk factors for disease cluster together among young people. Three health behaviour clusters were identified (see Figure 1):

[1] This Bulletin summaries the findings from three ESRI research series reports:
Nolan, A. and Smyth, E., “Clusters of Health Behaviours among Young Adults in Ireland”, *ESRI Research Series Report No. 101*, Available online: https://doi.org/10.26504/rs101
Nolan, A. and Smyth, E., “Talking about Sex and Sexual Behaviour of Young People in Ireland”, *ESRI Research Series Report No. 112,* Available online: https://doi.org/10.26504/rs112
Nolan, A. and Smyth, E., “Risk and Protective Factors for Mental Health and Wellbeing in Childhood and Adolescence”, *ESRI Research Series Report No. 120*, Available online: https://doi.org/10.26504/rs120

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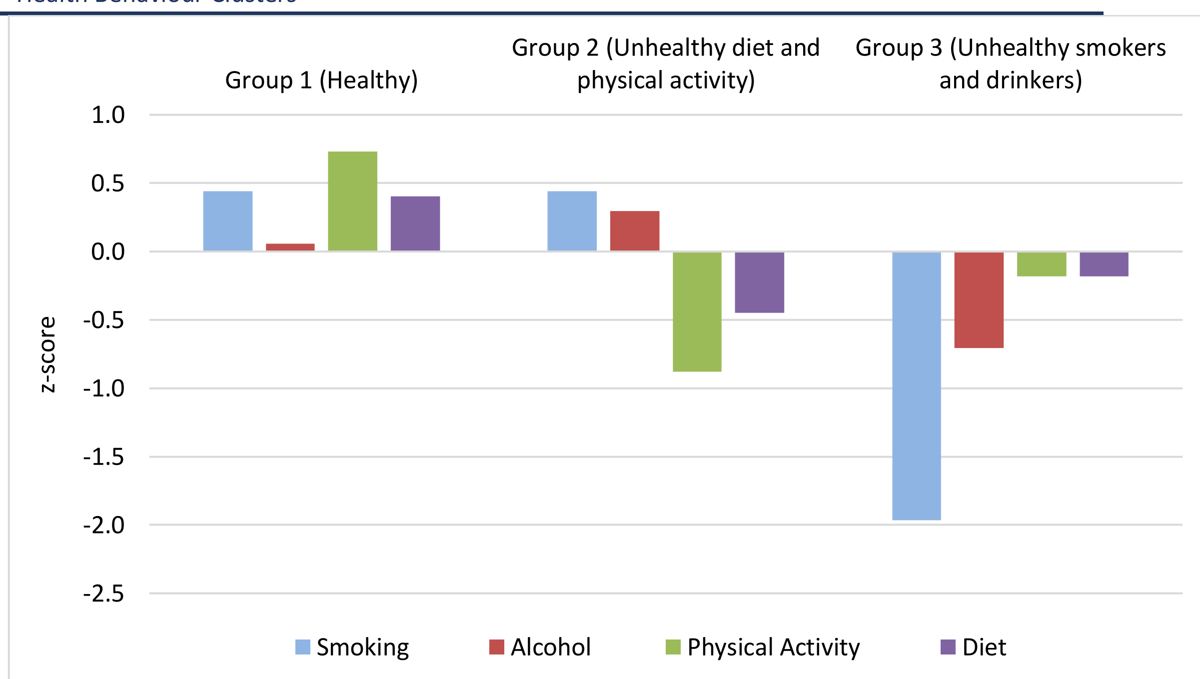
- A ‘healthy’ group (43 per cent) who did not smoke, drank rarely, engaged in exercise on six or more days in the previous fortnight and had the best quality diet;
- An ‘unhealthy diet and physical activity’ group (36 per cent of 17-year-olds), who did not smoke, drank alcohol rarely (monthly or less) but had the worst levels of physical activity (just 1-2 days in the previous fortnight) and had the poorest dietary quality;
- The remainder comprised an ‘unhealthy smokers and drinkers’ group (21 per cent of 17-year-olds), who had the highest level of alcohol consumption, were daily or occasional smokers, had moderate to low levels of physical activity and poor to moderate dietary quality.

FIGURE 1 Health Behaviour Clusters



Source: GUI, ‘98 Cohort, Wave 3.
Notes: As the four health behaviours were measured using different units, all four health behaviour variables were standardised using z-scores before analysis, with higher z-scores indicating ‘better’ health behaviours. Latent class analysis was used to identify groups of individuals characterised by similar clusters of health behaviours. For example, Figure 1 shows that cluster group 3 (‘unhealthy smokers and drinkers’) comprised young people with the highest rates of smoking and alcohol consumption, and poor (but not the worst) diet and physical activity levels.

Young women were significantly more likely than young men to belong to the ‘unhealthy diet and physical activity’ group while young people from a working-class background were more likely to fall into the ‘unhealthy smokers and drinkers’ group.

The research yielded new insights into the role of school-level factors in shaping health behaviours, with behaviours found to vary significantly by the individual second-level school and, to a lesser extent, the primary school attended. School policies, such as the provision of physical education and sports facilities, or having a healthy eating policy, had little direct impact on health behaviours. Instead, the

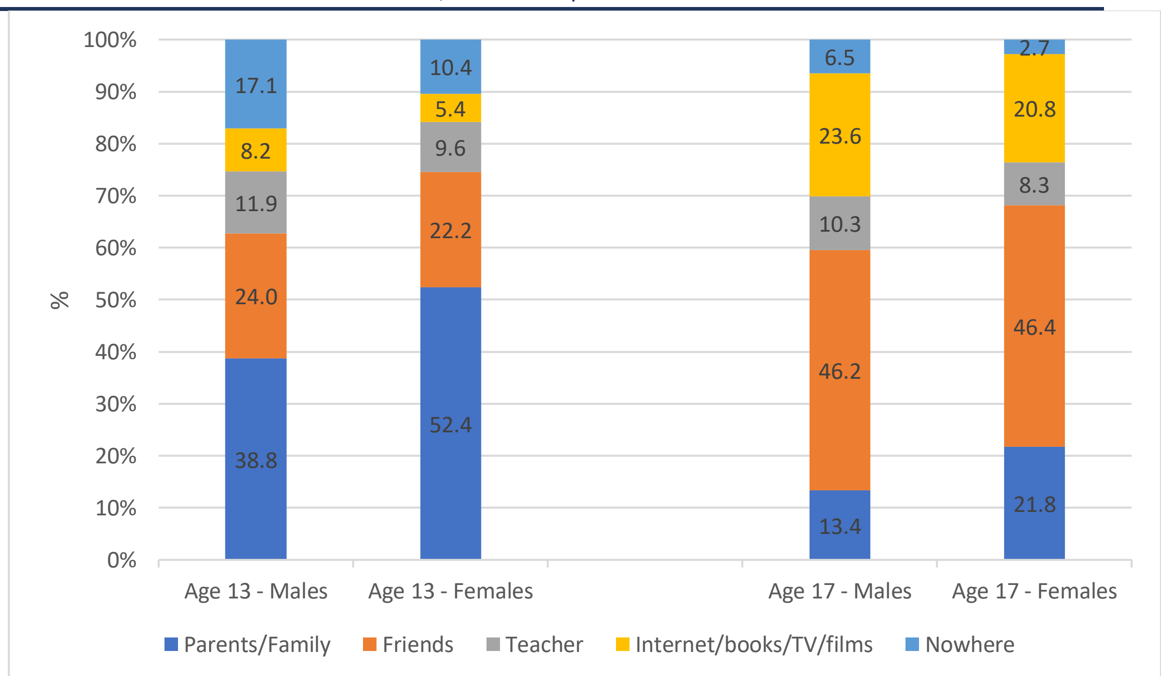
socioeconomic composition of students and school climate emerged as more important influences on health behaviours. Negative interaction with teachers and disaffection from school were associated with greater levels of drinking/smoking in particular.

Sexual Health

Sexual activity is an important component of physical and mental health and wellbeing. The development of positive sexual health behaviours during adolescence lays the foundation for healthy relationships throughout the life course. Using data from the '98 Cohort at 13 and 17 years of age, this research examined how young people received information about sex and relationships, and for those who have had sex, sexual health behaviours (e.g., use of contraception) during their first and subsequent sexual experiences.

The research found that at age 17, nearly 40 per cent of young people had never spoken to their parents about sex and relationships. While less than 5 per cent of young people reported no school-based Relationships and Sexuality Education (RSE) or parental discussions by the age of 17, young men were significantly more likely to belong to this group than young women.

Figure 2 Main Sources of Information about Sex/Relationships



Source: GUI, '98 Cohort, Waves 2 (age 13) and 3 (age 17).

Young people were asked about their main source of information on sex at both 13 and 17 years of age (see Figure 2). While parents/family were the main source at age 13, by age 17 friends were the most commonly cited source (by nearly 50 per cent of young people). At ages 13 and 17, young women were more likely than young men to cite their parents/family as their main source of information. At both

ages, young people were more reliant on their parents/family for information where they had a positive relationship with their mother. At age 17, nearly a quarter of young men, and just over 20 per cent of young women, cited the internet/books/TV/films etc. as their main source of information on sex. Young people were more likely to turn to the internet for information where they felt alienated from their peers.

Approximately one third of 17-year-olds reported they had had sexual intercourse, and of those, nearly 90 per cent had used contraception when first having sex. Those sourcing most of their information on sex from their friends were significantly less likely to report having used contraception when they first had sex. Of concern was that nearly a quarter of young people expressed regret over the timing of first sex, and this proportion was substantially higher among young women (31 per cent, almost all of whom wished they had waited longer) than young men (16 per cent, most of whom wished they had waited longer).

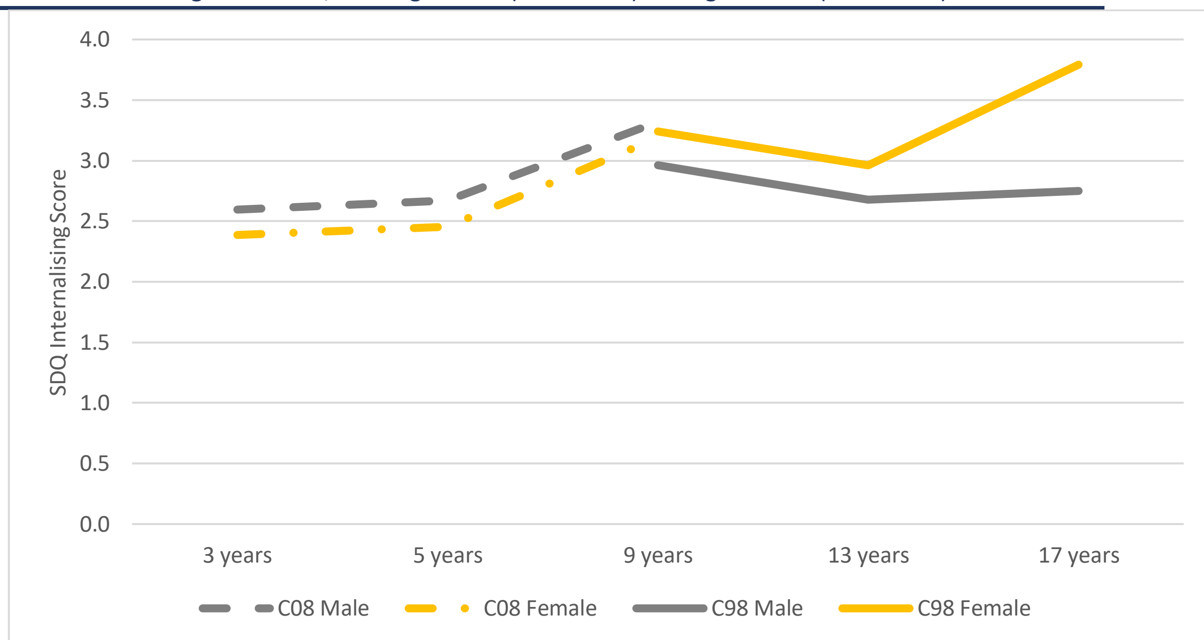
Mental Health And Wellbeing

Mental health matters for the wellbeing of children and young people in the here and now as well as influencing their life chances as adults. In the final report, information from both the ’98 and ’08 cohorts was used to look at two aspects of mental health and wellbeing from infancy to early adulthood. The first indicator, ‘internalising difficulties’, is assessed using responses to the Strengths and Difficulties Questionnaire. The measure of Internalising difficulties combines measures of emotional symptoms (e.g., ‘Child has many fears, is easily scared’) and peer relationship problems (e.g., ‘Child is rather solitary, tends to play alone’). The second indicator captures more positive aspects of wellbeing using measures of happiness and life satisfaction.

In general, low levels of internalising difficulties and high levels of happiness and life satisfaction were found among children and young people in Ireland. However, as illustrated in Figure 3, internalising difficulties were found to increase between three and nine years of age, before falling slightly between nine and 13. Between 13 and 17 years of age, levels remained stable for males but increased very significantly for females. At this age too, young women tended to have slightly lower levels of life satisfaction than young men.

Internalising difficulties were found to be socially structured, with higher levels found among more socio-economically disadvantaged families and among those who lived in lone-parent families or who had experienced family separation. In contrast, life satisfaction varied less markedly by socio-economic background, but was again lower in lone-parent families.

FIGURE 3 SDQ Internalising Difficulties, from age 3 to 9 ('08 Cohort) and age 9 to 17 ('98 Cohort)



Source: GUI, '08 Cohort, wave 2 (age 3) to wave 5 (age 9) and '98 Cohort, wave 1 (age 9) to wave 3 (age 17).

The findings highlighted the importance of the relationships and networks within which children and young people were embedded in either enhancing their wellbeing or contributing to socio-emotional difficulties. For both age-groups, positive parental-child relationships and parenting styles were associated with lower internalising difficulties. Friendships played a particularly important role in relation to adolescent wellbeing, reflecting the growing importance of peers at this phase of young people's lives. The quality of relationships with teachers emerged as an important factor in wellbeing. Even for younger children, conflict with teachers was associated with more internalising difficulties. For adolescents, positive interaction with teachers in the form of praise or positive feedback was linked to fewer socio-emotional difficulties and greater life satisfaction.

IMPLICATIONS FOR POLICY AND PRACTICE

Overall, across all three dimensions of health and wellbeing (health behaviours, sexual health, mental health and wellbeing), most children and young people were doing well. Just under half of 17-year-olds had positive health behaviours, in that they did not smoke, drank alcohol rarely, engaged in exercise on six or more days in the previous fortnight and had the best quality diet. In terms of sexual health, most young people had received RSE at school by age 17, and levels of contraceptive use at first sex were high (around 90 per cent). Looking at mental

health, levels of socio-emotional difficulties were low, and most children and young people were very satisfied with their lives.

However, a number of areas of common concern emerged, with implications for policy and practice in relation to children and young people. First, across all three dimensions of health and wellbeing examined, outcomes were socially patterned. In particular, young people from more disadvantaged social backgrounds were more likely to display poorer health behaviours and to report poorer mental health and wellbeing. Experience of financial strain in the family (i.e., 'difficulty making ends meet') was strongly linked to poorer mental health and wellbeing, highlighting the importance of poverty reduction policies in supporting families of children and young people.

Second, the scale of gender differences for all three dimensions of health and wellbeing highlights the need to target appropriate policy responses towards women and girls, men and boys. In terms of health behaviours, young women were found to be more likely to belong to the 'unhealthy diet and physical activity' group. At this age, approximately 90 per cent of the sample were still in school, facing Leaving Certificate examinations, the 'high stakes' examinations that determine entry to third-level education. Previous research in the Irish context has demonstrated the sharp drop-off in sports participation, particularly among young females, as students approach their Leaving Certificate examinations; these findings in relation to relatively poorer diet on the part of young females have not previously been identified, however, and merit further investigation. Young women also experienced a steeper decline in socio-emotional wellbeing as they aged through adolescence, and for those who have had sex, nearly one third expressed regret over the timing over their first sexual experience (in contrast with 15 per cent of young men). Young men were less likely than young women to have discussed sex with their parents, with almost four in ten not having done so by 17 (compared to just over a quarter of females). While the Framework for Junior Cycle has designated wellbeing as an area of learning at junior cycle, incorporating, but not limited to, existing curricular provision in the form of Social, Personal and Health Education (SPHE), Relationships and Sexuality Education (RSE) and Physical Education, there is currently a gap in curricular provision for wellbeing at senior cycle level, a life stage identified as a pressure point for young people in this research.

Third, the study findings point to the key role of the relationships and networks within which children and young people are embedded in supporting their health and wellbeing. Relationships with parents, peers and teachers emerged as crucial protective factors from infancy to early adulthood. Children and teenagers had fewer socio-emotional difficulties where they had close relationships with their parents, with low levels of conflict. As children aged into adolescence, the quality of peer relationships emerged as an important protective factor for mental health. However, peer influences were not always positive; young people who more reliant on their peers for information on sex were less likely to use contraception when first having sex. In addition, those who socialised with an older friendship group were more likely to engage in drinking and smoking. School climate (i.e., the

nature of the relationships between students and young people) emerged as a more important influence on health behaviours than formal school policies or facilities. A positive school climate was also a protective factor for positive mental health and wellbeing. Therefore, measures to enhance student engagement and promote a positive school climate are likely to have positive spill-overs for health behaviours, sexual health and mental health and wellbeing.

Finally, child and adolescent health and wellbeing has been further thrown into sharp focus by the COVID-19 pandemic. Young people's wellbeing has suffered as a result of the direct effects of interruption to their education and social interactions and the indirect effects of the strain of income and job loss within the family. Data from special COVID surveys of the '98 and '08 cohorts in December 2020 point to worrying findings in relation to reduced interaction with friends, job loss, deteriorating mental health, poorer diet and significantly reduced participation in sport and cultural activities for many children and young people during the pandemic. For some young people, these changes to their lives may be temporary; for others, they may be more severe and long-lasting. The wide-ranging effects of the pandemic on children and young people make it all the more important to be able to identify protective factors which will help enhance young people's wellbeing in the years ahead.

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