

Growing Up in Scotland – Sweep 2 – Topic Research Findings

Issues of child health and development at ages 1-2 and 3-4 years

The Growing Up in Scotland study (GUS) is an important longitudinal research project aimed at tracking the lives of a cohort of Scottish children from the early years, through childhood and beyond. Its principal aim is to provide information to support policy-making, but it is also intended to be a broader resource that can be drawn on by academics, voluntary sector organisations and other interested parties. Focusing initially on a cohort of 5,217 children aged 0-1 years old and a cohort of 2,859 children aged 2-3 years old, the first wave of fieldwork began in April 2005. This document is one of a series that summarise key findings from the second sweep of the survey which was launched in April 2006. At the second sweep, interviews were successfully completed with 4,512 respondents from the birth cohort and 2,500 from the child cohort.

Methods

GUS is based on a cohort or longitudinal design involving the recruitment of a 'panel' of children (and their families) who will be revisited on a number of occasions over an extended period of time. Members of the panel were identified in the first instance from Child Benefit records. For the second year of the study, interviews were sought with the person who had responded at sweep 1. In virtually all cases (98%), this proved to be the child's mother. As well as the main interview, at sweep 2, interviews were also undertaken with the resident partner of the main respondent, where applicable. A total of 2,975 partner's interviews were successfully completed in the birth cohort and 1,541 in the child cohort. As well as information on child health and development, the main interview also collected data on food and nutrition, childcare, parenting and local neighbourhood.

This report looks at parental perceptions of their child's health and development and their use of health-related services. It examines differences in child health and illness by key family characteristics and compares general parental assessments of their child's development against those attained on formal child development scales. Data from anthropometric measurements are also explored.

Main Findings

- The vast majority of respondents said their child's health was 'good' or 'very good'.
- Respondents with female offspring, higher levels of household income or who were part of couple families tended to rate the general health of their children more highly.
- In total, 11% and 16% of the birth and child cohorts respectively were reported as having a long-standing illness or disability. In both cohorts, long-standing illness was more common in boys than girls. Less than 10% of children in the child cohort, and less than 5% in the birth cohort were reported to have a long-standing illness at both sweeps.



- Data from the two sweeps suggest that accidents amongst young children are most common between the ages of 2-3 years. At sweep 2, parents of boys continued to be more likely to report their child had had an accident than were parents of girls.
- Nine out of ten parents in both cohorts had been in contact with a health professional in relation to their child's health at least once in the six months prior to their interview, and around two-fifths had done so on two or more occasions.
- GPs continued to be the main source of information or advice on child health. However, some key differences were identified across the sample in the extent to which this, and other, sources of information were likely to be used. For example, those in higher household income groups were more likely to say that they had sought help from books, leaflets, the internet (both cohorts) and the GP (birth cohort only) compared with those in lower household income groups.
- The majority of children in the older cohort were of normal weight. However, 23% were overweight (including obese). Girls were more likely than boys to be overweight (19% compared with 16% of boys) and more likely to be obese (7% compared with 5% of boys).
- In both cohorts, boys were shown to perform less well than girls on the child development scales. Some stark differences in levels of communication skills and problematic behaviour were also evident by household income and maternal education.

Parental perceptions of general health

The data in Table 1 show that most respondents at both sweeps thought that the health of their child was at least good. Perceived good health appeared to reduce between sweeps in both cohorts demonstrated by a decrease in the proportion of parents rating their child's health as very good and a slight increase in the proportion who said it was fair to very bad.

At sweep 2, respondents with female offspring, those with higher levels of household income or who were part of couple families tended to rate the general health of their children more highly, as was the case in sweep 1. For example, at sweep 2, in the child cohort 57% of lone parents compared with 69% of couple family parents perceived that their child's health was very good.

Long-standing illness and disability

Parents were asked whether their child had any long-standing illness (lsi) or disability – the definition of these illnesses or disabilities being any ailment that had troubled or was likely to affect the child over a period of time. In total, 11% and

Table 1 Perceptions of child's general health by cohort and sweep

Child health	Cohort (%)			
	Birth cohort		Child cohort	
	Sweep 1	Sweep 2	Sweep 1	Sweep 2
Very good	74.6	66.9	72.9	66.4
Good	19.6	25.6	21.6	26.1
Fair to very bad	5.8	7.5	5.5	7.5
<i>Bases</i>				
<i>Weighted</i>	4511	4510	2500	2499
<i>Unweighted</i>	4511	4510	2500	2499

16% of the birth and child cohorts respectively were reported as having such a health problem in sweep 2, representing a slight decrease from sweep 1. Of those who were reported as having at least one long-standing illness, around one-fifth in both cohorts was said to be limited in their activity as a result (about 2% of all children in the birth cohort and 3% of all children in the child cohort).

Respondents from households with lower levels of income were more likely to report that their children had experienced a lsi or disability at both sweeps 1 and 2 compared with those living in households with higher levels of income. For example, in the child cohort at sweep 2, 21% of parents in the lowest income group said their child had a long-standing illness or disability compared with 14% in the highest income group.

Accidents and injuries requiring NHS contact

In addition to health problems, respondents were also asked if the child had experienced one or more accidents or injuries which had required NHS contact since the sweep 1 interview. Overall, 23% of parents in the birth cohort and 19% of parents in the child cohort reported that their child had experienced such an accident. During the sweep 1 survey, accidents were more commonly reported in the older cohort whereas at sweep 2 they were more common in the younger cohort. This reflects the particular developmental stages of the children in each cohort at each sweep and suggests that accidents may peak between the ages of 2 and 3. Bangs on the head were the most common injury reported, followed by cuts or grazes, and cuts needing stitches.

Boys in both cohorts were more likely than girls to have an accident requiring NHS attention (in the birth cohort: 21% versus 16%), a trend also evidenced in sweep 1 data. In the birth cohort, children with lone parents, from households of lower socio-economic status and lower income were more likely to have had an accident requiring a visit to NHS facilities. However, these factors did not appear to have the same influence in the child cohort.

Anthropometric measurements, overweight and obesity

At sweep 2, height and weight measurements were taken of children in the child cohort. These measurements were used to calculate the child's body mass index (BMI). Using cut-off points derived from internationally collected data¹, BMI values can be used to indicate the proportion of children who are normal weight, overweight and obese.

As would be expected for this age, mean heights and weight for boys and girls were almost identical. The mean height for boys was 102cm and for girls, 101cm. The mean weights were 17.5kg for boys and 17.0kg for girls.

The majority of children (77%) of both sexes were of 'normal weight' (that is, their BMI fell below the 85% percentile). This meant that 23% of children were overweight (including obese). Girls were more likely than boys to be overweight (19% compared with 16% of boys) and more likely to be obese (7% compared with 5% of boys).

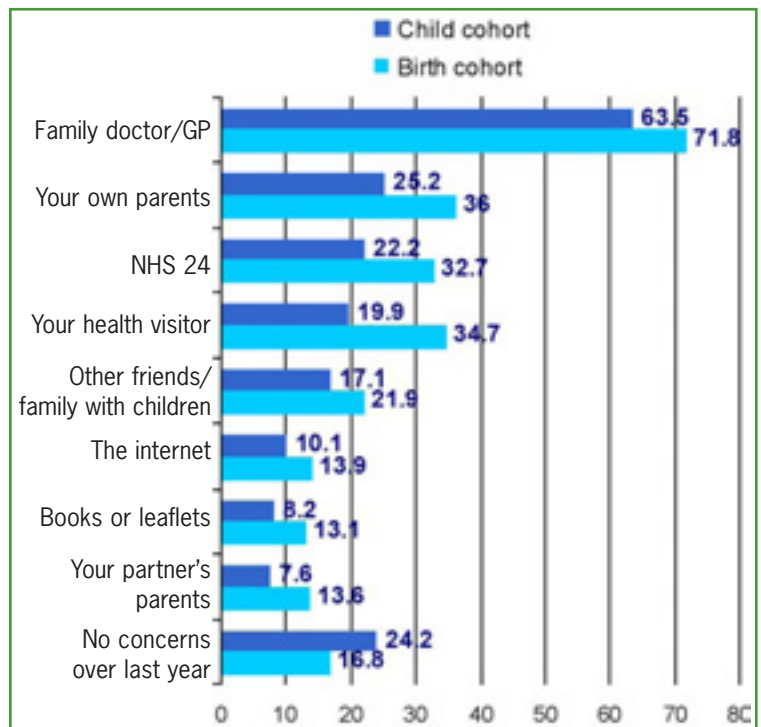
As maybe expected at this stage, parents of overweight and normal weight children were both likely to report their child's health as being good or very good (94% and 92% respectively). However, children who were obese were slightly more likely to have a long-standing illness than overweight (not including obese) or normal weight children (18% of obese children compared with 15% of non-obese children).

Sources of help, information and advice on child's health

As well as being asked about contact with specific health services, parents were also asked about sources of help, information and advice they had used in the last year when they had concerns over the sample child's health. The list included formal and informal resources.

Eighty-three percent of respondents in the birth cohort and 76% in the child cohort reported having used at least one source for information or advice about their child's health. The proportions using the various sources are detailed in Figure 2. The family doctor or GP was the most popular source of help with the respondent's parents, NHS 24, health visitors and other family members or friends with children also popular.

Figure 2 Percentage of parents using each source for help, information or advice on sample child's health by cohort



¹ The main child overweight and obesity prevalence estimates in this section have been produced using the International Obesity Taskforce cut-offs. These cut-offs are based on BMI reference data from six different countries around the world (over 190,000 subjects in total aged 0-25 from UK, Brazil, Hong Kong, The Netherlands, Singapore, and the United States).

Parents in the birth cohort were more likely to have used each source of information than their counterparts in the child cohort. This reflects not only fewer health problems observed in the older cohort but also perhaps a growing confidence among parents in their ability to diagnose and treat common and trivial illnesses in their children without the need to seek help or advice from others.

Some differences in use of particular sources were noted. For example, those in the lowest household income group were less likely to say that they had sought help from books, leaflets and the internet compared with those in the highest income quartile. Also, in the birth cohort 79% in the highest income group compared with 67% in the lowest income group reported seeking help from a GP, but this difference was not observed in the child cohort. Differences were also noted by level of maternal education; compared to those with no qualifications, mothers educated to Standard grade, Higher grade or beyond were more likely to have sought advice and to have consulted more sources.

Language and behavioural development

As well as registering their own general concerns of their child's development, language and behaviour, respondents were asked to complete questions which assessed specific aspects of their child's communication skills and behaviour. Questions for parents in the birth cohort form the Infant/Toddler checklist of the Communication and Symbolic Behaviour Scales (CSBS) (Wetherby and Prizant, 2001), whereas parents in the child cohort completed the Strengths and Difficulties Questionnaire (SDQ) (Goodman, 1997).

In relation to the CSBS, boys were more likely to be of concern than were girls, particularly in terms of their speech development – 20% of boys were classed as 'of concern' in relation to their speech compared with 12% of girls. Indeed, parents of male children were more likely to register their own concern about their child's speech and language development than were parents of female children. Lower scores on the CSBS scale, suggesting poorer relative communication skills, were also returned by parents in lower income households and by those who had no educational qualifications.

In the child cohort, responses to the SDQ indicated that male children, and children of respondents in lower income households or with no educational qualifications had higher average scores, indicating that they were more likely to exhibit difficult behaviour, than female children and those living in higher income households or whose parents had educational qualifications.

Conclusion

Overall, children of this age are reported as being healthy, with only a small percentage of parents reporting their children's health to be fair to very bad. The persistent differences in health status across both sweeps according to household income and family type suggest that we may be likely to see the gradual emergence of a gradient for these health related measures according to socio-economic status.

Use of health services in relation to the cohort child was predominant in both cohorts with the most common contact being a GP. GPs were also the most frequently cited source of advice about the child's health. This suggests that primary care remains a very important resource for parents and their children.

In relation to child development, quite clear differences were evident in both cohorts by the child's gender and by certain measures of advantage and disadvantage. Parental level of education is very important and is emerging as a crucial site for intervention if adverse outcomes for parents and children are to be avoided or ameliorated.

References

- Goodman, R. (1997) "The Strengths and Difficulties Questionnaire: A Research Note", *Journal of Child Psychology and Psychiatry*, 38, 581-586.
- Wetherby, A.M. and Prizant, B.M. (2001), *Communication and Symbolic Behaviour Scales - Infant/Toddler Checklist*, Baltimore: Paul H. Brookes Publishing Co.

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Education Information and Analytical Services
Scottish Government
Victoria Quay
Edinburgh, EH6 6QQ
Dissemination Officer on 0131-244 0894;
by e-mail on recs.admin@scotland.gsi.gov.uk
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