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Growing Up in Ireland

Research Needs Report for Cohort 24 at 3 years

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RESEARCH + EVALUATION

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Fás Aníos in Éirinn
Growing Up in Ireland

Acknowledgments

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A wide range of people and organisations took part in the extensive consultations used in preparing this report. These included two ongoing advisory panels comprised of academic researchers, policy-makers and representatives of non-governmental organisations.[1] Consultations were also undertaken with parents by Alison Flannery of Amárach Research on behalf of DCEDIY. There were also several contributors to the undertaking of consultations with young children including DCEDIY colleagues in Hub na nÓg and the Participation Unit, researcher and report writer Alexis Carey and her team, and crucially the staff, parents and children of the two participating Early Learning Centres. Finally, discussions on the format and focus of this report have been informed with input from our Growing Up in Ireland colleagues in the Central Statistics Office (CSO).

As always, the participants of Growing Up in Ireland – including children, young people, families, school staff and childcare providers – are central to the success of the study. The DCEDIY team would like to thank the participants who have recently joined, or will shortly join, Cohort 24. We are also grateful to the participants in the older cohorts (08 and 98) whose responses to previous surveys have informed the development of these new proposals.

[1] Expert consultation group participants, from the following organisations: Department of Children, Equality, Disability, Integration and Youth, NCSE, Barnardos, OMEP, ESRI, Daughters of Charity, SIPTU, Gaeloideachas, NPC, Children's Rights Alliance, University College Dublin, Trinity College Dublin, University of Galway, HSE, Maynooth University, NDA, Department of Social Protection, CDI, NCI, Treoir, Disability Federation, TUSLA, One Family, University of Limerick, Department of Justice, Alcohol Action, Department of Enterprise, Trade and Employment

Contents

Chapter 1: Introduction

About this Report

The main purpose of this report is to set out the policy and research needs that can be addressed by the second wave of Growing Up in Ireland's Cohort 24 at age 3 as identified by the Department of Children, Equality, Disability, Integration and Youth (DCEDIY). The Department is mindful that the study is a key national resource on a new generation of children and aims to meet as many cross-Government data needs as is feasible. However, there is a limit on the amount of time and information respondents can reasonably be expected to contribute so judgments between different topics have to be made.

To this end, the team at DCEDIY has consulted widely with other studies; academic, NGO and policy-maker stakeholders; and parents and children themselves. It has also drawn extensively from previous waves of the Growing Up in Ireland study, as the capacity for longitudinal and cross-cohort comparisons is a key element of the study's design. This wide range of potential source material has been evaluated and culminates in a set of recommendations from DCEDIY to the Central Statistics Office (CSO) who will be designing the instrumentation and collecting the data. Final decisions on content and methodology rest with the CSO.

1.1 Background

About the Growing Up in Ireland study

The Growing Up in Ireland study started with two cohorts in 2006. The older 'Cohort 98' were first interviewed when they were aged 9 years in 2007 and were most recently surveyed at age 25 in 2023. The younger of the two original cohorts, 'Cohort 08', were first surveyed at 9 months old in 2008/9. Cohort 08 were followed up at ages 3, 5, 7/8 (by post), 9 and 13. Both of these cohorts were also invited to complete an additional 'Covid survey' in December 2020.

In 2024, a third cohort was started with infants born that year and the first interviews at age 9 months are ongoing at time of writing (Winter 2024/25). It is envisaged that the timing of waves for Cohort 24 will replicate that of Cohort 08 to allow for cross-

cohort comparisons in due course. Hence, the next wave for Cohort 24 will be at age 3 years which is the focus of this report.

With some exceptions, the usual format for a Growing Up in Ireland survey is an in-person visit to the family home by an interviewer who administers a questionnaire to both resident parents, and to the child when they are old enough. More sensitive questions are self-completed by the respondents. For Cohort 08 at age 3, the child was not interviewed per se, but the interviewer did complete some direct assessments of their cognitive and motor skills with them. The child's height and weight, and those of their parents, were also measured by the interviewer using standardised equipment.

For Cohort 24 at 9 months, interviewers are conducting in-person interviews with both of the child's resident caregivers (where applicable). The questionnaires are structured slightly differently to Cohort 08 at 3 years: instead of a 'primary' and 'secondary' caregiver each parent does the same 'parent' interview and one of the parents also does a 'primary informant' interview about the baby and the household. In a one-parent household, the same person completes a parent interview and the primary informant questionnaire. The interviewer will measure the baby's length and weight as part of the household visit. There will be no attempt to survey a non-resident parent at the 9-month wave, based on the pilot experience. There will, however, be an attempt to survey regular childminders (home or centre-based) dependent on permission and contact details being provided by the child's parent.

Context for a new Growing Up in Ireland cohort

Much has changed in the national and international contexts since Cohort 08 turned 3 years old in 2011, and may change even further by the time Cohort 24 turn 3 years in 2027. Major events with repercussions for Ireland included Brexit, the Covid-19 pandemic and the Russian invasion of Ukraine. The evolving digital context is also noteworthy: smartphones and tablets were still a relatively new phenomenon when Cohort 08 were aged 3 (the Apple iPhone was launched in 2007 and the first generation iPad went on sale in 2010) but almost ubiquitous for the parents of Cohort 24.

In 2021, the Irish government ran a large-scale public consultation asking for ideas and priorities in relation to future research called 'Creating Our Future'. The call was completely open, and not focused on children or a particular discipline. Over 18,000 submissions were received and analysed by expert panels to reflect the Irish public's input into shaping research priorities. Some of the main themes relevant to young children that emerged from the public consultation were mental health, exposure to the digital world, and education for children with disabilities. In the commentary from the expert report (Hogan et al. 2022), one of the conclusions was a need for more research on 'the future of parenting' (p.21). The Growing Up in Ireland study was name-checked in the consultation as part of the research infrastructure which could be utilised to respond to the public's research priorities (p.19).

In preparation for the new Growing Up in Ireland birth cohort specifically, the Government of Ireland – through the Research and Evaluation Unit at DCEDIY – commissioned a scoping review from independent researchers based at University College Dublin and Trinity College Dublin. This review (Counihan et al. 2023) summarised the main rationale for a new cohort followed longitudinally as (a) being the best mechanism for making cause-and-effect inference, especially in terms of policy initiatives; (b) major changes in Irish demography including inward migration and same-sex marriage; (c) increased policy focus on traditionally marginalised groups such as Travellers and Roma; (d) recent methodological advances associated with cohort studies like Growing Up in Ireland such as online surveys, smartphone apps and 'wearables';[2] (e) the impact of the COVID-19 pandemic; (f) the potential for data linkage (nationally) and data harmonisation with similar international studies.

1.2 Changing demographic context

The changing demography of Ireland was one factor cited by the Cohort 24 scoping review in the rationale for a new birth cohort (Counihan et al. 2023). We can use the results of the Irish Census in 2011 and 2022 to look in more detail at some of those changes since Cohort 08 were aged 3 (in 2011).

[2] For example, fitness watches to measure physical activity

First, it is apparent that there was a large increase in the overall population of Ireland from 4,588,252 in 2011 to 5,149,139 in 2022 (CSO Table F3001).[3] However, the percentage of the population aged 0-4 years decreased over the same period from 7.8% to 5.7% (Table F1002). In 2022, there were 68,156 one-child family units whose only child was aged 0-4 years, a decrease from 95,694 in 2011 (Table F3008) despite the overall increase in population – and there were similar patterns of decline in the number of multiple-child family units where either the eldest or youngest child was aged 0-4 years (Table F3009). This corresponds to a decline in the overall birth rate, which had been 74,033 in 2011 but had dropped to 54,483 by 2022 (Table VSA04).

Family structures

Table 1.1 contrasts the marital status and size of all family units with children (of any age) in the 2011 and 2022 census. The overall trends for marital status remained relatively stable across time. For both 2011 and 2022, three-quarters of all families with multiple children were headed by a married couple but was just over half for families with one child. The proportion of one-parent family structures was greater in families with one child at both time-points, and one-parent mothers were much more common than one-parent fathers (30% vs 6% in 2022).

There was, however, a noticeable change over time in the number of children in families with a same-sex couple (CSO Table F3068). In 2011, there were just 353 children in this family type but that increased to 1853 by 2022. Female-female couples were predominant at both time-points.

Table 1.1: Family size and marital status for all families with children in the 2011 and 2022 census

	Number of children	Married couple	Cohabiting couple	One parent mother	One parent father	Number of family units
2011	1	54%	9%	31%	6%	339596 (100%)
	2+	76%	6%	16%	2%	494670 (100%)
2022	1	53%	11%	30%	6%	346938 (100%)
	2+	74%	9%	16%	2%	538961 (100%)

Source: CSO Table F3009

[3] All table references in the format 'F3 etc' or 'VSA etc' are the original CSO data tables

Housing

Table 1.2 compares the nature of housing occupancy for the two most common family units with children – headed by a married couple or a one-parent mother – in 2011 and 2022. The overall trends are similar for both Census years with owner-occupied housing the most common for married couples with children: 56% (2011) and 51% (2022) with a mortgage and 29% without a mortgage (both years). In contrast, rented accommodation was the most common type of occupancy for one-parent mothers – 47% in both 2011 and 2022. Potentially of note is the increase in the 'other' category (combining 'occupied free of rent' and 'not stated') across time: although remaining small overall, the proportion of families in that group doubled between 2011 and 2022 for both married and one-parent groups.

Table 1.2: Nature of housing occupancy in 2011 and 2022 for family units described as 'married couple with children' or 'one-parent mother with children'

	Family type	Rented	Owner occupied with loan or mortgage	Owner occupied without loan or mortgage	Other	All types (total)
2011	Married couple with children	15%	56%	29%	1%	558682 (100%)
	One-parent mother with children	47%	24%	27%	2%	186284 (100%)
2022	Married couple with children	17%	51%	29%	3%	580641 (100%)
	One-parent mother with children	47%	20%	29%	4%	186487 (100%)

Source: CSO Table F3078

Work

Between 2011 and 2022, there were notable changes in the principal economic status of the adult population with an increase in the percentage 'at work' for both men (54% to 61%) and women (46% to 51%). Other categories showed different patterns for men and women over time: for men the percentage 'unemployed' fell from 16% to 6% while the percentage 'looking after home/family' remained stable at 1%. In contrast, while the percentage of women 'unemployed' also declined - from 8% to 5% - it was less dramatic than that for men; but notably the percentage of women 'looking after home/family' also fell from 18% in 2011 to 12% in 2022.

Table 1.3: Principal economic status for adult males and females, in 2011 and 2022

	Sex (adults over 15 yrs)	At work	Unemployed	Student or pupil	Looking after home/family	Other categories	Number of persons (100%)
2011	Male	54%	16%	11%	1%	18%	1,771,510 (100%)
	Female	46%	8%	11%	18%	17%	1, 837,152 (100%)
2022	Male	61%	6%	11%	1%	21%	2,026,557 (100%)
	Female	51%	5%	11%	12%	22%	2,110,295 (100%)

Source: CSO Table F7012

Note: 'other categories' includes 'retired' and 'unable to work due to permanent sickness or disability'; the percentage unemployed includes those looking for a first job

Average travel time to work increased by 3 minutes, from 26.6 in 2011 to 29.1 minutes in 2022 (CSO Table F7068). More noteworthy perhaps, considering the impact of the COVID-19 pandemic, is the number of people working from home which was 83,326 in 2011 and 259,467 in 2022. According to the CSO, the 2022 figure represents an increase of 173% compared to the 2016 census (Table F7111).

Religion and ethnicity

There were substantial changes in religious affiliation between the 2011 and 2022 Census. For children aged 0-4 years specifically, the percentage described as 'Roman Catholic' declined from 84% to 65% over time (Table 1.4). The main increase was in the percentage with 'no religion' up from 5% in 2011 to 16% in 2022; and there was also an increase in the 'not stated' category for this age group from 2% to 8%. Table 1.4 below shows the 2011 and 2022 percentages for all categories above 1% in 2022 but note that were was a wide range of other religious affiliations with smaller numbers.

Table 1.4: Religious affiliation for children aged 0-4 years in 2011 and 2022, where the percentage for a particular category was at least 1% in 2022

	Age group	Roman Catholic	No religion	Not stated	Church of Ireland/England; Anglican; Episcopalian	Islam	Orthodox (Greek, Coptic, Russian)
2011	0-4 years	84%	5%	2.4%	2.5%	2.0%	1.1%
2022	0-4 years	65%	16%	8.4%	2.4%	2.8%	2.2%

Source: CSO Table F5701

Ireland was the place of birth for 80% of the entire usually resident population in 2022 – down somewhat from 83% in the 2011 Census (Table FY016). The next most common place of birth was England and Wales (5% in 2011 and 4% in 2022). Just over 1% of the population at both time-points gave their place of birth as Northern Ireland. No other individual country had a representation above 1% in 2022. Over 90% of children aged 0-14 years[4] were born within Ireland at both Censuses.

Although the percentage representation of any individual country of birth outside Ireland and the UK remains small, the CSO[5] notes that the biggest increases since the 2016 census - as measured by actual number of individuals - were from India, Brazil, Romania, Ukraine and Moldova. Table 1.5 below reproduces the CSO figures (from Figure 4.4 of that release).

Table 1.5: Birth countries with the biggest increases in Irish population numbers between 2016 and 2022, also showing change from 2011 census figures

	India	Brazil	Romania	Ukraine	Moldova
2011	17,856	9,298	17,995	4,123	3,421
2016	20,969	15,796	28,702	4,624	6,472
2022	56,642	39,556	42,460	15,678	16,155
Change between 2011 and 2022	+38,786	+30,258	+24,465	+11,555	+12,734

Reproduced from Figure 4.4 of the CSO publication in footnote 5

The ethnicity question was updated for Census 2022, meaning that a direct comparison with the 2011 Census is not possible. Looking just at the 2022 figures shows that 75% of children aged 0-4 years were described as 'White Irish' (Table 1.6).

[4] A 0-4 years breakdown was not published in the relevant table

[5] https://www.cso.ie/en/releasesandpublications/ep/p-cpsr/censusofpopulation2022-summaryresults/migrationanddiversity/

The next biggest groups were 'any other White background' (7%) and 'Asian or Asian Irish – Indian/Pakistani/Bangladeshi' (3%). Just over 1% of young children were 'White Irish Travellers' and less than half of one percent were 'White Roma'.

Table 1.6: Ethnicity for children aged 0-4 years in the 2022 Census (only)

Ethnicity in 2022 (age 0-4 years only)	%
White Irish	75.4%
White Irish Traveller	1.3%
White Roma	0.4%
Any other White background	7.3%
Black or Black Irish - African	1.3%
Black or Black Irish - any other Black background	0.2%
Asian or Asian Irish - Chinese	0.4%
Asian or Asian Irish - Indian/Pakistani/Bangladeshi	3.0%
Asian or Asian Irish - any other Asian background	0.7%
Arab	0.6%
Other including mixed background	2.3%
Not stated	7.2%
All ethnicities	292,797 (100%)

Source: CSO Table FY023

1.3 Changing policy context

First 5

In terms of policy context, a new flagship strategy for the early years, called *First 5* was introduced to cover a ten-year term from 2019 to 2028. It is described as a "whole-of-government strategy to improve the lives of babies, young children and their families".[6] Its "big steps" ambitions are:

- Access to a broader range of options for parents to balance working and caring
- A model of parenting support
- New developments in child health
- Reform of the Early Learning and Care system
- A package of measures to tackle early childhood poverty

[6] https://www.gov.ie/en/campaigns/5d81e-about-first5/?referrer=https://first5.gov.ie/

The First 5 strategy also lists the four main goals against which progress will be assessed as:

A. Strong and supportive families and communities
B. Optimum physical and mental health
C. Positive play-based early learning
D. An effective early childhood system

Young Ireland

Also of relevance in the policy context is *Young Ireland: National Policy Framework for Children and Young People 2023-2028 (DCEDIY, 2023)*. The stated central aim of the framework is, "to provide a platform to realise the rights of children and young people in Ireland, so that all partners can work effectively together to ensure children and young people can thrive" (p.4).[7] It is a successor to the previous *Better Outcomes, Brighter Futures* framework and aspires to the same five national outcomes for children and young people, as follows:

1. Active and healthy
2. Achieving in learning and development
3. Safe and protected from harm
4. Economic security and opportunity
5. Connected, respected and contributing to their world

The new Young Ireland framework also identifies a number of 'spotlights', where "greater, more focused attention is required in some areas where children and young people are struggling" (p.42). These spotlights are:

- (The establishment of) the Child Poverty and Well-Being Programme Office
- Child and youth mental health and well-being
- Disability services

More specific policies will be outlined in the individual topic chapters that follow. It is important to note that at time of writing in January 2025, a new programme for government was in development following the general election on 29th November,

[7] https://assets.gov.ie/280807/66d25198-b019-4734-b516-0014a119e261.pdf

2024. This was subsequently published on 23rd January[8] and there is an addendum to this report that summarises some of the main commitments relating to families and children. This could mean that there will be new policy initiatives relevant to young children in place by the time the survey of Cohort 24 at age 3 takes place in 2027.

1.4 Conceptual Framework

Since its inception, Growing Up in Ireland has drawn extensively from Bronfenbrenner's bioecological model (e.g. Bronfenbronner & Morris, 2006) for its conceptual framework. Depending on the age and stage of a particular wave, especially as the eldest cohort transitioned to adulthood, Bronfenbrenner's model has been complemented by other theoretical frameworks. For Cohort 24 at age 3, the bioecological model remains useful as a core framework for developing the survey instrumentation. It has been discussed at length in several previous Growing Up in Ireland publications (e.g. Greene et al. 2010) so will be outlined just briefly in the current work.

Overview of Bronfenbrenner's bioecological model

A core tenet of Bronfenbrenner's model is that an individual child develops within an ecological context, and in turn, interacts with and affects that context. Life does not merely happen to a young child because interactions and pathways are influenced by the child's individual characteristics such as gender, ethnicity, health status and temperament. In contrast to the first wave of Cohort 24 at age 9 months, by age 3 years the individual child will be much better placed to express their preferences to their adult caregivers (something that was commented upon several times in the course of the parent focus groups, see section 1.8).

The notion of 'context' includes other people and the child's relationships with them and, generally, the people that the child spends most time with are the most influential for their development. This immediate context is described as the child's 'microsystem' in the model (see Figure 1) and, at age 3, this would typically be the child's home and their childcare/early learning setting. From the perspective of designing the survey, therefore, it is important to collect information on both the

[8] https://www.gov.ie/en/publication/078a1-programme-for-government-2025-securing-irelands-future/

physical aspects of the home and childcare settings, as well as the people (such as parents) with whom the child regularly interacts.

The 'mesosystem' layer in the bioecological model refers to the interactions between other individuals in the child's microsystem, and how that affects the context in which the child is developing. Examples include the quality of the relationship between the parents, and communication between parents and the childminder or early years educator.

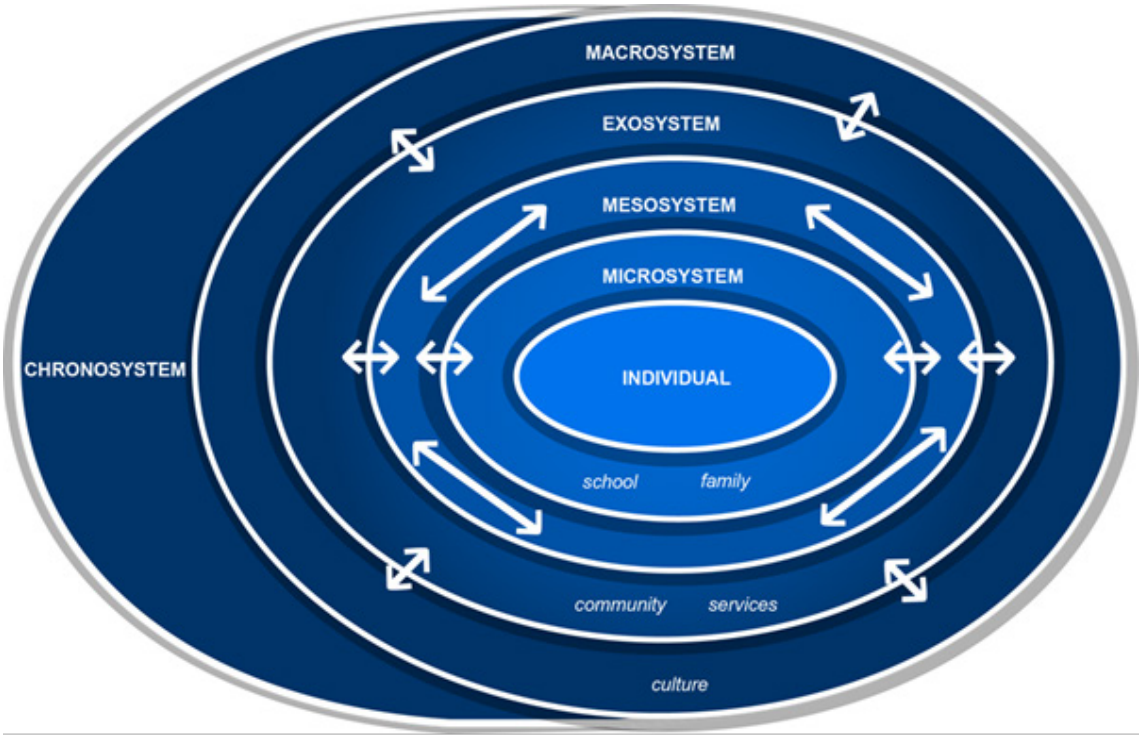

Figure 1.1: Bronfenbrenner's bioecological model

The 'exosystem' layer in the model refers to the wider community context in which the child grows up. For 3-year-olds, this would include the quality of the local area (such as air quality and play spaces), the services available, and the parents' workplace. As with other layers, interactions between elements/individuals are important; for example, the amount of flexibility the parent's employer allows in terms of taking leave or working from home.

The 'macrosystem' refers to characteristics of the wider environment within which the child's home and community are nested. It could include the influence of religious beliefs on parenting, cultural expectations for different genders, the national

economic context, issues of public debate, and policymaking. Recent policies relating to young children include free GP care for under 8's, the right to paternity leave, and the national childcare scheme. In terms of designing the survey instrumentation, the impact of certain policies, for example, could be assessed by asking questions such as whether the family have availed of childcare subsidies. It could also be indirectly evaluated by repeating questions – such as number of GP visits – from the survey with Cohort 08 at 3 to whom certain policies such as free GP care did not apply. For this latter approach, consistency in the wording of questions across cohorts is very important.

The final element in Bronfenbrenner's bioecological model is the 'chronosystem', in effect the different ways in which time can affect an individual's development. One aspect is the age of the individual, and how this might affect both their individual capacities – still very much in the growth stage at age 3 – and the expectations that other people will have of them. From the perspective of survey design, this lends emphasis to the importance of selecting questionnaire items and assessments that are appropriate for 3-year-olds and their families; sometimes this might have to be at the expense of longitudinal consistency. Temperament is a good illustration of where an age-appropriate measure would be particularly important, as what is 'normal' for a 3-year-old would be quite different to a baby or a 9-year-old.

Another aspect of the chronosystem is historical timing – for example, Cohort 24 will have been born shortly after the Covid pandemic, so avoiding the worst of the emergency in terms of lockdowns and restrictions but in an environment where the virus is still circulating (in contrast to the early childhoods of Cohorts 98 and 08). Finally, the chronosystem can also refer to the 'mistiming' of events; that is the experience of life events at an atypical time which may alter an individual's life trajectory, such as the premature death of a parent.

1.5 Criteria for Questions / Scales

Suggestions for new topics are evaluated according to a number of criteria. Four of these are considered 'core criteria' and are assigned extra weighting:

- Captures a key domain (i.e., health, early learning and care, relationships and socio-emotional well-being, family context)
- Is policy-relevant
- Is appropriate for the age/stage of the study child
- Is not readily available from another source

For continuing topics (i.e., previously used with Cohort 24 at 9 months or Cohort 08 at 3 years), there was an additional core criterion of 'longitudinal and/or cross-cohort consistency'. As this criterion will not, as a rule, apply to new topics these were scored according to a different fifth criterion of 'strong support' instead. This means that both new and continuing topics were scored out of a maximum of 10 on core criteria (5 x 2 points).

In addition, there were an additional six 'supporting criteria' used to evaluate both new and continuing topics. These were either 1 or 0 each, giving a maximum of six additional points on the scoring table. The supporting criteria were:

- Reflects a dynamic, rather than static, variable
- Is feasible to capture in a home-based survey, and is not overly burdensome for respondents
- Has scope for international comparability
- Captures diversity in the population of interest
- Has sufficient prevalence and or variance to allow for later analysis
- Is likely to be engaging to respondents as a topic

The scoring for each topic on the core criteria is presented in tabular format within each of the main domain chapters.

1.6 Lessons from Comparable Studies

A review of comparable studies was completed to identify topics and themes which were often included in other studies, indicating that their importance is generally accepted, as well as topics that have not been previously included in similar waves of Growing Up in Ireland. Nineteen comparable studies, including past waves of Growing Up in Ireland, were reviewed (listed below). Longitudinal studies which included questionnaires for data collection at around 3 years of age with a

multidisciplinary purpose were considered. For the majority of studies, topic overview materials were identified on each of the respective websites. Four of the studies were emailed directly and study materials provided by the corresponding research team.[9] User guides, data dictionaries, design reports, and questionnaires were used for topic identification, although differing levels of detail on the actual variables/questions were noted between sources.

Table 1.7: Summary of studies comparable to the forthcoming age 3 year wave of Cohort 24 of Growing Up in Ireland

Study	Age	Year	Country
Growing Up in Ireland - Cohort 08*	3 years / 5 years	2011 / 2013	Ireland
Avon Longitudinal Study of Parents and Children-Generation 2	3 years	2012-2018	UK
Born in Bradford 1000	3 years	2012	UK
Children of the 2020s	38 months	2024	UK
Early Childhood Longitudinal Study*	2 years / Pre-School	2003 / 2005	USA
Étude Longitudinale Française depuis l'Enfance	3 years	2013	France
Fragile Families	3 years	2001-2003	USA
German Health Interview and Examination Survey for Children and Adolescents	3 years	2014-2017	Germany
Growing Up in Australia	3 years	2006-2007	Australia
Growing Up in Hungary	3 years	2021	Hungary
Growing Up in Quebec	41 months	2023	Canada
Growing Up in Scotland	34 months	2013	UK
Growing Up in New Zealand*	2 years / 45 months	2011 / 2013	New Zealand
Kids in Taiwan	3 years	2017	Taiwan
Millennium Cohort Study	3 years	2004	UK
Origins Project	3 years	2021	Australia
Panel Study on Korean Children	3 years	2010	South Korea
Southampton Woman's Study	3 years	2002-2011	UK
Wirral Child Health and Development Study	3 years	2011	UK

* = data collection over two waves

[9] The GUI team at DCEDIY is grateful for the assistance received from the research teams in other cohort studies around the world

1.7 Consultation with Young Children

While the Growing Up in Ireland study has frequently consulted with children and young people in the development of each new phase of data collection, consultations with children as young as 3 years old have not previously been attempted. The decision to do so for Cohort 24 reflects actions specified by the recent publication of the *Participation of Children and Young People in Decision-Making Action Plan 2024-2028* (DCEDIY, 2024a), including "[to] consult with children and young people appropriately in the development of policy, legislation, research and services" (Action 1.1), and "[to] ensure that consultations are undertaken with a broad range of children and young people for the Growing Up in Ireland study and similar research projects so as to inform data collection and policy development" (Action 1.6).

In parallel, the knowledge about appropriate methodologies for effective consultations with young children has developed substantially compared to the equivalent period when Cohort 08 were approaching 3 years old in 2010. The Growing Up in Ireland team in DCEDIY are grateful to colleagues in the Participation Unit of this Department, and associated colleagues in Hub na nÓg, for the development of an appropriate methodology to capture the views of very young children.

Brief outline of methodology[10]

Two early learning centres with children of an appropriate age were recruited to participate in a set of consultation activities based on the theme of 'I wonder what you like'. The children's familiar educators in the centres were instructed on the methodology for the consultation by Hub na nÓg. A total of 30 children aged either 3 or 4 years participated in the consultation. Informed consent was collected from the associated parents in advance.

Different activities were incorporated into the children's daily routines over approximately one week. These activities included drawing pictures, taking photographs, and creating with Duplo-type blocks and Play-Doh. The educators asked the children to explain the significance of each of their artistic creations, and

[10] The independent report on the consultation with 3-year-olds by Carey et al. (2024) is published as an appendix to this report.

verbatim notes were added to photographs of the artworks for later analysis. There were also discussions with the children structured around telling a 'visiting puppet' who asks, 'I wonder what you like to (do, play with etc)?'.

The materials generated in this way were then forwarded, anonymously, to an external researcher familiar with these methodologies to summarise into themes for the Growing Up in Ireland team.

Summary of results

The researcher who analysed the materials from the child consultation noted some technical challenges such as difficulty reading the handwritten notes that accompanied the children's creations, and photographs of creations being either too small or too blurry to see clearly. It was also noted that while the principle of the consultation was to record the child's verbal explanations of their creations verbatim, some descriptions were so brief (e.g., 'a dog') that inferences as to meaning had to be limited.

Nonetheless, a considerable amount of material was generated by the two consultations and the independent researcher was able to identify the following themes significant to children:

- Significant relationships and social connections
- The natural world
- The prominence of play
- Celebrations and special events
- Gift giving
- Special interests
- Food

Recommendations for new or expanded topics arising from the child consultation:

Extended information on the child's microsystem: Further data on the child's wider family network was already recommended as a result of the consultations with advisory groups. Based on the parent and child consultations, it is recommended that this topic be extended further to include questions on the child's friends and pets –

and more detail on their relationships with siblings. The inclusion of one or two questions on pets would also help address the theme of the 'natural world'.

More information on play, especially outdoor and risky play: Again, a theme that also arose in the consultations with the advisory groups and parents, and strengthened by the themes of 'prominence of play' and 'the natural world' from the children.

New information on participation in organised activities and special events: The practice of increased engagement and attendance at organised activities and events also arose in the parent consultation, who seemed to feel that their 3-year-olds had reached an age where they would benefit from such experiences. This seems to be reinforced by the consultations with children, perhaps reflecting the timing of the consultation in the run-up to Christmas. As other celebrations and gift-giving was also a feature of the children's interests, the DCEDIY team suggest a question on whether the family celebrates special occasions.

An additional theme of picky eating emerged quite strongly from the parent focus groups, and it is interesting to see that '**food**' was also a theme coming from the children themselves. However, the additional items on picky eating and feeding strategies recommended on foot of the parent consultations should be sufficient.

1.8 Consultation with Parents

Two focus groups were held with parents of children aged 3 or 4 years old.[11] The focus groups were conducted by an independent social and market research company on behalf of DCEDIY. Both took place in mid-November 2024. There were eight parents in each group, with a mix of mothers and fathers. There was also a mix of family size, ethnicities, occupations, and geographical locations around Ireland. Each consultation lasted 90 minutes and took place online.

The primary aim of the focus groups with parents was to identify any issues that were emerging in the lived experience of families with young children that may not have featured in previous reviews and consultations. The instructions to the facilitators

[11] The age criterion was set as '3 to 4' rather than just '3' to include parents with recent experience of a 3-year-old even if they had since turned 4.

were to encourage spontaneous discussion of issues as much as possible, but a discussion guide was agreed in advance should some prompting be required. This included general prompts like what concerns they had as well as what they enjoyed about being a parent of a child aged 3 years. There was also a specific prompt to both groups about the environmental and sustainability challenges of raising a young child, on the basis that sustainability is a key overall policy objective.

The table below gives a summary overview of the topics raised by parents, as summarised by the facilitator who conducted the focus groups.

Table 1.8. Summary of topics raised by parents of children aged 3-4 years

Topic	Subtopic	Notes
Childcare and work-life balance	Difficulty securing childcare	Staff turnover in centres also mentioned
	Cost of childcare	Some employed mothers considering giving up work
	Balancing work and family life	Some feelings of guilt about too little time spent with child
Healthcare access and concerns	Difficulty accessing healthcare	Using emergency services as cannot get timely GP appointments; long waiting times for specialists
	Vaccinations	Some specific concerns about COVID vaccines for children
	Impact of COVID-19	Likely won't apply to parents of Cohort 24
Financial concerns and cost of living	Rising expenses	Cost of organised activities as well as food and clothes
	Economic pressure	Included specific concern about cost of healthy food over processed food
Child behaviour and development	Managing emotions and behaviours	Tantrums and stubbornness
	Encouraging independence	Children's individual skills emerging
	Sibling dynamics	Jealousy and fighting, fewer positive aspects of sibling relationships
Nutrition and feeding challenges	Picky eating habits	This was one of the most frequent themes
	Creative solutions	'Fooling' children into eating healthier or more diverse foods
	Food costs and accessibility	Tempting to revert to processed or junk food
	Food waste	Side effect of picky eating
	Sibling influence	Young children want to eat what older siblings are having
Technology and screen-time	Managing screen exposure	Ipads and 'youtube kids' mentioned multiple times
	Using digital devices to create 'quiet time'	Devices used to distract children while parent does something else

Topic	Subtopic	Notes
	Digital influence	Social media did not seem to be used with children of this age
	Balancing screen-time	Outdoor play mentioned as a good way of keeping children away from screens
Sleep patterns and routines	Disrupted sleep	A number of parents felt their child slept less well now that they were older
	Impact on parental well-being	Sleep deprivation affects mood of whole family
Playtime and activities	Outdoor play	A number of parents said their child really enjoyed outdoor play
	Structured activities	Cost can be prohibitive
	Family time	Several parents made an effort to set aside 'family time'
Safety and independence	Teaching safety	Growing independence of the child brought safety concerns such as 'stranger danger'
Environmental and sustainability concerns	Driving rather than walking	Easier to walk to places when child was in a buggy
(prompted topic to both groups)	Recycling and reusing/Challenges with sustainability	Schemes like 're-turn' meant extra tasks for already busy families
Parental well-being and self-care	Finding time for self-care	Also difficult to find time to do things just as a couple
	Impact of parenting challenges	Some reports of elevated anxiety, compounded by sleep deprivation
	Strategies for dealing with stress	'Cup of tea and quiet time'; support from family
Family support and dynamics	Role of extended family	Some families heavily reliant on family members for childcare
	Parenting approaches	Some tension between parents and grandparents about child-rearing (such as giving the child sweets)
	Sibling relationships	Mostly negative at this stage
	Support from communities	Some parents perceived a lack of community support in contrast to when they were children
Information sources and parenting advice	Reliance on personal networks	Preference for peers over older family members
	Use of instinct	Some parents particularly valued their own instincts for their child
Spending on family experiences	Experiences as a family	Many families had Christmas outings planned
	Cost considerations	Noted that activities and holidays were expensive but potentially valuable for the child

Source: Report prepared for DCEDIY by Amárach Research, December 2024

Recommendations for new and/or expanded topics arising from consultations with parents

In contrast to the briefing for the expert stakeholders on the advisory panels – who had been asked to consider emerging rather than established topics – the parent focus groups were open to all topics. This means that some of what the parents discussed were topics already earmarked for inclusion in the survey, such as childcare, financial strain, work-life balance, support from extended family, and screen-time; but their emergence in the parental discussions reinforces their importance for this wave.

There were, however, some specific issues that emerged quite strongly in the parent focus groups and which the DCEDIY team recommends adding or expanding in the survey for this wave. These are:

Picky eating: This was one of the most universal themes; it impacted the quality of the child's diet, caused parents a great deal of stress, and contributed to food waste in a context where healthy food was seen as expensive (see the health chapter for further discussion).

Difficulty getting GP appointments: This came up for a number of parents in the second group. While there is an existing question on unmet need due to being unable to get an appointment, the feedback from the parents was that they were using emergency services such as out-of-hours clinics, emergency departments and VHI clinics as a replacement for GP care rather than letting the child go without care (see health chapter for further discussion).

Participation in organised activities: A number of parents referred to enrolling the child in regular organised activities such as sports clubs, as well as bringing them to one-off events such as football matches or a pantomime. While such questions have been used before in Growing Up in Ireland with older cohorts, they weren't previously used for children as young as 3 years – however, parents felt that such activities were important for their child's development, and enjoyment, but lamented how costly they were (see chapter on early learning and care for further discussion).

Outdoor play: There were several references to children's enjoyment of outdoor play, and how parents valued it as a chance for children to get some physical exercise instead of screen-time – it was, however, weather and light dependent. There is an existing question from Cohort 08 at 3 about the household's access to an outdoor space but the survey did not previously ask about how often it was used. The value of outdoor play overlaps with the topic of 'risky play', which emerged from the consultations with the expert advisory panel and is also recommended as a new topic (see chapter on early learning and care for further discussion).

Sibling relationships: Much of what was discussed in relation to how 3-year-olds got on with siblings was negative. Some of the interactions appeared related to the more general theme of the 3-year-old strongly expressing their preferences and reacting negatively when these were not met. While there is an existing, single question on how well the child gets on with siblings, the feedback from the parent focus groups suggest that interactions are more complex and potentially disruptive to the family dynamic than is currently captured in a single question (see chapter on family relationships for further discussion).

It is also interesting to note that parents made frequent references to aspects of their children's **temperament** and how that affected both their individual interactions and wider family life. Positive descriptions included 'loving', 'curious', 'energetic' but there were also some negative traits such as 'fussy', 'moody', and 'jealous'. Three-year-olds having strong opinions on what they liked or did not like, and how those opinions were prone to change was also a common theme among the parents. While temperament is already part of the recommended content as a continuation of previous waves of Growing Up in Ireland, it is a useful reminder that it remains a key feature of living with and parenting a 3-year-old.

1.9 Consultations with Research and Policy Experts

Two expert advisory panels were set up in 2023 as part of the new model for the Growing Up in Ireland study. One panel is comprised mainly of policy-makers, and the other is a combination of academic researchers and representatives from non-Governmental organisations. In June 2024, members of both groups were invited to

participate in roundtable discussions about the content of the survey for Cohort 24 at age 3 years.

There were four consultations organised under the themes of 'physical health', 'early learning and care', 'family relationships and socio-emotional context', and 'family context'. The advisory panel members were asked to nominate themselves for one theme, and each themed discussion included members from both the policy-maker and research panels. The discussions were held online and facilitated by staff from the Research and Evaluation Unit in DCEDIY.

In preparing for the roundtable discussion, members were sent a short briefing document which asked them to consider (a) potential sources of data linkage, (b) the top five 'emerging areas' the survey might want to include as topics for age 3 years, and (c) a methodological change that could benefit the study. As a prompt, the briefing document contained a summary of potential new topics, and methodological considerations, that had already been identified by the Growing Up in Ireland team from a review of the literature and recent similar-aged surveys from other cohort studies.

Members of both panels were allowed a few weeks after the roundtable sessions to submit additional suggestions or other feedback by email. This option was also open to members who had been unable to attend the online discussion groups.

The following paragraphs give a short summary of the areas discussed at each of the roundtables, and/or subsequently submitted by email:

Physical health: There was strong support for including questions on parental eating disorders, the use of screens (by the child) while eating, feeding strategies (and associated picky or fussy eating), and using screens as a tool for emotion regulation. On methodological considerations, there was considerable discussion and agreement on the merits of collecting biomarkers from participants. Other suggestions from the panel centred around sustainable diets, awareness of dietary recommendations (i.e. health literacy), food insecurity, screen time behaviour (at night, marketing exposure, ownership), sleep habits, sun habits and safety practices. On this basis, the DCEDIY team recommend the following new topics for inclusion in the age 3 years survey:

parental eating disorders, screen time while eating, picky eating, and extra questions related to screen time behaviour.

Early learning and care: The highest degree of consensus in the area of early learning and care was around the importance of play (particularly outdoor and risky play) and childcare arrangements (particularly communication with providers). Other proposed topics included engagement with technology, engagement with nature, disability services, language exposure, family routines, challenging behaviour and preparedness for school. From a methodological perspective, daily diaries and interviewer observations of the childcare setting were discussed. The DCEDIY team are recommending questions relating to risky/outdoor play and communication with childcare providers for the new survey on the basis of this roundtable discussion.

Relationships and socio-emotional well-being: Topics related to interaction with the extended family, both face-to-face and virtually, identified as new areas of interest by this panel. There were also suggestions to include items on non-cognitive traits and gamification. Following from this discussion, the DCEDIY team recommend the inclusion of questions on extended family interaction, including frequency and modality, in the age 3 survey. The panel on family context also suggested a question on the child's friends which has been included in the recommendations for this domain.

Family context: While the study already has a well-established set of socio-demographic indicators, the panel members in this theme also identified the importance of collecting information across multiple generations of the family and the impact of care services for families with a child with a disability. Methodology and data linkage suggestions included means testing and further information on parental labour status. The DCEDIY team recommends the addition of questions on intergenerational socioeconomic, health and financial support information, and questions on accessing care services on this basis.

1.10 Report Outline

The majority of recommendations for the content of the survey with Cohort 24 at age 3 years are contained in the four chapters reflecting the primary domains in the Growing Up in Ireland study:

- Physical health (Ch. 2)
- Early learning and care (Ch. 3)
- Relationships and socio-emotional development (Ch. 4)
- Family context (Ch. 5)

Some topics (e.g. screen-time) overlap across multiple domains but are generally only discussed in one chapter; therefore, a keyword search may be useful if a specific topic initially appears to be omitted.

The final chapter makes recommendations in relation to how the survey is conducted and adjuncts to the main questionnaires. These adjuncts include the direct assessment of the child's cognitive ability, and questionnaires to respondents outside the main household (i.e. a non-resident parent and a regular childcare provider).

Chapter 2: Physical Health

2.1 Context Overview

The Irish Government has developed a wide range of policies, strategies and schemes to positively impact the health of children in Ireland. Collectively, these policies aim to develop dedicated high quality child health service and an associated workforce, whilst also promoting positive health behaviours and mental health amongst children, young people and their families.

The *National Healthy Childhood Programme* covers child health check-ups, vaccinations, and screening. It is free to all children, promoting equal access and greater acceptability for families. The programme covers the *Maternity and Infant Care Scheme*, the *Child Health, Immunisation, Screening and Surveillance Programme* and the *GP Visit Card Scheme* for children. Since 2015, all children under 6 years are entitled to a free GP Visit Card (subsequently extended to all children under 8). The scheme also covers age-based preventive health checks at ages 2 and 5, and a cycle of care for children with asthma.

The *Child Health, Immunisation, Screening and Surveillance Programme* makes available a range of free universal screening and surveillance services. These include screening for metabolic disorders, a hearing test, and regular developmental checks and assessments (from birth to four years).

The *Nurture Infant Health and Wellbeing Programme*, developed through the aforementioned *Healthy Childhood Programme*, aims to improve health and wellbeing for babies, young children and their families, with a strong emphasis on improving the information and professional supports provided to parents from pregnancy through to the first three years of life. The *National Women and Infant Health Programme* provides health promotion supports for mothers and their babies, including smoking cessation, access to antenatal dietetic services and nutritional advice.

In terms of policies aimed at improving health behaviours, the *Healthy Food for Life* guidelines and resources promote healthier food choices and are incorporated into all nutrition work with school, community and health service staff. *A Healthy Weight for Ireland* is the national obesity policy and action plan, the aim of which is to increase

the number of people with a healthy weight, with specific targets for children (a sustained downward trend in levels of excess weight in children and a reduction in the gap in obesity levels between the highest and the lowest socioeconomic groups). *Get Ireland Active* is the national physical activity plan, aiming to increase physical activity levels across the population with specific targets for children. *Healthy Eating and Active Living* is a national policy priority programme that ensures implementation of the obesity and physical activity plans across the health services.

In terms of parental health behaviours, *Tobacco Free Ireland* sets a target for Ireland to be tobacco free by 2025, with the protection of children prioritised. Legislation to ban smoking in places where children are present has been enacted (as is the case of smoking in cars) or is planned, and local authorities are engaged in a range of activities to make children's playgrounds, parks and beaches smoke-free. *Reducing Harm, Supporting Recovery: A Health-Led Response to Drug and Alcohol Use in Ireland* includes actions to mitigate risk and reduce the impact of parental substance misuse on babies and young children.

More broadly, *Sláintecare* is the ten-year programme to transform Ireland's health and social care services. It is billed as the roadmap for building a world-class health service in Ireland. The *Sláintecare Healthy Communities Programme* aims to improve the long-term health and well-being of children and adults living in the most disadvantaged communities by addressing the wider determinants of health. *Young Ireland*, the national policy framework for children and young people, identifies nutrition, physical activity, healthcare services, and the improved provision of outdoor play and recreation facilities amongst its priorities. As noted in Chapter 1, 'optimum physical and mental health' is one of the main goals of First 5, the whole-of-government strategy for the early years.

2.2 Findings from Growing Up in Ireland Cohort 08 at age 3 years[12]

Some key findings from Cohort 08 at age 3 years (Williams et al., 2013) relating to the physical health of the study's children are listed below:

[12] Subsequent references to 'Cohort 08 at 3' relate to the Growing Up in Ireland study unless otherwise specified

- One-quarter of children were overweight or obese; 19% overweight and 6% obese. Differences in levels of overweight and obesity were identified according to social class; those from less advantaged families were more likely to be overweight or obese. No differences were observed according to gender.
- In terms of diet, parental education was strongly and positively associated with "healthy" food consumption, such as fruit and vegetables, and strongly and inversely related to consumption of energy-dense "unhealthy" foods such as crisps, chips and burgers, and non-diet fizzy drinks.
- Almost all 3-year-olds (98%) were described as *very healthy* or *healthy* by their parents. Worryingly, the social gradient in parental ratings of children's health widened over time; there were no significant differences in children's health at time of birth, but by three years of age children from the least advantaged social class backgrounds were significantly less likely to be rated as *very healthy* compared with children from more advantaged backgrounds.
- Almost 16% of 3-year-olds were reported by their parents as having a longstanding illness, disability or other ongoing health condition. Respiratory illnesses were the most commonly-reported illness type; 6% of the sample had received a doctor diagnosis of asthma. Boys were significantly more likely than girls to have a doctor-diagnosed chronic illness. Of those who had a chronic illness, 6% reported that they were severely limited in their daily activities by that condition (equal to 1% of the overall sample).
- The average rate of general practitioner (GP) consultations for 3-year-olds in Cohort 08 was 2.6 per year. Children with a full medical card were significantly more likely to consult a GP, even when controlling for children's health status. The frequency of GP consultations was closely related to the level of household income; the highest rates were among those in the lowest income groups. A total of 16% of 3-year-olds had experienced an accident or injury that required hospital treatment or admission over their lifetime. Boys were more likely to have been injured than girls (18% vs 15%).

2.3 Topics from Comparable Studies

A review of the instrumentation used by comparable international studies indicates a high degree of consistency between those studies (see chapter 1 for a full list of studies) and Growing Up in Ireland for Cohort 08 at age 3 in terms of topics/subtopics explored within the surveys. The review also identified topics that were a) explored in Growing Up in Ireland but not in many comparable studies and b) explored in comparable studies but not previously in Growing Up in Ireland (i.e. potentially new topics for Growing Up in Ireland).

From a physical health perspective, almost all studies, including Growing Up in Ireland, explored topics relating to general health status, longstanding illnesses,

conditions and disabilities, diet (including parenting feeding strategies) and speech and language development. The majority of studies asked questions relating to health services utilisation (such as GP visits and hospitalization), sleep behaviour, vaccinations, historical injuries and accidents and child motor development, along with items relating specifically to respiratory illnesses and visually and auditory problems.

Fewer studies (again including Growing Up in Ireland) asked about allergies and food intolerances, antibiotic use, dental health and about (parental) perception of the child's weight status. Topics identified in other longitudinal studies but not in Growing Up in Ireland included food restrictions, sun safety habits, wider safety habits (car seat, smoke alarm, etc.), prescriptions and vitamins/supplements.

Focussing on physical measurements, almost all studies recorded the child's height and weight, while only a few studies (including Growing Up in Ireland) recorded the parents' height and weight. A number of studies recorded head circumference, skinfold thickness, waist/hip circumference, blood pressure, and took blood samples, although Growing Up in Ireland was not amongst these studies.

2.4 Summary of Continuing Topics

The table below lists the continuing health topics that are recommended for continuation for Cohort 24 at 3 years. Their scoring against the five core criteria is also provided. Note that subtopics which were included in both Cohort 24 at 9 months and Cohort 08 at 3 years – even if not the same actual questions – are weighted as '2' under the heading of 'longitudinal/cross-cohort consistency'. If a topic appeared in just one of the source questionnaires – that is, offering either a longitudinal or a cross-cohort comparison but not both – it is scored as '1'. In a small number of cases, if the topic featured in both waves but the measurement was very different then a score of 1 on the consistency criterion was recorded.

For ease of reading, the scores against the supporting criteria (e.g. being age appropriate) are not included; but most topics will have achieved maximum marks on these.

Table 2.1: Summary of proposed continuing topics in the area of health, including presence at previous waves of GUI and scoring on core criteria for inclusion

Topic	Subtopic	C'24 at 9mths	C'08 at 3yrs	Captures key domain	Policy relevant	Age appropriate	Not collected elsewhere	Longitudinal or cross-cohort consistency
Mother pregnant	Mother currently pregnant	Yes	Yes	2	2	2	2	2
Parent substance use	Smoking	Yes	Yes	2	2	2	1	2
	Vaping	Yes	No	2	2	2	1	2
	Drug-taking	Yes	Yes	2	2	2	1	2
	Drinking alcohol	Yes	Yes	2	2	2	1	2
Gambling	Any gambling	Yes	No	2	2	2	2	2
	Problem gambling scale	Yes	No	2	2	2	2	2
Parental health	Unmet need	Yes	No	2	2	2	1	2
	General health	Yes	Yes	2	2	2	1	2
	Long-term conditions and disability	Yes	Yes	2	2	2	1	2
Parent measurements	Height	Yes	Yes	2	2	2	1	2
	Weight	Yes	Yes	2	2	2	1	2
Child diet	Cessation of breastfeeding post 9 months	Yes	Yes	2	2	2	2	2
	Weaning catch-up	Yes	No	2	2	2	2	1
	Food allergies	Yes	No	2	2	2	2	1
	Food frequency items	No	Yes	2	2	2	2	1
	Parental feeding style subscale	No	Yes	2	2	2	2	1
	Parent assessment of child weight status	No	Yes	2	2	2	2	1
Child health	General health status	Yes	Yes	2	2	2	2	2
	Vaccinations	Yes	Yes	2	2	2	2	2
	Long-standing conditions	Yes	Yes	2	2	2	2	2
	Acute illness	Yes	No	2	2	2	2	1
	Asthma symptoms	No	Yes	2	2	2	2	1

Topic	Subtopic	C'24 at 9mths	C'08 at 3yrs	Captures key domain	Policy relevant	Age appropriate	Not collected elsewhere	Longitudinal or cross-cohort consistency
	Sight problem	No	Yes	2	2	2	2	1
	Hearing problem	No	Yes	2	2	2	2	1
	Tooth brushing	No	Yes	2	2	2	2	1
	Visit dentist	No	Yes	2	2	2	2	1
	Sleep	Yes	Yes	2	2	2	2	2
Healthcare utilisation	Consultations with medical professionals	Yes	Yes	2	2	2	2	2
	Hospitalisation	Yes	Yes	2	2	2	2	2
	Unmet need	Yes	Yes	2	2	2	2	2
	Accident/injury	Yes	Yes	2	2	2	2	2
	Antibiotic use	No	Yes	2	2	2	2	1
Cover for medical expenses	Medical card/GP card	Yes	Yes	2	2	2	1	2
	Private health insurance	Yes	Yes	2	2	2	1	2
Developmental checks	Receipt of checks	Yes	No	2	2	2	2	1
	Reason for not having check	Yes	No	2	2	2	2	1
Child measurements	Height	Yes	Yes	2	2	2	1	2
	Weight	Yes	Yes	2	2	2	1	2
Child development	Age first steps	No	Yes	2	2	2	2	1
	Status of toilet-training	No	Yes	2	2	2	2	1
	Soothing behaviours	No	Yes	2	2	2	2	1
	Speech problems	No	Yes	2	2	2	2	1
	Gross motor (ride tricycle)	No	Yes	2	2	2	2	1
	Fine motor (play with small pieces)	No	Yes	2	2	2	2	1
	Parental concerns about development	No	Yes	2	2	2	2	1

Mother currently pregnant

The study child's mother has been asked at all previous waves of the study if they were currently pregnant. This information is useful from a number of perspectives; in the short-term, it may impact the mother's general health and capacity to interact with the study child, and it will have implications in terms of the mother's ability to engage in employment (for a period). Long-term implications include changes to the family's overall composition, which is associated with a range of child developmental outcomes (McHale et al., 2012).

Recommendations for Cohort 24 at 3 years:

- Repeat questions from Cohort 24 at 9mths and Cohort 08 at 3yrs asking female respondents if they are currently pregnant

Parent substance use

There is strong evidence to suggest that parents' drinking behaviours and substance use habits can impact their child's own engagement in risky behaviours (drinking, smoking, vaping and taking drugs; Smith et al., 2016); if a child sees their parent(s) smoking, vaping or drinking alcohol on a regular basis, they may be more inclined to mimic their parent(s) behaviour and do so themselves. Further, if the parent is a regular drinker or smoker, they may have more liberal attitudes to their child's own engagement in similar behaviours as they enter adolescence (Murphy et al., 2016). Whilst 3-year-olds will not be engaging in these risky health behaviours themselves, their parents' engagement in and attitudes to risky behaviour now is predictive of their behaviour in the future, when their child will be at risk of drinking and smoking.

Environmental tobacco smoke, stemming from parents smoking, is extremely harmful for a child, and can lead to increased risk of asthma and other respiratory conditions (Vanker et al., 2017).

Research on the effects of parental drug use on children typically highlights such problem behaviours as antisocial behaviour and conduct or oppositional disorders in the child (Smith, 1993; Willens et al., 1995), as well as negative impacts on the quality of parenting provided for the child (Dawe et al, 2007).

With all of this in mind, it is important to gather information on both parent's engagement in smoking, vaping, drinking and drug use throughout the course of study child's childhood and adolescence. These questions would be better suited to a self-complete module.

Previous alcohol screening questions in Growing Up in Ireland

In the interest of facilitating cross-cohort comparisons between Cohort 08 at age 3 and previous waves of Growing Up in Ireland (for all three cohorts), it is worth considering the alcohol-specific screening tools that were employed at past waves and whether they would be suitable for inclusion at the forthcoming wave of Growing Up in Ireland.

Traditionally, Growing Up in Ireland has employed questions derived from one of two alcohol screening tools at any given wave of the study; the AUDIT or the FAST screening tools. The Alcohol Use Disorders Identification Test (AUDIT) is a 10-item scale that asks questions related to alcohol intake, potential alcohol dependence and experience of alcohol-related harm (Higgins-Biddle & Babor, 2018). It was developed in a World Health Organization study and is widely validated. The Fast Alcohol Screening Tool (FAST) was developed as a shorter alternative to the AUDIT and includes just four items; these questions explore alcohol intake and experience of potential alcohol-related harm. It has also been validated as a reliable screening tool (John et al., 2021).

The FAST scale has been used for screening parental alcohol use for Cohort 08 at age 13, Cohort 98 at ages 13, 17 and 20 years, and Cohort 24 at nine months. The AUDIT scale was included in the Young Person questionnaire for Cohort 98 at age 17, 20 and 25 years.

Recommendations for Cohort 24 at 3 years:

- Repeat questions from Cohort 24 at 9mths and Cohort 08 at 3yrs asking parent(s) if they drink, smoke, vape or take drugs. The FAST alcohol screening tool, used at Wave 1 for this cohort, should be retained.

Gambling

The prevalence of gambling is increasing in Ireland and internationally, strongly influenced by the accessibility of online gambling. Recent research suggests 1-in-30 adults in Ireland are problem gamblers (Ó Ceallaigh et al., 2023). Gambling addiction has been linked to mental health issues, depression, anxiety, and increased suicide risk, all of which would impact the relationship between a parent and child (Montiel et al. 2021). Such questions should be asked of both parents (where applicable) as part of the self-complete module.

Previous alcohol screening questions in Growing Up in Ireland

In the interest of facilitating cross-cohort comparisons between Cohort 08 at age 3 and previous waves of Growing Up in Ireland in terms of gambling behaviour, it is worth considering the specific scale(s) employed at past waves of the study and whether they would be suitable for inclusion at the forthcoming wave of Growing Up in Ireland.

The Problem Gambling Severity Index is a nine-item measure of problematic gambling behaviour. It can be used to classify people according to their risk level for problem gambling (none, low, moderate and problematic). It "presents a viable alternative to [other tools] for assessing degrees of problem gambling severity in a non-clinical context" (Holtgraves, 2009), and has been independently validated (Currie et al., 2013). This scale was used for Cohort 24 at 9 months.

Recommendations for Cohort 24 at 3 years:

- Include items asking parents if they have played and/or bet money on a range of games (lotto, fruit slot machines, casino, online gambling, betting) in the last year. Also ask them to complete the Problem Gambling Severity Index.

Parental health

It is important to capture indicators of **parental health**, as parental ill-health has implications for the health and wellbeing of children, particularly if it compromises the ability of the parent to care for their child. This is particularly true in terms of **long-term health conditions** and disabilities; they have the potential to disrupt aspects of parenting (e.g. support, reinforcement, discipline) by reducing capacity to provide care, or indirectly through the emotional distress of parents (e.g. depression;

Armistead et al., 1995). Each parent should report on their own health as part of the main interview, with an option to indicate an answer privately[13] to facilitate discretion if others are present.

Recommendations for Cohort 24 at 3 years:

- Include items on each parent's current general health, with more detailed questions regarding any long-term illnesses, conditions or disabilities, including the extent to which they limit one's day-to-day life. These could be repeated from Cohort 08 at 3.

Parents' physical measurements

A healthy weight is a key component of good general health. As mentioned above, poor health, in terms of obesity in this instance, can compromise a parent's ability to care for their child. Further, there are strong associations between parental obesity and the risk of their child being overweight or obese too (Lean, 2010). This may be informed by the fact that the child's diet and activity levels, key components of weight management, are strongly influenced/dictated by their parents at this young age.

Recommendations for Cohort 24 at 3 years:

- As at previous in-person waves of the study, having a trained interviewer take both parents' height and weight measurements with validated equipment is preferred. If a valid height measurement was captured at Wave 1 for an individual, then just a current weight measurement should suffice at Wave 2.

Child diet

Diet during early childhood is hugely important to a child's overall health and well-being. The quality and composition of diet during early childhood years has attracted increasing interest in recent years, especially in the context of rising obesity among childhood populations. There is very limited data on the food intake patterns of pre-school children in Ireland. However, numerous studies in Ireland indicate that social status is a strong determinant of diet quality, with those from less-advantaged backgrounds at increased risk of having a poor diet (Darmon & Drewnowski, 2008).

[13] Previously this was accomplished with a paper 'show card's where the answer options are shown to the respondent on a printed card and they call out 'a' or 'b' etc instead of 'high blood pressure' or 'arthritis'; however, the use of tablets could facilitate a different approach.

Differences in diet quality may partially explain the higher obesity risk among lower social class groups. Wider research has reported that dietary intake at age 3 has implications for academic attainment in later years, independent of other covariates (Feinstein et al., 2008).

Recommendations for Cohort 24 at 3 years:

- Collect information from the primary caregiver only about breastfeeding (if still ongoing at Wave 1), weaning, common foods eaten by the child, parental feeding style and the parent's assessment of the child's weight status. These topics have all been explored at past waves of the study.

Child health

Questions related to child health (here and subsequent sections) should be asked of the primary caregiver as part of the main questionnaires. In terms of topics, many national health surveys use a **general health**-related quality of life measure because they are quick to administer and have been found to be valid and reliable indicators of other objectively obtained measures of health status (Bowling, 2005). It has also been shown to have predictive validity as a longitudinal indicator of adult health outcomes.

Wave 1 captured information in respect of HSE-recommended **vaccinations** that should have been administered at two, four and six months. There are further vaccinations recommended by the HSE at 12 and 13 months; these could not have been administered in advance of Wave 1 of the study. Depending on the rate of vaccination take-up at 9 months, it may be worth asking a question on the catch-up of any missed vaccinations from Wave 1.

According to data from the Health Protection Surveillance Centre presented in the State of the Nation's Children report, vaccine uptake at 24 months ranged from 81% for MenC (meningococcal C disease) to 93% for other vaccines (p.159: DCEDIY, 2024b). A small number of parents in one of the focus groups expressed concerns about the safety of COVID vaccinations for children.

Ireland has been highlighted by the WHO as having one of the poorer vaccination uptake rates in the European Union.[14] Although the MMR vaccination is administered free of charge to children, the uptake is less than 90%, below the WHO's target coverage rate of 95 per cent. This is an important area of investigation, particularly given the rise in measles cases in Ireland and internationally and the health and infection risks associated with the disease.

Data from past waves of Growing Up in Ireland suggest that somewhere between 10% and 25% of children have **longstanding illnesses** or conditions (depending on the definition used and age of the cohort). The experience of childhood chronic illness can impose burdens on both the family unit and the child's own development. Research has found that children with a chronic illness or disability are at increased risk for poorer psychosocial, health and often, educational outcomes (Layte & McCrory, 2013). According to the State of the Nation's Children report for 2024, 10% of all children registered with a physical and/or sensory disability were under 5 years of age (DCEDIY, 2024b).

Respiratory illnesses, particularly **asthma**, are the most common illnesses of early childhood, and Ireland consistently ranks among the highest in the world in terms of asthma prevalence (World Health Organisation, 2007). Furthermore, the available evidence seems to indicate that rates of asthma have increased over time, particularly in children (Braman, 2006). Data from the 9-year wave of Growing Up in Ireland's Cohort 98 showed that 50 per cent of all those with a chronic illness (or about 6 per cent of the overall cohort) had a respiratory-related illness (Growing Up in Ireland Study Team, 2009). Early childhood could be an appropriate time to examine potential antecedents of asthma conditions that may develop over time and be picked up in future waves of the study.

Early-manifesting **sight and hearing problems**, left untreated, can seriously impact a child's development in both the short- and long-term, potentially influencing their speech, language and reading skills.

[14] Measles on the rise in the EU/EEA: considerations for public health response. Available at https://www.ecdc.europa.eu/sites/default/files/documents/measles-eu-threat-assessment-brief-february-2024.pdf

Recommendations for Cohort 24 at 3 years:

- Repeat questions from Cohort 24 at 9mths and Cohort 08 at 3yrs asking parent about the child's current general health status
- Ask the parent whether the child has any longstanding conditions or illnesses, whether they have been diagnosed by a health professional, and the extent to which it impacts their life

Healthcare utilization

Healthcare utilization has traditionally been explored in Growing Up in Ireland in terms of engagement with healthcare professionals, hospitalisations, unmet service needs, accidents and injury and antibiotic use.

According to data presented in the State of the Nation's Children report for 2024 (derived from the Hospital In-Patient Enquiry 2023 Annual Report), children aged 1-4 years accounted for 23% of childhood hospital discharges in 2023, a larger proportion than older age groupings (p.84). The same report also notes that children aged 1-4 years accounted for 21% of all childhood hospital discharges for "injury, poisoning, and certain other consequences of external causes" (p.86).

Consultations with medical professionals, **hospitalisations** and associated **unmet needs** and barriers to access, are important from a public policy and planning perspective, particularly where socioeconomic or geographic factors limit access. A delay in seeking or receiving healthcare is associated with more complications from illness. Using data from the National Treatment Purchase Fund, the State of the Nation's Children report noted that in 2023, there were 10,005 children on inpatient/day case waiting lists, and 77,682 children on outpatient waiting lists (p.163). The extent of this issue can be explored further at age 3 in terms of identifying increasing or worsening health conditions where there have been delays in seeking or obtaining healthcare for the child.

Injuries in childhood are an elevated source of public health concern, and studies tend to show a social gradient for risk of childhood injuries and their severity (Silversides et al., 2005; Hippisley-Cox et al., 2002). The State of the Nation's Children report also notes that, for all childhood age groups, 'accidental fall' was the single biggest subcategory (35%; p.86)

Preschool children consume more **antibiotic medicines** than any other age group (Wrigley, 2002). Moreover, recent research indicates that medical-card holders (30% of the population in Ireland) account for over 50% of antibiotic use, though it is unclear whether this relationship extends to children or not (McGowan et al., 2008). Moreover, a meta-analysis of eight studies found that antibiotic exposure during the first 12 months of life was associated with increased risk of developing asthma in early childhood (Penders et al., 2011).

Recommendations for Cohort 24 at 3 years:

- Collect information on the number of consultations the child has had with medical professionals in the last year, or if they were hospitalized
- Repeat questions from previous Growing Up in Ireland waves on any unmet healthcare need
- Repeat questions on injuries/accidents from Cohort 08 at 3
- Repeat the question on how often their child availed of antibiotics in the last year, as per Cohort 08 at 3

Cover for medical expenses

Children are some of the heaviest users of both primary and hospital healthcare services (Saxena et al., 1999; O'Cathain et al., 2007). Whilst GP care is now free for children up to the age of 8, the cost of other healthcare services in the Irish system means that many children who require medical attention may not receive this or may do so much later than they would have done had their parents not had to pay directly. Determining variations in childhood access to medical care is clearly a major policy issue, particularly given there is reason to suspect that a delay in seeking medical care is associated with more complications from, and consequences to illness.

Information pertaining to medical cards and private health insurance for respondents would be valuable in looking at changes in health care cover status over time, and whether these changes have any impact on health outcomes for the child or on healthcare utilization rates. This is particularly relevant given that Cohort 08 at 3 were not eligible for the universal free GP visit scheme that now applies to Cohort 24.

Recommendations for Cohort 24 at 3 years:

- Collect information on whether the child and family are covered by a medical card,[15] GP visit card and/or private medical insurance, similar to Cohort 08 at 3, to facilitate cross-cohort comparisons.

Developmental checks

Developmental checks carried out by a nurse in the home or a GP practice are an important opportunity to identify concerns and recommend a suitable intervention. Therefore, it is important to ask parents if the child has had the appropriate developmental checks carried out and, if not, why.

Recommendation for Cohort 24 at age 3 years:

- Ask a similar question to that used with Cohort 24 at 9 months but adapted for age 3 years

Developmental milestones

While children may develop at a different pace to their peers or have varying rates of progress for one skill area compared to another, delays in achieving milestones may affect their capacity to fully engage in activities such as play and education - and could indicate a more serious underlying issue. Typically, whether or not a child is at an age-appropriate level of development is considered under separate skill sets: **gross motor** (using arms and legs), **fine motor** (using hands and fingers), **speech and language**, and socio-emotional development. '**Self-care**' skills – such as being toilet-trained – also feature commonly in assessments of developmental status, especially in the context of the child spending more time outside the home, for example, starting pre-school.

Presence of an intellectual disability (ID) is one of the outcome indicators used in the State of the Nation's Children report (DCEDIY, 2024b). According to the most recent report, using data from the National Ability Support System, 5% of children registered as having an ID in 2022 were under 5 years old – equivalent to a rate of 1.5 per 1,000 based on population estimates. For all childhood cases, 'mild' or 'moderate' ID

[15] Note that medical card coverage includes the cost of the child's prescriptions, unlike the universal GP visit scheme for all under 8's which covers the cost of GP visits, but not prescritions

accounted for over half of cases but over a third were described as 'not verified' (p.89).

As questions on developmental milestones are very much tied to the age of the child, the following paragraphs discuss the measures used with Cohort 08 at 3 years:

Gross motor skills were estimated using a combination of questions to the primary caregiver and direct observation by the interviewer. The primary caregivers were asked whether the child could ride a tricycle, and a retrospective question on the age at which the child had taken their first steps. The interviewer observations involved asking the child to stand on one leg and throw a ball overhand.

Fine motor skills for Cohort 08 at 3 were estimated by (a) asking the parent a question on whether the child could play with small pieces such as Lego or a jigsaw and (b) two interviewer observations. These latter involved asking the child to copy a straight vertical line drawn by the parent and observing how they held the pencil while doing so.

Questions to the parent on development of **self-care skills** asked specifically about the continued use of nappies or 'pull-ups', and the use of a 'soother' or 'dummy'. There were no observations by the interviewer.

The parent was asked about any concerns in relation to the 3-year-old's **speech**. This was a 'tick all that apply' format and included response options such as a lisp or stammer, and 'difficulty finding words'. If the parent did have a concern, there was an additional question on whether the child had received any treatment for it.

The child's **cognitive ability** – specifically their expressive vocabulary and reasoning skills – were directly assessed by the interviewer using standardised tests from the British Abilities Scales. These are described in more detail in Chapter 6 on supplemental measures.

It would be very useful to repeat the Cohort 08 measures with Cohort 24 at 3 years to explore whether the current generation of toddlers are generally progressing at the same rate of development as their peers fifteen years previously. The items would, of course, also be useful in assessing the development of Cohort 24 cross-

sectionally – and the extent to which being 'on time' or delayed in a particular area at age 3 affects their outcomes at older ages.

There are, however, standardised measures of development that could be used for Cohort 24 at 3 years instead of repeating the individual questions and observations used with Cohort 08 at 3. The main contender in this space would be the **Ages and Stages Questionnaire**, given that a version of this measure was also used with Cohort 24 at 9 months.

Ages and Stages Questionnaire – 3rd edition (ASQ3, Squires & Bricker, 2009)

The ASQ3 is a standardised measure of development in the form of a questionnaire to parents. It covers development in the areas of communication, gross motor, fine motor, problem solving, and personal-social. The questions ask the parent if their child can perform certain specific tasks – for example, 'Does your child stack three small blocks or toys on top of each other by herself?[16]'. The primary caregiver may have already observed the child to perform some of the tasks, but other tasks could be so specific that the primary caregiver will need to do the task with the child before they can answer the question. This will have implications for the time in the home if the ASQ3 is completed with the interviewer; consideration could be given to leaving it with the parent to return by post but this is likely to result in a substantial number of missing responses.

The ASQ3 is available in an age '36 months' version which should be suitable for Cohort 24, assuming that the interviews are scheduled for the child's actual 36th month (as was the case for Cohort 08 at age 3). Two further arguments in favour of using the ASQ3 with Cohort 24 at 3 years are: (a) a version of the ASQ was used with Cohort 24 at 9 months and (b) the ASQ3 is used by public health nurses in Ireland to perform developmental checks – although clarification would be needed as to how often the 36-month version specifically is used.

[16] This is a sample item from the instrument for 16-month-olds as per the publisher's website: https://agesandstages.com/wp-content/uploads/2015/02/asq-3-16-month-sample.pdf

Recommendations for Cohort 24 at 3 years:

- Explore whether it would be feasible for the parent to complete the ASQ3 at 36 months old with the interviewer present
- If using the ASQ3, repeat any additional questions from Cohort 08 at age 3 that are not covered by the ASQ3 – such as the retrospective question on age of taking first steps
- If it is not feasible to administer the ASQ3, repeat the questions and interviewer observations as used with Cohort 08 at 3

Child measurements

Tracking children's levels of overweight and obesity is an important proxy indicator of overall health. Height and weight measurements can be used to calculate body mass index, from which levels of overweight and obesity can be derived. Weight status is also one of the indicators included in the State of the Nation's Children report for 2024: using data from the childhood obesity surveillance initiative, it reported that 20% of first-class children (age 7 approximately) were overweight or obese (p.88).

The association between obesity and both predictors of the disease, and health outcomes linked to it, can be explored, as can trends in obesity prevalence over time.

Recommendations for Cohort 24 at 3 years:

- As at previous in-person waves of the study, it would be preferable to have a trained interviewer take the child's height and weight measurements with clinically-approved equipment.

2.5 Summary of New Topics

The table below lists the new health topics that were proposed during the various consultation stages. Both those that are subsequently recommended for inclusion in the survey for Cohort 24 at age 3, and those that were considered but ultimately not recommended have been scored according to the main criteria. Topics that were raised during the consultations but are already listed under 'continuing topics' are not included here.

For ease of reading, the scores against the supporting criteria (e.g. being age appropriate) are not included; but most of the recommended new topics will have achieved maximum marks on these.

Table 2.2: Summary of new topics raised in the area of health during the consultations and review of comparable studies, scored according to the five core criteria

	Captures key domain	Policy-relevant	Age / stage appropriate	Not collected elsewhere	Strong support
Recommended new topics					
Parental eating disorder	2	2	2	2	2
Screen time while eating	2	2	2	2	2
Feeding strategies / picky eating	2	2	2	2	2
Emotion regulation via screen[17]	2	2	2	2	2
Using emergency services in lieu of GP	2	2	2	2	2
Biomarkers	2	2	0	2	2
Other topics considered but not put forward					
Sustainable diet	0	0	2	2	0
Awareness of diet RDAs, etc	0	0	2	2	0
Food insecurity	2	2	2	2	0
Food intake diary / food frequency q'aire	2	2	2	0	0
Screen time at bedtime	2	2	2	0	0
Marketing exposure via screens	2	2	2	0	0
Child screen ownership	2	2	0	0	0
Child modelling parent's screen time behaviour	2	2	2	0	0
Pre-school / creche diet (for parent q'aire)	2	0	2	2	0
Sedentary behaviour / physical activity	2	2	0	0	0
Sunscreen habits	2	2	0	2	0
Blood pressure	2	0	0	2	0
Safety practices - car seats, helmets, smoke alarms	1	2	2	2	0
Headphone usage	2	0	2	2	0
Impact of Covid-19	1	1	0	2	1
Parents' disrupted sleep	1	0	2	2	1
Prescriptions/medications	2	2	2	0	0
Vitamin supplements	2	1	1	2	0
Parents' fertility history	0	1	0	2	0
Parents' accidents and injuries	1	1	1	2	0
Parents' diet	1	1	1	1	0
Child head circumference	1	1	2	1	0
Other child measurements (chest, waist etc)	1	2	1	2	0
Skinfold thickness	2	2	1	2	0

[17] Screens as a tool for emotion regulation is included as part of a wider discussion on an expanded and updated screen-time in Chapter 3

Parental Eating Disorders

Good dietary behaviour is crucial in ensuring healthy growth and development for children. Parents influence their children's dietary behaviour through the promotion of positive eating habits and a balanced and nutritious diet. Parents' own dietary behaviour is strongly linked to that of their children, especially early in life. In particular, there is strong evidence that parental eating disorders can have a sizeable impact on a child's well-being, affecting it in a wide range of ways (Martini et al., 2020). According to the HSE's National Clinical Programme for Eating Disorders, an estimated 188,895 people in Ireland will experience an eating disorder at some point in their lives.[18]

Many studies argue for the existence of intergenerational eating disorders. One study found that children of women with eating disorders are at increased risk of developing anorexia or bulimia (Kothari et al., 2013), whilst the longitudinal *Growing Up Today Study* (GUTS) found that young girls (9-15yrs) were over twice as likely to purge at least weekly if their mother has a history of an eating disorder (Field et al., 2008).

Focussing specifically on parents with binge-eating disorders, studies suggest that such parents are significantly more likely to report binge-eating amongst their children. Through a survey provided to parents of children ages 5-15 years old, researchers noted that parents with eating disorders, regardless of weight status, were more likely than parents with no eating disorder to report child binge-eating (Lydecker & Grilo, 2017).

Parental eating disorders have also been linked with the feeding styles they employ with their children. Some studies have noted that mothers with either binge-eating disorders or bulimia are also more likely to report a restrictive feeding style for their child (Hoffman et al., 2012; Reba-Harrelson et al, 2010). Restrictive feeding styles include the strict limiting of certain types of foods as well as increased control over a child's dietary intake. The prevalence of binge-eating disorders amongst mothers also predicts increased frequency of other non-responsive feeding practices (Saltzman et al., 2016). The authors found that prevalence of binge-eating by the mother when the

[18] https://www.bodywhys.ie/media-research/statistics/

child was age 3 predicted increased use of non-responsive feeding practices two years later. Restrictive and non-responsive feeding practices are also known to be associated with increased risk of weight gain and development of unhealthy eating habits amongst pre-school and school aged children (Lindsay et al., 2017).

Further research has established links between parental eating disorders and a range of negative outcomes for children, including cognitive, neuropsychological and socio-emotional issues. Findings from the *Avon Longitudinal Study of Parents and Children (ALSPAC*; Kothari et al., 2013) showed that children of women with anorexia had decreased attention control, while children of women with bulimia had decreased visual-spatial functioning. Further research using data from ALSPAC (Micali et al., 2014) found that children of mothers who had a pre-pregnancy eating disorder were more likely to develop an emotional disorder diagnosis.

For Growing Up in Ireland, these questions should be included on the self-complete module for the primary caregiver as they are likely to be of a sensitive nature.

Recommendation for Cohort 24 at 3 years:

- Few longitudinal studies, and none in Ireland, explore the long-term effects of maternal eating disorders on child development. Including this topic in the forthcoming wave will allow researchers to explore all of the aforementioned associations.
- There are numerous multi-item scales that can be employed. However, these scales often include in excess of 20 items or a clinical interview for diagnosis. A more appropriate approach for Growing Up in Ireland could be to include a direct question about a previous or existing eating disorder diagnosis (a), and a routed question on the nature of that disorder (b):
- a) “Do you currently or have you ever had an eating disorder?” *Yes / No*
- b) “What type of eating disorder do/did you have?” *Anorexia / Bulimia / Binge Eating Disorder / Other*

Screen use while eating

Child screen-time and behaviours is an increasingly important area of research, given its wide-ranging and growing impact on child well-being and development. Excessive screen-time at 3 years of age is associated with increased sleeping problems, delayed motor function milestones and attention deficits, amongst other issues (Hale & Guan, 2015). Simultaneously, screen-time can negatively impact a child’s eating habits and

diet quality: increased TV viewing has been linked with obesity, poorer nutritional intake, and overeating (Semar & Bakshi, 2022).

One growing area of research in this field is that of screen-time while eating. Numerous international studies indicate that eating in front of a screen is a prevalent activity amongst young children; one US study noted that nearly one-third of parents who provide their 6-month-old with a screen do so during mealtime (Wiltshire et al., 2021). The figures seem to grow even starker as children get older; a recent Chilean study reported that over 80% of preschool children viewed a screen while eating a meal or snack at least once daily (Jensen et al., 2020).

Recent literature has examined the relationship between screen use while eating, increased media emotion regulation, and young children's socio-emotional development. Higher levels of parenting stress, difficulties related to child temperament, and parental reports of behavioural issues are associated with increased time spent watching screens while eating (Jusiene et al., 2019). The same study also notes that the exposure to screens during mealtime in early childhood is related to an overall increase in screen-time: amongst children aged 2 to 6 years, screen use during meals was positively related to average daily screen time, exposure to background TV, and junk food consumption (Jusiene et al., 2019).

Further studies have developed this association between screen use while eating and overall eating habits or dietary intake. Dubois et al. (2008) analysed data from the Longitudinal Study of Child Development in Quebec of children at ages 2 to 4 years: they found that eating meals while watching television predicted an increased consumption of soft drinks, carbohydrates, fats, and sugar as well as a decrease in fruit and vegetable consumption. Findings from a study conducted by Liang et al. (2009) in Canada were similar: meals eaten in front of the television involved a higher percentage energy intake from sugar, carbohydrates, fat, and snack food than meals eaten away from the screen.

In Ireland, the HSE recommends that televisions are turned off and phones kept away when feeding children under the age of 4.[19]

[19] https://www2.hse.ie/babies-children/weaning-eating/nutrition-child/healthy-eating/

Recommendation for Cohort 24 at 3 years:

- Whilst general screen-time behaviour is a well-established topic (13 of the comparable studies reviewed in chapter 1 included questions on screen time), only two studies, *Growing Up in New Zealand* and *Growing Up in Quebec*, asked a question specifically related to the use of screens and media exposure while eating. The topic could be addressed in Growing Up in Ireland with the addition of a single question, similar to that used in Growing Up in Quebec, *In general, how often does your child watch TV shows, videos or movies during meals (not including snacks)?* as part of the primary caregiver main questionnaire.

Feeding strategies for picky eaters

A decrease in appetite between 2 and 6 years of age is recognised as a normal feature of child development that many children experience (Tharner et al., 2014). As a result, picky eating is a common concern for parents of young children. Food preferences can vary on a weekly, if not daily, basis. There is evidence that children need to try novel or new foods many times before accepting them as part of their normal diet. Whilst the phenomenon of picky or fussy eating tends to resolve (or begin resolving) itself by the time children are of school-going age, for parents of 3-year-olds, it is a very real, persistent and difficult issue to navigate.

This sentiment was certainly echoed during the consultation phase for the forthcoming wave of data collection with Cohort 24 at age three. During the parents' focus groups, picky eating was identified as one of the most frequently flagged concerns. Parents spoke about having to 'fool' their children into eating healthier and more diverse foods, and how they were often tempted to revert to serving their child less healthy (junk) food, in the hope that it would be better received by the child.

There exists a variety of measures to gauge picky eating behaviour amongst children (Brown & Perrin, 2020). These include the 6-item food fussiness subscale (of the Child Eating Behaviour Questionnaire), three items from the Child Feeding Questionnaire, the 8-item Stanford Feeding Questionnaire, the 3-item Eating Behaviour Questionnaire, the Oregon Research Institute Child Eating Behavior Inventory, the 6-item Child Food Neophobia Scale and the 10-item Picky Eating Questionnaire. Whilst these tools vary in terms of length and detail, there is substantial overlap in terms of the core questions asked.

Recommendation for Cohort 24 at 3 years:

- Review the above listed measures and select a set of questions that gather information pertaining to the following; whether the parent considers their child to be a picky/fussy eater, if the child is resistant to the introduction of new foods into their diet, and if their diet is varied.
- The selected items could be included with the primary caregiver main questionnaire, possibly with a 'show card' option in case the child is present.

Use of emergency health care in lieu of GP service

As noted in the overview of themes emerging from the consultations with parent of 3-year-olds, several focus group participants expressed frustration at being unable to get timely appointments with their GP. While the issue of unmet need due to the inability to get an appointment should be covered by continuing questions, some parents in the consultation were resorting to emergency care in lieu of a routine GP appointment. Such emergency options included out-of-hours GP care, emergency departments and clinics run by private health insurance companies.

This is a potentially important policy and practice issue, especially in light of the investment in free GP visits for children under 8 years. It could also mean additional pressure on emergency health services from issues that should have been dealt with by a routine GP appointment. It would, therefore, be useful to at least pilot a new question on this specific topic for Cohort 24 at 3 years to get a better idea of how widespread the practice is.

Recommendation for Cohort 24 at 3 years:

- Include an additional question for the primary caregiver in the main questionnaire, in the section with other healthcare utilisation items, to the effect of, "how many times in the past year have you used an emergency health care service, such as an out-of-hours GP service, because you were unable to get a regular GP appointment for <child>?"

Biomarkers

There have been repeated calls for the collection of advanced biomarkers at the last three rounds of expert consultations. Broadly, biomarkers refer to a wide range of 'biological markers', that is, objective and measurable indicators of medical state in a person (Strimbu & Tavel, 2010). This can include simple measures already conducted

as part of the Growing Up in Ireland study (i.e. height, weight) but it also includes biological measurements that are derived from more clinical tests, such as hair, saliva or blood sampling. From these, molecular, cellular and even genetic information about an individual can be explored. Understanding the relationship between biomarkers and health outcomes is an important area of research to further our understanding of both normal, healthy physiology and the aetiology of disease. From the perspective of longitudinal research studies, biomarkers can assist in understanding the interaction between genetic and social/environmental factors as predictors of health behaviour and development throughout the life course. A distinct benefit of incorporating biomarker testing in a longitudinal panel study is the unique opportunity to combine genetic data with the wide range of socio-demographic information that will have already been collected in such a study.

At the most recent physical health expert consultation, there was collective agreement amongst academics working in this field that Growing Up in Ireland should consider collecting a wider suite of biomarkers, a practice that is increasingly common in other cohort studies. It was noted that Growing Up in Ireland may be behind the curve in terms of biomarker collection when compared with similar studies in other countries.

Comparable studies

Looking at biomarker collection in comparable studies, biological samples were collected by many other studies. *ALSPAC* included a clinical session where measurements were completed and blood was collected (replaced for saliva in the participant refused blood). During a health examination completed as part of the German *Study on the Health of Children and Adolescents (KiGGS)*, blood and urine samples were provided. The *KiGGS* examination also included the collection of the aforementioned physical measurements and resting blood pressure/ heart rate. *The Origins Project* similarly involved a clinical check-in appointment where an allergy test was completed and blood, buccal cells, dust, saliva, stools, and urine collected. Lastly, urine, hair, and stools as well as various environmental samples during the home visit were collected as part of the *ELFE* study. Environmental samples included dust which was taken by the interviewer from the vacuum cleaner or using a cloth and wiping home surfaces.

The 1958 National Child Development Study has collected blood and saliva samples. The 1970 British Cohort Study has also collected blood samples, while the most comparable study to Growing Up in Ireland, the Millennium Cohort Study (MCS), has collected saliva samples from participants. Saliva sampling was chosen as it allowed for genotyping, was considered a minimally invasive approach and could be collected by trained interviewers (forgoing the need for nurses/phlebotomists) in the participants' homes.

In Ireland, The Irish Longitudinal Study on Ageing (TILDA) has gathered biomarker data from study participants, collecting blood samples from almost 6,000 participants. Initial analysis has been conducted (for lipid profiles), while samples have been stored for future genetic and biomarker studies into healthy ageing.

Recommendation for Cohort 24 at 3 years:

- It is recommended that consideration be given to biomarker collection for subsequent waves of data collection for all Growing Up in Ireland cohorts, with a consultation process initiated on what should be collected.
- It is acknowledged that there would be considerable hurdles associated with collecting biomarker data (in terms of cost, expertise/training required and storage/analysis protocols) but it should be noted that there are examples of other longitudinal panel studies successfully collecting biomarker data in Ireland (TILDA).
- While the timeline to set up this complex function might be considered too tight for Cohort 24 at age 3, starting an exploration of requirements and logistics now could put the study in a position to roll this out at the following wave (age 5 years).
- Analysis of such samples could allow researchers to investigate genetic predictors of health outcomes, as well as the interaction between genetic and environmental factors.

Chapter 3: Early Learning and Care

3.1 Policy Context Overview

Many Government policies, schemes and initiatives have been developed in recent years to improve the quality, availability and affordability of early learning and care (ELC) facilities for children in Ireland. The *First 5* early years strategy specifically aims to *"further improve affordability, accessibility, and quality (in early learning and care)"* (DCYA, 2019, p. 11). Specific measures developed to achieve these aims include the introduction of the Affordable Childcare Scheme, moving progressively towards a graduate-led professional ELC workforce, the extension of regulations and supports to all paid childminders and school-age childcare services, and the introduction of a new funding model for ELC.

The *universal pre-school programme* provides children with 15 hours per week of pre-school education over a 38-week programme year. Since September 2018 children qualify for two years of universal pre-school. In 2019, the *National Childcare Scheme* (NCS) was delivered to provide financial support to help families with their early learning and childcare costs, including both a universal subsidy, and an income-assessed subsidy for families needing additional help. It consists of both a universal subsidy that provides €2.14 per hour for a maximum of 45 hours per week as well as an income-assessed subsidy that is means tested on an individual family basis (NCS).[20]

More recently, *Together for Better*, the new funding model for ELC was introduced, this includes the *ECCE* programme, the Access and Inclusion Model, the NCS and a new Core Funding Scheme. A fourth element of this funding model, the *Equal Participation Model* (EPM), is under development. In 2023, State investment in early learning and childcare exceeded €1 billion, achieving the 2028 investment target in First 5 well ahead of schedule.

The universal and targeted *Community Childhood Subvention* (CCS) Schemes provide weekly subsidies to offset fees charged by ELC settings. CCS is available to families who hold a Medical Card or are in receipt of social welfare benefits. Other schemes

[20] https://www.ncs.gov.ie/en/

include the *Access and Inclusion Model* (AIM), which supports ELC providers to deliver an inclusive preschool experience, ensuring that children with a disability can fully participate in the universal pre-school programme, and the *Training and Employment Childcare Schemes*, which provide a weekly subsidy to offset fees charged by ELC (and school-age childcare) settings for parents on approved education or training courses, Community Employment schemes, or those returning to work who need school-age childcare.

Nurturing Skills: The Workforce Plan for Early Learning and Care and School-Age Childcare 2022-2028[21] sets out a series of actions to meet targets in respect of ELC workforce set out in First 5, focussing on employee recruitment, supply, recruitment and retention. Turnover is high in this sector, average wages are relatively poor and seasonal and part-time contracts are common, making ELC employment an unattractive option for many (ibid).

A new *Workforce Development Plan* aims to develop a graduate-led ELC workforce, in line with a recommendations that all staff will have career development opportunities. Through this plan, there will also be a concerted effort to raise the status of and value placed on the ELC workforce, with a particular focus on supporting employers to provide more favourable working conditions that will attract and retain staff. As part of the *Child Care (Amendment) Act 2024*, all childminders will be required to register with TUSLA by 2027, with a view to safeguarding children and provide assurances to parents of the quality of their childminding arrangements. Further, childminders will only be allowed to look after a maximum of six children at a time (and only two under 15 months).

3.2 Findings from Growing Up in Ireland Cohort 08 at age 3 years[22]

Some key findings from Cohort 08 at age 3 years (Williams et al., 2013) regarding early learning and care are listed below:

[21] Available at https://www.gov.ie/en/publication/97056-nurturing-skills-the-workforce-plan-for-early-learning-and-care-elc-and-school-age-childcare-sac-2022-2028/

[22] Subsequent references to 'Cohort 08 at 3' relate to the Growing Up in Ireland study unless otherwise specified

- For Cohort 08 in 2011, half of all 3-year-olds were in some form of non-parental childcare. Just over a quarter of children (27%) were cared for in a crèche, Montessori, pre-school or naoínra (an Irish-language playgroup for pre-school children), 11% were cared for by a relative in a home-based setting and 12% were cared for by a non-relative in a home-based setting.
- Parents who were working, those with higher educational qualifications, and from more advantaged social class backgrounds were more likely to be availing of non-parental childcare for their 3-year-old.
- Looking at trends from age 9 months to 3 years for Cohort 08, the proportion of children in non-parental childcare increased from 39% to 50%. Most of the change could be accounted for by those who transitioned from parental care (at 9 months) to centre-based care; just under a third of children were cared for in centre-based care at age 3, almost three times the proportion at nine months.
- Three-year-olds spent an average of 23 hours per week in childcare across all main types of non-parental childcare. Children cared for by non-relative childminders spent the most time on average in childcare, and the greatest cost for childcare provision was incurred for these types of childcare providers. More than 60% of relatives who provided care did not receive any financial remuneration.
- The average hourly expenditure on childcare was €4.50 per hour, but this varied across type of childcare, being highest for those using non-relative care in the parental home (e.g. au-pair, childminder), at €5.70 per hour, and lowest for those who had a relative care for the child in the relative's home, at €3.65 per hour (discounting those who did not have to pay a relative for childcare).
- There were high levels of parental satisfaction with the quality of childcare provided; more than 90% of parents endorsed positive statements about environmental characteristics (e.g. availability of toys, books, etc) and programme characteristics (e.g. learning objectives).
- In terms of gross motor development, the mean age for a child taking their first step was 13 months, but considerable variation was reported. Children who played physically active games more often with someone at home tended to have better gross motor skills (pedalling a tricycle, throwing a ball overhand, etc.).
- Most children were able to use a pencil and play with small objects such as jigsaw pieces. Having someone at home to engage the child in activities that required fine motor skills such as painting and drawing appeared to foster these abilities.

3.3 Topics from Comparable Studies

A review of the instrumentation used by comparable international studies indicates a high degree of consistency between those studies (see chapter 1) and Growing Up in

Ireland for Cohort 08 at age 3. The review also identified topics that were a) explored in Growing Up in Ireland but not in many comparable studies and b) explored in comparable studies but not previously in Growing Up in Ireland.

Almost all studies asked about specific childcare arrangements. A large proportion of studies, including Growing Up in Ireland, included items about the parents' role in fostering learning at home, as well as including some form of cognitive ability measure. Less common topics included the number of (children's) books in the home, quality of the childcare environment, and primary school registration.

Topics within the domain of early learning and childcare explored in other studies but not in Growing Up in Ireland included the education model of the childcare setting. Other studies also had more detailed information on screen time (specifically passive screen time, screen content, screen time while eating and screen time before bed) than featured in Growing Up in Ireland's Cohort 08 at 3.

3.4 Summary of Continuing Topics

The table below lists the continuing topics relating to early learning and care that are recommended for continuation for Cohort 24 at 3 years. Their scoring against the five core criteria is also provided. Note that subtopics which were included in both Cohort 24 at 9 months and Cohort 08 at 3 years – even if not the same actual questions – are weighted as '2' under the heading of 'longitudinal/cross-cohort consistency'. If a topic appeared in just one of the source questionnaires – that is, offering either a longitudinal or a cross-cohort comparison but not both – it is scored as '1'. In a small number of cases, if the topic featured in both waves but the measurement was very different then a score of 1 on the consistency criterion was recorded.

For ease of reading, the scores against the supporting criteria (e.g. being age appropriate) are not included; but most topics will have achieved maximum marks on these.

Table 3.1: Summary of proposed continuing topics in the area of early learning and care, including presence at previous waves of GUI and scoring on core criteria for inclusion

Topic	Subtopic	C'24 at 9mths	C'08 at 3yrs	Captures key domain	Policy-relevant	Age/stage appropriate	Not collected elsewhere	Longitudinal/cross-cohort consistency
Parenting	Parental beliefs	Yes	No	2	2	2	2	1
	Responsibility for parenting tasks	Yes	No	2	2	2	2	1
Play	Access to outdoor space	Yes	Yes	2	2	2	2	2
	Details on type of play/home learning	Yes	Yes	2	2	2	2	2
	Child screen-time	Yes	Yes	2	2	2	1	2
	Availability of toys	Yes	No	2	2	2	2	1
	Availability of books	Yes	Yes	2	2	2	2	2
Childcare	Use of any childcare	Yes	Yes	2	2	2	1	2
	Details on type of childcare	Yes	Yes	2	2	2	1	2
	Details on amount of childcare	Yes	Yes	2	2	2	1	2
	Detail on cost of childcare	Yes	Yes	2	2	2	1	2
	Characteristics of centre-based care setting	Yes	Yes	2	2	2	2	2
	Childminder characteristics	Yes	No	2	2	2	2	1
	Permission to contact childcare provider	Yes	Yes	2	2	2	2	2
	Reason for choosing type of care	Yes	No	2	2	2	2	1
	Difficulties securing childcare	Yes	No	2	2	2	2	1
	Funding of childcare	Yes	No	2	2	2	2	1
	Satisfaction with current childcare	Yes	Yes	2	2	2	2	2
	Reason for not using childcare	Yes	No	2	2	2	2	1
	Future plans for childcare if not using	Yes	No	2	2	2	2	1
Early education plans	Intention to avail of free pre-school years	No	Yes	2	2	2	2	1

Parenting

The 3-year-old child will still be very much dependent on their parent(s) to meet their basic needs and to guide them as they develop and interact more with the world. Both parents in Cohort 24 at 9 months were asked to rank the three aspects of parenting that they thought were most important from a list that included behaviours such as 'showing my child love and affection' and 'taking care of my child financially'. This question on **parenting beliefs** had been used intermittently with earlier waves of Growing Up in Ireland but repeating it at age 3 would provide longitudinal rather than cross-cohort comparisons. It is recommended that the data resulting from this question with Cohort 24 at 9 months be assessed for variability and usefulness before reaching a final decision on including it again at age 3.

Cohort 24 at 9 months also included a new question on whether **interactions with the child** – such as feeding and playing – should be led by the parent or the child (or somewhere in between). Again, an analysis of responses to this question at 9 months would be helpful to inform whether it would be worth repeating it at age 3 years. Potentially, it could be interesting to see if the parent's attitudes towards structuring interactions with the child change between infancy and toddlerhood. Input from the parents who took part in focus groups to inform the survey made frequent references to how their 3-year-olds expressed stronger preferences for food and activities, compared to their younger selves. And sometimes not getting their preferences resulted in tantrums and other kinds of behaviour that parents found stressful or disruptive.

A question on who took **responsibility for specific parenting tasks** was included with Cohort 24 at 9 months. The tasks included bathing, feeding, playing, and taking the infant to appointments or childcare. The answer options for each task included variations 'you', 'your spouse/partner', 'someone else' or 'no one does this'. If repeated at age 3, some items such as 'changing his/her nappy' would need to re-worded or omitted but most of the parenting tasks in the list still apply to toddlers. Some of the parents in the focus group referred to the challenge of balancing all the tasks associated with parenting with their work commitments, and other household chores. For some families, support was received by extended family for jobs such as

bringing the child to appointments. Therefore, it is likely that repeating a similar list at age 3 could show how evenly distributed parenting tasks are divided between parents in two-parent household, or how much support lone parents get from another person. However, an analysis of the data collected from Cohort 24 at 9 months would be useful in reaching a final decision.

In general, there is merit on getting the perspective of both parents for the above topics but some could be limited to just the primary caregiver main questionnaire if needed.

Recommendations for Cohort 24 at 3 years

- Repeat question on beliefs about structuring interactions with the child, as used with Cohort 24 at 9 months
- Explore data collected with the question on beliefs about most important roles for a parent, from parents in Cohort 24 at 9 months, to inform a decision on repeating them at age 3
- Repeat a version of the question on who takes responsibility for specific parenting tasks, as used with Cohort 24 at 9 months, to be informed by an analysis of responses in that wave

Play and learning

Play is the primary mechanism through which young children learn about the world. Increasingly early education in Ireland has been moving towards a play-based pedagogy;[23] however, much of the child's early play will take place within the home environment. In the consultations with expert stakeholders, **'risky play'** was identified as an emerging area that is understudied – and is discussed separately as a new subtopic later in this chapter. The more conventional aspects of play, which have previously featured in Growing Up in Ireland surveys, are discussed in the following paragraphs.

In the parent consultations, there were multiple references to how much 3-year-olds enjoyed **playing outside**. For both Cohort 24 at 9 months and Cohort 08 at 3 years, there is a question on whether the household has access to an outdoor space. However, given the parent reflections, it would be useful to expand this item with

[23] https://www.aistearsiolta.ie/en/play/

one or two follow-up questions on how often they use the outdoor space – and, if not frequently used, why not.

The 'parent play' questionnaire as used with Cohort 24 at 9 months is only suitable up to age 2.5 years (Ahmadzadeh et al., 2020) and so is unlikely to be suitable to repeat at age 3. The questions used with Cohort 08 at age 3 were more oriented towards **home-learning**: how often someone at home did activities such as painting, singing, and reading with the child. These items could usefully be repeated with Cohort 24 at 3 with the added benefit of cross-cohort comparison potential.

This still leaves something of a gap in understanding of how the child engages in **free play**. There was a single question for Cohort 08 at 3 on whether the child typically preferred active pastimes (e.g. kicking a ball), inactive play with toys or both kinds of play; however, a more detailed set of items on types of play would be more useful – to include pretend play, play with toys, dancing, sport etc.

In the consultation with parents, there were several mentions of the 3-year-old starting to engage in **organised activities**, such as sport. There was also reference to how much these activities cost. Therefore, it is recommended that the survey for Cohort 24 at 3 pilot some questions on participation in organised activities, similar to those used with previous cohorts at older ages. The pilot could then inform a decision on whether to include this subtopic in the main data collection.

There was a three-part item on the Cohort 24 at 9 months survey about the number of (a) soft toys/dolls, (b) activity toys and (c) books available to the infant. In relation to books, it would be preferable for age 3 to switch to the question wording used with Cohort 08 at 3 and most other Growing Up in Ireland waves. This question referred to how many **children's books** the child had access to in the home, including library books. The answer options were bundled into categories of 'none', 'less than 10' etc. As to whether it would be useful to continue the items on the specific number of soft toys and activity toys in the home from Cohort 24 at 9 months, this would require an analysis of the responses from that survey. It may be that the specific **number of toys** is less important than having at least some, and it may turn out that there are very few (or even no) households where toys of either type are completely absent by the time the child is aged 3.

It should be sufficient to record the details on play and home-learning activities from the primary caregiver, although it could be interesting to include one or two items for the other resident parent along the lines of how, and how often, they play with the 3-year-old.

Cohort 08 at 3 included three items on **screen-time**, specifically watching television. As the digital context has expanded exponentially since 2011, the topic of screen-time is dealt with as a new topic later in this chapter.

Recommendations for Cohort 24 at 3 years

- Repeat the question on access to outdoor space, from Cohort 24 at 9 months and Cohort 08 at 3, and extend it to ask about frequency of use or reasons for not using it
- Repeat parent-reported items on home-learning activities as used with Cohort 08 at 3
- Add the single item on number of children's books in the home, also used with Cohort 08 at 3
- Add new item(s) to capture more detail on what play activities the 3-year-old prefers when engaging in free play (to replace the somewhat limited question used with Cohort 08 at 3)
- Explore the data on number of soft toys and activity toys from Cohort 24 at 9 months to inform a decision on their likely usefulness at age 3; it may be that an alternative item on the child's free play preferences – as noted above – may be more useful
- Expand sections on risky play and screen-time, as discussed under 'new topics' later in this chapter

Childcare

Finding a suitable childcare arrangement is a key consideration for many parents, particularly for those with young children. Increases in female participation in the labour market have meant that an increasing number of children are availing of non-parental care during the day. According to data gathered through the EU-SILC survey and presented in the State of the Nation's Children report, in 2023 22% of children under 3 years were in formal childcare or education, compared to 94% for children aged between 3 years and the minimum school starting age (p.64).

The Irish Government currently delivers the Early Childhood Care and Education Programme (ECCE), which affords all children in Ireland two-years of free preschool

(up to three hours per weekday). It is available to children who have turned 2 years and 8 months and is available until they start primary school (for a maximum of two years). Uptake levels exceed 90%, meaning that at the time of the forthcoming wave of data collection, many respondents will be availing of ECCE, and will have a study child in a participating childcare service.

There has been much debate about the likely short- and longer-term implications of the **use of different types of childcare** in terms of their effect on children's outcomes. Research suggests that the details of early childcare, including **type, timing and duration**, can have a significant impact on a range of aspects of the child's development. Whilst some longitudinal studies indicate long-term benefits of quality early childcare on cognitive development for school-aged children (Loeb et al, 2007), particularly those from at-risk backgrounds (Peisner-Feinberg et al, 2001), other studies have reported associations between early entrance to group-care and subsequent behavioural problems (Sylva et al, 2004; Loeb et al. 2007). The **characteristics of the childcare setting and the childminders** themselves may also be helpful in this regard.

There is strong evidence of shortages in suitable childcare services for parents, in both urban and rural parts of the country; the latest Pobal Annual Early Years Sector Profile survey revealed that there were more than 30,000 children aged 0-3yrs on creche waiting lists. [24] Through Growing Up in Ireland there is an opportunity to gather objective information on respondents' experiences of **difficulties securing childcare** to quantify the extent of the issue across the country. This information could also explore if difficulty in arranging childcare had ever prevented the respondent from doing certain things, such as looking for a job or engaging in social activities. This could provide useful information on which to build childcare policies. Note, previous questions on this topic were adapted from the Quarterly National Household Survey 2002 Childcare Module.

Satisfaction with childcare arrangements feeds into broader considerations around parents' work-life balance and time available for family and children. These questions

[24] https://www.earlychildhoodireland.ie/press-release-january-2025/

also give an insight into the convenience or otherwise of the chosen childcare arrangement.

It should be sufficient for just the primary caregiver to answer questions about childcare.

Recommendations for Cohort 24 at age 3:

- Collect detailed information on current childcare arrangements as described above. Questions should focus on the intention to avail of one or two years of ECCE, and separately if any other form of childcare is being used to supplement that. Questions on this topic previously featured in Cohort 08 at age 3 and Cohort 24 at 9 months for reference.
- Include questions to the parent on the childcare setting itself, the cost of the service, the characteristics of the providers and, where applicable, of the childminder(s). These could be particularly important if there is low engagement with the direct survey of childcare providers (see Chapter 6).
- Include further questions outlining the parents' experience of securing childcare; the reason they chose their current childcare arrangement, difficulties securing childcare, and their satisfaction with their current childcare.
- For parents of children not currently availing of childcare, it would be useful to ask them why they are not currently doing so and if they have any future plans to avail of childcare.
- To facilitate an associated survey of childcare providers, it will be necessary to get the parents for permission to contact their childcare provider, and associated details.

3.5 Summary of New Topics

The table below lists the new early learning and care topics that were proposed during the various consultation stages. Both those that are subsequently recommended for inclusion in the survey for Cohort 24 at age 3, and those that were considered but ultimately not recommended have been scored according to the main criteria. Topics that were raised during the consultations but are already listed under 'continuing topics' are not included here.

For ease of reading, the scores against the supporting criteria (e.g. being age appropriate) are not included; but most of the recommended new topics will have achieved maximum marks on these.

Table 3.2: Summary of new topics raised in the area of early learning and care during the consultations and review of comparable studies, scored according to the five core criteria

Topic	Captures key domain	Policy-relevant	Age / stage appropriate	Not collected elsewhere	Strong support for
Recommended new topics					
Risky / outdoor play	2	2	2	2	2
Screen-time (extended and updated)	2	2	2	1	2
Participation in organised activities	2	2	2	2	1
Communication / feedback from childcare provider	2	2	2	2	2
Other topics considered but not put forward					
Digital disadvantage	2	2	2	0	0
Tech / digital games used	0	0	0	0	0
ELC educational model impact	2	2	2	0	0
Sustainability	0	2	0	2	0
Disability - staff recruitment issues	2	2	2	0	0
Language exposure, languages spoken, Irish	2	2	2	0	0
Play, broader context - indoor/outdoor, (in)formal	2	2	2	0	0
Play as it affects language	2	0	2	0	0
Impact of early years programs	2	2	2	0	0
Diary - who child spends time/day with	2	2	2	0	0
Language acquisition - social inequalities therein	2	2	2	0	0
Socialisation supports (outside ELC)	2	2	2	0	0
Challenging behaviour (home/ELC)	2	2	2	0	0
Preparedness for school transition	2	2	0	0	0
Interviewer observation of ELC setting	2	2	2	0	0
Teaching safety to children	1	2	2	2	0
Self-care for parents	1	1	2	2	1
Specialised skills (e.g. chess)	1	1	2	2	0
Use of a comfort object	1	0	2	2	0
Listening to music	2	1	1	2	0
Cleanliness in the home	1	1	2	2	0

Risky and outdoor play

Play is essential to positive physical, mental and social well-being for children (Brussoni et al., 2012). In recent decades, social trends around play have increasingly prioritized the supervision and protection of children; this has seen unscheduled free play outdoors steadily giving way to planned, structured activities (Yogman et al., 2018). As a result, children tend to spend more of their recreational time indoors, often on screens, than playing outside with minimal supervision. A more recent shift in thinking, in response to this trend, has suggested children's play should be "as safe as necessary", not "as safe as possible" (Tremblay et al., 2015), giving rise to the concept of 'risky play'.

Risky play is defined as a physical, expressive and exciting activity that provides opportunities for children to learn about challenge, test limits, explore boundaries and learn about risk of possible injury.[25] Risky play can be broadly grouped into six categories: rough and tumble play, disappearing / getting lost, playing at height, playing at speed, playing with tools and playing with natural elements (such as water and fire). Given the nature of risky play, it is most often associated with outdoor activities; the natural world provides rich opportunities for children to engage in risky play.

Engaging in these categories of risky play has many perceived benefits for children – increased decision-making skills, a sense of achievement, and the ability to assess risk, problem-solve, and both cope with and overcome challenges (Beaulieu & Beno, 2024. Without exposure to risky play children can potentially develop fearful or reckless dispositions and may have limited ability/opportunity to develop skills associated with risk-assessment and problem-solving (Sandseter & Kennair, 2011). As a result, the development of these skills associated with risky play is central to positive socio-emotional and physical well-being.

There was consensus amongst consultation experts that information relating to risky play should be gathered at the forthcoming wave of data collection for Cohort 24 at age 3. Researchers suggested information should be gathered about the following:

[25] https://www.aistearsiolta.ie/en/play/resources-for-sharing/risky-play-birth-six-years-.pdf

- Regularity of engagement on risky play
- Where it takes place, and who starts it?
- Whether it's organised and unorganised?
- How early learning centres feel about risky play; is it encouraged or frowned upon?

Recommendation for Cohort 24 at age 3:

- Ask the primary caregiver, how often does <child> engage in risky play (this includes rough and tumble play, disappearing / getting lost, playing at height, playing at speed, playing with tools, and playing with natural elements such as water)?

Communication with childcare provider

During the consultation with experts and policy-makers in the field of early learning and care, the issue of the relationship, and communication, between childcare providers and parents was raised as an important area of exploration. Childcare providers can spend up to ten hours of the day caring for a child. As a result, they have the capacity to act as an excellent source of information and advice on parenting and child development (Reid et al., 2016). Communication between parents and childcare providers, particularly informal communication at transition time (when child is arriving at or leaving childcare) is key to building trust and increasing satisfaction on the part of the parent (Hummel et al., 2022).

Recommendation for Cohort 24 at age 3:

- The existing questions on childcare (Cohort 08 at 3yrs, Parent Main, G7A-F) should be expanded to include two questions on communication between parents and childcare providers (items G and H, below). Where the child avails of more than one form of childcare (i.e. childcare centre and childminder), the parent should be asked in respect of both providers.
- *G7. [Card G7] The next questions are about the place where is cared for. Please read each statement and indicate how characteristic each statement is of the MAIN place where is cared for.*
- *a. There are plenty of toys, books, pictures and music for my child*
- *b. My caregiver knows a lot about children and their needs*
- *c. My child is happy in this arrangement*
- *d. The place where my child is cared for is kept*
- *e. My child spends time learning letters and numbers*

- *f. There are different play activities, e.g. water based, sand based, outdoor play, construction, painting etc. available to <child>*
- ***g. My caregiver gives me regular feedback on my child's development***
- ***h. My caregiver asks for and listens to my input about my child's well-being***

Screen-time[26]

The digital context and the amount of time spent on screens, for both adults and children, has been one of the areas with the most change since Growing Up in Ireland started in 2006. Therefore, although screen-time questions have previously featured on Growing Up in Ireland surveys, it is discussed in detail here as a 'new topic' given the amount of addition and revision that is being recommended.

As well as traditional screen-time activities of watching television and playing computer games, a young child's screen-time may now also include video calling with family members – a practice that was accelerated during the pandemic lockdowns. A child may also have a presence on social media, possibly with an account in their name, via their parents' sharing of images, video and other information about them online. The number and type of devices that offer opportunities for screen-time in and outside the home has expanded over time: smartphones and tablets have joined more traditional television and computer screens. There is also a large amount of content available 'on demand', including self-published videos (e.g. on youtube)[27] that are arguably not held to the same standards for accuracy and appropriate content as traditional, commercially-produced material.

The current guidelines are no more than one hour of screen-time per day for children aged between 2 and 5 years (Health Service Executive – HSE, Ireland).[28] The HSE guidelines further recommend that parents should watch or play content with young children, not to allow devices in the child's bedroom, and not to use screen-time to soothe a distressed child. This last point has been discussed at some length in the recent academic literature: a longitudinal study conducted by Radesky et al. (2022) determined that frequent reliance on digital media as a method to calm down

[26] While there were some topics relating to screen-time for Cohort 08 at 3 years, the revisions proposed are so extensive that it has been written up as a 'new' rather than 'continuing' topic

[27] Although parents who took part in consultations in preparation of this report, appeared to favour a more-moderated version of youtube called 'youtube kids'

[28] https://www2.hse.ie/babies-children/play/screen-time/

toddlers may result in decreased ability for the child to gain crucial self-regulation skills and higher emotional reactivity in later childhood. In another study, families with children between 3 and 4 years of age who employed the use of technology to calm their child were more likely to indicate yes on questions such as “when my child has had a bad day, screen media seems to be the only thing that helps him/ her feels better” and “the amount of time my child wants to use screen media keeps increasing” (Coyne et al., 2021).

Research on the impact of screen-time on the sleep and executive functioning of pre-school children has been taking place in the Irish context (Michelle Downes, UCD, personal communication). There are a number of potential pathways for screen-time to negatively impact on these aspects of development including exposure to ‘blue light’, stimulating rather than soothing content before bed, and the ‘on demand’ nature of streamed content. Compared to older children and adults, at the moment, little is known about the actual mechanisms and/or effect of screen-time on younger children. Some suggestions for questions on screen-time were sought from the UCD research team and one of these, the ‘seven in seven screen exposure’ instrument is suggested for Cohort 24 at age 3 (see below).

Capturing detailed information on the screen-time content viewed by 3-year-olds is not within the scope of a survey such as Growing Up in Ireland. It should, however, be possible to ask about specific activities – watching television, playing games, video-calling – as well as estimates of time spent on screens, and the extent to which parents moderate or supervise the child’s access to screen-based content. A recent (2024) event discussing generative AI in relation to children (attended by one of the authors) posited the question what, if any, impact a child’s engagement with human-like AI devices might have on their development. With a view to future-proofing the study for 2027 (and beyond), it may be useful to include some items on whether the household owns an ‘Alexa’ type AI device and, if it does, whether the 3-year-old engages with it.

Separately, a question on whether screen-time is used as a soothing aid could be included to further explore the themes emerging in the literature, such as whether this parenting practice is associated with later unhealthy screen-time use. Parents

who took part in the focus groups as part of the consultation process made several references to using ipads and similar devices to distract the child while they did something else. In consultations with the expert stakeholders, there were specific requests to extend the questions on this topic to include the child's early interactions with social media but this did not come up in the parent focus groups. There were further suggestions to explore the issue of screen time while eating (recommended as a new topic in the health domain, see section 2.5), screen time at bedtime, marketing exposure via screens, and the mirroring of parental screen time behaviour.

Previous screen-time questions in Growing Up in Ireland

In terms of cross-cohort comparisons with Cohort 08 at age 3, it is likely that exact comparisons over time will need to be given up in favour of capturing the current context more accurately. There were three questions asked at that phase: amount of time the child spent watching television, rules about content; and if there was a television, computer or console in the child's bedroom.

The questionnaire for Cohort 24 at 9 months had a stand-alone question on the amount of time per day the infant spent watching screens (including phones and tablets). This was in conjunction with a 'screen-time' subscale of the Parent Play Questionnaire that had additional questions about whom the infant watched screen-based content with. However, a 3-year-old child will be able to engage much more interactively with digital material and so there may be limited usefulness in this subscale going forward.

Cohort 24 at 9 months also included questions to parents about their own use of screen-time for leisure. These would be useful to continue at age 3, given the potential for parental use of screens to disrupt interactions with the child, contribute to passive-viewing of adult-oriented content by the child, and the possibility for excessive screen-time to be 'modelled' as a behaviour (e.g. Canadian Pediatric Society, 2017; Hoyos Cillero & Jago, 2010). To consider these implications, an additional question as to what proportion of the parent's overall leisure screen-time occurs in the presence of the child would be required.

Seven-in-seven screen exposure questionnaire (Yalçin et al. 2021)

This short scale comprises seven questions about children's screen-time to capture: daily screen time, viewing with parent(s), setting screen limits, screen exposure during meals and in the hour before bedtime, age of onset of screen exposure, and viewing low-quality content. The scale generates a total problematic screen exposure score (range 0–13) that can be categorised as 'low' or 'high'. In an evaluation of the measure (ibid) using 1,245 mother-child pairs, with children having an average age of 3.9 years, 22.5% of children were categorised as having 'high' levels of problematic screen-time exposure.

Recommendations for Cohort 24 at 3 years

- Some consistency with Cohort 08 at 3 could be achieved by repeating questions on the existence of rules about TV content and the presence of a television or other screen device in the child's bedroom. The item on rules for TV content could be supplemented with additional detail on supervision of the child's screen use. It would also be useful to collect some information, at least in the pilot, as to whether parents use screen-time either as a soothing aid or a reward for good behaviour; to evaluate the longer-term effect on the child's relationship with digital media if it is associated with a reward and not just an entertainment.
- A question about the amount of time the child spends on all screen activities – including television, games, social media – would provide some consistency with Cohort 24 at 9 months and Cohort 08 at 3 but likely not an exact match. It would be useful to ask for additional detail on the specific screen-based activities that the 3-year-old engages in; for example, interactive games or video calls to family may affect development in a different way to passive television viewing.
- Problematic screen-exposure could be captured using the 'seven-in-seven screentime exposure questionnaire' or similar measure. This may require revision of other 'stand-alone' questions on screen-time to avoid duplication.
- It would be interesting to pilot a question on the child's early engagement with AI – such as speaking to an 'Alexa' type device.
- It is also recommended that the questions for parents on their own leisure screen-time, used with Cohort 24 at 9 months be continued with an additional question as to what proportion of that screen-time occurs in the child's presence.
- Note that related questions on the implications for screen-time and snacking behaviours, and using technology to maintain relationships with extended family are discussed separately in the health and family context chapters of this report.

Participation in organised activities

The topic of the 3-year-old's participation in organised activities arose in the consultations with parents. A combination of enrolling in classes, such as sporting activities, and attendance at once-off events such as football matches, pantomimes etc was discussed. Parents seemed to feel that children were becoming old enough to benefit from participating in – or at least attending – such activities. They also spoke about their happiness in seeing their child's skills developing. There were no similar questions for Cohort 08 at 3 years, probably on the assumption that age 3 was too young for most organised activities, but it is possible that this has changed over time. It is also possible that as the children of the parents in the focus groups were aged 3 and some months, and some had recently turned 4 years, their participation in organised activities will be greater than for children who have only just turned 3 years (like Cohort 24 at time of interview, presumably).

Nonetheless given that this is a possible unexplored avenue for the young child's learning and development, and a potential source of inequality in the early years for families who cannot afford such activities, it is worth piloting some questions on the issue.

Recommendation for Cohort 24 at 3 years:

- Include some questions about the child's participation in, and attendance at, organised activities and events. Examples include sports classes and matches, and theatre/dance/music. The question should distinguish between children participating versus being a spectator. It could also be useful to ask why the children does not participate in activities with potential response options of 'not available', 'too expensive', 'child too young'.

Chapter 4: Relationships and socio-emotional well-being

4.1 Policy Context Overview

Policy related to children's relationships with their parents in the first years of their life has centred on creating time for the parents to spend with their child to build close relationships. As part of *First 5: A Whole-of-Government Strategy for Babies, Young Children and their Families 2019-2028*, Objective 1 states: "Parents will be assisted to balance working and caring to contribute to optimum child development and to best suit their family circumstances." (DCYA, 2019). As part of this objective, the government has seen the enactment of a new paternity leave policy of 2 weeks' paid leave, an extension to the amount of leave given under parent's leave to 9 weeks in the child's first 2 years and the inauguration of the National Childcare Scheme (see section 3.1). Additionally, the adoptive benefit facilitates parents who have recently adopted a child to spend time with their child, offering a 24-week paid benefit.

The main policy in relation to socio-emotional well-being for both parents and children is *Sharing the Vision: A Mental Health Policy for Everyone 2020-2030* (DoH, 2020). The stated vision for this policy framework is, "to create a mental health system that addresses the needs of the population through a focus on the requirements of the individual" (p.16). There is a focus on support that is oriented to recovery and based in the community. In relation to young children, the policy states its support for Objective 6 from the First 5 strategy: "that 'babies, young children and their parents enjoy positive mental health'. The aim of this objective is to improve the early identification of mental health difficulties among babies, young children and families, and to provide access to mental health supports and services that integrate into child-serving settings and the wider community" (p.27). Additionally, the *Draft Programme for Government 2025 – Securing Ireland's Future* makes specific commitments to supporting perinatal mental healthcare (Department of the Taoiseach 2025, p. 96), while Tusla have published *Area Based Childhood Programme: A Framework for Infant & Early Childhood Mental Health – Supporting Young Children's Mental Health from pregnancy to 5 years* (Infant Mental Health Subgroup [IMHS] 2022).

In 2024, the Health Research Board [HRB] published a 'Mental Health Research Strategy' to support the implementation of *Sharing the Vision* (HRB, 2024). Four of the 'priority groups' identified are children: those who are (a) in care, (b) living with a parent who has a mental health difficulty, (c) experiencing bullying, or (d) experiencing family conflict (p.32). The strategy also notes that the first high-level priority in the EU's Roadmap for Mental Health Research in Europe is "research into mental health prevention, promotion, and interventions in children, adolescents and young adults." (p.12). It is important, therefore, that Growing Up in Ireland is in a position to support these research objectives.

4.2 Findings from Growing Up in Ireland Cohort 08 at age 3 years[29]

Below are some interesting key findings about *relationships and socio-emotional well-being* from when Cohort 08 were surveyed at age 3 (Williams et al. 2013):

- The average scores from the Primary Caregiver (PCG) on the *positive aspects* and *conflict* sections of the Pianta scale were 34 and 15, respectively, indicating a strong relationship and low levels of conflict between the PCG and study child.
- There were significant differences between boys and girls on four of the five Strengths and Difficulties Questionnaire (SDQ) subscales, which measures emotional and behavioural well-being. Boys showed higher levels of difficulties on the conduct problems, hyperactivity and peer-problems subscales, according to parental report. Although there was no significant difference between boys and girls on the emotional symptoms subscale, when averaged across the four dimensions comprising the total difficulties score, boys had significantly higher levels of difficulties overall. Girls by contrast scored more highly than boys on the pro-social subscale of the SDQ.
- Five per cent of children were classified as having a problematic behavioural profile on the SDQ where the Primary Caregiver scored in the less-stressed group of the parenting stress score at both Wave 1 and Wave 2, but the prevalence of behavioural problems increased to 25% among parents who were in the more-stressed group at both time points.
- The amount of contact children had with their non-resident parent (according to the resident parent) varied considerably; 23% had daily contact but 28% had no contact. For those children whose biological parent was non-resident at both waves, just over half (55 per cent) of those who had daily contact as

[29] Subsequent references to 'Cohort 08 at 3' relate to the Growing Up in Ireland study unless otherwise specified

infants still had daily contact as 3-year-olds, but nearly 9 per cent had no contact at Wave 2.

- With relation to parenting support from grandparents, around 64% of study children had a grandparent babysit them at least once every 3 months or more regularly.

4.3 Topics from Comparable Studies

A review of the instrumentation used by comparable international studies indicates quite a high degree of consistency with material already used with Cohort 08 at age 3.

For the child's socio-emotional development, a majority of studies had items on the child's temperament, psychological adjustment and behavioural difficulties (such as the SDQ). Questions on relationships with siblings only featured in one other study, but this may be because larger families are more common in Ireland than elsewhere (O'Toole & Slaymaker, 2024). There were no topics in the area of socio-emotional well-being that were common in other studies but not already covered by Growing Up in Ireland, although 'child's early self-concept' and 'experience of traumatic life event' featured in one study each.

In terms of parental well-being, nearly all studies (including Cohort 08 at age 3) had a measure of depression and/or anxiety. Measures of parenting stress and self-efficacy were less common but did feature in multiple studies. Three studies had a measure relating to parental satisfaction with their life, job or finances but most other new topics only featured in a single other study – such as family mental health history and expectations about parenting.

Among topics on relationships, questions on parenting style, grandparent involvement, and receipt of social support were reasonably common in other studies as well as Growing Up in Ireland. Questions on the child's own friends did not previously feature in Cohort 08 at 3, but did feature in one of the international studies (and arose in the consultation with 3-year-olds and one of the advisory groups). Four studies also featured questions relating to parental beliefs about values and qualities for children. In terms of relationships between parents, most studies (including Growing Up in Ireland) asked about marital status; a majority also collected

data on the quality of the parental relationship. Five studies, including Cohort 08 at 3, asked something about a non-resident parent where relevant. A couple of studies asked about sharing of parental tasks. Just one study included physical abuse in the parental relationship.

4.4 Summary of Continuing Topics

The table below lists the continuing topics in the areas of relationships and socio-emotional well-being that are recommended for continuation for Cohort 24 at 3 years. Their scoring against the five core criteria is also provided. Note that subtopics which were included in both Cohort 24 at 9 months and Cohort 08 at 3 years – even if not the same actual questions – are weighted as '2' under the heading of 'longitudinal/cross-cohort consistency'. If a topic appeared in just one of the source questionnaires – that is, offering either a longitudinal or a cross-cohort comparison but not both – it is scored as '1'. In a small number of cases, if the topic featured in both waves but the measurement was very different then a score of 1 on the consistency criterion was recorded.

For ease of reading, the scores against the supporting criteria (e.g. being age appropriate) are not included; but most topics will have achieved maximum marks on these.

Table 4.1: Summary of proposed continuing topics in the area of relationships and socio-emotional well-being, including presence at previous waves of GUI and scoring on core criteria for inclusion

Topic	Subtopic	C'24 at 9mths	C'08 at 3yrs	Captures key domain	Policy-relevant	Age/stage appropriate	Not collected elsewhere	Longitudinal/ cross- cohort consistency
Child-parent relationship	Pianta child-parent relationship scale (conflict and closeness)	No	Yes	2	2	2	2	1
	Parental bonding	Yes	No	1	1	1	2	1
	Discipline strategies	No	Yes	2	2	2	2	1
	LSAC parenting style measure	No	Yes	2	2	2	2	1
	Family has a meal together	No	Yes	1	1	2	2	1
Relationship with siblings	Has siblings	No	Yes	2	1	2	2	1
	How child gets on with siblings	No	Yes	2	1	2	2	1
Socio-development and well-being	Child temperament	Yes	Yes	2	1	2	2	1
	Strengths and Difficulties Questionnaire	No	Yes	2	2	2	2	1
Parental mental health	Treatment for depression or other mental health issue	Yes	Yes	2	2	2	1	2
	CES-Depression scale	Yes	Yes	2	2	2	2	2
	Well-being index	Yes	No	2	2	2	1	1
	Parental stress	Yes	Yes	2	2	2	2	2
	Parental self-efficacy	No	Yes	2	1	2	2	1

Topic	Subtopic	C'24 at 9mths	C'08 at 3yrs	Captures key domain	Policy-relevant	Age/stage appropriate	Not collected elsewhere	Longitudinal/ cross- cohort consistency
Parental relationship	Marital status	Yes	Yes	2	2	2	1	2
	Marital satisfaction	Yes	Yes	2	2	2	2	2
	Parental conflict	No	Yes	2	2	2	2	1
	Relationship status with other biological parent	Yes	Yes	2	2	2	2	2
Relationship with non-resident parent	Nature of relationship with non-resident parent	Yes	Yes	2	2	2	2	2
	Shared parenting arrangement with non-resident parent	Yes	Yes	2	2	2	2	2
	Contact with non-resident parent	Yes	Yes	2	2	2	2	2
	Support from non-resident parent	Yes	Yes	2	2	2	2	2
	Emotional quality of relationship with non-resident parent	Yes	Yes	2	2	2	2	2
	Permission to contact non-resident parent	No	Yes	2	2	2	2	1
Parental screen-time	Parental screen-time	Yes	No	2	2	2	2	1
Parenting support	Details on (formal) support accessed	Yes	No	2	2	2	1	1
	Barriers to accessing formal support	Yes	No	2	2	2	1	1
	Support from family and friends	Yes	Yes	2	2	2	2	2
	Sources of parenting advice and support	Yes	No	2	2	2	2	1

Child-parent relationship

The relationship between the child and their parent(s) is a central feature of their microsystem. Given the child's rapid cognitive, social and linguistic development between the ages of 9 months and 3 years, measures previously used with Cohort 08 at 3 years are likely to be more age appropriate for this topic than continuing measures from Cohort 24 at 9 months.

The main sub-topics/measures that could be continued from Cohort 08 at age 3 are (a) the 'conflict' and 'positive aspects' subscales from the **Pianta child-parent relationship**; (b) a measure of **parenting style**, originally adapted from the Longitudinal Study of Australian Children (LSAC); (c) a set of items on **discipline** strategies; an individual question on how often the family has a **meal together**. The scaled items (a and b) are described in more detail in the following paragraphs.

Parents may employ a range of discipline strategies with an individual child, but a key consideration is the frequency with which they employ constructive strategies, such as explaining why a behaviour was wrong, in contrast to punitive strategies such as shouting. Discipline strategies could differ between parents so it would be preferable to ask each person separately. The item on the family eating together could reflect time spent with siblings, as well as parents, but is a potentially interesting indicator of parental attitudes towards 'quality time' with the family. It could be asked just of the primary caregiver/informant.

The parent survey for Cohort 24 at age 9 months included a set of items on the parent's bonding to the then-infant – which had no equivalent in the Cohort 08 at age 3 survey. The items in the former came from a wave of the ALSPAC study. While it would be useful to revisit the parent's bonding to the child as a toddler, rather than a baby, the items included at 9 months would need to be checked for suitability with an older child.

Pianta child-parent relationship scale (Pianta, 1992)

Previously used with Cohort 08 at age 3, there are two subscales of interest in the Pianta child-parent relationship measure: 'conflict' and 'positive aspects' (with the latter sometimes referred to as 'closeness'). To get a fuller understanding of the parent-child relationship, it is preferable to ask about both positive and negative

interactions. This scale is originally credited to Pianta (1992) and has been used in varying iterations in multiple waves of Growing Up in Ireland – lending its use with Cohort 24 at age 3 to future as well as current comparisons longitudinally and cross-cohort. This measure could be asked of both parents in relevant households as there may be differences between the two dyads (e.g. mother-child and father-child).

Parenting style measure (LSAC, see Lucas et al. 2011)

Also previously used with Cohort 08 at age 3, the parenting style measure – which originated from the Longitudinal Study of Australian Children (LSAC) - comprises three subscales of 'warmth', 'hostility' and 'consistency' across 17 items. Re-using these items offers cross-cohort comparisons and the potential for longitudinal consistency. The measure could be asked of both parents in relevant households as parenting styles may differ within the household.

Recommendations for Cohort 24 at 3 years:

- Repeat Pianta child-parent relationship, and LSAC parenting style scales from Cohort 08 at age 3
- Repeat individual items on discipline strategies and frequency of family eating a meal together from Cohort 08 at age 3
- Consider whether the parental bonding measure used with Cohort 24 at 9 months would be suitable for repeating with Cohort 24 at age 3 for longitudinal consistency

Relationship with siblings

The relationship between the child and their sibling(s) is another central aspect of their early life environment. As with the section relating to the child's relationship with their parents, the child's development during the time since the previous wave makes it more prudent to adopt measures previously used for Cohort 08 at age 3 than continuing topics from Cohort 24 at 9 months.

The main sub-topics/measures that could be continued from Cohort 08 at age 3 are (a) whether the study child has **siblings** and how many and (b) how the study child **gets on with their sibling(s).** Re-using these items offers cross-cohort comparisons and the potential for longitudinal consistency. Additionally, these items allow within-

cohort comparisons to analyse how having or not having siblings affects other aspects of the study child's development.

Recommendations for Cohort 24 at age 3:

- Repeat individual items on having siblings and getting on with siblings from Cohort 08 at age 3.

Socio-emotional development and well-being

The child's socio-emotional development progresses rapidly between infancy and age 3. The parallel development of language skills can help the child to communicate their needs to caregivers and to start 'labelling' their feelings. However, the ability to regulate emotional responses and be aware of others' needs will be less well developed than would be expected from school-age children.

Socio-emotional development and well-being is of particular interest at this stage as the child is likely to have more interactions with other children and adults than previously, particularly if they have already (or are about to be) enrolled in an early learning setting. Measuring constructs such as **temperament** and **socio-emotional development** at age 3 are potentially important contemporary snapshots to capture for future analyses; for example, in relation to how well they transition to formal schooling and any later concerns about their socio-emotional well-being. Typically, such constructs are measured using sets of scaled items; potential candidates are discussed briefly in the following paragraphs.

Strengths and Difficulties Questionnaire (SDQ – Goodman, 1997, 2001)

The SDQ has been used with almost all previous waves of Growing Up in Ireland, including Cohort 08 at age 3 (but not Cohort 24 at 9 months). It comprises four 'difficulties' subscales and one positive 'prosocial' subscale. The difficulties subscales – conduct, peer problems, hyperactivity, and emotional symptoms - can be summed to give a 'total difficulties' score. The SDQ is one of the most widely used measures in existing Growing Up in Ireland waves and it would be important to include it for Cohort 24 at 3 years to facilitate cross-cohort comparisons and future longitudinal consistency. The SDQ is also widely used by other international studies. Although

the SDQ could be asked of both parents where applicable, only inclusion on the primary caregiver instrument would be needed for consistency with previous waves.

Temperament measure

Temperament has been less consistently measured across previous waves of Growing Up in Ireland. A decision was taken to use a shortened version of the Infant Behaviour Scale for Cohort 24 at 9 months, based on what had been used for the pilot of the UK's Early Life Feasibility Study. In contrast Cohort 08 had used Bates' (1979) Infant Characteristics Questionnaire at 9 months, and an abbreviated version of the Short Temperament Scale for Toddler (STST; Sewell et al. 1988) for the age 3 follow-up.

The STST measure was previously used by the LSAC study. It comprises three subscales – reactivity, sociability, and persistence – across 13 items. Re-using this measure for Cohort 24 at 3 years would allow for cross-cohort comparisons but this capacity may not be as pressing for temperament as some other constructs. If there were a toddler version of the measure used with Cohort 24 at 9 months, longitudinal consistency in temperament measure would likely be considered more valuable by researchers. However, as the Early Life Feasibility study had not progressed to age 3 by the time of writing, it isn't yet known whether such a measure – at least in abbreviated form – will be available in time for use in Growing Up in Ireland.

It would be sufficient to have just one report of the child's temperament, from the primary caregiver, as for Cohort 08 at 3.

Recommendations for Cohort 24 at 3 years:

- Repeat parent-reported SDQ as used with Cohort 08 at age 3
- Explore whether an age 3 version of the abbreviated temperament measure used with Cohort 24 at 9 months is available

Parental mental health

The parent's own mental health is an important part of the family context in which the child is growing and developing; potentially impacting the parent's ability to respond effectively to the child's needs, as well as other dynamics within the household (e.g. Knitzer et al. 2008). Items and scales relating to the parent's mental

health and well-being should be collected separately from both parents – where relevant – and be included in the self-complete module.

The parent's current experience of **depressive symptoms** has been measured by a scale called the **CES-D (8)** in all previous waves of Growing Up in Ireland – including Cohort 24 at 9 months and Cohort 08 at 3 years. However, depressive symptoms are not the same as a diagnosis and so some questions on history of **treatment for depression, anxiety or other mental health issue** are required. These also featured on previous waves of Growing Up in Ireland.

The other potential sets of scale items relate to **parental stress** and a more positively worded **well-being index**, which are outlined in more detail below. Cohort 08 at 3 included a single question which asked the parent about their feelings of **self-efficacy** as a parent (on a five-point scale from 'not very good as a parent' to 'a very good parent'). Even though this item was not used with Cohort 24 at 9 months, it may be a useful snapshot of how well the parent feels they are coping with the parental role and would allow for a cross-cohort comparison with Cohort 08.

Centre for Epidemiological Studies -Depression scale (CES-D 8)

The CES-D is an eight-item scale which asks parents about their experience of depressive symptoms, such as feeling sad or lonely, in the past week. As noted, using it with Cohort 24 at 3 years would provide consistency with all previous waves of Growing Up in Ireland.

WHO Well-being Index (WHO, 2024)

The WHO well-being index is a five-item scale which is positively framed (e.g. 'I felt calm and relaxed'). Respondents are asked to think about how they felt in the previous two weeks. It was used with Cohort 24 at 9 months, so re-using this scale at age 3 years would allow an examination of change over time. However, it was not previously used with Cohort 08 at 3 so there would be no cross-cohort comparison.

Parental Stress Scale (Berry and Jones 1995)

Various iterations of the Parental Stress Scale have been used in most child-age waves of Growing Up in Ireland. There are four subscales in the full measure – stressors, rewards, satisfaction and 'lack of control' – but some waves of Growing Up

in Ireland have used just the 'stressors' subscale (including Cohort 08 at age 3). Ideally all subscales from the Parental Stress Scale would be included for Cohort 24 at 3 to give a more rounded view of the parent's experience but if space were limited, including at least the 'stressors' subscale would give allow for both cross-cohort comparisons and longitudinal consistency with Cohort 24 at 9 months.

Recommendations for Cohort 24 at 3 years:

- Repeat CES-D (8) measure of depressive symptoms as used with Cohort 24 at 9 months and Cohort 08 at 3
- Repeat the WHO well-being index as used with Cohort 24 at 9 months
- Repeat the Parental Stress Scale, but could consider using just the 'stressors' subscale as per Cohort 08 at 3
- Repeat factual questions on treatment for depression, anxiety etc as used with Cohort 24 at 9 months but adjust response windows for the change in child age
- Include the single item on self-rated parental efficacy as used with Cohort 08 at 3

Parental relationship

The relationship between the study child's parents is another aspect of the child's ecosystem that is desirable to capture. In terms of Bronfenbrenner's bioecological model, it is part of the 'mesosystem' (interactions between individuals in the child's microsystem) so very proximal to the child's development. Most of the measures that are recommended to use to evaluate the relationship between the study child's parents were asked of Cohort 24 at age 9 months and can be brought forward to this wave.

The main sub-topics/measures that could be continued from Cohort 24 at age 9 months are (a) an item asked of the study child's parents on **marital status;** (b) a scale used for **marital satisfaction;** and (c) the item on **relationship status** with the study child's other biological parent. Additionally, a sub-topic that could be continued from Cohort 08 at age 3 is (d) the questions and scales asking about **parental conflict**. The scaled item (b) is explained in more detail later in the following paragraph.

DAS-4 Measures of marital satisfaction (Sabourin et al. 2005).

Previously used for Cohort 24 at age 9 months, the DAS-4 scale consists of two core questions. The first question asks how frequently three separate behaviours/events occur, with 6 response options ranging from "Never" to "More often than once a day". The behaviours/events in question are a mixture of positive and negative, to provide a holistic insight into the dynamics and current status of the marriage. The second question asks the respondent to rank their degree of happiness in their marriage on a scale of 0 ("Extremely unhappy") to 6 ("Perfect"), with 3 ("Happy") taken as a typical score. This scale is originally credited to DAS-4 and has been used in varying iterations in multiple waves of Growing Up in Ireland, including the previous wave for this birth cohort – lending its use with Cohort 24 at age 3 to future as well as current comparisons longitudinally and cross-cohort.

Parental conflict

Previously used for Cohort 08 at age 3, the parental conflict measure consists of two questions. The first question asks how frequently the couple argues, with five options ranging from "Most days" to "Never". The second question prompts those who did not answer "Never" to answer how often, whilst arguing, they: yell at each other; throw something at each other; or push, slap or hit each other, with five response options ranging from "Almost never/Never" to "Almost always/Always". As these measures have been previously used for other cohorts across various waves, it is prudent to include them for Cohort 24 at age 3 to facilitate cross-cohort comparisons as well as future longitudinal analysis.

Recommendations for Cohort 24 at age 3:

- Repeat individual items on marital status and marital satisfaction from Cohort 24 at age 9 months.
- Repeat individual item on relationship status from Cohort 24 at age 9 months.
- Repeat individual items on parental conflict from Cohort 08 at age 3.

Interactions with a non-resident parent

In previous waves and cohorts of Growing Up in Ireland, circa 15% of study children had a biological parent living elsewhere; that is, a 'non-resident' parent. This group combines parents who used to live with the child and those who have never done so.

As discussed elsewhere in this report, collecting information directly from the non-resident parent has proved challenging in earlier waves of Growing Up in Ireland (in common with other similar studies). Therefore, it is important that the interview with the resident primary caregiver collects at least some basic information about the non-resident parent, albeit with the caveat that such information will be from one perspective only. This information should continue to be collected as part of the self-complete module as it may be sensitive for the respondent.

The instruments for Cohort 24 at 9 months and Cohort 08 at 3 collected similar information on interactions with the non-resident parent. However, as longitudinal consistency in individual families is more important than cross-cohort comparison for this topic, it is recommended that the Cohort 24 at 9 months items be used as the basis for Cohort 24 at 3 years. The initial questions should collect some basic information on the **status of the primary caregiver's relationship with the non-resident parent**, both currently and when the child was born. If the parents have previously been married or lived together, the survey should also note the age of the child when they split up.

Details on any **shared parenting arrangement** should be collected including the time-split and how the arrangement was negotiated (e.g. through a court). In contrast to Cohort 08 at 3, this section on the questionnaire for Cohort 24 at 9 months included some more qualitative questions on the primary caregiver's perception as to how well this arrangement was working. It would be useful to assess responses to these new questions from the Cohort 24 at 9 months' data collection but it is assumed, at time of writing while fieldwork is still underway at 9 months, that continuing these questions at age 3 would be worthwhile.

The **frequency of contact** between the non-resident parent and the child is key information. Also noting how far away the non-resident parent lives helps to put the frequency of contact in context. Although Cohort 24 at 9 months only asked about face-to-face contact with the child, because of their age, questions on **virtual/remote contact** – such as by phone or video call - with the non-resident parent should be added for age 3 (as used with older waves of Growing Up in Ireland cohorts).

The nature of any **financial support** received from the non-resident parent is also of obvious interest. Previous research, including with Growing Up in Ireland data, has demonstrated that one-parent families are at particularly high risk of poverty (e.g. Russell & Maitre, 2024). Although not collected for either Cohort 24 at 9 months or Cohort 08 at 3 years, consideration should be given to adding a question on the monetary value of the support received from the non-resident parent. Furthermore, there was a significant legislative change in 2024 whereby money received as child maintenance payments will now be disregarded from the means test for social welfare payments (Department of Social Protection, 2024). The instrument for Cohort 24 at 9 months included, for the first time, a question on whether the resident primary caregiver also makes a financial contribution for the child while they are staying with the other parent. This is particularly relevant if there is a shared parenting arrangement in place, but the responses to this question at 9 months may guide a decision on whether to continue it for 3 years.

Finally, this section should collect some information on the resident **primary caregiver's perception of the emotional quality of their current relationship** with the non-resident parent. This adds contextual information for the emotional tone of the relationship between the child's biological parents. For Cohort 24 at 9 months, there were just two questions in this sub-topic: how often the primary caregiver spoke to the non-resident parent about the child, and whether they described their own relationship with that person as positive or negative.

Recommendations for Cohort 24 at 3 years:

- Repeat questions from the resident primary caregiver as used with Cohort 24 at 9 months
- Add a question on the frequency of remote/virtual contact, as distinct from face-to-face contact, between the child and the non-resident parent
- Consider adding a question on the monetary value of the financial support received from the non-resident parent

Parental screen time

As the proliferation of personal devices and tablets has increased, the amount of time an individual spends using a device with a digital screen is relevant not only for the

study child, but also their parents. As the child develops, they absorb habits and behaviours from those around them and so it is advantageous to ask the parents about the amount of time they spend using digital devices (e.g. Hoyos Cillero & Jago, 2010). With the study child being more observant and susceptible to absorb parental behaviours at age 3 as compared to 9 months, it is once again important to collect this information.

The main sub-topic/measure that could be continued from Cohort 24 at age 9 months are items that ask about **parental screen time** on an average day. This measure is split up into a question on screen time on an average weekday and on an average weekend. As screen time has become an increasingly salient discussion point and topic for research, it is desirable to collect this information from at least the child's primary caregiver to complete both within- and cross-cohort analysis to study the impact on the child's development.

Recommendations for Cohort 24 at age 3:

- Repeat individual item on parental screen time from Cohort 24 at age 9 months.

Parenting support

Parenting can be a strenuous and complicated task and parents may draw on their networks - whether they be familial, friends, community-based or even internet-based - to assist and support them with different aspects of parenting. However, an equally important aspect is use of formal support services to help assist them with the typical struggles associated with early and new parenting. In 2022, the government published *Supporting Parents: A National Model of Parenting Support Services*, a national model for improving parenting support services with four goals: "greater awareness of parenting support services; greater access to parenting support services; more inclusive parenting support services; and needs-led and evidence-informed parenting support services." (DCEDIY, 2022, p. 10). It is important to ask parents about their experiences with both formal and informal support networks to gauge gaps in services and potential areas for improvement. These items are still quite relevant at age 3 as the growing child is still going through several new phases of development and still requires near constant attention, supervision and care.

The main sub-topics/measures that could be continued from Cohort 24 at age 9 months are (a) an item asking what formal **parenting support** services have accessed since the study child was born and an associated question on frequency of access; (b) a question asking about the **barriers to accessing formal supports** for parents who answered that they were unable to access the services or were unaware of them; (c) an item asking about the level of **support from family and friends** the parent receives; (d) an item asking about **sources of parenting advice and support**; and (e) an item asking about the level of **support received from the grandparents** of the study child.

Recommendations for Cohort 24 at age 3:

- Repeat items on parenting support and barriers to accessing formal supports from Cohort 24 at age 9 months.
- Repeat individual item on support from family and friends from Cohort 24 at age 9 months.
- Repeat individual item on sources of parenting advice and support from Cohort 24 at age 9 months.
- Repeat individual item on support received from grandparents from Cohort 24 at age 9 months.

4.5 Summary of New Topics

A number of recommendations for new topics in the family relationships and socio-emotional well-being domain arose from the consultation process and reviews of other research. Some additional topics that were mentioned but ultimately not selected for recommendation for inclusion include further information on relationships within the home, data linkage related to access to courts and hospitals, non-cognitive traits, and gamification and its links to gambling.

Both topics that were subsequently recommended for inclusion in the survey for Cohort 24 at age 3, and those that were considered but ultimately not recommended have been scored according to the main criteria in Table 4.2. Topics that were raised during the consultations but are already listed under ‘continuing topics’ are not included here.

For ease of reading, the scores against the supporting criteria (e.g. being age appropriate) are not included; but most of the recommended new topics will have achieved maximum marks on these.

Table 4.2: Summary of new topics raised in the area of relationships and socio-emotional well-being during the consultations and review of comparable studies, scored according to the five core criteria

	Captures key domain	Policy-relevant	Age / stage appropriate	Not collected elsewhere	Strong support
Recommended new topics					
Interaction with extended family	2	2	2	2	2
Virtual contact with family members	1	1	2	2	2
More detail on sibling relationships[30]	2	1	2	2	2
Number of friends child has	2	1	2	2	2
Presence and type of family pets	1	1	2	2	2
Other topics considered but not put forward					
Data linkage on familial access to courts	1	2	1	0	1
Data linkage on familial access to hospitals	1	2	1	0	1
Testing of non-cognitive traits	1	1	1	2	1
Gamification	1	1	1	2	1
Number of friends parent has	1	1	2	2	0
Conflict resolution style	1	1	1	2	1
Family mental health history	1	2	1	1	0
Effect of child's health on parents	2	2	2	2	0
Satisfaction with amount of time spent with child	2	1	2	2	0

Interaction with extended family

The consultation group members noted that beyond capturing multigenerational information, it would also be useful to collect data about the study child's level of interaction with other extended family members such as uncles, aunts and cousins.

[30] Note that sibling relationships is also mentioned as a continuing topic in this chapter, due to a single question in C08 at 3.

These family members can play an integral role in the child's development, especially as modern-day family dynamics change and evolve. This is also a relevant topic given the immigration in Ireland over the last few decades, as immigrants often reach their destination country without extended family to interact with as part of their social network (Lim et al., 2022). In other scenarios, immigrant families may spend substantial time with extended family due to tightly knit migration networks (Cox & Fafchamps, 2007).

In order to capture the experiences of the study children with their extended family members, the study child's caregiver can be asked how frequently, if at all, the study child interacts with their aunt(s)/uncle(s) and cousin(s). Previous questions for Cohort 08 at age 9 asked how many times per week/month the study child saw their extended family, differentiating between cousin(s) and aunt(s)/uncle(s). While this may not capture the quality of the relationship, it will provide insight into the nature of modern-day family dynamics and help researchers to understand how involvement with extended family members relates to a child's development. Similar to other new topics, this topic is of longitudinal value, as interaction levels may change over time and across different life stages; collecting this information from an early age allows analysis to compare the level of interaction with extended family as the child ages.

Recommendation for interaction with extended family:

- Bring forward Question I9 from the Cohort 08 at 9 years Primary Caregiver Questionnaire, which asks about the frequency of interaction with extended family members, or an equivalent item.

Face-to-face vs virtual contact with extended family

A potential key point to consider about the study child's interaction with extended family is whether that contact is in a face-to-face physical setting or occurs virtually via phone call or video call. Given the proliferation of smartphones and other methods for engaging with friends and family via video or audio call, accelerated by face-to-face restrictions during the COVID-19 pandemic, it is possible that the study child has regular contact with their extended family members via digital channels. Video chats have been shown to help children aged 0-5 years bridge distances

between themselves and extended family (Strouse et al., 2021), which may also be relevant for the children of immigrant parents.

Having already asked the study child's parent about the child's interaction with their extended family, it is important to ask about the nature of this interaction given the increased prevalence and ease of access to videochats. Like the new question about interaction with extended family, this question has longitudinal value and can help inform what impact different modes of familial interaction may have on the study child's outcomes. This is likely to be particularly relevant to children whose parents have emigrated to Ireland, where in-person contact with extended family members is not possible. It could also help researchers understand the extent to which the digital world is integrated into the young child's 'microsystem' of family relationships.

Recommendation for face-to-face vs virtual contact with extended family:

- Ask the study child's parent if the contact they have with their extended family, using the categories of grandparent(s); aunt(s)/uncle(s); and cousin(s), is entirely face-to-face contact, entirely virtual contact, or a mix. If the answer is either virtual or a mix, ask if it is via videochat or via voice call.

More detail on the child's relationship with their siblings

A recommendation to asking additional questions on the child's relationship with their sibling arises mainly from the consultations with parents and young children. However, there are not many examples to draw on from otherwise comparable studies. Consideration could be given to extending the basic questions previously included for Cohort 08 at 3 by adapting a set of questions later asked of 13-year-olds. Those questions were originally adapted from a measure used by the ALSPAC study and cover both negative and positive interactions with siblings (from the child's perspective) such as pushing and shoving or, conversely, playing sports and games together. The items could potentially be re-worded to be answered by the parent.

Recommendation for Cohort 24 at age 3:

- Extend the questions on sibling relationships to capture more information about specific positive and negative interactions. Consideration could be given to adapting questions previously asked of children in Cohort 08 at 13, to be asked of the primary caregiver.

Number of friends child has

The topic of the 3-year-olds' friends came up in the consultation with children themselves, and was mentioned in the consultations with the advisory panel on family context. It also features as a topic in one of the comparable international studies. Given the cross-cutting nature of this topic in the consultations, it is recommended that one or two questions be asked of the primary caregiver. This could be the questions on 'number of friends' and 'number of close friends', similar to those asked at older waves of Growing Up in Ireland, as a starting point for future longitudinal consistency. As it is expected that a substantial portion of 3-year-olds will be participating in some sort of regular care in a group-setting at the time of interview in 2027 – due in part to increases in funding - questions on their friends could be very timely.

Recommendation for Cohort 24 at age 3:

- Ask two questions on the number of friends, and the number of 'close' friends, the 3-year-old has to the primary caregiver main questionnaire.

Presence and type of family pets

Questions on family pets have been previously asked at older waves of Growing Up in Ireland but a question at age 3 would be new. Animals and pets emerged as a theme in the consultation with 3-year-olds. Although the basic nature of the accompanying notations made it difficult to draw specific conclusions, the researcher who examined the material noted that pets were sometimes included in the children's drawings of their "family". We know from later waves in the older cohorts of Growing Up in Ireland that pet ownership and engagement with pets is common: two-thirds of 9-year-olds in Cohort 08 had a pet (dogs and cats typically) and most said they helped look after that pet 'often' or 'occasionally' (McNamara et al., 2021).

Having a family pet is also one of the indicators used by the State of the Nation's Children report (DCEDIY, 2024b). In the most recent report, using HBSC data, 76% of children aged 10-17 had a pet in 2022 (p.54) but with noticeably lower rates in the Dublin region (62%).

The presence of pets in the household may also be of interest to health researchers (e.g., in relation to respiratory or allergy issues), in which case specifying the type of pet(s) could be important.

Recommendation for Cohort 24 at age 3

- Include a couple of questions on the number and type of pets that live with the 3-year-old on the primary caregiver main questionnaire. Consideration could also be given to a single question in the section on the child's play (see chapter 3) on whether they play with a pet (even if not one belonging to their household but possibly present in a childminder's or grandparent's home).

Chapter 5: Family Context

5.1 Policy Context Overview

There are myriad policies that seek to affect and improve topics that are related to this broad domain; therefore, the following discussion is focused on a smaller number of flagship policies and initiatives.

The issue of housing has been a policy priority for a number of years, as reflected in the *Housing for All – a New Housing Plan for Ireland* government plan to 2030. The policy seeks to implement a wide range of strategies to enable access to good quality homes using four pathways: supporting home ownership and increasing affordability; eradicating homelessness, increasing social housing delivery and supporting social inclusion; increasing new housing supply; and addressing vacancy and efficient use of existing stock (Department of Housing, Local Government and Heritage, 2021).

In other initiatives, the National Broadband for Ireland (NBI) Plan is the Irish government's initiative to deliver high speed broadband services to all premises in Ireland,[31] as research has shown that there is a substantial discrepancy in broadband coverage between urban and rural areas (Dempsey & Hoy, 2025). According to the NBI website, the new network will use a combination of State subsidy and commercial investment and the plan states that it "will radically change the broadband landscape across the country to ensure that every farm, business and home has access to high-speed broadband, no matter where they are located." Improving access to high quality internet services is key to the family context, especially in terms of flexible or hybrid arrangements for parents to work from home.

The *First 5* national strategy, published in 2019, has the objective that "Families and communities will be supported to provide children with the necessary material and practical resources to encourage positive development in the early years." (p. 32). This can be seen across a wide range of social welfare policies such as Increases for Qualified Children, the Working Family Payment (a weekly tax-free payment available to employees with children and net average weekly family income below a certain

[31] https://nbi.ie/the-national-broadband-plan/

amount for family size), the One Parent Family Payment, and several other policies.[32] A recent development relevant to one-parent families saw a major reform to the child maintenance system; these payments are no longer means tested which saw over 16,000 lone parents benefit from this reform (Department of Social Protection, 2024). As previously mentioned in Chapter 1, the number of people working from home increased 173% between 2016 and 2022. Initially driven by COVID-19 restrictions, many employers have subsequently offered more remote or blended-working arrangements even after the lifting of restrictions. Additionally, as mentioned in Chapter 4, under the *First 5* strategy there has been the enactment of a new paternity leave policy of 2 weeks paid leave and an extension to the amount of leave given under parent's leave to 9 weeks in the child's first 2 years. The *Parental Leave (Amendment) Act 2019* saw the parental leave entitlement, to be taken prior to the child turning 12, extended from 18 weeks unpaid to 26 weeks unpaid.[33]

Additionally, the *Roadmap for Social Inclusion 2020-25* seeks "to reduce the national consistent poverty rate to 2% or less of the population and to make Ireland one of the most socially inclusive States in the EU" (Department of Social Protection, 2020, p. 15). Of its seven high-level goals, one specifically focusses on supporting families and reducing child poverty, while also having an interest in supporting lone parents who may be disadvantaged due to only working part-time. Reducing child poverty is also a 'spotlight' issue in the new *Young Ireland* policy framework, including the establishment of a specific office within the Department of the Taoiseach.

5.2 Findings from Growing Up in Ireland Cohort 08 at age 3 years[34]

Some interesting findings previously published (Growing Up in Ireland Study Team, 2011a & 2011b; Williams et al. 2013) in relation to *family context s* from when Cohort 08 were surveyed at age 3 from when Cohort 08 were surveyed at age 3 are:

- The most frequent change to family structure between interviews was the arrival of a new sibling into the family (33% of all families).

[32] https://www.citizensinformation.ie/en/social-welfare/families-and-children/

[33] https://www.irishstatutebook.ie/eli/2019/act/11/enacted/en/pdf

[34] Subsequent references to 'Cohort 08 at 3' relate to the Growing Up in Ireland study unless otherwise specified

- Nearly 8 per cent of the Study Children spoke a language other than English as their first language.
- A substantial percentage of both mothers (43%) and fathers (50%) at work outside the home felt that they had missed out on family activities as a result of work responsibilities. Furthermore, approximately one-third of both (35% of mothers and 32% of fathers) agreed/strongly agreed that their family time was less enjoyable and more pressured as a result of out-of-home work responsibilities.
- Overall, 21% of the families of 3-year-olds recorded that they could make ends meet only with great difficulty or with difficulty, while a further 40% were doing so with some difficulty. In contrast, 27% were making ends meet fairly easily, with the remaining 12% doing so easily / very easily. Note that interviews for Cohort 08 at age 3 took place in 2011 around the peak of what later became known as the 'Great Recession'.
- One-parent families were more likely than two-parent families to receive financial support from grandparents. Just under one-third of both one-parent family types received financial support from grandparents at least once every three months (i.e. quarterly), compared to around 12% for two-parent families.

5.3 Topics from Comparable Studies

A review of the instrumentation used by comparable international studies indicates a degree of consistency with material already used with Growing Up in Ireland's Cohort 08 at age 3 while also highlighting areas where Growing Up in Ireland is innovating and collecting information that other studies do not.

For information on parents, a majority of studies had items on the parent's education levels and the language primarily spoken in the home. Less common were questions on the parents' literacy and numeracy, citizenship and ethnic/cultural background, and the household's religion. There were no topics in the area of parent background that were common in other studies but not already covered by Growing Up in Ireland, although 'language exposure/number of languages spoken' featured in one study.

In terms of socio-demographics, nearly all studies (including Cohort 08 at age 3) collected information on the parents' occupational status, household income and receipt of social welfare payments, as well as type of housing. Questions on housing condition/quality, intent to remain in accommodation, time spent working in office versus at home, car ownership and a basic deprivation scale were less common but did feature in multiple studies. Questions on financial assistance from grandparents,

the cleanliness of the house, number of bedrooms and bathrooms, list of monthly expenses, and benefits acquired through employment each appeared in one other study, respectively.

There were no established topics relating to the neighbourhood/community in other studies. A few studies asked about the parents' perception of and satisfaction with the local area, length of time lived in the area, access to public transport and local services, and about family and friends living in the area. An emerging topic was community participation, which was included in two studies, while questions on attitude towards police and the parents' number of close friends in the area each appeared in one other study, respectively.

5.4 Summary of Continuing Topics

The table below lists the continuing topics in the areas of family context that are recommended for continuation for Cohort 24 at 3 years. Their scoring against the five core criteria is also provided. Note that subtopics which were included in both Cohort 24 at 9 months and Cohort 08 at 3 years – even if not the same actual questions – are weighted as '2' under the heading of 'longitudinal/cross-cohort consistency'. If a topic appeared in just one of the source questionnaires – that is, offering either a longitudinal or a cross-cohort comparison but not both – it is scored as '1'. In a small number of cases, if the topic featured in both waves but the measurement was very different then a score of 1 on the consistency criterion was recorded.

For ease of reading, the scores against the supporting criteria (e.g. being age appropriate) are not included; but most topics will have achieved maximum marks on these.

Table 5.1: Summary of proposed continuing topics in the area of family context, including presence at previous waves of GUI and scoring on core criteria for inclusion

Topic	Subtopic	C'24 at 9mths	C'08 at 3yrs	Captures key domain	Policy-relevant	Age / stage appropriate	Not collected elsewhere	Longitudinal / cross-cohort consistency
Parent socio-dem characteristics	Ethnicity	Yes	Yes	2	2	2	0	2
	Religion	Yes	Yes	2	2	2	0	2
	Parental education	Yes	Yes	2	2	2	0	2
	Language spoken in the home	Yes	Yes	2	2	2	0	2
	English fluency	Yes	Yes	2	2	2	2	2
	Literacy	Yes	Yes	2	2	2	2	2
	Parent citizenship and country of birth	Yes	Yes	2	2	2	0	2
	Time spent in other countries	Yes	No	2	2	2	2	1
	Child citizenship	Yes	No	2	2	2	0	1
Parent contact with CJS	Contact with Criminal Justice System (CJS)	Yes	Yes	2	2	2	1	2
Parental PES	Principal Economic Status (PES)	Yes	Yes	2	2	2	1	2
	Details of current or most recent job	Yes	Yes	2	2	2	2	2
	Blended work	Yes	No	2	2	2	2	1
	Spouse/partner occupation	Yes	Yes	2	2	2	2	2
	Reasons for not working	No	Yes	2	2	2	2	1
Use of leave	Any leave	Yes	No	2	2	2	2	1
	Returning to work after birth of Study Child	Yes	Yes	2	2	2	2	2
	Details on use of variety of leave	Yes	No	2	2	2	2	1

Topic	Subtopic	C'24 at 9mths	C'08 at 3yrs	Captures key domain	Policy-relevant	Age / stage appropriate	Not collected elsewhere	Longitudinal / cross-cohort consistency
	Difficulties taking leave	Yes	No	2	2	2	2	1
	Flexible working	Yes	No	2	2	2	2	1
	Childcare as barrier to participation	Yes	Yes	2	2	2	2	2
Attitudes to work as a parent	Effects of being working parent	Yes	No	2	2	2	2	1
	Work-life balance	Yes	Yes	2	2	2	2	2
Household (hsd) composition	Basic details of each person in hsd	Yes	Yes	2	2	2	0	2
	Siblings outside the hsd	No	Yes	2	2	2	2	1
Changes to hsd grid	Reason for person leaving	No	Yes	2	2	2	2	1
	Date person left	No	Yes	2	2	2	2	1
Housing	Type and occupancy	Yes	Yes	2	2	2	1	2
	Housing tenure	Yes	No	2	2	2	2	1
	Housing costs	Yes	No	2	2	2	2	1
	Housing quality	Yes	Yes	2	2	2	1	2
	Access to outdoor space	Yes	Yes	2	2	2	2	2
	Future plans	Yes	No	2	2	2	2	1
Neighbourhood	Quality of environment	Yes	No	2	2	2	2	1
	Outdoor facilities	Yes	No	2	2	2	2	1
	Safety of/integration into neighbourhood	Yes	Yes	2	2	2	2	2
	Services available locally	Yes	No	2	2	2	2	1

Topic	Subtopic	C'24 at 9mths	C'08 at 3yrs	Captures key domain	Policy-relevant	Age / stage appropriate	Not collected elsewhere	Longitudinal / cross-cohort consistency
	Family and friends nearby	Yes	No	2	2	2	2	1
	Availability of someone to mind child informally	Yes	No	2	2	2	2	1
	Length living in area	No	Yes	2	2	2	2	1
	Intention to stay in Ireland	No	Yes	2	2	2	2	1
Transport	Transport used	Yes	No	2	2	2	2	1
	Access to a car	Yes	Yes	2	2	2	2	2
	Access to public transport	Yes	No	2	2	2	2	1
	Barriers to using public transport	Yes	No	2	2	2	2	1
	Barriers to walking	Yes	No	2	2	2	2	1
	Barriers to cycling	Yes	No	2	2	2	2	1
Household income	Earnings	Linkage only	Yes	2	2	2	0	2
	Social welfare receipt via data linkage	Linkage only	Yes	2	2	2	0	2
Financial well-being	Material deprivation; EU SILC	Yes	Yes	2	2	2	1	2
	Savings	Yes	No	2	2	2	2	1
	Financial strain	Yes	Yes	2	2	2	2	2
	Income requirements	Yes	No	2	2	2	2	1
	Food insecurity	Yes	No	2	2	2	2	1

Parent socio-demographic characteristics

The socio-demographic background of the study child constitutes key aspects to observe and analyse, in the context of the child's lifelong development, in a longitudinal multi-cohort study. Capturing aspects such as ethnicity, parental education, religion, citizenship and capabilities in English allow for insightful investigations of differences across groups that feed into important policies designed to work towards equality. It is crucial to have this information included as these characteristics comprise the key aspects that are used when analysing differences between groups with the same cohort and often comparing those results to the same results from an earlier birth cohort.

The main sub-topics/measures that could be continued from Cohort 24 at age 9 months are (a) an item asking about the family's **ethnicity/background**; (b) a question asking about the family's **religion**; (c) questions related to **parental education** and highest qualification levels; (d) items on which is the **main language spoken in the home,** the parent's **English fluency** and the parent's **literacy**; and (e) items asking about the parent's **citizenship and country of birth** as well as their **time spent in other countries** prior to living in Ireland.

Where the primary caregiver remains the same between 9 months and 3 years, much of the above information could be fed-forward to save time. The item on parent's citizenship, and a related item on the **child's citizenship**, could be repeated only where the response was something other than Irish at Wave 1.

If needed, these questions could be asked as part of the individual parent main questionnaires.

Recommendations for Cohort 24 at age 3:

- Repeat the 2022 Census question on ethnic group/background from Cohort 24 at age 9 months for new respondents (else forward-feed from Wave 1)
- Repeat individual item on religion from Cohort 24 at age 9 months for new respondents (else forward-feed from Wave 1)
- Repeat items on parental education and highest level of qualifications from Cohort 24 at age 9 months; this could be forward-fed but with an option for the parent to update the information if they have attained a new qualification since Wave 1

- Repeat items on main language spoken in the home, whether English is parent's first language and the parent' s literacy from Cohort 24 at age 9 months - for new respondents (else forward-feed from Wave 1)
- Repeat items on the parent's citizenship and country of birth and questions on any time spent in other countries prior to Ireland from Cohort 24 at age 9 months - for new respondents or citizenship other than Ireland (else forward-feed from Wave 1); similar for child citizenship

Parent contact with Criminal Justice System

A parent's interaction with the Criminal Justice System can have a large impact on the family dynamic and the child's development (Wakefield & Montagnet, 2019). Criminal and legal trouble can be traumatic for both parent and child as well as potentially causing the parent to spend substantial time away from their child in the event of incarceration or lengthy trials. Additionally, the setbacks from interaction with the Criminal Justice System, such as loss of employment opportunities, reputation damages and incarceration, may lead to longstanding obstacles that influence the trajectory of the parent's and child's life. Therefore, it is important to collect this information to be able to compare outcomes across different levels of interaction with the Criminal Justice System. As the status of this variable may have changed in-between waves, it is advantageous to capture again at this wave, as well as capturing the impact that any change may have had on the developing child.

Recommendations for Cohort 24 at age 3:

- Repeat items on the parent's interaction with the Criminal Justice System from Cohort 24 at age 9 months.

Parental Principal Economic Status

The economic status of the parent is a vital characteristic at all stages of their child's life, but especially the early years - before the child starts school - when families face a choice of one parent staying at home or availing of a childcare provider. The parent's employment status, occupation, how many hours they work and blended work status all impact the family's income as well as the amount of time the parent may spend with the child. In order to design supports for parents of young children, it is crucial to understand what typical employment and hours look like for this group and how that affects their child's outcomes. This is useful to capture not only for

between-group analysis within cohorts, but also for cross-cohort analysis to view how these dynamics have changed over time. As changes may have occurred between waves, it is necessary to repeat questions on economic status and employment for both parents (where applicable).

The main sub-topics/measures that could be continued from Cohort 24 at age 9 months are (a) an item asking about the parent's **principal economic status** and questions on the **details of their current or most recent job**; (b) an item capturing information about whether the parent has any **blended working** arrangements; and (c) an item asking about the **occupation of the spouse/partner**. Additionally, a sub-topic/measure that could be repeated from Cohort 08 at age 3 is an item that asks the parent their **reason for not working**.

Recommendations for Cohort 24 at age 3:

- Repeat items on parent's principal economic status and questions on their job details from Cohort 24 at age 9 months.
- Repeat individual item on blended work from Cohort 24 at age 9 months.
- Repeat item on spouse/partner occupation from Cohort 24 at age 9 months.
- Repeat item on reason for not working from Cohort 08 at age 3.

Use of leave

Just as details surrounding the parent's economic status are important to capture, so are details surrounding their use of different types of leave while employed. Given the various types of leave that are available to those in employment, such as maternity/paternity leave, carer's leave, career break, flexible working and more, it is prudent to ask parents about which types of leave they have availed of (if any), as well as any barriers that prevent them taking leave. Capturing this information helps to understand the effectiveness of different types of leave schemes and ascertain what types of supports are necessary to help parents avail of the different types of leave, as well as any changes in the use of different leave as the child ages between waves.

The main sub-topics/measures that could be continued from Cohort 24 at age 9 months are (a) an item asking about the parent's **current leave status**; (b) an item

asking about **returning to work after the birth** of the study child; (c) items on the **details of use of various types of leave** and on any **difficulties in taking leave;** (d) an item on **flexible working**; and (e) an item asking about **childcare as a barrier to participation** for several activities.

It would be preferable to ask these questions of both parents as part of their main questionnaire.

Recommendations for Cohort 24 at age 3:

- Repeat item on parent's current leave status from Cohort 24 at age 9 months.
- Repeat items on returning to work after the birth of the study child from Cohort 24 at age 9 months (if primary caregiver had not already returned at the Wave 1 interview).
- Repeat items adapted from the CSO Personal and Work-Life Balance Survey 2021 on details of use of various types of leave, difficulties in taking leave, and flexible working from Cohort 24 at age 9 months.
- Repeat item on childcare as a barrier to participation from Cohort 24 at age 9 months.

Attitudes to work as a parent

In keeping with the previous two sections, it is important to include questions on their attitudes towards work as a parent. Balancing work and parental responsibilities can be difficult for new parents and as such it is important to understand how these parents view the split of time and responsibilities between their jobs and their child/children. This is not just in the view of work as detrimental to parenting, as it can also have some positive connotations in that space, which should be captured. These attitudes may shift as the child develops and grows their own personality amidst changing needs, so should be repeated for this wave.

The main sub-topics/measures that could be continued from Cohort 24 at age 9 months are (a) items on the **effects of being a working parent** and (b) an item asking about **work-life balance**.

Recommendations for Cohort 24 at age 3:

- Repeat items from Growing Up in Australia on effects of being a working parent from Cohort 24 at age 9 months.
- Repeat individual item on work-life balance from Cohort 24 at age 9 months.

Household composition

A key component of any household survey is the '**household grid**' which collects basic information on the age, gender, economic status, and relationship to the head of household for everyone living there. For Growing Up in Ireland, there is an additional question on how each person is related to the study child. In circumstances where there is more than one family sharing the accommodation, defining who forms part of the child's household - and who does not - can occasionally be complicated.

Now that Cohort 24 will be completing the second wave of the survey, it will be important to capture any **changes to the household** composition. In previous waves, this has been done on a relatively efficient basis by 'forward feeding' the details recorded at the last interview and asking for confirmation or any updates. New people in the household, or anyone mistakenly omitted previously, will need to have their full details added. The number of children in the household can have implications for the family's socioeconomic status: the 2024 State of the Nation's Children report indicated that in 2023, using EU SILC data, one-parent, one-child households and households with 2 adults and 3+ kids had the highest rates of consistent poverty at household level at 7% each, although both groups showed a substantial decline from 2022 (DCEDIY, 2024b p. 144).

One sub-topic that was collected with Cohort 08 at 3 but may not have been collected with Cohort 24 at 9 months, are basic details on any full, step or half **siblings of the study child living outside the household**. This information is most relevant to establishing the correct birth order of the study child, such as where the eldest sibling has already moved out and is not included on the grid. It is also relevant to whether the parents have any other dependants who are not recorded on the household grid, and if the study child is part of a wider 'blended' family that may not be apparent from the household grid alone. For example, one of the child's resident parents may have children from a previous relationship living elsewhere.

All of the above information could be collected from the primary caregiver as part of the main interview. For certain household members who have left since the previous wave, it would be useful to know the **reason for leaving**. On older waves of Growing Up in Ireland, this information was linked from the main grid to the self-complete

'sensitive' questionnaire where the primary caregiver was asked why someone had left (e.g. deceased, moved out to own household etc). However, as this specific information is most relevant to when one of the child's parents has left the household, it could be reduced to just the reason for leaving in respect of a child's parent. It should, however, remain on the self-complete module as it is likely to be sensitive.

Recommendations for Cohort 24 at 3 years:

- Repeat the questions on household composition, as used with Cohort 24 at 9 months, but on a 'forward-feed' basis for most families
- Add the questions on siblings outside the household, and reason for leaving (parent only), from Cohort 08 at age 3

Housing

The accommodation in which the child lives is important to their well-being given how much time they spend there and because it is the location where so many of the proximal interactions that promote development occur. The topic of housing continues to be a 'hot' topic in the Irish context at the time of writing[35] and is likely to remain so by the time Cohort 24 are being interviewed at age 3 years. In the State of the Nation's Children 2024 report, data provided by the Housing Agency indicated there were nearly 21,000 households with children identified as being in need of social housing in 2023 (DCEDIY, 2024b p. 145).

The subtopics under the broader heading of 'housing' includes the physical characteristics of the home – such as size and quality – and 'non-physical' characteristics such as the nature of the occupancy and how much it costs. There were more, and updated, questions on housing on the survey for Cohort 24 at 9 months than Cohort 08 at 3 so the former is recommended as the basis for Cohort 24 at 3. It should be sufficient to collect information on housing just from the primary caregiver.

Specifically on physical characteristics, there were previous questions on **size** (number of bedrooms and bathrooms, and sense of adequate space), **housing quality**

[35] For example, the BBC published an article on 5th February 2025 with the headline, "Housing 'number one issue' for government, says Irish PM": https://www.bbc.com/news/articles/cedne54nw37o

(e.g. damp, noise), **type of energy** used, and **access to an outside space** for the child to play. These characteristics are important for the child's health and physical development, and overall comfort in the home, and should be continued. Previous questions on aspects such as **nature of occupancy/tenure, costs and burden** thereof are important for housing security and financial strain on the family. There was a new pair of questions for Cohort 24 at 9 months on whether the **family expects to continue living in their present home**, and if not, why. It would be useful to collect this information again at age 3, to judge both the family's feelings towards the accommodation and the likelihood that they will have to be traced to a new address by the time of the subsequent wave.

Recommendations for Cohort 24 at 3 years:

- Repeat the questions on housing as used with Cohort 24 at 9 months
- Link to administrative data to capture if the household is in receipt of the Housing Assistance Payment (HAP), Rental Accommodation Scheme (RAS) and other grants and supports for homeowners, in efforts to supplement what is known about the other characteristics of housing

Neighbourhood

The neighbourhood or locality in which the child lives is a potentially important influence on their development. The influence can be multi-faceted: from physical characteristics such as green space and air quality, to the services and facilities that are available, to the behaviour of other people in the community – which may be positive (e.g., supportive neighbours) or negative (e.g. anti-social behaviour, littering). At the age of 3 years, some of the child's interactions with their neighbourhood will be mediated through their parents (e.g., availing of services) but others, such as access to parks, will be more direct. In Growing Up in Ireland, 'local area' has generally been left to respondents to self-define; this means that the actual distance to, for example, shops or a playground, might mean within walking distance for an urban family or a 10-minute drive for a rural household. Information on the local area could be collected solely from the primary caregiver.

Comparing the two surveys, there were more questions about the local neighbourhood on the questionnaire for Cohort 24 at 9 months than Cohort 08 at 3

years. Partly, this was because the latter had been the second wave for that cohort and it was anticipated that a majority of families would still be living in the same area as the first wave. However, between household mobility and possible change in the local area in a two-year period, it is unlikely that 'forward feeding' neighbourhood information collected for Cohort 24 at 9 months will be a viable option.

Looking in more detail at the individual sub-topics, the only two used with both Cohort 08 at 3 and Cohort 24 at 9 months were items referring to **perceived safety of the area** (including **safe play spaces**), and being **settled in the community**. As well as being important indicators of how content the family are in their community, continuing these items for Cohort 24 at age 3 offers scope for both longitudinal and cross-cohort comparisons.

Other sub-topics collected for Cohort 24 at 9 months included the **quality of the neighbourhood** (e.g. litter), **access to services** such as a GP, schools, grocery shopping and childcare. These two topics are as relevant to the child's development at age 3 as they were in infancy, and so should be continued.

The Cohort 24 at 9 months survey also included individual questions on whether the primary caregiver had **family and friends living in the area**, and whether there was **someone who could mind the child** when they went out. Again, these are still very relevant to parenting a 3-year-olds and relate to the potential support network available to the parent. The importance of the wider family network outside the immediate household was also one of the topics emphasised in the expert stakeholder consultations undertaken for this report.

There was an additional question on the Cohort 08 at 3 survey which asked the parent if they **intended to stay living in Ireland**. This could be useful information both cross-sectionally, and in terms of planning for future waves of Cohort 24; especially as it is anticipated that the Cohort 24 sample will have proportionally more non-national parents who may permanently move from Ireland.

Recommendations for Cohort 24 at 3 years:

- Repeat the questions on the local area as used with Cohort 24 at 9 months
- Add the question on intention to stay living in Ireland from Cohort 08 at age 3

Transport

An important part of everyone's lives is the way they get from place to place and their access to various methods of transportation. Public transport may be difficult to access for some while for others private methods of transportation may be too costly. Additionally, with increased focus on the environment, it is important to understand how this is impacting people's choices for getting from place to place. Since families may have moved, had public transport patterns in their area altered, or changed their preferred modes of transport, it should be captured again at age 3. Additionally, some parents in the focus groups commented that they actually used their car more now that the child is 3 because of the length time it takes to walk anywhere with them, in contrast to pushing them in a buggy when they were an infant.

The main sub-topics/measures that could be continued from Cohort 24 at age 9 months are (a) whether the family has **used public transport**; (b) whether the family has **access to a car** and also **access to public transport**; and (c) if the family has experienced any **barriers to using public transport**, in addition to any **barriers to cycling** or **walking.**

Recommendations for Cohort 24 at age 3:

- Repeat item on using public transport from Cohort 24 at age 9 months.
- Repeat items on access to a car and access to public transport from Cohort 24 at age 9 months.
- Repeat items on barriers to using public transport, barriers to cycling and barriers to walking from Cohort 24 at age 9 months.

Household income

One of the key determinants of the path of a child's life is their household income. Children from higher income households typically have better outcomes across domains like education, health and socio-emotional development when compared to their peers with lower household incomes (Growing Up in Ireland Study Team, 2018a, 2018b, 2018c). Household incomes determine the resources available to a family to support, enrich, nurture and entertain their child, and capturing this information is paramount for within-cohort, cross-cohort and longitudinal analysis. Capturing household income allows analysis of its interaction with outcomes across all domains

and also helps to track potential improvement or worsening of a family's income overtime, lending itself to poverty analysis and other important issues related to financial status. As this domain is both highly influential on the child's development and susceptible to change between waves, it is necessary to repeat at age 3.

The main sub-topics/measures that could be re-captured from Cohort 24 at age 9 months are (a) information about the family's **earnings** and (b) information on **receipt of social welfare benefits**. Both items were previously captured via administrative data linkage for Cohort 24 at age 9 months in efforts to reduce the burden on participants but were captured via questionnaire for Cohort 08 at age 3.

Recommendations for Cohort 24 at age 3:

- Repeat administrative data linkage for household earnings from Cohort 24 at age 9 months.
- Repeat administrative data linkage for receipt of social welfare benefits from Cohort 24 at age 9 months.

Financial well-being

In keeping with household income, financial well-being also must be captured, as the two domains cannot be considered synonymous or as exact substitutes. Household income may not fully capture the difficulty of making ends meet, for example, due to higher-than-average commitments or indebtedness. These are important aspects to capture for both within-cohort and cross-cohort analysis, as well as longitudinal tracking. Similar to household income, the importance of this domain coupled with its potential to change between waves makes it necessary to repeat at age 3. In the 2024 report of the State of the Nation's Children, data from the EU SILC survey indicated that in 2023, 12% of children were at risk of poverty while 4% of children under 6 were experiencing consistent poverty (DCEDIY, 2024b, p. 141 & 144).

The main sub-topics/measures that could be continued from Cohort 24 at age 9 months are (a) a set of items on **material deprivation** (see next paragraph); (b) items on **savings** and **financial strain**; and (c) items on **income requirements** and **food insecurity**. The first sub-topic is discussed in further detail in the following paragraph.

EU SILC Material Deprivation measure

This measure is adapted from the European Union Survey on Income and Living Conditions (EU SILC). It asks whether the household has been unable to afford certain items, having to go without heating due to lack of money, and ability to spend time doing an activity for entertainment that cost money.

Recommendations for Cohort 24 at age 3:

- Repeat EU SILC measure on material deprivation from Cohort 24 at age 9 months.
- Repeat items on savings and financial strain from Cohort 24 at age 9 months.
- Repeat items on income requirements from Cohort 24 at age 9 months.
- Repeat item on food insecurity from Cohort 24 at age 9 months.

5.5 Summary of New Topics

A number of recommendations for new topics in the family context domain arose from the consultation process and reviews of other research. Some additional topics that were mentioned but ultimately not selected for recommendation for inclusion include means testing, further questions on parental labour status, and information on community child play groups.

Both topics that were subsequently recommended for inclusion in the survey for Cohort 24 at age 3, and those that were considered but ultimately not recommended have been scored according to the main criteria in Table 5.2. Topics that were raised during the consultations but are already listed under ‘continuing topics’ are not included here.

For ease of reading, the scores against the supporting criteria (e.g. being age appropriate) are not included; but most of the recommended new topics will have achieved maximum marks on these.

Table 5.2: Summary of new topics raised in the area of family context during the consultations and review of comparable studies, scored according to the five core criteria

	Captures key domain	Policy-relevant	Age / stage appropriate	Not collected elsewhere	Strong support
Recommended new topics					
Intergenerational socioeconomic and health information	2	2	2	2	2
Intergenerational financial support	2	2	2	2	2
Accessing care services	2	2	2	2	2
Celebrating special occasions	2	1	2	2	2
Other topics considered but not put forward					
Means testing	2	2	1	2	2
Community child play groups	1	1	2	1	0
Awareness of Diet RDAs, etc	2	1	2	2	0
Work hours of primary caregiver prior to birth of child	2	2	0	0	2
Work hours of secondary caregiver prior to birth of child	2	2	0	0	0
Parental isolation	2	1	2	2	0
Child exposure to coercive control	2	2	1	1	0
Environmental and sustainability concerns	0	2	2	2	0
Support from wider community (not own network)	1	1	2	2	0
Community quality of life	1	1	2	1	0
Number of bathrooms	1	1	1	0	0
Benefits through current job	1	1	1	1	0
Reasons for moving house	2	1	1	2	0
Parental attitudes to police	1	1	0	1	0

Intergenerational socioeconomic and health information

Members of the research and policy advisory panels repeatedly mentioned exploring intergenerational dynamics, particularly with regards to multigenerational social mobility and other sociodemographic information. While questions relating to the career and health of the study child's grandparents were not asked of the primary caregiver or secondary caregiver at Wave 1 when the child was aged 9 months, there

were questions within Cohort 98. Acquiring this information early on facilitates tracking of social mobility between grandparent and parent, given that in Ireland children who grow in poor financial circumstances are more likely to experience economic difficulties in adulthood (Curristan et al., 2022), and begin to track it early on in the child's own life.

Although previous Growing Up in Ireland cohorts have been asked for this information when the child was older, it may be pertinent to ask for it at an earlier age to start investigating multigenerational social mobility and intergenerational transmissions at the earliest age possible. The topic of grandparent employment also featured in one of the other comparable longitudinal studies for children in the early years. In previous Growing Up in Ireland surveys, the study child's parent was asked about the education and occupation of their parents and if their household had difficulty making ends meet when they were a child. This information can be used to explore how health and developmental outcomes are impacted by intergenerational characteristics and analysing three generations of a family from the beginning of the study child's lifecourse. This domain is therefore important to include due to its longitudinal value, rather than just cross-sectional significance, as the family socioeconomic and health history will likely influence the study child's development. Collecting this information at age 3 will help inform how early different family histories begin to manifest in outcomes across the cohort.

Recommendation for Cohort 24 at 3 years:

- Bring forward questions on the study child's grandparents asked of the child's parents from Cohort 98 at age 17, or an equivalent item. Questions on age of death (if deceased) may not be necessary yet, given the young age of the cohort.

Intergenerational financial support

In keeping with the interest in collecting intergenerational information expressed in the consultation group meetings, another topic that was discussed was intergenerational financial support, or the study child's parents' reliance on financial support from their own parents. This is particularly relevant in the Irish context; in 2013, two-thirds of women aged 50 to 69 with adult children provided financial

support to their adult children, at an average of €1,500 per year (McGarrigle & Kenny 2013, p.i). While this rate may have decreased in the years since due to changing economic circumstances, especially given Ireland's increase in immigrants (who may be financially isolated from their family), it is unlikely to have disappeared completely.

This topic is of substantial relevance, highlighted by the recent increase in the threshold for when inheritance tax must be paid on transfers to adult children from €335,000 to €400,000.[36] As such, it is pertinent to ask about financial transfers between the study child's parents and grandparents as early as possible to better understand financial strain and support networks for families with young children. Financial support from grandparents also featured in one of the comparable longitudinal studies and was featured for Cohort 08 at age 3, but in less detail than is being proposed for Cohort 24 at age 3 in terms of value and frequency; as such, this is more of an extension and expansion of a topic rather than a completely new topic. This point is policy relevant, as responses can help evaluate current policies relating to government transfers to new parents. Additionally, this topic has longitudinal value, as it can be used to analyse differences in outcomes across the cohort from an early age.

Recommendation for Cohort 24 at 3 years:

- Insert a question asking the study child's caregiver if they have received financial assistance from their parent(s). If the answer is yes, ask a second question if this was in the form of a once-off transfer or occurs regularly. If it is a once-off transfer, ask what the value was and if it was for a house deposit. If it is regular, ask what the average monthly value of that financial assistance is. As this may be a sensitive topic for parents, include these questions in the self-complete section rather than the main questionnaire.

Accessing care services

During consultation group meetings, experts highlighted the need to capture the parents' experiences of coming into contact with support services for their child. Young children with a disability often require additional care services to help support their parents and family and the degree of ease with which they can be accessed can vary greatly (Russell et al., 2021). The 2022 *Government Policy Framework for Service*

[36] https://www.thejournal.ie/inheritance-tax-threshold-increased-budget-2025-6501719-Oct2024/

Delivery of Children's Disability Network Teams (CDNT) seeks to "Provide a clear pathway and fair access to services for each child with a disability and their family based on their need, regardless of their diagnosis, where they live or go to school." (CDNT, 2022 p. 3). Therefore, it is desirable to ask the study child's caregiver about this aspect to provide findings that can inform recommendations for policymakers. This is especially relevant for improving accessibility for such important services, as recent analysis using Growing Up in Ireland data reveals that the disability prevalence amongst 13-year-olds has doubled between Cohort 98 and Cohort 08 (Smyth & Russell, 2024).

To this end, questions can be employed to serve three separate purposes. First, to know whether a study child living with a disability is currently accessing care services; second, to potentially know what services the study child and their family are availing of; and third, to learn with what degree of ease or difficulty the family accessed care services. In order to qualify for care support services for children living with a disability, caregivers must apply for an Assessment of Need[37] to determine what services their child will have access to. This topic has great policy relevance as it can help to evaluate how effective current services for children with disability care needs are and potentially inform new policy to better support families that need to avail of care services for their young child.[38] Additionally, asking about accessing care services has longitudinal importance, as whether the child gets a timely and effective intervention by age 3 may have a significant influence on their future development.

Recommendation for Cohort 24 at 3 years:

- Insert a question asking if the child has received an assessment of need. If the answer is yes, ask which services the family avails of for the child (if any) and ask if the child is registered with the local Children's Disability Network Team, with an option for being registered but not yet receiving support. Finally, ask how easy it was for the family to avail of care services, with scaled responses.

[37] For more information, visit: https://www.hse.ie/eng/services/list/4/disability/disability-assessment/

[38] The Access and Inclusion Model (AIM) seeks to create a more inclusive environment in pre-schools, so all children, regardless of ability, can benefit from quality early learning and care. The model achieves this by providing universal supports to pre-school settings, and targeted supports, which focus on the needs of the individual child, without requiring a diagnosis of disability. It has helped tens of thousands of children with a disability to access and meaningfully participate in the ECCE (Early Childhood Care and Education) programme in pre-school settings nationwide.

Celebration of special occasions

Analysis of the materials from the child consultations suggested that special events and gift-giving were important to 3-year-olds. The parents who took part in focus groups also made multiple references to special events, especially in the approach to Christmas. It may be that an existing question on celebrating special occasions as part of the material deprivation set of items will be sufficient to address this topic. If not, consideration should be given to a single question – possibly with a graduated set of response options rather than just yes/no.

Recommendation for Cohort 24 at 3 years:

- If not already part of the items on material deprivation, add a single question on whether the family celebrates special occasions such as birthdays – preferably with a wider set of response options than yes/no.

Chapter 6: Methodological Considerations

6.1 Respondents and Instruments

It is preferable that both parents/guardians who are resident with the child at age 3 years are interviewed. Ideally there would be longitudinal consistency in the individual who completes the primary caregiver-type instrument as much as feasible and depending on the family context at the time of the wave 2 interview.

It is recommended that the main interview with each parent/guardian is conducted face-to-face, with more sensitive questions extracted into a self-complete module. An in-home visit would be necessary to complete physical measurements and cognitive assessments of the child.

Other potential respondents, where applicable, are the child's non-resident, biological parent and their non-parental caregiver (e.g. childminder). These respondents are discussed in more detail later.

6.2 Sample

The sample should be the study children who participated in wave 1 at 9 months. Ideally the age 3 interview would take place in the month after the children turns 36 months old, both for consistency with Cohort 08 and for intra-cohort consistency. Given the continuing rapid pace of development in the early years, it is important that Cohort 24 are interviewed at the same month of age as much as possible – although the need to retain individual participants in the study means that there will likely need to be some exceptions to this.

6.3 Respondents Outside the Household

Non-resident parents

In most waves of Growing Up in Ireland there has been approximately 15% of study children living in a one-parent household (e.g. Cohort 08 at 3, Williams et al. 2013, p.74); this implies that a similar percentage have another biological parent

elsewhere.[39] Previous analysis of Growing Up in Ireland data (e.g. Cohort 08 at 13, DCEDIY, 2024c) also suggests there is considerable variation in the amount of contact a child has with their non-resident parent (usually their father), with some having very frequent contact and others none at all. For some children, therefore, their non-resident parent is a key figure in their 'microsystem' and they may have a second home with that person if a shared parenting arrangement is in place. This implies that collecting information from and about the non-resident parent, their relationship with the study child, and the context (such as housing) in which that relationship develops is important for a complete picture of the child's life.

Furthermore, we know from a longitudinal perspective on Cohort 08 that among children who had a non-resident parent by age 13, over two-thirds were no longer living (or had never lived) with that parent by the time they were 4 years old (DCEDIY, 2024c). If a similar pattern is repeated with Cohort 24, then we can expect a sizeable number of non-resident parents to be associated with the cohort and contemporary data on those early years of the child's life would be useful in planning policies to support both parents and children.

However, collecting information from the non-resident parent has proved challenging in Growing Up in Ireland and for other similar studies in other countries. A significant initial hurdle is obtaining the contact details for that person if the resident parent either declines to provide them or does not know them. In theory it should be possible, in the Irish context, to use information from the birth register and other administrative records to trace the child's non-resident parent (if they live in Ireland) but that may be unacceptable to the child's resident parent, risking the household withdrawing from the study. While Growing Up in Ireland has attempted to survey non-resident fathers in almost all waves prior to the COVID-19 pandemic in 2020-22, the number of returns was relatively low and likely to be unrepresentative of the entire population of relevant non-resident parents. Critically, following a low level of engagement in the pilot, the CSO decided not to attempt to survey non-resident parents in the first wave of the new cohort (CSO, 2024). This means that the

[39] An exact match between the number of one-parent households and the number of children with a non-resident, biological parent is not expected. Some households may be headed by a lone parent due to widowhood; and some two-parent households may include a step-parent meaning that the study child could still have a biological parent living elsewhere.

decision whether to survey them at the next wave when Cohort 24 is age 3 is particularly important.

Interim findings on a scoping review of engaging non-resident parents

In light of the above considerations, the team at DCEDIY commissioned the ESRI to conduct a review of the engagement of non-resident fathers in surveys (fathers tend to be the vast majority of non-resident parents). This review included focus groups with stakeholders including advocacy groups, parents with lived experience of being either a lone parent or a non-resident parent, interviews with the principal investigators of other child cohort studies, and a literature review. The report, when finished, will also include an analysis of response patterns in the non-resident surveys previously conducted with Cohort 08 at ages 3 and 9 years (Smyth et al. in press).

At time of writing, the review has reached the following preliminary conclusions:

- While many studies similar to Growing Up in Ireland do attempt to survey non-resident parents, engagement is typically comparable to that achieved in previous waves of Growing Up in Ireland (i.e. low).
- One of a small number of exceptions to low response rates for non-resident parents is Growing Up in Australia. In a personal communication, they advise that 69% of resident mothers provided contact details for the non-resident father. Attempts to survey the non-resident parent were filtered on him having at least some contact with the child. The response rate was 35% via postal survey at wave 2, but 79% with a telephone interview at wave 3. The Growing Up in Australia study team felt that a telephone call from an interviewer was an important feature in the improved response rate. They also sent out advance letters that gave detailed information on the rationale for including non-resident parents in the survey.
- Most of the other cohort studies that collect data from non-resident parents archive that data for use by researchers.
- Consultations with stakeholder groups indicated that accounts of the relationship between the non-resident parent and child are likely to be skewed if reported solely by the resident parent. These consultations also confirmed that many resident parents would be reluctant to provide the contact details for a non-resident parent for a variety of reasons including domestic violence at one end of the spectrum to not wanting to get the non-resident parent in some kind of trouble at the other end.
- An ESRI analysis of the characteristics of resident parents who did provide consent and contact details to contact the non-resident parent in Wave 1 of Cohort 98 and 08, showed that consent was more likely from households where the couple had previously lived together, they got on reasonably well,

and where financial support was received from the non-resident parent. This would seem to confirm previous concerns that the completed non-resident surveys that were received in the past are unlikely to be representative of the whole population.

Recommendations for Cohort 24 at 3 years:

- A more detailed recommendation on including a non-resident parent survey for Cohort 08 at 3 years will follow once the completed scoping review is received from the ESRI.
- On the basis of the available information, however, the Department is inclined to the view that collecting data directly from non-resident parents would be important even if the previous methodology needs to be revised.

Childcare providers

It is expected that a substantial proportion of Cohort 24 at age 3 will be in some form of non-parental childcare. Childcare, and associated challenges, was a recurring theme in the recent consultations with both the advisory panels and parents. While parents spoke mainly about the logistics of securing and affording childcare (although they also had concerns about high staff turnover in centres), the advisory panels were mainly concerned with the child's experiences within the centre or in the childminder's home. Childcare and early education are a key pillar of the *First 5* whole-of-Government strategy for the early years, with several major initiatives such as the national childcare scheme (for subsidising the cost of care), and a new registration and inspection requirement for home-based childminders, being implemented as a result.

Potentially some 3-year-olds will be spending more of their waking hours within a childcare facility than at home with their parents, which means that much of their food consumption, activities and interactions with other people take place in that environment. Hence capturing some information directly from the care provider on, for example, diet, screen-time, types of play, learning activities and interactions with other children and staff, would be a useful addition to compiling a detailed picture of the child's lived experience.

It could also be informative to record some structural details of the care environment such as the number of staff and children, staff qualifications, and the facilities

available – information which the child's parent may not know in detail. Government policy has targeted the upskilling of people working in early years education and, according to the most recent State of the Nation's Children report (DCEDIY, 2024b), the percentage of ELC staff with a qualification at QQI Level 7 or higher was 37% in 2023, up from 25% in 2019 (p.64, using data from Pobal). Collecting data at the level of the individual child could shed light on whether progress in areas such as staff qualifications result in better outcomes for young children.

An important decision will need to be made in relation to who receives a childcare provider and/or early learning questionnaire if the child spends long periods in two quite different settings (e.g. an early learning centre 20 hours per week then a home-based childminder for another 20 hours). Previously parents of Cohort 08 were asked to nominate a 'main' care provider, usually based on hours per week – but with the extension of the free pre-school year provision, there is an increased likelihood of split-care with similar durations.

A possible impediment to surveying childminders and centre-based caregivers directly is the relatively poor response in the Cohort 24 at 9 months pilot. While the response from centres who were contacted was quite good, there was a high degree of reluctance from parents to provide the contact details in the first place (CSO, 2024). Data on participation in the care providers' survey in the main phase will not be available until late 2025 at the earliest.

Recommendations for Cohort 24 at 3 years:

- Survey childminders and centre-based carers directly, where a child spends at least 8 hours per week in that childcare.
- The survey could draw on previous surveys used with Cohort 24 at 9 months and Cohort 08 at 3 years for longitudinal and cross-cohort comparisons, but extended or new coverage of topics such as diet, activities, and screen-time should be included.

6.4 Recommendations for Supplementary Measurements

Direct assessments

Tests of cognitive ability

Three-year-olds in Cohort 08 completed two tests of their cognitive ability. Both tests were components of the British Ability Scales (Elliott et al., 1996) suite for the early years. The 'naming vocabulary' test measured the child's expressive vocabulary by showing them a sequence of pictures and asking them to name the object in the picture (e.g. 'book', 'scissors' etc). The 'picture similarities' test measured their reasoning ability by showing them a target picture and four possible matches for the target (a hypothetical example: the target picture could be of a coin which matches to a picture of a screw because they are both made of metal, while the other possible matches – cushion, dog, apple - don't have anything in common with the coin).

These cognitive tests are an important marker of the child's ability in skills that will be critical to their future cognitive development and school readiness (e.g. Rowe et al. 2012). It is also crucial that they be administered in a standard format to make comparisons between children fair and accurate. Cross-sectionally, the test results can be used to compare children at the age of 3 and examine what factors help or hinder ability at this early stage (e.g. breastfeeding, home learning environment, quality of childcare). Longitudinally, the age 3 results can be used to map the extent to which the child is facilitated or impeded in achieving their full educational potential as they get older. For example, previous work by Feinstein (2003) in the UK was very influential in showing that economically disadvantaged children with strong cognitive potential in the pre-school period were at risk of falling behind their economically advantaged (but less cognitively able) peers by the end of primary schooling. A similar trend of 'struggling to maintain potential' was observed in the Cohort 08 data by McNamara et al. (2021): children with lower-educated mothers but in the top quartile for vocabulary at age 3 had lower average reading scores by age 9 than their peers who had been in the bottom vocabulary score at age 3 but whose mothers had a degree (Fig 4.18, p.77).

The cognitive test scores, particularly the vocabulary test scores, have been very widely used by researchers using the Cohort 08 data. Even when the focus of an

analysis is on reading ability or academic attainment at an older age, being able to control for earlier ability can be an essential component. It should be noted that the tests, as previously used, must be administered in English and answers for the vocabulary test have to be in English.

Recommendation for Cohort 24 at age 3

- Ideally, in the interests of cross-cohort comparison, the same cognitive tests would be used with Cohort 24 as Cohort 08. The British Abilities Scales are currently published as a 'version 3' by GL Assessments.[40]
- If for some reason it was not possible to use the same tests, for example if the current version of the BAS has different subscales, then a similar test could be selected as long as it offered the possibility of being re-administered at age 5 to capture change over time. It is particularly important that the child's vocabulary level is directly assessed: as well as being an indicator of their overall ability, a wider vocabulary helps the child to foster other skills related to socio-emotional and academic competence (e.g. Slot et al., 2020).

Height and weight

It is recommended that the height and weight of both parents and child are measured using medically approved equipment during the interviewer visit. If the height of the parent was validly measured at the previous wave, it should be sufficient just to take a new weight measurement. These and other physical measurements, including biomarkers, are discussed in sections 2.4 and 2.5 within the health chapter.

6.5 Other Methodological Approaches from Other Studies

Data Linkage

Six comparable studies reported the imploring of data linkage opportunities between their collected dataset and various health, education, and location datasets. *Born in Bradford* noted that their datasets can be linked with NHS health data, education records through the use of a Unique Pupil Number and National Pupil Database, social care data held by the Department of Education, employment and benefits data recorded by the local authority, and housing or crime statistic data through the matching of geographic information provided. *Growing Up in Scotland* and *ALPSAC* report the same UK health and education related linkage availabilities. Additionally,

[40] https://support.gl-assessment.co.uk/knowledge-base/assessments/bas3-support/general-information/about-bas3

ALSPAC has geo-location data-linkage opportunities using either participant co-ordinates or health, political, and administrative geographies. Lastly, *Growing Up in Australia* and *Growing Up in New Zealand* have similar health and education data-linkage options. *Growing Up in New Zealand* also reported that their dataset can be linked with Census literacy/ numeracy data and housing data.

Mode

Fifteen of the seventeen comparable studies (not including Growing Up in Ireland) conducted data collection through face-to-face interviews. A number of studies included an online or phone option as well to facilitate increased participation. *Growing Up in Quebec* and *Growing Up in Hungary* collected data through the use of an online questionnaire.

Apps/ Recordings

Children of the 2020s has implemented the use of a smartphone application called BabySteps. During data collection, the participants are asked to record videos with the app for later interviewer observation. Alternatively, the participants can record the activity without the use of the application. *Children of the 2020s* will collect a video recording of the parents reading an interviewer-provided picture book to the child as well as the child interacting with an everyday toy.

Alternatively, *Wirral Child Health and Development Study* and *ALPSAC* have implemented the use of head cameras to record activities and allow for later interviewer observations through new pilot studies. During their most recent wave, *Wirral Child Health and Development Study* requests both the teenager and their parent to wear a provided head camera while taking part in a card game as well as while sharing a snack or drink and discussing their upcoming plans for the week. *ALSPAC* conducted a similar pilot study which included the providing of a head camera to specifically fathers and requesting them to record interactions while feeding their baby or playing at home.

Interviewer Observations

In total, six comparable studies included some form of interviewer observation metrics. The *Early Childhood Longitudinal Study* requested the submission of a taped interaction through the submission of the parent and child taking part in a 'Two Bags Task' (10-minute activity where the parent and child were asked to play with a set of dishes and a picture book, each placed within a separate numbered bag and opened in numerical order). The videotapes were later observed and coded by the interviewer for parental sensitivity, intrusiveness, stimulation of cognitive development, positive regard, negative regard, detachment, sustained attention, child engagement, and child negativity behaviours.

Growing Up in Scotland and *Fragile Families* included observation items from the HOME (Home Observation for the Measurement of the Environment) inventory such as parental responsivity and parental acceptance. *Growing Up in Scotland* also included three items from the 'Waiting Room Checklist': child's reservations or lack thereof toward the interviewer, child's eye contact, and child's spontaneous movement. *Fragile Families* asked the interviewer to observe various household deprivation indicators such as whether there was a highchair or toys in the home, any hazardous housing conditions, or whether there was an operational lift. *Growing Up in Australia* and *Growing Up in New Zealand* had similar observational questions related to the general condition of the home, cleanliness of the child, and condition of buildings nearby. *Growing Up in Australia* also included measures of parental and child behaviour during the interview such as whether there was unprompted praise, positive/negative moods, or any shyness/anxiety. *Growing Up in New Zealand* used a method involving photographs for child-parent interaction.

In terms of measuring child development, *Growing Up in New Zealand* included a 'stack and topple' game to observe the child's socio-emotional and cognitive development. The interviewer demonstrated the activity, prompted the child to take part in it independently, and then asked the child to cooperate on the activity through taking turns. Seven comparable studies used the British Ability Scales (BAS) to measure cognitive ability. *Fragile Families* used an alternative - the Peabody Picture Vocabulary Test - as well as a Walk the Line task to assess motor control. The *Early Childhood*

Longitudinal Study observed whether the child had a knowledge of basic colours, could walk backwards along a line, catch a bean bag, build structures using blocks, and a number of other motor assessments. *Children of the 2020s* uses three other direct assessments administered on a table device: a go-no-go activity (whether the child taps or does not tap depending on image presented) to measure response inhibition, a corsi block task (the child is asked to tap various identical blocks) to measure visuo-spatial working memory, and a tracing task for fine motor skills.

Diaries

Southampton Women's Survey and *Born in Bradford* request the parent to complete a detailed food frequency diary. *Born in Bradford* had a very detailed time-use diary for the parent to complete. *Growing Up in Hungary* included a household task diary which asked who in the household was responsible for which task, while *Fragile Families* used a childcare calendar. The aforementioned BabySteps App used with *Children of the 2020s* requests the parent to input information in the form of various daily trackers including, but not limited to, the child's sleep schedule. The app also provides the parent with a monthly research activity which is released between data collection waves.

Accelerometers / Bio-markers

Étude Longitudinale Française depuis l'Enfance (ELFE) provides children with an accelerometer to measure their physical activity and sleep quality over the course of seven days. The same is done during the 7-year-old wave of the *Millennium Cohort Study*.

Height and weight were overwhelmingly the most popular physical measurements collected in other cohort studies. Four studies – *Southampton Women's Survey*, *Born in Bradford*, *German Health Interview and Examination Survey for Children and Adolescents (KiGGS)*, and *Early Childhood Longitudinal Study* – also collected child head circumference measurements. *Southampton Women's Survey* measured mid-upper arm, chest, waist, and hip circumference as well as resting blood pressure. Waist circumference was also collected by *Growing Up in Australia* and *KIGGS* while *ELFE*

also measured mid-upper arm circumference. Lastly, three studies – *Southampton Women's Survey*, *Born in Bradford*, and *ALSPAC* – measured skinfold thickness.

Biomarkers are discussed in detail in Chapter 2, section 2.5.

6.6 Data Linkage Possibilities for Cohort 08 at 3

As noted in earlier chapters, the CSO has established protocols for linking some existing administrative datasets such as income and receipt of social welfare payments. This section instead considers a wider set of datasets that may be available to link to the Growing Up in Ireland dataset. The advantage of data linkage is that it allows researchers to access a wider range of information about the household or individual child without increasing the burden on respondents. Some information, such as water or air quality, may be unknown to the respondent in any case.

Factors to consider in evaluating linkage to a particular dataset include the potential for statistical disclosure and the structural characteristics of the dataset, in terms of coverage and the existing format (e.g. how are individuals identified: name, PPS, eircode etc). It also depends on the agreement and co-operation of the data controller for the other dataset.

Family context

Pobal deprivation index

This index uses a number of indicators to calculate a relative deprivation score for over 18,000 'small areas' with around 100 households in each. The deprivation scores go from 1 'extremely disadvantaged' to 8 'extremely affluent'. The index was recently updated with data from Census 2022. The indicators used include the education, employment status and number of people per room in the household.

Water quality

Uisce Éireann has responsibility for public drinking water supplies. As part of that process, the water quality test results for individual treatment plants – which can in turn be associated with individual eircodes – are published. This dataset has potential for examining whether variations in quality or composition are associated with health

outcomes. For example, public drinking water in Ireland has added fluoride to promote better oral health. Households who have private water supplies, such as a well, would not be included in this dataset but one or two survey questions could be added to the primary caregiver questionnaire on the household's water source and whether they drink the tap water.

Air quality

The Environmental Protection Agency (EPA) undertakes regular monitoring of air quality around the country and produces a measure called the Air Quality Index for Health. Archived datasets are available from the EPA website but further exploration would be required to assess the practicalities of linking to Growing Up in Ireland households or local areas. A recent study linked health data from the Irish study of aging (TILDA) to long-term air pollution data to examine associations with mental health indicators collected as part of the survey. The authors (Lyons et al., 2024) describe the linkage process as follows: "Data on annual average PM2.5 levels for each of the years from 1998 to 2014 were sourced from a global database of PM2.5 levels at 1km-grid resolution. Because respondents in the TILDA survey supplied their current and previous residential addresses, the research team could match annual average PM2.5 data to each respondent and calculate a long-term (17-year) average of PM2.5 levels in their locality.". Higher than average levels of PM2.5 (fine particulate matter) were associated with higher levels of depression and anxiety.

Distance to green (or blue) spaces

The TILDA study has also linked map data to investigate any association between the proximity of green space to obesity for older adults living in urban areas. Data from the European Urban Atlas 2012, produced by the European Union was used for that analysis, and was linked to individual households using geocodes (Dempsey et al., 2018b). A similar methodology was used to look at the effect of proximity to coastal blue space for the depression scores of TILDA participants, this time using map data from Ordnance Survey Ireland (Dempsey et al., 2018a) The successful linkage with the TILDA dataset suggests that a similar exercise to link geographical data to Growing Up in Ireland households is theoretically possible.

Distance to services (schools, GPs etc)

Work done by the Data and Analytics Unit in DCEDIY to map service locations around the country could potentially be leveraged to estimate an approximate distance of relevant services from Growing Up in Ireland households. Examples of already or soon-to-mapped services relevant to Growing Up in Ireland Cohort 24 at 3 are childcare providers, schools, GPs and hospitals. Any linkage would be subject to statistical disclosure and other data protection evaluations but is at least open to exploration.

Social welfare and housing payments

As noted earlier in this report, linkage to administrative data on payments received by the family – such as the working family payment or housing assistance payment – would be very useful for policy-related research. It would also reduce respondent burden in the interview itself.

Health

Given that health data is a special category of personal data under GDPR, the process for negotiating linkage to these datasets is likely to be more complex than the area-level characteristics described in the preceding section.

Primary Care Reimbursement Service Data (HSE)

The Primary Care Reimbursement Service (PCRS) is part of the health service, and is responsible for making payments to healthcare professionals, like GPs, dentists and pharmacists, for the free or reduced costs services they provide to the public.[41] There is also a Drugs Payment Scheme, whereby individuals are reimbursed for the costs of any medicines over a certain monthly threshold.

Other suggestions received from the health advisory panel

At the roundtable consultation with experts working in health research, practice and policy, attendees were asked to consider potential data linkage sources. There were several suggestions, although not all are yet in operation and may ultimately prove to

[41] https://www.hse.ie/eng/staff/pcrs/

be unfeasible for linkage. For future reference, these were the other ideas from the advisory panel:

- The planned national emergency department database
- IPUMS (Integrated Public Use Microdata Series) datasets providing health and census data available through hospitals
- GP data (particularly with regard to developmental checks on height, weight and obesity)
- Immunisation records
- Blood spot (i.e. heel prick) screening data
- The unique health identifier (once implemented)

Addendum – Programme for Government announced January 2025

This report and the various consultation processes were nearing finalisation when a new Programme for Government was published on 23rd January 2025,[42] following the general election in November 2024. The following are some extracts from this new programme which are likely to be relevant to families with 3-year-olds and, as such, should be considered in future decisions on the final content for the age 3 survey with Cohort 24.

Physical health

- Continually review the number of conditions for which babies are screened.
    - *Note: A newborn hearing screening programme (NHSP) was implemented in Ireland in April 2011. Over the last five years [2018-2022] three new conditions have been brought into the bloodspot screening programme. Two more conditions will be added, bringing the total up to 11.*
- Expand free GP services to children up to at least 12 years, and keep its further extension under review.
    - *Note: The government introduced free GP care for children aged under 6 in July 2015. From August 2023, the Under 6s GP Visit Card scheme has been expanded to become the Under 8s GP Visit Card scheme now providing free GP care for all children aged under 8 in Ireland.*
- Promote at least 60 minutes of daily physical activity for children of all abilities.
    - *Note: The current target of 60 minutes in the HSE Guidelines applies to children aged 2-18 years*[43]

Early learning and care

- Introduce and expand arts programming in early childhood education and care settings, nurturing creativity from a young age.
- Examine and expand the Access and Inclusion Model (AIM) and make it available to younger children.
    - *Note: The Access and Inclusion Model (AIM) was launched in June 2016 to enable the full inclusion and meaningful participation of children with disabilities in the Early Childhood Care and Education (ECCE) programme.*

[42] https://www.gov.ie/en/publication/078a1-programme-for-government-2025-securing-irelands-future/

[43] https://www.hse.ie/eng/about/who/healthwellbeing/our-priority-programmes/heal/physical-activity-guidelines/

Relationships and socio-emotional well-being

- Deliver the first inpatient mother and baby mental health unit.
- Proactively provide mental health supports through maternity hospitals following trauma events connected to pregnancy and childbirth.
    - *Note: While Cohort 24 at 3 may be too old to collect information on postnatal and infant mental health specifically, it indicates recognition of the importance of mental health in the early years.*

Family context

- Ensure children and their families who need early intervention and therapy input can access that support in a timely way by increasing staffing, training more therapists, and prioritising children's disability teams to deliver supports and services.
- Support families who are waiting too long for an Assessment of Needs to procure assessments privately.
- Build capacity in primary care therapy services to support a broad range of children and adults with lower levels of complexity in line with the HSE's Access Policy.
- Set a new child poverty target and examine ways to lift more children out of child poverty.
- Examine the further expansion of free public transport for children.
- Encourage employers to publish statistics of the take up, by both genders, of parental leave and flexible working.
- Examine the extension of Parents Leave and Benefit and additional flexibilities.
    - *Note: The emphasis on leveraging new and existing policies for families of young children in this Programme for Government opens up further possibilities for data collected in Growing Up in Ireland to provide useful evidence for such policies.*

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