LIFECOURSE TRACKER

Wave Two report – FINAL

Prepared by: Bridget Williams, Claire Bhaumik and Elisabeth Brickell


GfK NOP Social Research

Issue: FINAL October 2013

Table of Contents

1 Introduction and methods

1.1 Background and introduction

The main aim of the Public Health White Paper *Healthy Lives, Healthy People*[1] is to encourage local authorities and health professionals to build local relationships and partnerships to improve the health of the public across the course of their lives. Informed by Professor Sir Michael Marmot's *Fair Society, Healthy Lives* report[2], the strategy adopts a lifecourse framework for tackling the wider social determinants of health, and aims to build self-esteem, confidence and resilience from infancy.

The *Social Marketing Strategy for Public Health*[3] set out the Department of Health's[4] intention to change the way in which health messages are delivered to the public. Instead of running a large number of single issue campaigns, the Department of Health (the Department) aims to adopt a lifecourse approach to treat individuals holistically, and deliver support on all topics which are relevant to the individual at that stage in their life. This approach acknowledges the interaction between different health behaviours, and understands that individual motivations, values and influences can impact across the range of health behaviours. It is also felt that, by taking a lifecourse approach, cross-behavioural messages can reinforce and amplify each other, and the Department can enter into a longer term 'conversation' with individuals, using more frequent and regular communications with people.

An approach which is centred on the person rather than the behaviour should feel more relevant to the individual at their stage in their life, and will establish trusted sources or brands which will provide the information, support and resources that individuals need. The only exceptions to this approach will be the on-going communications around tobacco, and any tactical health protection campaigns (e.g. flu pandemic).

Given the new focus on lifecourse and on holistic treatment of the individual across all health behaviours, the Department of Health commissioned a new survey called the Lifecourse Tracker, which aimed to give tailored information reflecting the change in emphasis.

The programme of research aims to:

- Enable the tracking of combinations of health behaviours and how they interact with lifestage, rather than only looking at specific behaviours (or groups of behaviours) in isolation
- Track in detail the links between health motivations and behaviours: to assess the impacts of the social marketing programme on the interim behavioural and attitudinal goals of the social marketing campaign, as well as looking at the end results (i.e. core behaviours identified by the strategy)
- Provide more timely information on health behaviours: this research does not aim to replace other large and robust surveys which aim to provide robust prevalence measures (e.g. Health Survey for England, General Household Survey, British Crime Survey), but instead to supplement them with data which can be tailored and temporally linked to social marketing activities

[1] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/151764/dh_127424.pdf.pdf
[2] http://www.marmotreview.org/
[3] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/147325/dh_126449.pdf.pdf
[4] At the time of commissioning the Lifecourse Tracker survey, the Department of Health held responsibility for government policy for health and social care matters and for the National Health Service (NHS). Following a reorganisation of the National Health Service (NHS) in England, from 1st April 2013 these responsibilities became the remit of Public Health England (PHE). Throughout this report we refer to Department of Health as 'the Department'. More information on the Department and PHE is provided in the glossary of terms in section 16 of the appendices.

- Provide a holistic view of outcomes which may have been influenced by multiple communications, campaigns: rather than looking at shorter and longer-term outcomes on an individual campaign level. The study accounts for seasonal effects (by completing two waves each year) and takes a longer term view
- Feed into the development of the Social Marketing Strategy and its component parts in the long and short term

The research also aims to understand **variations**:

- Across different audience groups/lifestages, demographic and situational groups, and attitudinal or behavioural groups
- Over time, both at the total sample level, but also within the key groups shown above

This report focuses on the results from the first two waves of research, which were conducted in Spring and Autumn 2012. The Lifecourse Tracker aims to build a picture of health behaviours and attitudes over time, and further reports will comment on changes in behaviours or patterns of behaviour over time.

1.2 Methods

The main group of interest for the Lifecourse Tracker research was adults aged 18+ in England. Two further key groups were identified: young people aged 11-17 and pregnant women and mothers of 0-2 year old babies. Separate surveys were conducted with 11-17s and pregnant women/mothers of 0-2s because of their relatively low penetration in the general population.

The methods employed for the three surveys are summarised below:

- Adult survey: conducted face to face in respondents' homes, with the sample drawn using random location sampling. Quotas were set at each wave to achieve a representative sample, and the profile of sampling points was matched from wave to wave to ensure comparability over time. A boost was included of interviews with those in the 10% most deprived areas to enable further analysis within this group. The average interview length was 40 minutes
- Young people survey: conducted face to face in respondents' homes, again using random location sampling, using sampling points with a household penetration of 11-17s of 8% or more. Once again, a boost was conducted with those in the 10% most deprived areas. Interlocking quotas were set on the age and gender of the young person. The average interview length was 34 minutes
- Pregnant women and mothers of 0-2s: interviews were conducted online with the sample drawn from the Emma's Diary database. The sample was drawn following stratification of the database by region, age of mother and stage of pregnancy/age of child. The questionnaire comprised circa 100 questions

Further details of the survey methods for each group are described in the appendices.

Before conducting the survey, an extensive development stage was conducted to ensure that the questionnaire met the needs of the Department and other users of the data. The development stage included a knowledge review, expert interviews, a stakeholder workshop and three stages of piloting.

Figure 1 shows fieldwork dates and number of interviews achieved within each sample group.

Figure 1 **Key fieldwork figures**

	Adults		**Young people**	
	Wave 1	**Wave 2**	**Wave 1**	**Wave 2**
Fieldwork dates	12th – 31st March 2012	17th Sept - 17th October 2012	14th March- 9th April 2012	17th Sept - 17th October 2012
Number of interviews	1010	1019	608	602

	Pregnant women and mothers of 0-2s	
	Wave 1	**Wave 2**
Fieldwork dates	21st – 31st March 2012	28th September - 5th October 2012
Number of interviews	300 with pregnant women 247 with mothers of 0-2s	294 with pregnant women 303 with mothers of 0-2s

The achieved samples were weighted to known profiles:

- The adult and young people samples to profiles taken from the Census, including down weighting the boost of interviews in deprived areas. The effective sample size was around 65% of the achieved sample
- The pregnant women/mothers of 0-2s sample to profiles taken from GfK NOP's Financial Research Survey (itself weighted to the National Readership Survey). The effective sample size was 84% of the achieved sample

1.3 Structure of this report

This report focuses on the behaviours and attitudes of people in England today. The report aims to provide a reference and resource for those interested in health behaviours and attitudes, and their interactions and influences. Differences in levels of reported health behaviour by demographic group are noted, though it is acknowledged that similar information is also available from other surveys (e.g. Health Survey for England). More emphasis is, therefore, placed on areas where the Lifecourse Tracker survey adds to the overall evidence base, for example by looking at interactions between behaviours, influences on behaviour and on attitudinal information which is not available elsewhere.

Changes between the two waves in reported behaviours and/or attitudes are noted in the commentary. However, it should be remembered that attitudes and behaviours change slowly, so we did not expect to observe many changes over such a short period of time.

The report is structured to reflect the lifecourse approach.

- Chapter 2 provides an overview
- Chapters 3 and 4 cover general well-being and cross-behavioural comparisons amongst adults
- Chapters 5 to 11 cover health behaviours amongst adults in England
- Chapter 12 looks in detail at the views and experiences of pregnant women and mothers of 0-2s
- Chapter 13 focuses on young people aged 11-17

- While those aged 55+ are also included in the all adult sample, this audience is also of particular interest, so Chapter 14 looks in detail at this group: looking at differences in response between 55+s and the average adult population

1.4 Notes on reading this report

The following should be noted when reading this report:

- All comments on health behaviours are based on respondents' own reports of what they do, rather than on observation, measurement or diary studies
- Where respondents answered about their consumption of fruit/veg, they answered about their consumption on the day before they were interviewed, rather than an average consumption level. Similarly, responses on physical activity levels and alcohol consumption were based on the week before they were interviewed rather than on average levels. It is acknowledged that these may not be typical of the respondent's usual consumption/activity, and this may mean that the strength of association with other variables (e.g. attitudes) may be systematically diluted as a result
- The non-random survey method employed means that true statistical significance cannot be inferred but we have used it as a proxy for our analysis. Any differences reported would be statistically significant at the 95% confidence level. Where differences are large but not significant these have been referred to as 'somewhat' different, but the fact that they are not significant is noted
- It should be noted that statistical significance is not intended to imply substantive importance
- In order to conduct this significance testing, we have used the effective sample size for the research, which takes into account the impact of weighting
- All base sizes shown in the figures show the unweighted base, which is the number of people answering that question. However, all figures shown have been weighted. More details can be found in section 15.4.4
- In some cases %s shown in the figures may sum to more or less than 100% because of rounding error, because the question was a multi-coded option or because 'Don't know' and 'Prefer not to say' answers are not shown
- Where '*' is shown instead of a % in a chart or table this indicates a proportion of less than 0.5% but greater than 0
- A glossary of terms is provided in section 16 of the appendices

2 Management Summary

2.1 Overview

Associations with lifecourse

There are strong associations between lifecourse and health behaviours:

- Age: prevalence of risk behaviours (e.g. smoking and drug use) peaks at age 18-35. Thereafter prevalence tails off quickly. In addition, the youngest (18-24s) and oldest age groups (75s+) were least likely to eat 5 a day and 75+s were the least likely to be physically active
- Living with a partner: those living with a partner tended to report fewer negative behaviours, even when age is taken into account
- Becoming a parent: parenthood appears to be a trigger for a range of positive changes to health behaviour, in particular giving up smoking, cutting back on alcohol and improving diet. However, these changes may not always be sustained after becoming a parent

Associations with socio demographic status

The social gradient of health inequalities highlighted in 'Fair Society, Healthy Lives'[5] is still evident. Those in C2DE[6] households, in deprived areas and with lower levels of education tended to report more negative health behaviours. They also tended to feel less empowered to make healthy changes, which indicates that they may need more support to encourage behaviour change.

Household environment was also important, with those living with a smoker, drinker or drug user more likely to report those negative health behaviours themselves.

Perceptions and images of healthy lifestyles

The survey findings suggest that adults do not perceive healthy lifestyles in the round. For many of the public, physical appearance and weight are considered most important, and while diet and exercise are understood to be constituent parts of a healthy lifestyle, there are lower levels of engagement with the detail of what a healthy diet or being physically active means.

People who feel that they are an ideal weight or who are more physically active but who report other negative health behaviours (e.g. smoking, increasing/higher risk drinking) were less likely to intend to change their other negative health behaviours, which further suggests that they are not thinking about health more broadly.

Associations with social norms

Those perceiving that healthy lifestyles are the norm for their friends/family tend to report more positive health behaviours. Healthy norms were more prevalent amongst older people (55+s) and ABC1s.

Stopping smoking was acknowledged as the norm by the majority of adults, and smokers who intend to give up smoking also state strong intentions to make other healthy changes (e.g. cutting back on alcohol, eating a healthier diet). This is positive, given that smokers tend to report poorer diets than non-smokers.

---

5 http://www.instituteofhealthequity.org/

6 This is a social grade grouping and is based on the occupation of the chief income earner of the household. For more details please see 16.2.1

Fewer adults thought that more people are cutting back their alcohol consumption nowadays, and levels of worry about the impact of alcohol on health and intentions to cut back consumption amongst increasing/higher risk drinkers were also lower. Increasing/higher risk drinkers were also the most likely to think that daily drinking is acceptable. Taken together these findings suggest that further education would be useful to encourage heavier drinkers to consider the health impacts of their behaviour: this is especially important as most increasing risk drinkers thought of their alcohol intake as 'moderate'.

A relatively high proportion of 18-24s (57%) thought that most young people of their age take drugs nowadays, and those thinking that drug use is more common were more likely to take drugs themselves.

Norms were particularly influential in driving behaviours for 11-17s: those perceiving risky behaviours to be common amongst their peer group or perceiving those engaging in risky behaviours to be popular or clever were more likely to report risky behaviours themselves.

In addition, pregnant women and mothers of 0-2s who felt that breastfeeding was the norm were more likely to intend to try breastfeeding, or to breastfeed exclusively beyond 6 weeks.

2.2 Adults – management summary

This section summarises the findings from the adult survey and follows the structure of this report.

2.2.1 Adults – core indicators

Core behavioural indicators were selected for each target group in conjunction with the relevant policy teams to reflect policy priorities. One core indicator was selected to represent each behaviour for longer term tracking but other behavioural characteristics were also measured. For instance, fruit and veg consumption was the core indicator, or proxy, for nutritional behaviour but consumption levels of sugar, fat and fizzy drinks were also measured in the survey.

Figure 2 and Figure 3 summarise the core indicators measured in the adult survey by key analysis variables including lifecourse group. Negative health behaviours are shown, for example the proportion eating fewer than five portions of fruit/vegetables a day, the proportion smoking nowadays.

Figure 2 **Adults - core health behaviour measures by gender, age and social grade**

	All adults (2029) %	Male (895) %	Female (1134) %	18-34 (559) %	35-54 (637) %	55+ (833) %	ABC1 (853) %	C2DE (1176) %
Fewer than five portions fruit/veg on the day before interview	79	80	78	86↑	78	74↓	75↓	83↑
Fewer than 150 active minutes in the week before interviewed	53	50↓	56↑	51	50	57↑	49↓	57↑
Increasing/higher risk drinker[7]	15	19↑	12↓	15	18	13↓	18↑	12↓
Current smoker	24	27	22↓	33↑	31↑	11↓	18↓	32↑
Used drugs in last 12 months	7	11↑	3	15↑	6	1	6	8
Unprotected sex[8]	5	7↑	4↓	12↑	6↓	N/A	4	7↑

Base: All 2012 adults in each group
↑↓ Indicates a significant difference, compared with the all adult average

Figure 3 **Adults - core health behaviour measures by lifecourse group**

	18-24 (223) %	25-34 P (185) %	25-34 NP (151) %	35-44 P (228) %	35-44 NP (99) %	45-54 P (101) %	45-54 NP (209) %	55-64 (300) %	65-74 (288) %	75+ (245) %
Fewer than five portions fruit/veg on the day before interview	90↑	82	83	69	84↑	76	83	69↓	71↓	84
Fewer than 150 active minutes in the week before interviewed	53	51	48	52	50	50	49	48	54	71↑
Increasing /higher risk drinker	15	13	16	15	22	18	18	15	13	9↓
Current smoker	33↑	33	32	26	49↑	21	29	14↓	14↓	3↓
Used drugs in last 12 months	18↑	9	14	6	8	6	3	3↓	1↓	N/A
Unprotected sex	18↑	7	8	4	7	9	5	N/A	N/A	N/A

Base: All 2012 adults in each group. P= Parent, NP = non-parent
↑↓ Indicates a significant difference, between parents and non-parents in same age group or compared with the all adult average

[7] Classified on the basis of weekly alcohol unit consumption of 22+ units for men and 15+ units for women
[8] Defined as sex without a condom with more than one partner or a new partner in the last six months

2.2.2 General views of health and well-being (see section 3)

Though almost seven in ten adults rated their own health as good or very good, older people were less likely than other groups to say this. Older people were also more likely than average to report both long term limiting illnesses and most lifestyle-related health problems, though it was women in the 35-54 group who were most likely to say they had depression or stress for which they were receiving treatment.

When asked to consider healthy lifestyles in general, most adults spontaneously thought about diet and exercise, and there were few mentions of what a healthy lifestyle entails. Lower proportions considered aspects of a healthy lifestyle which were not related to diet or exercise (e.g. stopping smoking, reducing alcohol consumption) and few mentioned any aspects of mental health.

Overall, those reporting negative health behaviours were *less* likely than average to think that healthy lifestyles are easy to achieve, to be in their control or to be the norm.

While over four fifths of adults agreed that they feel good about themselves, the survey found that around three fifths expressed short-termist attitudes, and a third agreed that there is little they can do to change their lives.

There were clear social gradients in views of health. Those in social grades DE (in particular Es), and thus in relatively poor households tended to report worse health with consequent impacts on their day to day activities. They also tended to feel less knowledgeable and less empowered about living a healthy lifestyle, and were less likely to believe that a healthy lifestyle is the norm. In addition, those in social grade E reported lower levels of self-esteem, locus of control, and were more short-termist in their views.

In addition, and reflecting their lower social grade profile, smokers and those eating less healthy diets tended to report poorer health and less positive attitudes to health and to life in general. They were also less happy and had lower levels of life satisfaction.

Increasing/higher risk drinkers also tended to have lower levels of life satisfaction than average, despite their more AB social grade profile, however they did tend to feel more positive than average about their own ability to change their lives and their health.

2.2.3 Comparisons across behaviours (see section 4)

On average adults reported 1.8 out of the five negative health behaviours asked of all in the survey [9] with significantly higher averages amongst 18-24s (2.1) and 35-44 non-parents[10] (2.1). Men, C2DEs, those in deprived areas and those not living with a partner tended to report more negative health behaviours on average.

The most common clusters of negative health behaviours related to nutrition and physical activity, with over two fifths of adults reporting that they had both eaten fewer than five portions of fruit/veg yesterday and had done fewer than 150 active minutes last week.

The Change4Life strategy includes messages around nutrition, physical activity and alcohol consumption, and 90% of all adults reported at least one negative health behaviour on these three factors, with 6% reporting negative behaviours on all three.

A third of adults said they were either smokers, increasing/higher risk drinkers or drug users, though only 1% reported all three behaviours.

---

[9] Fewer than five portions of fruit/veg yesterday, fewer than 150 active minutes last week, smoke cigarettes nowadays, increasing/higher risk drinker, drug user. Only under 55s were asked about sexual health, so this has been excluded from this analysis.

[10] Non-parents are defined as those who do not have children in their household for whom they have caring responsibilities. Some of these non-parents may have caring responsibilities for children outside of their household, but this was not explored in the questionnaire.

A sub-sample of those reporting negative health behaviours was asked how worried they were about the impact of their behaviour on their health. Smokers were most likely to worry about the impact of their smoking on their health, and also to worry about the impact of their other negative health behaviours on their health.

Respondents were more worried about the impact of weight on their health than possible contributing factors to health (e.g. low levels of fitness, poor diet), so there may be scope to get people to think about healthy diets and lifestyles as more than just weight.

Levels of worry were lower about alcohol and drug use, with over two thirds of those reporting negative health behaviours saying that they are not worried about the impact of these behaviours on their health.

In terms of physical activity and consumption of fruit and vegetables our sample reported relatively strong intentions to make positive changes: for example half of those who reported *fewer* than 150 active minutes said they intended to be more active over the next three months, and two fifths of those not eating 5 portions of fruit/veg yesterday said they intended to eat a healthier diet over the same time period. Changes which meant doing *less* or giving up (e.g. giving up smoking or drug use, or drinking less alcohol) had lower levels of intention to change.

It was notable that those who intended to change one behaviour were more likely to intend to change other behaviours, suggesting an opportunity to work holistically with those reporting multiple negative health behaviours to help them make changes.

Those who said they had done 150+ active minutes last week were less likely to intend to make healthy changes, as were those who perceived themselves to be an ideal weight. These findings may suggest a belief that as long as someone is active and not overweight, it doesn't matter what other behaviours they exhibit.

2.2.4 Nutrition (see section 5)

While the vast majority of adults say that healthy eating is a priority for them, in practice, eight in ten reported they ate *fewer* than five portions of fruit/veg on the day before they were interviewed. Only a minority were making positive and consistent decisions about their food choices - under half said that they limited salt whilst a third said they limit the amount of high calorie food they eat - and only half perceived healthy eating to be the norm amongst those they knew.

The following groups of adults tended to report poorer diets: 18-24s, C2DEs, smokers and men. Across nearly all nutritional measures, 18-24s tended to be eating more poorly than other adults (including being most likely to report eating fewer than five portions of fruit/veg a day) and were less likely to say that healthy eating is a high priority or the norm, despite there being no practical or financial barriers to healthy eating specific to this age group.

While some of those reporting a less healthy diet (including 18-24s) have acknowledged the impact of their diet on their health and intend to change, it is notable that those who said they consume high calorie/sugary foods often were no more likely than average to intend to make healthy changes to their diet. This may imply that for some, frequent consumption of high calorie/sugary foods may not be viewed as unhealthy.

2.2.5 Physical activity (see section 6)

Nearly all adults (9 in10) agreed that there are plenty of ways to be physically active without going to a gym or taking part in organised sports. Despite this, only half of adults reported levels of exercise sufficient to meet the current guidelines on physical activity in the week before they were interviewed (150 weekly minutes of moderate activity). C2DEs were also more likely to say they had done fewer than 150 weekly active minutes, and they were also less likely to acknowledge that it is possible to be active without going to the gym/playing organised sports. No particularly strong barriers to being more active were

reported: lack of time was most commonly cited, though for many inertia was a key barrier. Poor health and age were also mentioned as barriers to being more active.

For adults the mean number of sedentary hours on the day before interview was just under six. Men, social grade Es and those aged 75+ tended to report more sedentary hours than average.

While half of those who were not being sufficiently active said that they intended to increase their activity levels in the next three months, respondents were less worried about the impact of their fitness levels on their health than they were about the impact of their weight.

2.2.6 Children's (2-11s) nutrition and physical activity (see section 7)

Eight in ten parents said that their child ate fewer than five portions of fruit/veg yesterday. Similar proportions of parents said this about their own consumption.

Whilst most parents claim to make sure their child eats child size portions, in practice, 2-11s were more likely to consume sugary foods and drinks on a daily basis than adults, and only a third of parents said they limit the number of snacks their child eats. This suggests that whilst portion size may be smaller for 2-11s, frequency of consumption of some unhealthy foods may be an issue.

Six in ten parents (61%) said that their child spends at least one hour a day being physically active and reported an average of 2.5 sedentary hours per day outside of school / nursery hours for their child. While over half of parents (54%) agreed that most other parents are increasing their children's activity levels, fewer (39%) said they intend to increase their own child's activity levels.

Close links were noted between parents' and children's behaviour: parents eating 5 a day were more likely to have a child who does the same, and parents who reported 150+ weekly active minutes were more likely to have an active child.

2.2.7 Alcohol (see section 8)

One in seven adults were classified as increasing or higher risk drinkers; prevalence was similar between the ages of 18 and 64 but from the age of 65 prevalence declined sharply. Non-parents aged 25-44 and ABs were the most likely to be classified as increasing or higher risk drinkers. It is notable that this is the only negative health behaviour which was more prevalent amongst the AB social grade.

Perceptions of the impact of alcohol consumption on health and intentions to change drinking habits were not particularly prominent in the minds of adults, particularly in comparison with other health behaviours. For instance, few thought that more people are cutting back their alcohol consumption nowadays, whilst future intentions to change and worry about the impact of drinking on health were not as strong as other health behaviours measured in the survey.

This may be linked to the fact that increasing/ higher risk drinkers did not necessarily perceive themselves to be heavy drinkers. Whilst acknowledging that they drank more than other adults, these increasing/higher risk drinkers thought of their alcohol consumption as moderate, rather than heavy. They were also more likely to agree that it is ok to drink every day as long as you are not getting drunk

Differences between increasing and higher risk drinkers were also noted, suggesting that this group cannot be treated homogenously. Increasing risk drinkers were more likely to think others were cutting back alcohol these days even though their own efforts to reduce consumption were no greater than lower risk drinkers (based on past behaviour and future intentions to change). Meanwhile, higher risk drinkers were less likely to feel that others

are cutting back but were more likely to intend to cut back themselves, perhaps because they were the most worried about the impact of their drinking behaviour on their health.

2.2.8 Tobacco (see section 9)

Smoking prevalence varied considerably by lifecourse. Whilst a quarter of adults said they smoked, under 35s and non-parents were the most likely to be current smokers and prevalence tailed off sharply from age 65. However, older smokers tended to smoke more cigarettes on an average day.

Smoking prevalence was also particularly high amongst those from social grades D and E, people in poor households, and in deprived areas.

Lower prevalence levels amongst parents may be associated with to having a child – certainly pregnant women and mothers of 0-2s were less likely to smoke than other women their age and pregnancy was often cited as a reason for quitting. Exposure to smoking through other household members was also associated with smoking prevalence: half of smokers lived with a smoker, compared with 17% of non-smokers.

Eight in ten of all adults said that smoking is not allowed in their home or the family car (where one is available), with younger people and ABC1s least likely to allow smoking in their home or family car

Most adults acknowledged the harm smoking does to their health, but smokers were more likely to feel that the health risks from smoking are greatly exaggerated. Despite this, smoking was the negative health behaviour that most were worried about.

In addition, giving up smoking was a broadly perceived and well established social norm, with six in ten adults agreeing that more people are stopping smoking nowadays. A quarter of smokers said they really want to quit smoking and intend to do so in the next three months, and four in ten had made at least one serious quit attempt in the past 12 months. The main barriers to quitting mentioned related to just not wanting to quit, enjoying smoking and habit.

On average, smokers reported significantly more negative health behaviours than non-smokers, and they were also more frequent consumers of unhealthy foods.

2.2.9 Illegal drug use (see section 10)

Use of illegal drugs/legal highs peaks between ages 15-24 (17% of 15-17s, 18% of 18-24s). However, the perception was that drug use is more prevalent than it actually is, as almost six in ten (57%) of 18-24s thought that most people of their age use drugs nowadays. This age group was also most likely to say that they live with other people who take drugs, perhaps further contributing to the perception that usage is more prevalent.

Those not living with a partner were more likely to report drug use, even when age biases were controlled for. Parents and non-parents were equally likely to report drug use.

Relative to other negative health behaviours drug users were the least likely to worry about their drug use or say they intend to give up in the next three months, with personal choice and enjoyment the main reasons for not wanting to stop using drugs.

2.2.10 Sexual health (see section 11)

One in ten 18-54s had had unprotected sex with multiple partners or a new partner over the past 6 months (defined as sex without a condom): 18-24s and those who did not live with a partner were most likely to report this.

Males, those not living with a partner and drug users were the most likely to report unprotected sex in potentially risky situations, such as when drunk or within a few hours of meeting someone.

2.3 Pregnant women and mothers of 0-2s – management summary

Figure 4 summarises the key indicators measured in the pregnant women and mothers of 0-2s survey by key analysis variables.

Figure 4 **Core health behaviour measures – Pregnant women and mothers of 0-2s**

	All women (1144) %	Pregnant women (594) %	Mothers of 0-2s (550) %	Other women* (370) %	ABC1 (651) %	C2DE (443) %
Fewer than five portions fruit/veg on the day before interview	79	74	84↑	83	74	83↑
Fewer than 150 active minutes in the week before interviewed	N/A	N/A	79	55	36	41
Drunk alcohol in the last week	19	8	30↑	45↑	25↑	15
Current smoker	11	4	18↑	29↑	8	14↑

Base: All 2012 women in each group: as shown. *Taken from the all adult survey
↑↓ Indicates a significant difference, compared with the corresponding sub-group

2.4 Pregnant women and mothers of 0-2s (see section 12)

This section summarises the findings from the pregnant women and mothers of 0-2s survey.

Although both groups reported generally positive frames of mind, pregnant women reported higher levels of well-being than mothers of 0-2s and other women on all of the key measures. In addition, pregnant women were more likely to report getting enough sleep to feel rested at least some of the time in the past four weeks. There were some apparent links between the amount of rest women were getting and how they felt generally, with those who felt rested at least some of the time in the past four weeks reporting significantly better well-being, better general health and lower prevalence of post-natal depression.

Most mothers of 0-2s indicated that they had good support networks of family/friends around them, living close enough and being able to see each other as often as they wanted. Parents, health visitors and friends were the most common sources of support for mothers of 0-2s, the majority of whom felt supported overall in their role as a parent. Mothers of 0-2s who felt more supported were also more likely to report that they were coping well with parenthood.

Pregnancy appeared to act as a trigger for healthy behaviour changes – not only for women themselves, but also amongst other members of their households. Pregnant women were significantly less likely than mothers of 0-2s to report eating fewer than five portions of fruit/veg a day, less likely to have drunk alcohol in the past seven days and less likely to smoke. Amongst those who did report negative health behaviours, pregnant women generally stated stronger intentions to make healthy changes over the next three months. In addition, leading a healthy lifestyle was a higher priority for women during pregnancy and pregnant women were more likely to feel that achieving a healthy lifestyle would be easy and in their control.

The majority of mothers of 0-2s said they had breastfed/given breast milk to their baby, and the majority of pregnant women intended to do so. Around half of mothers of 0-2s had breastfed exclusively at six weeks or beyond. Women overall held positive attitudes towards breastfeeding – understanding the benefits of breast milk and recognising that it is better for a baby than formula milk. However, almost half of all women said they would feel uncomfortable breastfeeding "out and about".

The majority of mothers of 0-2s had/intended to introduce solid foods into their baby's diet before the age of six months. The majority of mothers who had already given their baby solid foods were feeding their child in the way suggested in the Start4Life guidelines around child nutrition – varying tastes and textures, including vegetables every day and avoiding salt and sugar – though associations with Start4Life communications cannot be inferred..

Mothers of 0-2s were more likely than other women (non-parent women of a similar age taken from the all adult survey) to say they had not been sufficiently physically active in the past week (doing fewer than 150 active minutes). A third of all women said they were as active during pregnancy as they had been before, but most said they were less active; with levels of physical activity reducing as pregnancy progressed.

Smoking prevalence and alcohol consumption were lower amongst all women surveyed than other women – and lower amongst pregnant women than mothers of 0-2s.

2.5 Young people (11-17s) – management summary

Figure 5 summarises the key indicators measured in the young people survey by key analysis variables. Figure 6 summarises a number of additional indicators also measured amongst 15-17s by key analysis variables.

Figure 5 **Core health behaviour measures – 11-17s**

	All 11-17s (1210) %	Male (607) %	Female (603) %	11-12 (377) %	13-14 (397) %	15-17 (436) %	ABC1 (490) %	C2DE (720) %
Fruit/veg less often than several times a day	73	75	70	73	68	75	68	77↑
Moderate activity 0-6 days a week	67	62	71↑	59	66	72↑	68	66
Drinks at least once a month	23	23	22	1	14↑	42↑	26↑	20
Smoker	9	9	10	*↓	6↓	17	5	13↑
Used cannabis, ecstasy or cocaine in last 12 months	7	8	5	1↓	3↓	13	4	9↑
Ever had intercourse	14	16	13	-	3	30	11	17

Base: All 2012 11-17s: as shown
↑↓ Indicates a significant difference, compared with the corresponding sub-group

Figure 6 **Core health behaviour measures – amongst 15-17s only**

	All 15-17s (436) %	Male (209) %	Female (227) %	ABC1 (180) %	C2DE (256) %
Age of first proper alcoholic drink (not just a sip) - before 15	37	41	34	35	40
Age of first intercourse -before 15	7	8	5	4	10

Base: All 2012 15-17s only: as shown

2.6 Young people (11-17s) (see section 13)

This section summarises the findings from the young people's survey.

Young people (11-17s) generally felt happy and healthy. Some groups (for example girls aged 13-17 and those reporting risk behaviours) were more likely to report a negative mindset and say that they have self-harmed, feel that they are not the right weight or report health conditions such as dizziness or tiredness.

As they get older, young people's priorities appeared to change. While most young people felt close to their parents, the oldest age group were less likely to say that they enjoyed spending time with family or feel comfortable talking to their mum and dad about things that bother them. In terms of specific worries, pressures related to school were the most common and were the predominant concern for 15-17s whilst worries were more mixed for 11-12s: as well as school pressures, other common concerns for this age group were bullying and risky health behaviours (e.g. people smoking, drinking alcohol and taking drugs).

Most young people were not eating fruit and veg several times a day and/or were not moderately active on a daily basis. Other measures of diet showed that, in comparison with adults, young people reported poorer diets. Young people in C2DE households tended to have poorer diets than average and girls aged 13-17 were not as physically active as other 11-17s. There was no evidence to suggest that there was an association between diet and prevalence of risk behaviours amongst young people.

Prevalence of all negative behaviours was generally lower amongst 11-17s, with much higher levels amongst 15-17s: particularly amongst those living in C2DE households (except for monthly drinking which was more prevalent amongst those living in ABC1 households). In addition, young people who were exposed to risk behaviours in the home (e.g. smoking, heavy drinking) were more likely to report those risk behaviours themselves.

11-17s tended to perceive risk behaviours as bad for health and viewed peers who engaged in these behaviours more negatively than positively. Drug use amongst peers was judged most negatively and perceived to be the least prevalent, whilst having sex was perceived to be the least negative and most prevalent risk behaviour. Those reporting risk behaviours and 15-17s (these groups do overlap) tended to view each risk behaviour more positively and to think that it is acceptable to engage in these behaviours.

Parents and young people had varying perceptions of conversations with one another about risk behaviours. Young people were less inclined to say that conversations about risk behaviours had happened and less likely than parents to think such conversations would be easy. The most commonly discussed behaviours, and also most likely to be deemed easy to talk about, were drinking alcohol and smoking.

For all behaviours, the first conversation was predominantly a proactive conversation (rather than as a reaction to the parent discovering their child was engaging in that behaviour).

2.7 Older people (55+) (see section 14)

This section summarises the findings from the adult survey and is specifically about 55+s.

Overall, older people reported lower levels of well-being than the all adult average in relation to the ONS well-being measures, self-reported health and attitudes towards their own health now and in the future.

Older people's health behaviours were generally better than the all adult average. They were less likely to report all negative health behaviours with two exceptions: physical activity and alcohol consumption. Over 55s were more likely than the all adult average to say that they were active for fewer than 150 minutes in the previous week. In addition, a similar proportion as the all adult average reported alcohol consumption which classified them as increasing/higher risk drinkers.

The over 75s, in comparisons with 55-74s, were less likely to consume 5+ portions of fruit/veg a day and were less likely to be physically active, but also were less likely to be smokers,

Perhaps linked to their lower prevalence of negative health behaviours, 55+s were significantly more likely than the all adult average to think that positive health behaviours are the norm for all behaviours except physical activity. Amongst those who did report each negative health behaviour, older people were generally less likely than the all adult average to worry about the effect of this on their health and less likely to intend to change these behaviours over the next three months.

Older people were significantly more likely than the all adult average to have had at least one health-check with a health professional in the past two years, but no more likely to report regular self-health checks

Most older people reported seeing or speaking to a relative or other adult outside of their household every day. Regardless of whether or not they live alone, the proportion of older people saying they see or speak to a relative or other adult outside their household every day declines with age. Most had had some sort of conversation with a friend or family member about health-related subjects in the three months prior to interview, with over 65s more likely to have done so than 55-64s.

3 General views of health and well-being

As well as looking in detail at health behaviours, the Lifecourse Tracker aimed to add value to the Department's thinking by looking for links between health related attitudes and behaviours. In particular, we sought to identify lead indicators for future behaviour change.

In addition to asking about general views on health and well-being, the survey also looked in detail at views related to specific health behaviours (e.g. attitudes towards smoking, drinking alcohol, etc.). Responses to these questions are detailed in the relevant behavioural sections of this report.

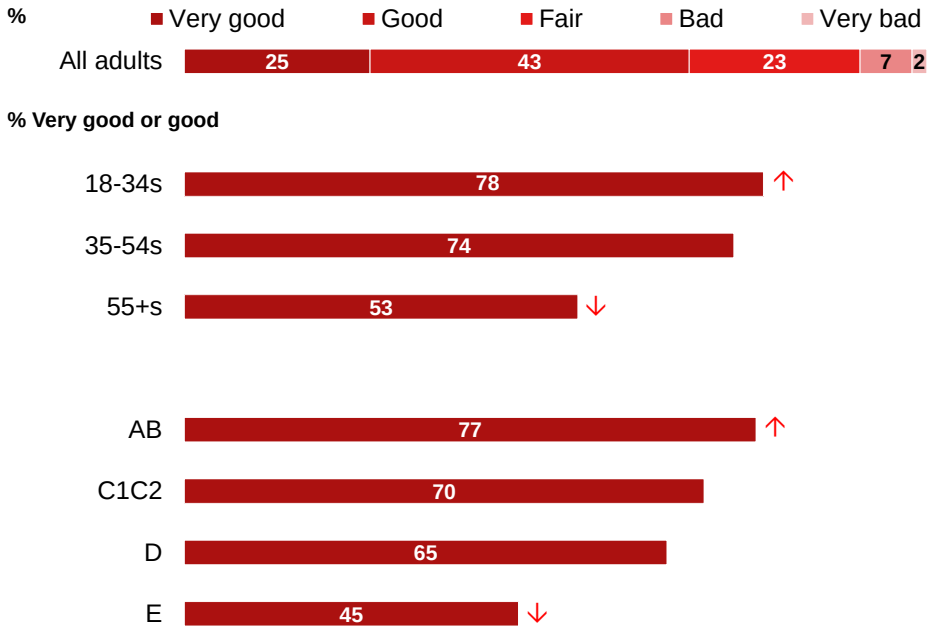
This chapter includes the following:

- Respondents' self-reported health status, and their views of their own health, including perceptions of their own weight
- General views on health and healthy lifestyles
- Norms related to health (e.g. how common they felt healthy behaviours are amongst their friends/family and other people they know)
- General (non-health related) attitudes (e.g. attitudes to risk, self-esteem, locus of control) and self-perception of well-being (e.g. life satisfaction, happiness)
- Details of the associations between negative health behaviours and attitudes/well-being measures

3.1 Health status and views of own health

Early in the interview all respondents were asked how they rate their own health in general, and the majority (68%) of all adults rated their health as very good or good. Only one in ten (9%) said that their health was bad or very bad (Figure 7). These proportions are broadly similar to those reported in the 2011 Health Survey for England, where three quarters (76%) of adults aged 16+ rated their health as very good or good[11].

Figure 7 **Rating of health in general**



Base: All 2012 adults (2029); 18-34 (559), 35-54 (637), 55+ (833); AB (384), C1C2 (852), D (317), E (476)
↑↓ Indicates a significant difference, compared with the corresponding sub-group

[11] http://www.hscic.gov.uk/catalogue/PUB09302

Perhaps unsurprisingly, older people were less likely to rate their health as good or very good: the proportion saying this fell from 78% of 18-34s to 53% of 55+s. There was a corresponding increase in the proportions saying that their health was bad or very bad: rising from 4% of 18-34s to 13% of 55+s, though it is notable that those aged 75+ were no more likely than 55-74s to rate their health as bad or very bad (14% of 75+s v 12% of 55-74s).

There were also strong differences in perceptions based on social grade, with those in the AB social grades most likely to rate their health as good or very good (77%), and Es least likely to give this rating (45%). These differences remained apparent, even when looking at social grade within age group.

Respondents who, later in the interview, reported alcohol consumption that would classify them as increasing/higher risk drinkers were more likely than average to rate their health as good or very good (75% v 67% of those who were not increasing/higher risk drinkers). However, the responses given by smokers and drug users did not vary significantly from the average.

There were some positive associations, with respondents who reported meeting the government's guidelines for physical activity (150+ active minutes in the previous week) being more likely to rate their health as good/very good (74% v 63% of those not meeting the guidelines). In addition to asking respondents to rate their own health, they were asked in more detail about their health state later in the interview.

All were asked if they had any long standing illness, disability or infirmity that limits their day to day activities[12]. One in ten (9%) said they had any long term condition that limits their activities all of the time, and a similar proportion (12%) said that their activities were limited some of the time, with a further 6% reporting any condition but saying that it does not limit their activities. Overall, just over a quarter (27%) reported any long term condition, and a fifth (21%) reported any condition which limits their activities. Definitions differ slightly, but in the 2011 Health Survey for England 16% of adults aged 16+ reported any acute sickness (an illness or injury that causes the participant to cut down on usual activities in the last two weeks) so estimates are similar[13].

Patterns in response in the Lifecourse Tracker survey were also similar to those observed in the Health Survey for England, with older people and those in the DE social grades more likely to report any long term condition:

- Only 13% of 18-34s reported any long term condition, but this rose to 44% of 55+s and as high as 54% of those aged 75+
- Only 23% of ABC1C2s reported any long term condition, but this rose to 28% of those in social grade D and 48% in social grade E
- While those living in households in poverty[14] were more likely to report a long term condition (38% v 23% of those not in poverty), there were no differences in response based on area-based deprivation, which suggests that differences are related to the household rather than the area in which the respondent lives

Further, all respondents were shown a list of potential lifestyle-related health problems and asked whether they had any of them: it is acknowledged that Type I diabetes is not a lifestyle-related health problem but this was included in the list to enable the identification of people with Type II diabetes. The question was asked in the self-completion section of the questionnaire so that the respondent could answer in privacy.

---

12 Further detail was given in the question to clarify concepts for respondents. Long standing was defined as something which has troubled them over a period of time or that is likely to affect them over a period of time. Normal day to day activities were defined as everyday things like eating, washing, walking or going shopping.

13 http://www.hscic.gov.uk/catalogue/PUB09302

14 Defined as household income below 60 percent of median income

Two fifths (41%) of adults reported at least one of the listed health problems, though this was as high as 66% amongst those aged 55+ (Figure 8). Older people were particularly likely to report circulatory problems such as high blood pressure (34%) and heart disease/stroke (13%) and were considerably more likely than those in the younger age groups to report Type II diabetes (12% v 5% on average).

Figure 8 **Reported health problems**

		Age		
	All adults (2029) %	18-34 (558) %	35-54 (636) %	55+ (833) %
Any	**41**	**20**	**33**	**66↑**
Cancer	2	-	*	5↑
Stomach, liver, kidney or digestive problems	5	4	4	8↑
Heart disease/stroke	6	*	4	13↑
High blood pressure	15	2	8	34↑
Type I diabetes	1	*	1	1
Type II diabetes	5	*	2	12↑
Diabetes – not sure which type	1	*	1	1
Asthma/other breathing difficulty	9	7	8	12↑
HIV/AIDS	*	*	-	*
Any sexually transmitted infection	*	*	*	*
Stress or depression for which treatment is being received	8	7	10↑	7
Other	6	3	5	9↑
None	**57**	**77↑**	**64**	**34↓**
Don't know/prefer not to say	**2**	**3**	**3**	*****

Base: All 2012 adults: as shown
↑↓ Indicates a significant difference, compared with the all adult average

The only listed condition which older people were less likely than average to report was stress or depression for which treatment is being received, which was most commonly reported by those aged 35-54 (10%) and in particular by women in this age group (14%). Overall, women (11%) were more likely than men (5%) to say that they were receiving treatment for stress or depression, and levels were particularly high amongst single parents (18%).

In line with other findings reported above, respondents from social grade E were considerably more likely than the average to report any of the listed health conditions (63%), and in particular the following:

- High blood pressure: 25% in social grade E v 15% on average
- Stress or depression for which treatment is being received: 19% v 8% on average
- Asthma/other breathing difficulties: 18% v 9% on average
- Heart disease/stroke: 10% v 6% on average

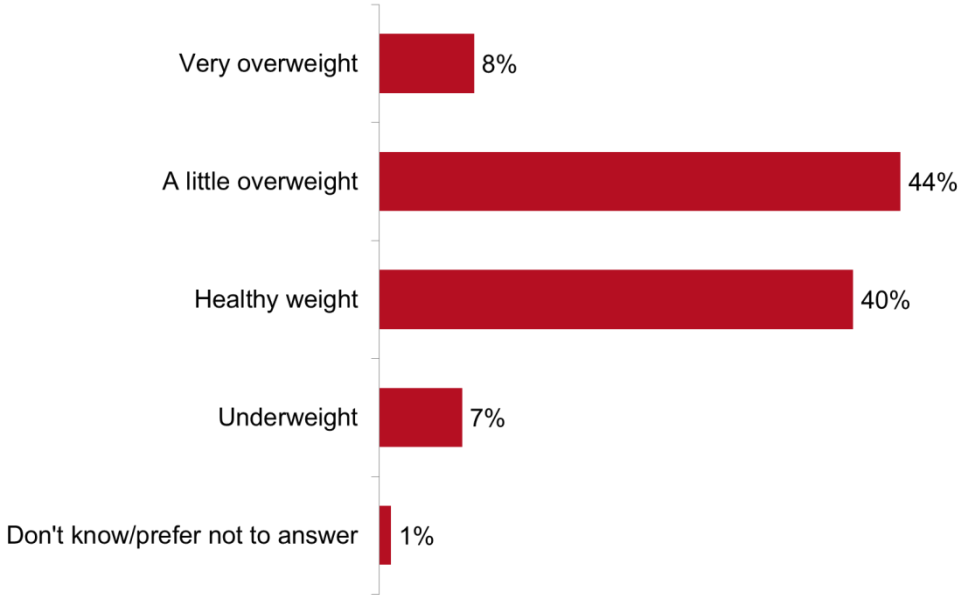
Overall, therefore, the picture is of older people and those in social grade E reporting poorer health, and that this impacts on their day to day activities.

3.2 Perceptions of weight

The Lifecourse Tracker also asked respondents for their views on their own weight. For reasons of space on the questionnaire and because of the poor quality of reporting seen on other surveys (e.g. Health Survey for England in 2011[15]), respondents were not asked to give their height and weight for the calculation of BMI. Instead, they were asked to describe their own weight: the Health Survey for England report suggests that this is an important measure, because part of the challenge in encouraging healthy lifestyles is the extent to which people are able to judge whether their own weight is healthy.

Figure 9 shows that around one in ten (8%) adults perceived themselves to be very overweight, and 52% thought they were overweight at all. Only two fifths (40%) thought that they were a healthy weight.

Figure 9 **Self-perception of weight**



Base: All 2012 adults (2029)

Younger people were less likely than their older counterparts to perceive themselves as overweight: 38% of 18-34s felt they were overweight, compared with 61% of 35-54s and 55% of 55+s. The proportion of women aged 35-54 rating themselves as overweight was particularly high at 65%, and over all age groups women (56%) were more likely than men (49%) to perceive themselves as overweight. There were no significant differences in perceptions of whether they were overweight based on social grade, poverty or deprivation, though those in social grade E were the most likely to rate themselves as very overweight (12%).

It was also notable that there were no significant differences in perceptions based on health behaviours, so those who met the government's guidelines for 150+ weekly active minutes or who ate 5+ daily portions of fruit/veg were no less likely than average to perceive themselves as overweight.

[15] For example, see https://catalogue.ic.nhs.uk/publications/public-health/surveys/heal-surv-eng-2011/HSE2011-Sum-bklet.pdf, p.14

3.3 General views of health and healthy lifestyles

The Lifecourse Tracker aimed to look in some detail at attitudes and perceptions of health and healthy lifestyles, and to understand the extent to which these perceptions impacted on health behaviours and health outcomes. The main constructs to be included in the survey were identified from the literature review conducted to feed into the development of the Healthy Foundations Survey in 2007[16], and a decision on which to include was based on analysis of which most strongly influenced health behaviour.

The constructs themselves were refined in the piloting phase and the number of items reduced. References to the original scales from which the constructs were developed are shown in the appendices (section 16), though it should be noted that for most only one question item was taken to represent the scale, rather than using the full range of items.

A number of constructs were included in the Lifecourse Tracker survey, as shown in Figure 10. Many of these were much shortened versions of longer scales or attitude batteries, but these had been distilled to a single statement or question because there was insufficient space on the questionnaire for the inclusion of the full question sets.

Figure 10 **Health attitudes included in the Lifecourse Tracker**

Construct	Description
Health fatalism	Agreement/disagreement with "If a person is meant to get ill, they will get ill anyway, regardless of whether they lead a healthy lifestyle" (Agree strongly – disagree strongly)
Self-positivity	"Compared with other people of your age, how likely do you think it is that you will get seriously ill at some point over the next few years" (Much more likely – much less likely)
Health locus of control	Agreement/disagreement with "The main thing which affects my health is what I personally do" (Agree strongly – disagree strongly)
Response efficacy	"How easy or difficult would it be to lead a healthy lifestyle over the next 12 months?" (Extremely difficult – extremely easy)
Self-efficacy	"How much control do you think you have over whether or not you lead a healthy lifestyle over the next 12 months?" (No control – complete control)

Opinions were divided related to health fatalism: while two fifths (43%) expressed fatalistic attitudes (agreeing that if a person is meant to get ill they will get anyway, regardless of whether they lead a healthy lifestyle), a similar proportion (45%) disagreed. Higher levels of health fatalism were expressed by those in the oldest age groups (52% of those aged 65+ agreed with the statement). There was also a strong socio-economic gradient evident: while only 32% of ABs agreed, this rose to 56% of Ds and 66% of Es, and linked to this, those living in poverty were more likely to agree (54% v 37% of those not living in poor households).

There were also strong links with health behaviour, as smokers and those who did not meet the guidelines of 150+ weekly active minutes were all more likely to agree that if a person is meant to get ill, they will get ill anyway regardless of whether they lead a healthy lifestyle (Figure 11). There were, however, no differences in views based on consumption of fruit/veg or drug use.

[16] http://www.thensmc.com/sites/default/files/301846_HFLS%20Report%20No1_ACC.pdf

Figure 11 shows the proportions of those reporting *negative* health behaviours agreeing with the statement, and compares them with their counterparts who do not report each negative health behaviour. In each pair of figures, those reporting the negative behaviour are labelled 'Yes' and the counterparts not reporting that negative behaviour are labelled 'No'.

Figure 11 **Health fatalism and self-positivity by health behaviours**

	Base		% **agree** *If a person is meant to get ill they will get ill anyway regardless of whether they lead a healthy lifestyle*	% think they are ***less likely*** *to get seriously ill than others of the same age*
All adults	**2029**	**%**	**43**	**29**
Fewer than five portions of fruit/veg yesterday				
Yes	1631	%	45	28
No	398	%	39	32
Fewer than 150 active minutes last week				
Yes	1167	%	46↑	24
No	862	%	40	34↑
Increasing/higher risk drinker				
Yes	275	%	36	29
No	1754	%	45↑	29
Smoker				
Yes	559	%	55↑	20
No	1443	%	40	32↑
Illegal drugs/legal highs in past 12 months				
Yes	133	%	44	25
No	1896	%	43	29

Base: All 2012 adults: as shown.
NB: Table shows horizontal percentages
↑↓ Indicates a significant difference, compared with the corresponding sub-group

There were also significant differences based on health behaviour when considering levels of self-positivity (i.e. thinking that they are less likely than others of the same age to get seriously ill over the next few years). Smokers and those who reported fewer than 150 weekly active minutes saw themselves as potentially less healthy. When asked if they were more likely, or less likely, to get seriously ill than others of their own age – this group chose the "more likely" option more often than average, and the "less likely" option less often (proportions shown in Figure 11, above).

Overall, 29% of adults thought they were less likely than others of their age to get ill, and 18% thought they were more likely. Perhaps linked to the prevalence of negative health behaviours, 55+s (22% said more likely) and those in the DE social grades (26% said more likely) tended to express lower levels of self-positivity.

A further linked construct is the extent to which adults recognise the links between their health behaviours and health outcomes: health locus of control. Most adults recognised the link, with two thirds (67%) agreeing that the main thing that affects their health is what they personally do, and only a quarter (23%) disagreeing. Levels of agreement were significantly lower amongst older people (62% of 55+s, including 60% of women aged 55+) and those in the D and E social grades (63% of Ds and 61% of Es, compared with 72% of

ABs). In addition, and linked to the above, those who were increasing/higher risk drinkers (66% v 73% of other adults) and those not doing 150+ weekly active minutes (64% v 71% of those doing 150+ weekly active minutes) were also less likely than average to recognise the links between their health behaviours and health outcomes. However, it is notable that smokers (69%) were no less likely than average to agree, suggesting that these links are better embedded for smoking than for alcohol consumption or physical activity.

The final set of statements examined attitudes towards a healthy lifestyle, including how respondents described a healthy lifestyle, and whether they thought achievement of a healthy lifestyle is easy and in their control.

All respondents at wave 2 only were asked to think about healthy lifestyles and to describe what things they need to do or avoid doing as part of a healthy lifestyle. They were asked to answer in their own words to give an understanding of their top of mind views.

The main descriptions which were given were fairly general and centred on the need to have a healthy diet (mentioned by 76%) and to do regular exercise (68%). There were fewer specific mentions of what a healthy diet entails, and even the most common suggestions were mentioned by 10% or fewer. For example 10% mentioned reducing fat in the diet, 6% mentioned reducing salt and 5% said maintaining low cholesterol is part of a healthy diet.

Lower proportions considered other aspects of a healthy lifestyle which were not related to diet or exercise. Around half (51%) said that avoiding smoking was part of a healthy lifestyle, and 43% mentioned not drinking too much alcohol.

Around one five mentioned aspects of mental health as part of a healthy lifestyle:

- 17% reducing stress
- 15% keeping your mind active
- 12% getting enough sleep

And around one in ten (9%) said that having regular health checks were part of a healthy lifestyle.

It is notable that ABC1s, and ABs in particular, tended to have a more rounded view of what a healthy lifestyle means – mentioning more aspects of a healthy lifestyle and being more likely to mention some of the less common aspects such as sleep and aspects of mental health (e.g. 15% of ABC1s mentioned getting enough sleep as part of a healthy lifestyle, compared with 9% of C2DEs).

There were also some links to actual behaviour, as shown below:

- Smokers, and those living with smokers were more likely to mention not smoking as part of a healthy lifestyle (e.g. 48% of smokers mentioned not smoking as part of a healthy lifestyle, and 51% of those living with a smoker, compared with 42% of non-smokers)
- Increasing/higher risk drinkers, and in particular the increasing risk drinkers, were more likely to mention not drinking too much as part of a healthy lifestyle (45% increasing/higher risk drinkers said this v 36% of others)

Having considered what a healthy lifestyle entails, all respondents were asked how easy or difficult they would find it to lead a healthy lifestyle, and how much control they have over whether or not they lead a healthy lifestyle over the next 12 months.

Around half of adults (51%) thought it would be extremely easy to lead a healthy lifestyle over the next 12 months[17] and two thirds (67%) thought that they would have complete control[18] over whether or not they lead a healthy lifestyle over that time.

There was a clear social gradient in response, with ABs the most likely to feel that achievement of a healthy lifestyle would be easy and in their control, and DEs the least likely. There were no such strong differences in response by age (Figure 12).

Figure 12 **Response efficacy and self-efficacy by demographics and health behaviours**

	Base		% think it would be extremely **EASY** to live a healthy lifestyle	% think they have complete **CONTROL** over whether they live a healthy lifestyle
All adults	**2029**	**%**	**51**	**67**
Age				
18-34	585	%	54	66
35-54	719	%	51	68
55+	725	%	49	66
Social grade				
AB	384	%	59	71
C1C2	852	%	53	69
D	317	%	48↓	67
E	476	%	36↓	51↓
Fewer than five portions of fruit/veg yesterday				
Yes	1631	%	49↓	65
No	398	%	58	72
Fewer than 150 active minutes last week				
Yes	1167	%	44↓	60↓
No	862	%	59	74
Increasing/higher risk drinker				
Yes	275	%	56	69
No	1754	%	50↓	66↓
Smoker				
Yes	559	%	42↓	59↓
No	1443	%	54	69
Illegal drugs/legal highs in past 12 months				
Yes	133	%	49	65
No	1896	%	51	67

Base: All 2012 adults: as shown
NB: Table shows horizontal percentages
↑↓ Indicates a significant difference, compared with the corresponding sub-group

In addition, it is notable that smokers and those who reported fewer than 150 weekly active minutes were significantly less likely than their counterparts to think that a healthy lifestyle would be easy and in their control. However, there were no differences in response based on fruit/veg consumption or drug use, which suggests that these may not have been considered when answering the question.

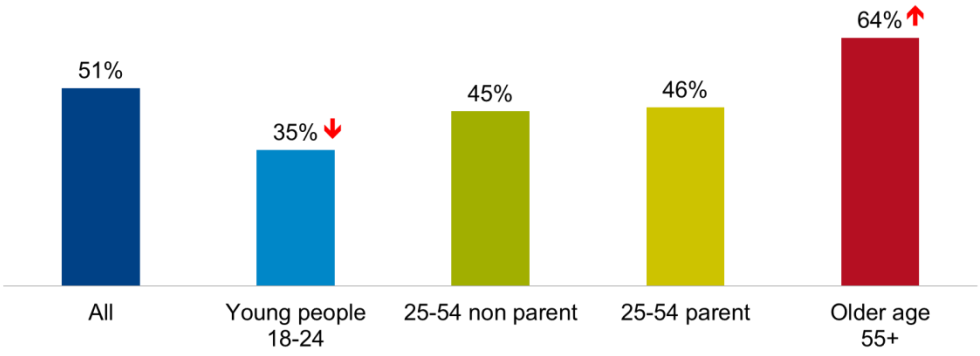
[17] They gave a score of 6 or 7 out of 7, where 1= extremely difficult and 7 = extremely easy
[18] They gave a score of 6 or 7 out of 7, where 1= no control and 7= complete control

3.4 Norms related to health

Many models of behaviour change (e.g. Ajzen and Fishbein's Theory of Reasoned Action[19]) recognise the importance of social norms as motivating factors for behaviour change. In order to understand the prevailing norms of adults in England and their relative influences on behaviour, all respondents were asked to say what proportion of their friends or family lead a healthy lifestyle (in general) nowadays, and for each health behaviour included in the survey, whether the respondent perceives that all or most people they know are making healthy changes.

Around half (51%) of all adults perceived that all or most of their friends and family lead a healthy lifestyle, though under 25s were the least likely to say this (35%) and 55+s were the most likely (64%).

Figure 13 **% believing that all or most friends/family lead a healthy lifestyle nowadays**



Base: All 2012 adults (2029); 18-24 (223), 25-54 non-parent (514), 25-54 parent (459), 55+ (833)
↑↓ Indicates a significant difference, compared with the all adult average

There were also clear differences by environment, with those living in more deprived areas or living with other people who were behaving 'negatively' less likely to perceive that all/most of their friends/family lead a healthy lifestyle:

- Those in the DE social grade (41% v 58% of ABs and 52% of C1C2s)
- Those living in the 10% most deprived areas (44% v 51% of those in other areas)
- Those living with a smoker, heavy drinker or drug user (37% v 55%)

[19] Ajzen I, Fishbein M (1975). Belief, Attitude, Intention and Behaviour: An introduction to theory and research. Reading, Mass: Addison-Wesley.

In addition, there were clear differences by health behaviour, as those who were not eating 5+ portions of fruit/veg a day, those not meeting the physical activity guidelines, smokers and drug users were all less likely than average to perceive that all/most of their friends and family lead a healthy lifestyle nowadays (Figure 14).

Figure 14 **% thinking that all or most of friends or family lead a healthy lifestyle Nowadays**

	Base		
All adults	**2029**	**%**	**51**
Fewer than five portions of fruit/veg yesterday			
Yes	1631	%	48↓
No	398	%	59
Fewer than 150 active minutes last week			
Yes	1167	%	46↓
No	862	%	56
Increasing/higher risk drinker			
Yes	275	%	52
No	1754	%	50
Smoker			
Yes	559	%	41↓
No	1443	%	54
Illegal drugs/legal highs in past 12 months			
Yes	133	%	40↓
No	1896	%	51

Base: All 2012 adults: as shown.
NB: Table shows horizontal percentages
↑↓ Indicates a significant difference, compared with the corresponding sub-group

The only exception was increasing/higher risk drinkers, who were no less likely than average to perceive that all/most of their friends/family lead a healthy lifestyle nowadays. However, this pattern may be linked to the fact that increasing/higher risk drinkers tend to have a more upmarket profile than the average.

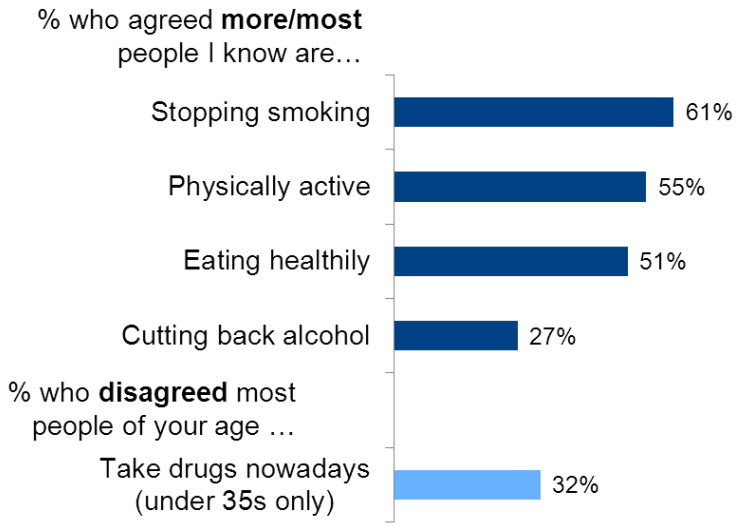
In addition to asking about healthy norms in general, all respondents were asked about norms related to individual health behaviours. Questions about norms were asked in conjunction with questions about the individual behaviours rather than all together, so respondents were answering about each behaviour in isolation, and not ranking the behaviours against each other.

For each behaviour, all were asked to say whether they agreed or disagreed that more or most people they know are acting healthily or making healthy changes (Figure 15). Only respondents aged 18-34 were asked to comment on norms related to drugs, and asked whether they agreed or disagreed that most young people of their age take drugs nowadays: the light blue bar at the base of Figure 15 shows the proportion *disagreeing* with this.

The most commonly perceived norm was related to giving up smoking, as three fifths (61%) of adults thought that more people are stopping smoking nowadays. Around half thought that most of the people they know are being active (55%) and eating healthily (51%) nowadays.

However, the norm related to cutting back on alcohol consumption was much less well established with much lower proportion (27%) thinking that more people are cutting back on alcohol nowadays.

Figure 15 **Perception of how many people are making healthy changes nowadays**



Base: All 2012 adults (2029); under 35s (586)

Young people were less likely than average to agree that more people are stopping smoking nowadays: only 38% of 18-24s agreed, compared with 66% of those aged 35+. However, it should be noted that younger people were themselves more likely than average to be smokers (33% of 18-24s v 24% on average). In addition, the healthy changes norms were less prevalent for 18-24s related to healthy eating (28% v 56% of 35+s) and cutting back on alcohol (13% v 30% of 35+s).

All 18-34s were also asked the extent to which they agreed that most people of their age take drugs nowadays. Perhaps surprisingly, four in ten (43%) agreed, but this was as high as three fifths (57%) of 18-24s and 61% of DEs aged 18-34.

Taken together, these results suggest that young people (18-24s) may be surrounded by less healthy norms.

Those reporting risk behaviours (smoking, increasing/higher risk alcohol consumption) were more likely to perceive that more people are reducing their risk behaviours nowadays: this may be linked to the fact that they see more people who are engaging in these risk behaviours, and therefore they are more likely to see reductions in these behaviours overall. For example:

- 63% of smokers agreed that more people are stopping smoking nowadays; slightly (but not significantly) higher than 60% of non-smokers
- 31% of increasing/higher risk drinkers agreed that more people are cutting back the amount of alcohol they drink nowadays, compared with 26% of those who are not increasing/higher risk drinkers. Within this, there were significant differences based on weight of consumption: while over a third (35%) of increasing risk drinkers agreed, the proportion was considerably lower amongst higher risk drinkers (17%), which suggests that the cutting back norm is not prevalent amongst those in the highest consumption category

However, amongst those aged 18-34, users of illegal drugs or legal highs were significantly more likely than non-users to perceive that most people of their age take drugs nowadays. Amongst users over seven in ten (72%) agreed, compared with 38% of non-users.

3.5 General (non-health related) attitudes

As well as asking about specific attitudes related to health, the survey also looked at more general attitudes and well-being, to examine associations between these views on health behaviours. Once again, the constructs to be included in the survey were identified from the Healthy Foundations literature review, and the specific items to be included were decided on because they had the greatest impact on health behaviours.

Figure 16 **General attitudes included in the Lifecourse Tracker**

Construct	Description
Self-esteem	Agreement/disagreement with “I feel good about myself” (Agree strongly – disagree strongly)
Locus of control	Agreement/disagreement with “There is little I can do to change my life” (Agree strongly – disagree strongly)
Risk taking	Agreement/disagreement with “I believe you need to take risks to lead a full life” (Agree strongly – disagree strongly)
Short termism	Agreement/disagreement with “I generally focus on the here and now rather than worry about the future” (Agree strongly – disagree strongly)

Most adults reported high levels of self-esteem, with 82% agreeing that they feel good about themselves, though only 15% agreed strongly. Three in five (61%) *disagreed* that there is little they can do to change their lives, though again a similar proportion (16%) disagreed strongly.

There were clear age and socio-economic grade gradients in response: younger people and those from the AB social grades tended to have higher levels of self-esteem and greater locus of control than their older and DE counterparts (Figure 17). For example, levels of self-esteem (% agreeing *I feel good about myself*) ranged from 86% amongst 18-34s to 78% amongst 55+s, and from 86% amongst ABs to 68% amongst those in social grade E.

While men tended to have higher levels of self-esteem than women, there were no differences in levels of locus of control between the genders. The higher levels of self-esteem amongst men were mainly amongst those aged under 55: 89% of men aged 18-34 and 87% of men aged 35-54 agreed, compared with 78% of men aged 55+. Patterns in response amongst women were very similar across the age groups.

Figure 17 **Self-esteem and locus of control by demographics and health behaviours**

	Base		% agree "I feel good about myself"	% disagree "There is little I can do to change my life"
All adults	**2029**	**%**	**82**	**61**
Gender				
Male	895	%	85↑	63
Female	1134	%	80	60
Age				
18-34	559	%	86↑	71↑
35-54	637	%	82	65
55+	833	%	78↓	50↓
Social grade				
AB	384	%	86↑	72↑
C1C2	852	%	85	63
D	317	%	79	52
E	476	%	68↓	43↓
Fewer than 5 portions of fruit/veg yesterday				
Yes	1631	%	82	59↓
No	398	%	84	71
Fewer than 150 active minutes last week				
Yes	1167	%	79↓	54↓
No	862	%	86	70
Increasing/higher risk drinker				
Yes	275	%	84	70
No	1754	%	82	60↓
Smoker				
Yes	559	%	76↓	60
No	1443	%	84	62
Illegal drugs/legal highs in past 12 months				
Yes	133	%	78	71
No	1896	%	82	61

Base: All 2012 adults: as shown.
NB: Table shows horizontal percentages
↑↓ Indicates a significant difference, compared with the corresponding sub-group

In addition smokers, and those not meeting the guidelines for physical activity tended to report lower levels of self-esteem, while physical activity was also significantly associated with locus of control: only 54% of those not meeting the physical activity guidelines disagreed that there is little they can do to change their life, compared with 70% of those doing 150+ weekly active minutes. Similarly, lower levels of locus of control were observed amongst those not eating 5 portions of fruit/veg on the day before they were interviewed.

It is interesting to note that there were no strong differences in response amongst increasing/higher risk drinkers who were equally likely as average to agree that they feel good about themselves, and more likely than average to disagree that there is little they can do to change their life. This pattern may be related to the fact that increasing/higher risk drinkers are more likely than average to come from the AB social grades, and those in the AB social grades tend to have higher levels of self-esteem and locus of control.

Further constructs of interest related to risk taking and short termism. Overall around two thirds of respondents (65%) agreed that they believed you need to take risks to lead a full life, and a similar proportion (58%) agreed that they generally focus on the here and now rather than worry about the future.

While the proportions agreeing with the two statements were similar, patterns in response were quite different. While there were no significant differences in levels of risk taking by age, younger people were less likely than average to take a short term view (only 50% of 18-34s agreed that they generally focus on the here and now rather than worry about the future). In addition, while levels of risk taking were lowest amongst those in social grade E, levels of short-termism were lowest amongst ABs (Figure 18).

Men were more likely than women to agree that they believe they need to take risks to lead a full life (69% of men v 62% of women).

Figure 18 **Risk taking and short termism by demographics and health behaviours**

	Base		% agree "I believe you need to take risks to lead a full life"	% agree "I generally focus on the here and now rather than worry about the future"
All adults	**2029**	**%**	**65**	**58**
Gender				
Male	895	%	69↑	59
Female	1134	%	62	57
Age				
18-34	559	%	68	50↓
35-54	637	%	65	59
55+	833	%	63	63
Social grade				
AB	384	%	70	49↓
C1C2	852	%	63	58
D	317	%	72	68
E	476	%	58↓	65
Fewer than 5 portions of fruit/veg yesterday				
Yes	1631	%	65	57
No	398	%	65	61
Fewer than 150 active minutes last week				
Yes	1167	%	63	60
No	862	%	67	56
Increasing/higher risk drinker				
Yes	275	%	70	52
No	1754	%	64	59
Smoker				
Yes	559	%	67	58
No	1443	%	65	5658
Illegal drugs/legal highs in past 12 months				
Yes	133	%	79↑	49
No	1896	%	64	58

Base: All 2012 adults: as shown.
NB: Table shows horizontal percentages
↑↓ Indicates a significant difference, compared with the corresponding sub-group

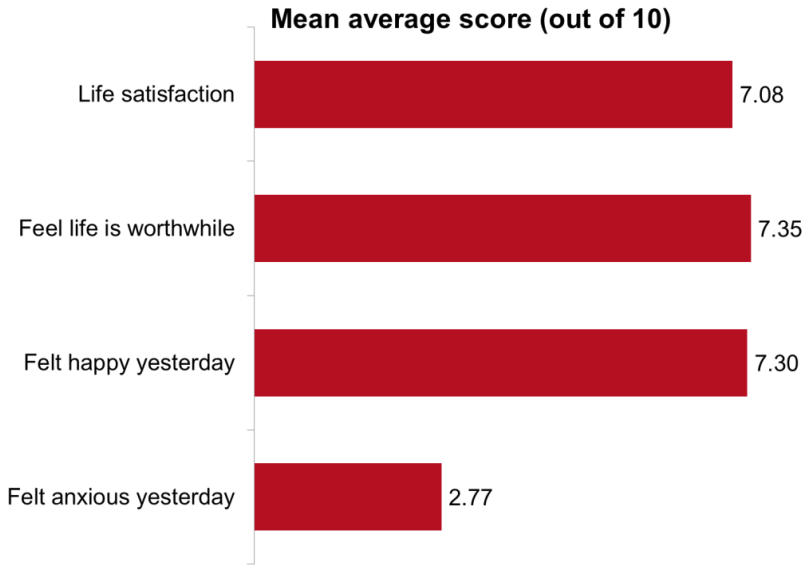
There were few significant differences in levels of risk taking or short-termism by health behaviour: only users of illegal drugs/legal highs were more likely than average to agree that they believe they need to take risks to lead a full life, and they were no more likely than average to agree that they focus on the here and now rather than worry about the future.

3.6 Well-being

The National Well-being programme aims to enable understanding and tracking of well-being to provide a snapshot of life in the UK. The ONS subjective well-being questions[20] were introduced in April 2011 and are measured and monitored across a range of national surveys.

In order to assess the effects of well-being on health behaviour, the four subjective well-being questions were included in the self-completion section of the Lifecourse Tracker survey. The questions were all scored on a scale of 0-10, where 0 meant that the statement applied 'not at all' and 10 meant that it applied 'completely'. Figure 19 shows the mean average scores out of 10 for each of the four constructs.

Figure 19 **Well-being**



Base: All 2012 adults (2029)

The highest mean average score was observed in relation to feeling that the things that you do in life are worthwhile: the mean average score was 7.35/10, with three in ten (29%) giving a score of 9-10 which indicated that they completely (or close to completely) felt that the things they do in their life are worthwhile.

A similarly high mean average score (7.30) was achieved in relation to feeling happy yesterday: 34% of adults agreed that they felt happy yesterday. Life satisfaction was slightly behind with a mean score of 7.08, though 27% of adults said that they were completely satisfied with their life nowadays.

The fourth dimension was anxiety, and given that the statement was negatively worded (how anxious did you feel yesterday?) it is unsurprising that the mean score achieved here is lower (2.77), with only 3% saying that they felt completely anxious, and 42% saying they didn't feel anxious at all yesterday.

[20] http://www.ons.gov.uk/ons/guide-method/method-quality/specific/social-and-welfare-methodology/subjective-well-being-survey-user-guide/index.html

These levels are somewhat different to national estimates observed by ONS on other research[21]; though the extremely large sample size for the ONS work (over 120,000 respondents) means that even seemingly small differences are significant. In addition, it should be noted that the ONS estimates are based on respondents aged 16+ whereas adults in the Lifecourse Tracker survey are aged 18+. The only dimension for which the two surveys achieved similar estimates was 'felt happy yesterday'.

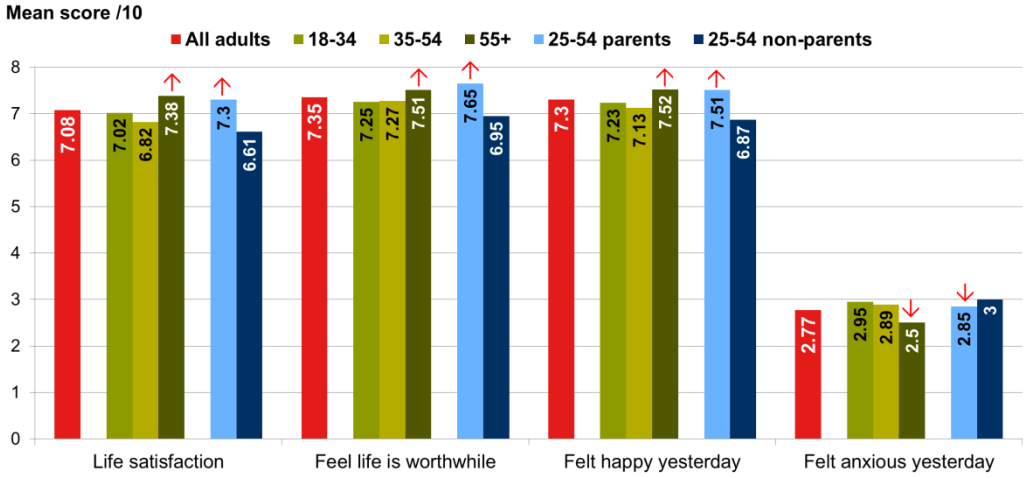
Figure 20 **Well-being measures: comparison of Lifecourse Tracker and ONS estimates**

	Lifecourse Tracker estimate (2029) Mean score	ONS estimate (120393) Mean score
Satisfied with life nowadays	7.1↓	7.4
Feel life is worthwhile	7.4↓	7.7
Felt happy yesterday	7.3	7.3
Felt anxious yesterday	2.8↓	3.2

Base: All 2012 adults (LCT), All adults 16+ (ONS): as shown
Mean scores have been rounded to one decimal place
↑↓ Indicates a significant difference, between the two survey results

In the Lifecourse Tracker survey, it was notable that older people and parents[22] tended to report higher levels of well-being on all measures (Figure 21).

Figure 21 **Well-being measures: age and parents v non-parents**



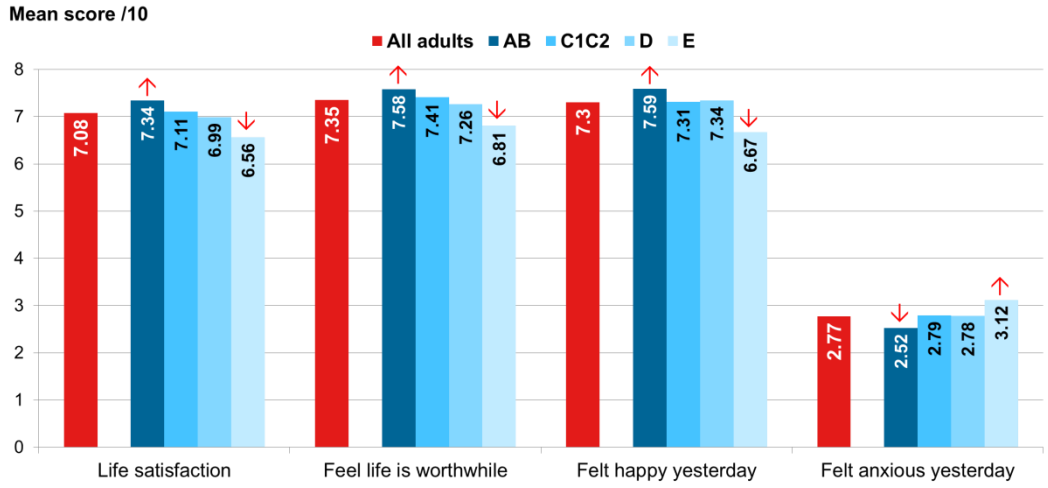
Base: All 2012 adults (2029); 18-34 (585), 35-54 (719), 55+ (725); 25-54 parents (513); 25-54 non-parents (458)
↑↓ Indicates a significant difference, compared with the corresponding sub-group

21 Source: April 2011 to March 2012, Annual Population Survey Subjective Well-being Experimental dataset, ONS

22 To control for differences by age, comparisons are made between parents and non-parents aged 25-54

There was also a clear gradient of well-being based on social grade, with ABs reporting significantly higher levels of well-being than those in social grade E (Figure 22). Linked to this, those living in poverty also tended to report lower levels of well-being.

Figure 22 **Well-being measures: social grade**



Base: All 2012 adults (2029); AB (384), C1C2 (852), D (317), E (476)
↑↓ Indicates a significant difference, compared with the corresponding sub-group

Given the higher well-being scores reported by those in the AB social grades, and the fact that increasing/higher risk drinkers were more likely than average to come from these social grades, it is somewhat surprising to note that increasing/higher risk drinkers tended to report significantly lower levels of life satisfaction and feeling that life is worthwhile than average (Figure 23).

Figure 23 **Well-being measures: health behaviours**

MEAN SCORES / 10	Base	Life satisfaction	Feel life is worthwhile	Felt happy yesterday	Felt anxious yesterday
All adults	**2029**	**7.08**	**7.35**	**7.30**	**2.77**
Fewer than five portions of fruit/veg yesterday					
Yes	1631	6.93↓	7.23↓	7.18↓	2.85↑
No	398	7.62	7.79	7.74	2.46
Fewer than150 active minutes last week					
Yes	1167	7.00	7.26	7.11↓	3.03↑
No	862	7.17	7.45	7.51	2.47
Increasing/higher risk drinker					
Yes	275	6.92↓	7.17↓	7.26	2.57
No	1754	7.11	7.38	7.31	2.80
Smoker					
Yes	559	6.47↓	6.93↓	6.75↓	2.73
No	1443	7.26	7.47	7.46	2.79
Illegal drugs/legal highs in past 12 months					
Yes	133	6.40↓	6.89↓	6.68↓	2.96
No	1896	7.13	7.38	7.34	2.75

Base: All 2012 adults: as shown
NB: Table shows mean scores based on horizontal bases
↑↓ Indicates a significant difference, compared with the corresponding sub-group

This pattern was similar for other negative health behaviours, with 'negative behavers' reporting lower well-being scores than average. The biggest differences were between smokers and non-smokers, though smokers were no less likely than average to feel anxious. Those who said they did not have 5+ portions of fruit/veg yesterday tended to report lower well-being scores on all measures.

3.7 Associations between negative health behaviours and attitudes/well-being

Above we have shown associations between negative health behaviours and attitudes and well-being dimensions, and to investigate these further, correlation analysis was conducted. This shows the strength of association between variables, and outputs are shown in the form of correlation coefficients which range from -1.00 to +1.00: 0 indicates that there is no association between the variables, and +1 indicates a perfect positive association.

Because of the structure of the data, correlations were run using Spearman's rank correlation coefficient. Correlations were run to look at associations with *negative* health behaviours. Figure 24 summarises the strongest associations for each individual health behaviour, and only those which are significant at the 99% level are shown.

Figure 24 **Correlations between attitudes/well-being and negative health behaviours (2012 adults)**

	Correlation coefficient
Nutrition (Fewer than five portions of fruit/veg yesterday)	
Feel it would be difficult to lead a healthy lifestyle	.104
Not satisfied with life nowadays	.105
Did not feel happy yesterday	.093
Physical activity (Fewer than 150 active minutes last week)	
Disagree I feel good about myself	.129
Agree There is little I can do to change my life	.182
Disagree The main think which affects my health is what I personally do	.089
High self-positivity	.133
Feel it would be difficult to lead a healthy lifestyle	.175
Feel have no control over whether lead a healthy lifestyle	.171
Did not feel happy yesterday	.113
Felt anxious yesterday	.105
Increasing/higher risk drinker	
Disagree There is little I can do to change my life	.091
Smokes nowadays	
Agree If a person is going to get ill, they will get ill anyway, regardless of whether they lead a healthy lifestyle	.141
High self-positivity	.128
Think it would be difficult to lead a healthy lifestyle	.126
Not satisfied with life nowadays	.151
Does not feel things done in life are worthwhile	.112
Did not feel happy yesterday	.096
Taken illegal drugs/legal highs in past 12 months	
Agree I believe you need to take risks to lead a full life	.118
Does not feel things done in life are worthwhile	.092

It is notable that, while significant, none of the correlation coefficients were very high, which suggests that other factors influence behaviours, as well as attitudes.

Many of the strongest correlations related to smoking and physical activity and indicated that self-positivity, feeling that a healthy lifestyle would be too difficult and lower levels of well-being (in particular feeling unhappy) were strongly associated with behaviour.

Drug use was associated with risk taking and feeling that life is not worthwhile.

It is also apparent that few of the attitudinal constructs were significantly associated with whether or not the respondent reported alcohol consumption classifying them as an increasing/higher risk drinker. This is likely to be because of the strong social grade differences in the profiles of increasing/higher risk drinkers: as already noted those in the AB social grades tended to report more positive attitudes and higher levels of well-being than their counterparts in social grades D and E.

3.8 General views of health and well-being - summary

Though almost seven in ten adults rated their own health as good or very good, older people were less likely than other groups to say this. Older people were also more likely than average to report both long term limiting illnesses and most lifestyle-related health problems, though it was women in the 35-54 group who were most likely to say they had depression or stress for which they were receiving treatment.

When asked to consider healthy lifestyles in general, most adults spontaneously thought about diet and exercise, and there were few mentions of what a healthy lifestyle entails. Lower proportions considered aspects of a healthy lifestyle which were not related to diet or exercise (e.g. smoking, reducing alcohol consumption) and few mentioned any aspects of mental health.

Overall, those reporting negative health behaviours were *less* likely than average to think that healthy lifestyles are easy to achieve, to be in their control or to be the norm.

While over four fifths of adults agreed that they feel good about themselves, the survey found that around three fifths expressed short-termist attitudes, and a third agreed that there is little they can do to change their lives.

There were clear social gradients in views of health. Those in social grades DE (in particular Es), and thus in relatively poor households tended to report worse health with consequent impacts on their day to day activities. They also tended to feel less knowledgeable and less empowered about living a healthy lifestyle, and were less likely to believe that a healthy lifestyle is the norm. In addition, those in social grade E reported lower levels of self-esteem, locus of control, and were more short-termist in their views.

In addition, and reflecting their lower social grade profile, smokers and those eating less healthy diets tended to report poorer health and less positive attitudes to health and to life in general. They were also less happy and had lower levels of life satisfaction.

Increasing/higher risk drinkers also tended to have lower levels of life satisfaction than average, despite their more AB social grade profile, however they did tend to feel more positive than average about their own ability to change their lives and their health.

4 Comparisons across behaviours

One key area where the Lifecourse Tracker can add value to thinking is by looking at groups of behaviours, how they interact and cluster and which groups this is most likely amongst. This analysis enables an understanding of where multiple risk behaviours are more prevalent, and further analysis of the potential underlying reasons and intentions.

In addition, because questions about health concerns, intentions to change and barriers to behaviour change were asked consistently about the range of behaviours included on the survey, it is possible to compare across behaviours and look at commonalities and differences between them.

In this chapter, we report on the prevalence of certain health behaviours. However, it should be noted that the Lifecourse Tracker does not aim to replace other prevalence measures (e.g. those reported in the Health Survey for England[23]), but instead to gain general measures of each behaviour to allow analysis in comparison with other behaviours and attitudes and intentions.

This chapter includes the following:

- Prevalence of the negative health behaviours included in the survey, as well as how these negative behaviours group and cluster
- Comparisons between behaviours in levels of worry about the impact of the behaviour on health, intentions to change, and barriers to making healthy changes

4.1 Overview of negative health behaviours

Questions in the Lifecourse Tracker were designed to enable the creation of indicators for each health behaviour. For simplicity, a single indicator was developed for each health behaviour: these were designed in conjunction with policy leads in the Department of Health to reflect the key behaviours identified in the Social Marketing Strategy. Indicators focussed on *negative* health behaviours: for some behaviours the indicator described an *absence* of the behaviour (e.g. not eating 5 portions of fruit/veg a day was the indicator for nutrition), whereas for other behaviours the indicator described the *presence* of that activity (e.g. smoking cigarettes nowadays for tobacco).

[23] Health Survey for England 2011 – Adult Trend tables. Health and Social Care Information Centre, 2012. www.ic.nhs.uk/pubs/hse11trends

Estimates of the proportions of respondents reporting each negative health behaviour are based on self-reported behaviours as recorded in the survey questionnaire, rather than from any other method (e.g. observation, diary study, clinical testing). Because of potential sensitivities, questions about alcohol, tobacco, drug use and sexual health were asked in a self-completion section in the interview: this means that the respondent entered their own responses into the laptop computer, rather than answering questions asked by an interviewer. Questions about nutrition and physical activity were administered by the interviewer. The indicators employed for the all adult sample are shown in Figure 25.

Figure 25 **Indicators employed in Lifecourse Tracker Adult survey**

Policy area	Indicator
Nutrition	Ate *fewer* than five portions of fruit or vegetables yesterday
Physical activity	Did *fewer* than 150 active minutes (to the point of breathing faster than usual) in the week before interview
Alcohol	Increasing or higher risk drinker (weekly units 22+ men/15+ women)
Tobacco	Smokes cigarettes nowadays
Drug use	Used any illegal drugs/legal highs in past 12 months
Sexual health	Had unprotected casual sex (sex without a condom with more than one partner or a new partner in the last 6 months), 18-54s only

For simplicity, the indicators were binary in nature: that is for each respondent they described whether they reported the negative health behaviour or not. The interview collected more granular detail on each of the health behaviours, and this is described in the relevant chapters of this report.

Figure 26 shows the prevalence of each individual behaviour amongst all adults aged 18+ in England. Further detail, including detailed analysis of prevalence amongst different sub-groups in the population, are shown in the relevant chapters of this report. In addition, comparisons with prevalence estimates taken from other surveys are shown in the relevant chapters.

Figure 26 **Prevalence of negative health behaviours**

		All adults (2029) %
Nutrition	Ate *fewer* than five portions of fruit or vegetables yesterday	79%
Physical activity	Did *fewer* than 150 active minutes in the week before interview	53%
Tobacco	Smokes cigarettes nowadays	24%
Alcohol	Increasing or higher risk drinker	15%
Drug use	Used any illegal drugs/legal highs in past 12 months	7%
Sexual health	Had unprotected casual sex in past 6 months (18-54s)	9%
Base: All 2012 adults: as shown		

The most commonly reported negative health behaviour related to nutrition, with almost eight in ten (79%) of all adults reporting that they had eaten fewer than five portions of fruit/veg on the day before they were interviewed. Over half (53%) had done fewer than 150 active minutes in the week before they were interviewed.

While the prevalence of negative health behaviours varied between lifecourse groups, the ranking of behaviours did not vary significantly. Nutrition (fewer than five portions of fruit/veg a day) and physical activity (less than 150 weekly active minutes) were the most commonly reported negative behaviours amongst all lifecourse groups. However, amongst 18-24s higher reported prevalence of drug use and unprotected casual sex meant that these behaviours sat higher in the sub-group ranking than increasing/higher risk drinking. Amongst 55+s, the very low smoking prevalence pushed smoking lower down the sub-group behavioural ranking. Figure 27 shows the ranking of negative health behaviours amongst each lifecourse group.

Figure 27 **Differences in ranking of negative health behaviours by lifecourse group**

18-24s (223) %	25-54 parents (514) %	25-54 non-parents (459) %	55+s (833) %
• <5 a day (90%) • <150 weekly active minutes (53%) • Smoker (33%) • Drug user (18%) ↑ • Unprotected casual sex (18%) ↑ • Increasing/higher risk drinker (15%) ↓	• <5 a day (75%) • <150 weekly active minutes (51%) • Smoker (27%) • Increasing/higher risk drinker (15%) • Drug user (7%) • Unprotected casual sex (6%)	• <5 a day (83%) • <150 weekly active minutes (49%) • Smoker (35%) • Increasing/higher risk drinker (18%) • Drug user (8%) • Unprotected casual sex (6%)	• <5 a day (74%) • <150 weekly active minutes (57%) • Increasing/higher risk drinker (13%) ↑ • Smoker (11%) ↓ • Drug user (1%)

Base: All 2012 adults: 18-24s (223), 25-54 parents (514), 25-54 non-parents (459), 55+s (833)
↑↓ Indicates that a behaviour sits higher or lower in the ranking for that lifecourse group, compared with the all adult average

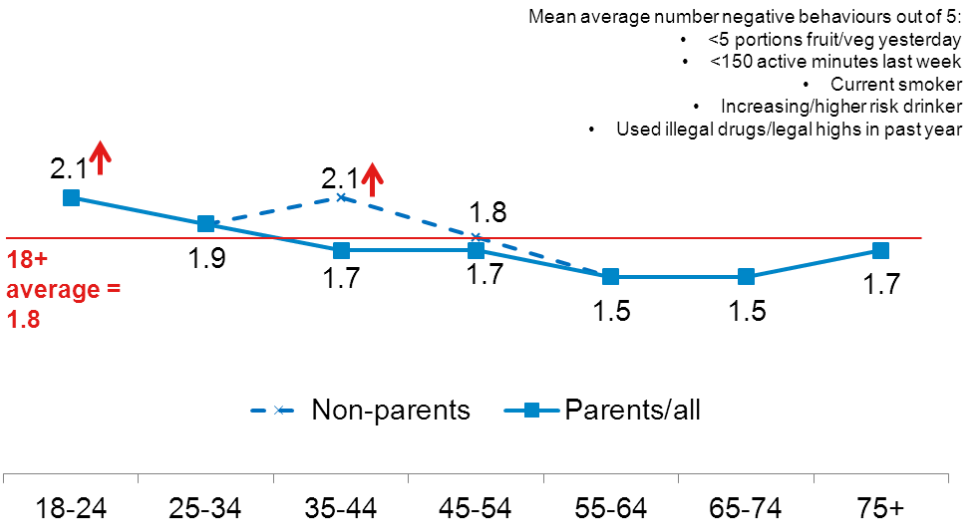
4.2 Interactions between health behaviours

The Lifecourse Tracker can add real value because it enables us to look at a number of health behaviours all together, to understand which groups in the population are more likely to report multiple negative behaviours, and what particular clusters of behaviours exist. Because 55+s were not asked about sexual health, our analysis of multiple health behaviours does not include the sexual health indicator, so we describe the number of negative health behaviours out of five.

Firstly, looking at the number of negative health behaviours reported, only 8% of all respondents reported none of the five negative health behaviours, three in ten (31%) reported one and 41% reported two negative health behaviours. However a fifth of all adults (20%) reported three or more of the five negative health behaviours.

Adults reported an average of 1.8 negative health behaviours out of five. The average number of negative health behaviours reported was significantly higher amongst 18-24s and non-parents aged 35-44: mainly because of their higher than average prevalence of smoking (Figure 28).

Figure 28 **Mean average number of negative health behaviours reported (out of 5)**



Base: All 2012 adults: 18-24 (223), parents/non-parents: 25-34 (185/151), 35-44 (228/99), 45-54 (101/209), 55-64 (300), 65-74 (288), 75+ (245)
↑↓ Indicates a significant difference, compared with the all adult average or between corresponding parent/non-parent group

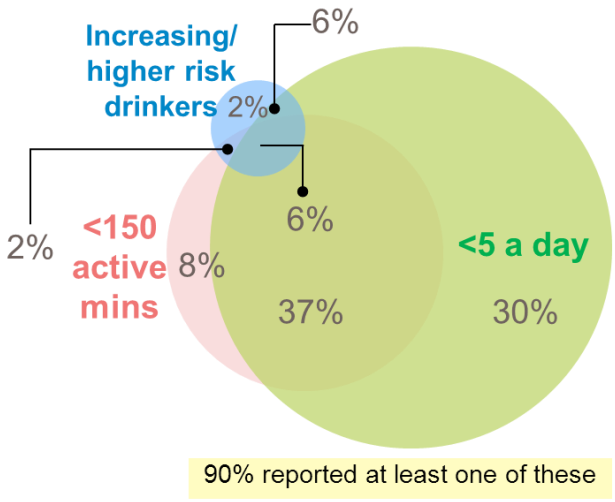
The following groups reported higher than average numbers of negative health behaviours, though this was mainly because of higher prevalence of smoking amongst these groups:

- Men (average of 1.9 v 1.7 amongst women)
- C2DE social grades (average of 1.9 v 1.7 amongst ABC1s). The average rose to 2.0 amongst those in social grade E
- Those living in the 10% most deprived areas (2.1 v 1.7 amongst those not living in these areas)
- Those who do not live with a partner (2.0 v 1.7 of those living with a partner)
- Those who lived with a smoker in the household (2.1, compared with 2.6 amongst those living with someone else but not a smoker).

The most common clusters of negative health behaviours unsurprisingly included the most commonly reported behaviours: namely those related to nutrition and physical activity. Over two fifths (43%) of all adults said they had eaten fewer than five portions of fruit/veg on the previous day AND had done fewer than 150 active minutes in the past week. Almost half (48%) of 18-24s reported both of these negative health behaviours, as did 45% of 55+s. 25-54s were significantly less likely to report both negative health behaviours, though it is still notable that over two fifths (41%) of them did so.

The Change4Life strategy includes messages around nutrition, physical activity and alcohol consumption, and the analysis looked at the overlap between these three behaviours (Figure 29). The majority (90%) of all adults reported at least one of these three negative health behaviours, though only 6% reported all three behaviours. Men (8% v 4% women), and in particular men aged 35-54 (10%) and ABs (8% v 4% DEs) were the most likely to report all three behaviours, though the difference is generally because of a higher than average prevalence of increasing/higher risk drinking amongst them.

Figure 29 **Combinations of Change 4 Life behaviours**

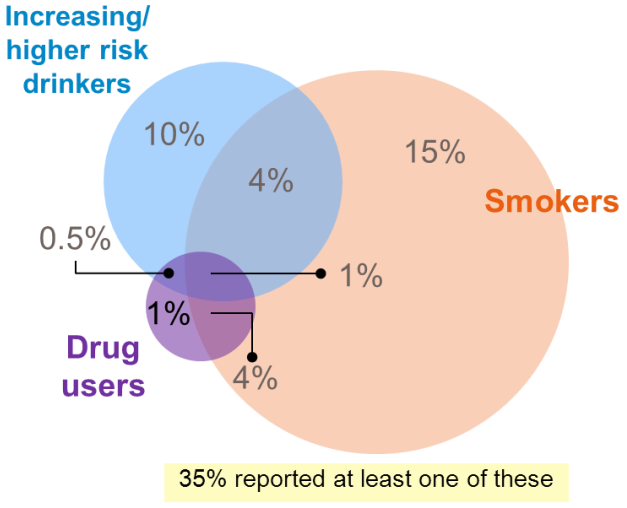


Base: All 2012 adults (2029)

In addition, the analysis examined combinations of risk behaviours, including smoking, increasing/higher risk drinking and drug use (Figure 30). Over two thirds (65%) of adults did not report any of these risk behaviours, and only 1% reported all three behaviours, though 18-24s (3%) and those from the C2DE social grade (2% v 1% ABC1s) were more likely to report all three negative behaviours.

Combinations of risk behaviours including smoking were most prevalent, which is unsurprising given that smoking was the most commonly reported risk behaviour (24% were smokers, 15% were increasing/higher risk drinkers and 7% reported drug use).

Figure 30 **Combinations of risk behaviours**



Base: All 2012 adults (2029)

4.3 Worry about behaviour

All those reporting negative health behaviours, including some more detailed nutritional behaviours, were asked how worried they felt about the impact of their behaviour on their health. They were asked to answer on a scale of 1-7, where a score of 1 indicated that they did not feel at all worried, and 7 indicated that they felt very worried. Results for each behaviour are discussed in detail in the relevant chapters of this report, but comparisons between behaviours are shown below.

The behaviour which caused most worry was smoking: smokers gave a mean average smoking worry score of 4 out of 7: 43% of smokers said that they were worried (giving a score of 5-7 out of 7) but a similar proportion (40%) said they weren't worried (score of 1-3 out of 7).

Similar levels of worry about weight were reported by those who perceived themselves as under or overweight – the mean average weight worry score was 3.7 amongst this group, though more said they weren't worried (49%) than worried (35%).

Figure 31 **Worry about impact of behaviours on health**

Behaviour	Base	Average worry score (out of 7)	Worried (score 5-7/7)	Not worried (score 1-3/7)
Smoking	Smokers (558)	4.0	43%	40%
Weight	Perceive themselves as under- or overweight (1232)	3.7	35%	49%
Fitness	Fewer than 150 weekly active minutes (1167)	3.3	28%	54%
Alcohol	Increasing/higher risk drinkers (275)	2.9	20%	66%
Diet	Fewer than five portions fruit/veg (1631)	2.7	18%	67%
Drugs	Drug users (133)	2.5	19%	75%
Salt	Add salt to food without tasting (353)	2.7	17%	68%

Base: All 2012 adults: as shown
NB: Average worry score is the mean average out of 7 where 1 indicates that the respondent is not at all worried, and 7 indicates that they are very worried
NB: Table shows horizontal percentages and mean scores

Levels of worry about fitness were lower (average worry score of 3.3 amongst those who reported fewer than 150 weekly active minutes). The average worry score about alcohol amongst increasing or higher risk drinkers was lower at 2.9, with 66% of increasing/higher risk drinkers saying that they were not worried about the impact of their alcohol consumption on their health. However, it was notable that higher risk drinkers gave higher average worry scores than increasing risk drinkers (3.7 amongst higher risk drinkers, 2.6 amongst increasing risk drinkers).

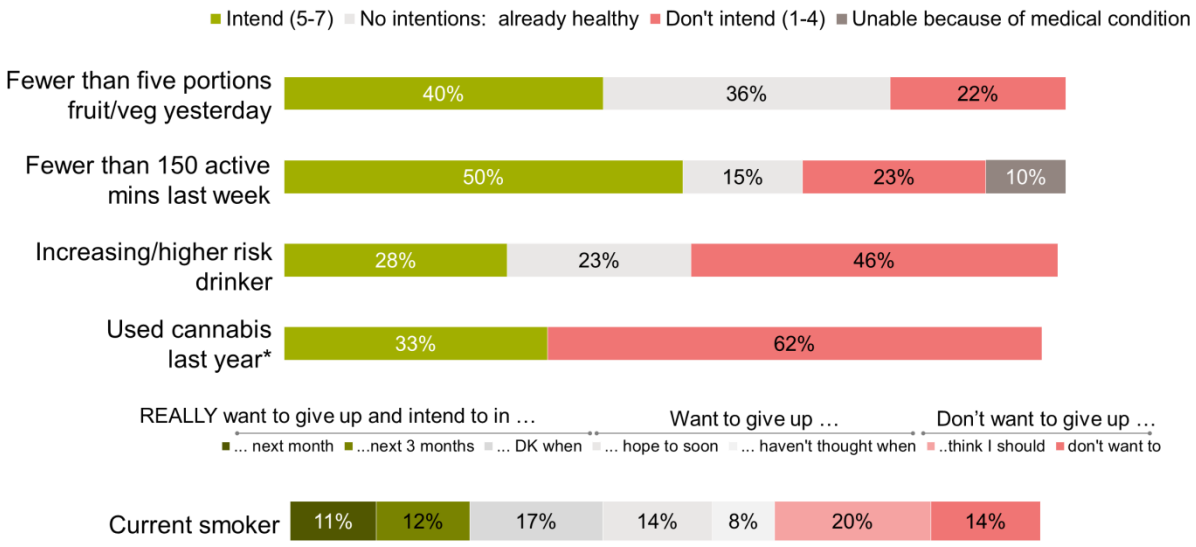
The lowest worry scores were given in relation to diet, with those eating fewer than five portions of fruit and veg on the previous day giving a mean worry score of 2.7 to show how worried they were about the impact of their diet on their health, and those who add salt to food without tasting also gave a mean worry score of 2.7 when asked how worried they were about the impact of the amount of salt they take in on their health.

It is notable that respondents were more worried about the impact of their weight on their health than they were about the impact of some of the contributing factors to being overweight – diet, exercise, alcohol intake. This suggests that there may be some scope to get people to recognise that diet and lifestyle are the key drivers of weight status.

4.4 Intentions to change

All respondents reporting negative health behaviours were also asked to say to what extent they intended to change their behaviour over the next three months. Figure 32 compares intentions to change across behaviours, and more detail about intentions to make healthy changes are shown in the relevant behaviour chapters of this report.

Figure 32 **Intentions to make healthy changes: comparisons of behaviours**



Base: All 2012 adults who reported each negative health behaviour: Fewer than five portions fruit/veg (1631): Fewer than 150 weekly active minutes (1069): Increasing/higher risk drinkers (268): Used Cannabis in past year (77* caution, low base): Smokers (559)

Amongst those who ate fewer than five portions of fruit/veg on the day before they were interviewed, two fifths (40%) said they intended to eat a healthier diet over the next three months, though 22% didn't intend to, and a further 36% said they didn't intend to because they felt that their diet was already healthy. It is notable that intentions did not vary greatly based on the number of portions of fruit/veg eaten, as those who reported eating two or fewer portions of fruit/veg on the previous day were no more likely to intend to eat a healthier diet, or less likely to perceive that their diet is already healthy, than those who said they had eaten 3-4 portions. In addition, those reporting frequent intake of fatty foods, sugary soft drinks and high calorie foods were no more likely than average to intend to eat a healthier diet.

Similar questions were asked about physical activity, alcohol, and cannabis use (the base size for users of other drugs was too small for reliable analysis). Half (50%) of those who reported fewer than 150 weekly active minutes said they intended to be more physically active over the next three months, though a quarter (23%) didn't intend to do so. One in ten of those who did fewer than 150 weekly active minutes said they were unable to increase their activity levels because of a medical condition: most (77%) of those giving this answer were aged 55+ and eight in ten (81%) of those giving this answer reported a long term limiting illness later in the interview.

The negative health behaviour which was associated with the lowest levels of intention to change was alcohol use: only 28% of increasing/higher risk drinkers said they intended to cut back their alcohol intake over the next three months, and almost a half (46%) said they do not intend to. Levels of intention to cut back were lowest amongst increasing risk drinkers: only a quarter (23%) said they intended to cut back, compared with 43% of higher risk drinkers.

Over three fifths (62%) of those who had taken cannabis in the past 12 months said they didn't intend to stop it.

The question asked of smokers was slightly different, to align with other datasets (e.g. the Smoking Toolkit survey). A quarter (23%) of smokers said they intend to stop in the next three months, but a third (34%) didn't want to quit.

It is notable that there were greater intentions (and lower levels of unintentions) to make behaviour changes which involved doing more (e.g. eating more fruit/veg, being more physically active) than to do less (e.g. smoke less, drink less alcohol). This may be in some way related to the endowment effect[24] which suggests that people value things they feel they already own (or do) more than things they do not: this might imply that smokers may feel more aggrieved because they feel that their cigarettes are being taken away from them, rather than being asked to do more of something like eat more fruit/veg. In addition, physical or psychological addiction will impact on intentions.

While intentions were highest (and unintentions were lowest) to eat a healthier diet and be more physically active, these were the most prevalent negative health behaviours in the population. This means that the proportions in the population reporting each negative behaviour but not intending to change in the next three months were as follows:

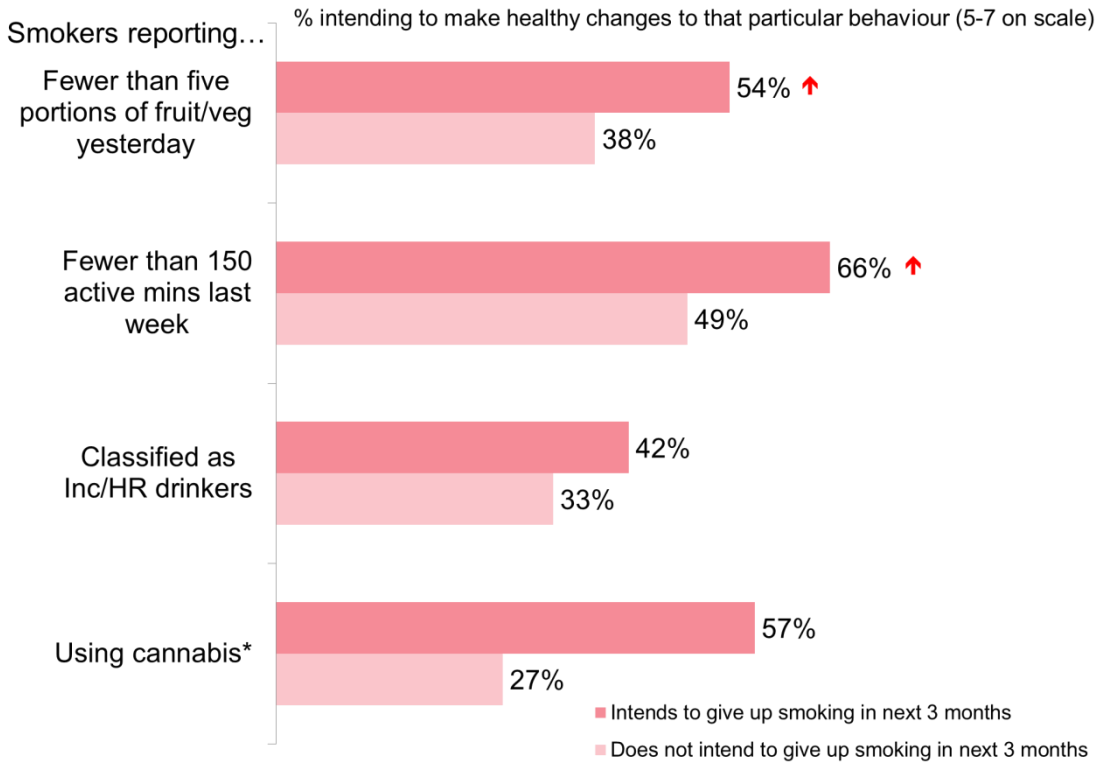
- 46% of all adults ate fewer than five portions of fruit/veg on the day before they were interviewed AND did not intend to start eating a healthier diet
- 20% did fewer than 150 active minutes in the previous week AND did not intend to increase their activity levels
- 18% smoked cigarettes AND did not intend to give up
- 10% were increasing/higher risk drinkers AND did not intend to cut down
- 2% were cannabis, cocaine or ecstasy users AND did not intend to stop using

[24] Thaler (1980) labelled the increased value of a good to an individual when the good becomes part of the individual's endowment the "endowment effect." This effect is a manifestation of "loss aversion," the generalization that losses are weighted substantially more than objectively commensurate gains. People dislike losses more than like gains of an equivalent amount (Kahneman & Tversky, 1979). In the case of smoking, people are thinking of what they will lose which deters them from quitting. Reference: Kahneman, Knetsch, Thaler, 1990

There were also interesting patterns related to who was more or less likely to state intentions to make healthy changes.

Firstly it was notable that those who intended to change one behaviour were more likely to intend on changing other behaviours. For example, smokers who said they intended to quit were more likely to say that they intended to improve their diet, cut back on alcohol and be more physically active, than smokers who did not intend to quit (see Figure 33).

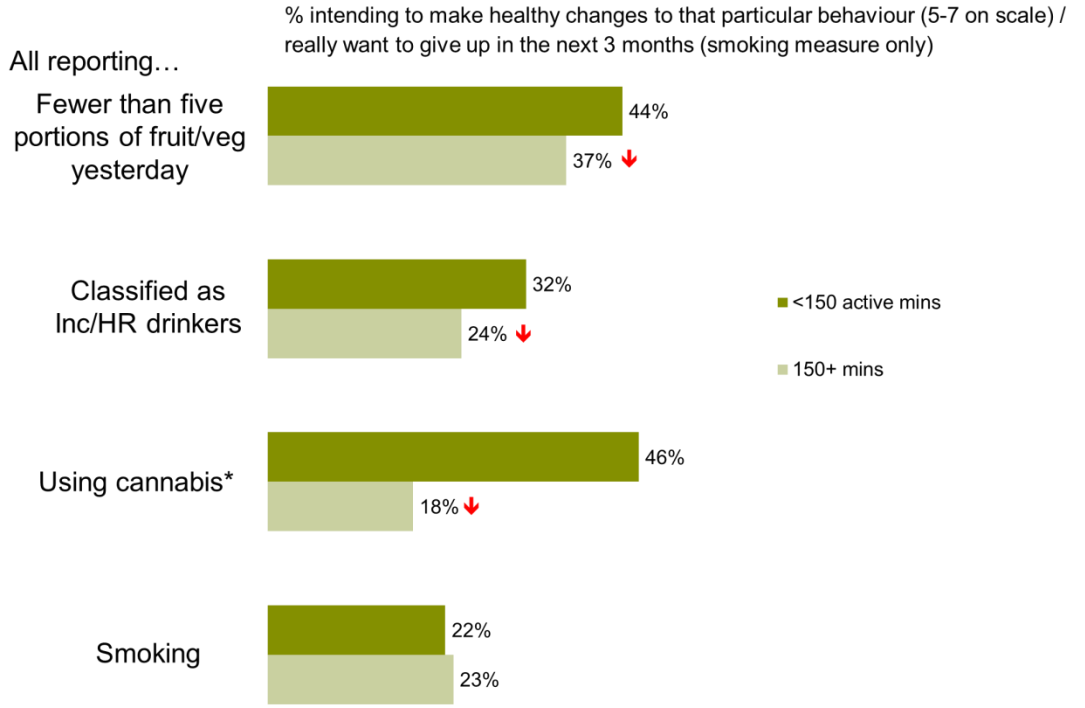
Figure 33 **Intentions to make healthy changes: comparisons of smokers who intend to quit v those who do not intend to quit**



Base: All 2012 adult smokers who intend to quit/do not intend to quit who report other negative health behaviours: (fewer than five portions of fruit/veg yesterday 104*/363, fewer than 150 mins last week 57*/232, classified as inc/HR drinker 25*/77*, using cannabis 11*/48*) * Caution low base size
↑↓ Indicates a significant difference, compared with the corresponding group of smokers who do not intend to quit

Some notable patterns were also observed related to barriers to making healthy changes. In particular, those who reported 150+ weekly active minutes but also other negative health behaviours were less likely to say that they intended to make healthy changes to many of their other negative behaviours (Figure 34). Similar patterns were observed in the Healthy Foundations study in 2007[25], where a segment called the Balanced Compensators was identified, the members of which tended to hold a view that other negative health behaviours could to a certain extent be compensated for by physical activity (e.g. a visit to the gym balances out a night's heavy drinking).

Figure 34 **Intentions to make healthy changes: comparisons of those reporting 150+ weekly active minutes v fewer than 150 weekly active minutes**



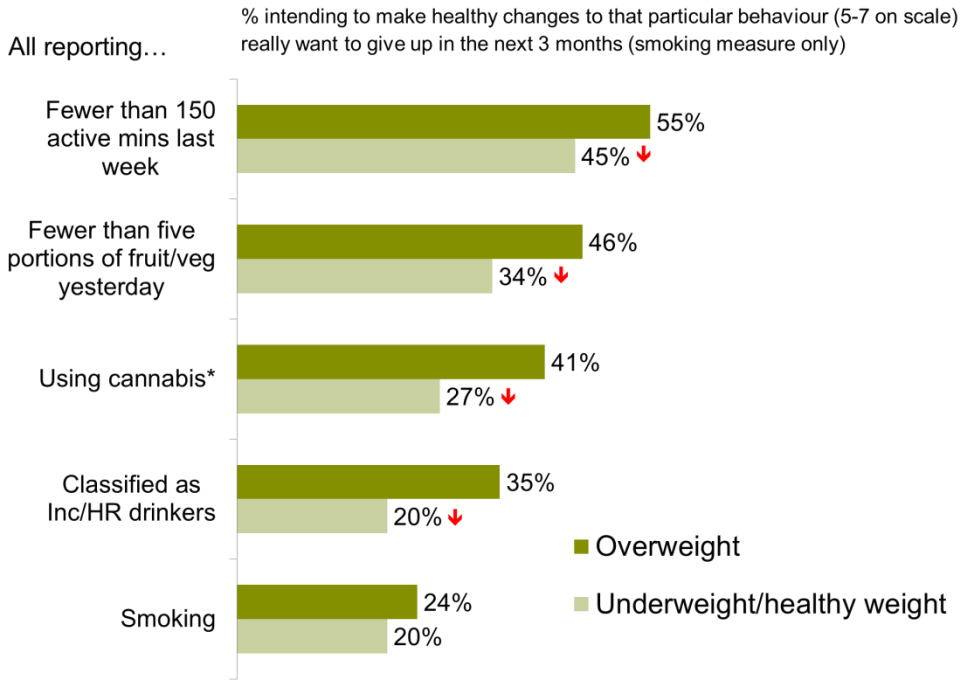
Base: All 2012 adults who report fewer than 150 active mins/150 active minutes who report negative health behaviours: (fewer than five portions of fruit/veg yesterday – 983/648, classified as inc/HR drinker – 137/138, using cannabis 38*/38*, smoking – 304/255) * Caution low base size
↑↓ Indicates a significant difference, compared with the corresponding group of adults who report 150+ active minutes

For example, only 24% of increasing/higher risk drinkers who reported 150+ weekly active minutes said they intended to cut back on their alcohol consumption over the next three months, compared with 32% of their counterparts reporting fewer than 150 weekly active minutes. Similar patterns were observed in relation to diet (5 a day) and cannabis use, though there were no differences related to smoking.

[25] http://www.thensmc.com/sites/default/files/301846_HFLS%20Report%20No1_ACC.pdf

In addition, and potentially linked to the above, respondents who felt that they were underweight/healthy weight were also less likely to intend to make changes to the negative health behaviours they reported. This may be linked to the view expressed elsewhere in this chapter that there may be a perception that not being overweight is the most important consideration (Figure 35).

Figure 35 **Intentions to make healthy changes: comparisons of those perceiving themselves as overweight v those who perceive themselves as underweight/healthy weight**



Base: All 2012 adults who say they are overweight/under/healthy weight who report negative health behaviours: (fewer than 150 active mins last week – 633/520, fewer than five portions of fruit/veg yesterday – 368/745, using cannabis 20*/56*, classified as inc/HR drinker – 138/130, smoking – 283/271) * Caution low base size
↑↓ Indicates a significant difference, compared with the corresponding group of adults who perceive themselves as overweight

For example, only 20% of increasing/higher risk drinkers who perceived themselves as underweight/healthy weight said they intended to cut back on their alcohol consumption over the next three months, compared with 35% of their counterparts who perceived themselves as overweight. Similar patterns were observed in relation to physical activity (150 active minutes), diet (5 a day) and cannabis use, though there were no differences related to smoking.

These results may indicate that there is a mindset amongst a minority that precisely what they eat, drink or do doesn't matter as long as they are not overweight.

4.5 Barriers to behaviour change

Towards the end of the wave 2 interview, but still in the self-completion section to allow respondent privacy when answering, all those reporting negative health behaviours were asked what prevents them from changing their behaviour, answering in their own words. To reduce burden and interview length, each respondent was only asked about one specific behaviour, and the least prevalent behaviours were prioritised to ensure sufficient base sizes for analysis.

Details of specific barriers to behaviour change for each health behaviour are shown in the individual behaviour chapters, but below we summarise more general patterns in response.

Figure 36 **Barriers to behaviour change: comparison across behaviours**

Barriers to …				
Eating more fruit/veg	**Being more physically active**	**Cutting back on alcohol**	**Stopping smoking**	**Stopping taking drugs**
Don't want to 33%	Time 33%	Don't want to 26%	Don't want to 24%	Don't want to 32%
Cost 15%	Poor health 29%	Lifestyle 16%	Stress 19%	Enjoyment 11%
Time to buy/prepare 12%	Don't want to 14%	Enjoyment 17%	Enjoyment 11%	Boredom 5%
Already eat enough 11%	Age 8%	Stress 13%	Addiction 9%	Lifestyle 4%
Time to shop 5%	Lack of motivation 8%	Don't drink that much 6%	Lack of willpower 6%	Stress 2%
Don't like taste 4%			Too difficult to quit 3%	Addiction 2%
Base: 207	Base: 415	Base: 130	Base: 221	Base: 61*

Base: All Autumn 2012 adults asked and reported relevant negative behaviour: as shown
*Caution low base
NB: Based on Autumn 2012 data only

Across all behaviours, simply not wanting to change their behaviour was cited in the top 3 reasons preventing a change. Between a quarter and a third of smokers, drug users and increasing/higher risk drinkers said they simply did not want to cut back or stop, and a third of those eating fewer than five portions of fruit/veg a day said this.

When answering about risk behaviours (alcohol, smoking, drug use), not wanting to stop, enjoyment and using the behaviour to cope with stress came out most strongly. In addition, the fact that the behaviour is part of their lifestyle was also commonly cited as a reason for not changing behaviour.

Other barriers were also mentioned as reasons for not eating more fruit/veg or being more physically active: time was a barrier for both, while cost was commonly mentioned as a barrier to eating more fruit/veg and poor health/age as a barrier to being more physically active.

4.6 Comparisons across behaviours - summary

On average, adults reported 1.8 out of the five negative health behaviours asked of all in the survey [26] with significantly higher averages amongst 18-24s (2.1) and 35-44 non-parents[27] (2.1). Men, C2DEs, those in deprived areas and those not living with a partner tended to report more negative health behaviours on average.

The most common clusters of negative health behaviours related to nutrition and physical activity, with over two fifths of adults reporting that they had both eaten fewer than five portions of fruit/veg yesterday and had done fewer than 150 active minutes last week.

The Change4Life strategy includes messages around nutrition, physical activity and alcohol consumption, and 90% of all adults reported at least one negative health behaviour on these three factors, with 6% reporting negative behaviour on all three.

A third of adults said they were either smokers, increasing/higher risk drinkers or drug users, though only 1% reported all three behaviours.

A sub-sample of those reporting negative health behaviours was asked how worried they were about the impact of their behaviour on their health. Smokers were most likely to worry about the impact of their smoking on their health, and also to worry about the impact of their other negative health behaviours on their health.

Respondents were more worried about the impact of weight on their health than possible contributing factors to health (e.g. low levels of fitness, poor diet), so there may be scope to get people to think about healthy diets and lifestyles as more than just weight.

Levels of worry were lower about alcohol and drug use, with over two thirds of those reporting negative health behaviours saying that they are not worried about the impact of these behaviours on their health.

In terms of physical activity and consumption of fruit and vegetables our sample reported relatively strong intentions to make positive changes: for example half of those who reported fewer than 150 active minutes said they intended to be more active over the next three months, and two fifths of those not eating 5 portions of fruit/veg yesterday said they intended to eat a healthier diet over the same time period. Changes which meant doing *less* or giving up (e.g. giving up smoking or drug use, or drinking less alcohol) had lower levels of intention to change.

It was notable that those who intended to change one behaviour were more likely to intend to change other behaviours, suggesting an opportunity to work holistically with those reporting multiple negative health behaviours to help them make changes.

Those who said they had done 150+ active minutes last week were less likely to intend to make healthy changes, as were those who perceived themselves to be an ideal weight. These findings may suggest a belief that as long as someone is active and not overweight, it doesn't matter what other behaviours they exhibit. This may be an issue for further research and potential communication.

---

[26] Fewer than five portions of fruit/veg yesterday, fewer than 150 active minutes last week, smoke cigarettes nowadays, increasing/higher risk drinker, drug user. Only under 55s were asked about sexual health, so this has been excluded from this analysis.

[27] Non-parents are defined as those who do not have children in their household for whom they have caring responsibilities. Some of these non-parents may have caring responsibilities for children outside of their household, but this was not explored in the questionnaire.

5 Nutrition

Current government recommendations are that everyone should eat at least five portions of fruit and vegetables a day, and that foods and drinks high in salt, fat and sugar should be consumed infrequently and in small amounts. This is represented in the eatwell plate[28], which aims to make healthier eating easier to understand.

The Lifecourse Tracker survey aims to give a broad understanding of behaviours, attitudes and intentions related to nutrition in the round. As with all other behaviours, the Lifecourse Tracker does not aim to replace other prevalence measures, but instead to add value to thinking by enabling analysis of nutritional attitudes and behaviours in comparison with other health behaviours (e.g. smoking, physical activity).

This chapter includes the following:

- Respondents' own reports of their nutritional behaviours, including whether they ate 5 or more portions of fruit/veg on the day before they were interviewed, and frequency of consumption of other types of food such as high fat/fried foods and high calorie/sugary foods
- Attitudes to healthy eating, including norms related to healthy eating, barriers to change and intentions to change

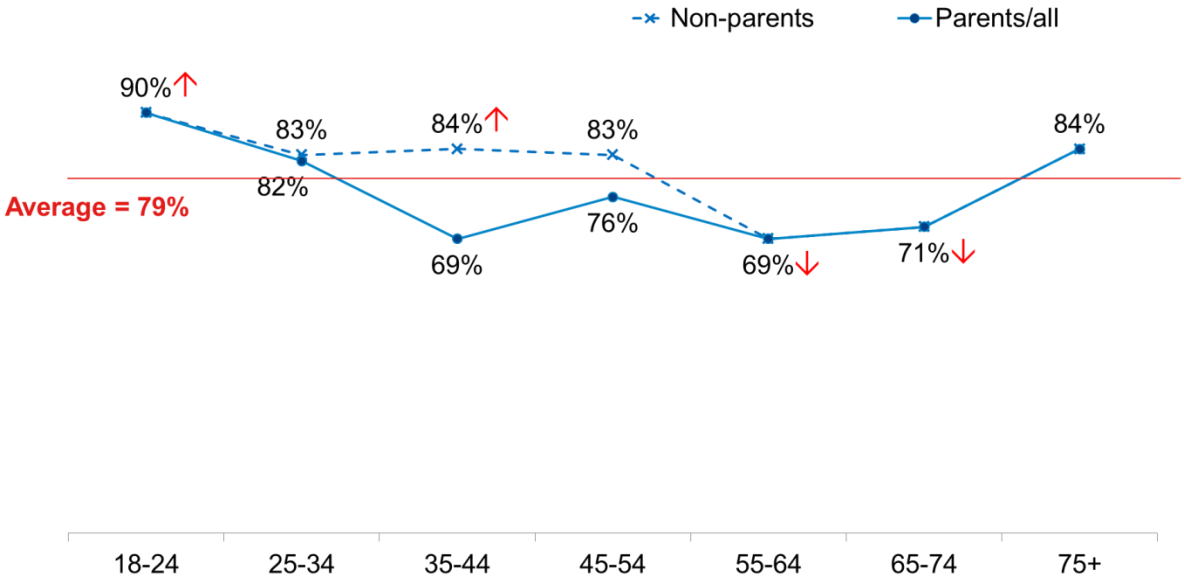
5.1 Five a day

The core nutritional indicator for this survey was whether the respondent ate five or more portions of fruit or veg on the day before they were interviewed. All were asked how many portions they had eaten: they were asked to include fresh, frozen, tinned, dried or juiced fruit or vegetables, and were told that a portion is a medium sized piece of fruit such as an apple, a glass of 100% fruit juice, or three heaped tablespoons of cooked vegetables. They were asked not to include potatoes in their answer. Because respondents only answered about their consumption yesterday it is acknowledged that these may not be typical of the respondent's usual consumption.

[28] http://www.nhs.uk/Livewell/Goodfood/Pages/eatwell-plate.aspx

Across the sample of all adults, eight in ten (79%) said they had eaten *fewer* than five portions of fruit or veg on the day before they were interviewed (Figure 37). The youngest and oldest respondents were the most likely to say that they had eaten fewer than five portions: nine in ten (90%) of 18-24s and 84% of 75+s said this.

Figure 37 **% who reported eating fewer than five portions of fruit or veg on the day before they were interviewed**



Base: All 2012 adults: 18-24 (223), parents/non-parents: 25-34 (185/151), 35-44 (228/99), 45-54 (101/209), 55-64 (300), 65-74 (288), 75+ (245)
↑↓ Indicates a significant difference, compared with the all adult average or corresponding parent/non-parent group

At the overall level, there were no significant differences in the proportions of men and women saying they had eaten fewer than five portions of fruit or veg (80% of men, 78% of women).

Similar questions were asked on the Health Survey for England in 2011[29], though the question set was more extensive, asking respondents how many portions of different types of fruit/veg they had eaten. Because respondents were asked in more detail, it is unsurprising that respondents on the Health Survey for England were more likely to say they had eaten five or more portions of fruit/veg on the day before they were interviewed: 27% of adults said they had done so, compared with 21% of respondents to the Lifecourse Tracker. Patterns in response by age were similar for the two surveys, with younger and older people least likely to have consumed five or more portions of fruit/veg.

[29] Health Survey for England 2011 – Adult Trend tables. Health and Social Care Information Centre, 2012. www.ic.nhs.uk/pubs/hse11trends

Amongst Lifecourse Tracker respondents, levels of fruit/veg consumption were particularly low amongst respondents aged 18-34 (28% had eaten only one or no portions on the previous day), and C2DEs (29%). The average number of portions of fruit/veg consumed on the previous day by C2DEs was 2.8: significantly lower than the 3.6 portions reported by ABC1s (Figure 38).

Figure 38 **Number of portions of fruit/veg eaten on the previous day**

		Age			Social Grade	
	All (2029) %	18-34 (559) %	35-54 (637) %	55+ (833) %	ABC1 (853) %	C2DE (1176) %
None	11	15↑	10	7	7	14↑
One	11	13	10	10	8	14↑
Two	18	18	19	17	17	19
Three	23	19	26↑	23	24	21
Four	15	18↑	12	17↑	18↑	12
Five	13	9	12	17↑	14↑	11
Six or more	9	6↓	10	10	10↑	6
Don't know	*	1	*	-	*	1
Mean average	*3.2*	*3.0*	*3.0*	*3.5*	*3.6↑*	*2.8*

Base: All 2012 adults: as shown
↑↓ Indicates a significant difference, compared with the corresponding sub-group

Linked to these social grade differences, it is unsurprising to note that fruit/veg consumption levels were particularly low amongst smokers: 35% of smokers had had one or fewer portions of fruit/veg on the previous day with 21% having had none. This compares with only 7% of non-smokers reporting no portions on the previous day, and 17% reporting one or fewer.

Figure 39 shows the average number of portions of fruit/veg eaten on the previous day by smokers and non-smokers within the different social grades, and shows that there is a large and significant difference in the average number of portions of fruit/veg eaten by smokers in different social grades: the average number of portions eaten by ABC1 smokers was 3.1, compared with only 2.1 amongst C2DE smokers.

Figure 39 **Average number of portions of fruit/veg eaten on the previous day**

	All	ABC1	C2DE
All	3.2 (2029)	3.6↑ (836)	2.8 (1152)
Smokers	2.5 (559)	3.1↑ (158)	2.1 (395)
Non-smokers	3.4 (1443)	3.7↑ (678)	3.1 (757)

Base: All 2012 adults (Base shown in parentheses after means)
↑↓ Indicates a significant difference, compared with C2DEs

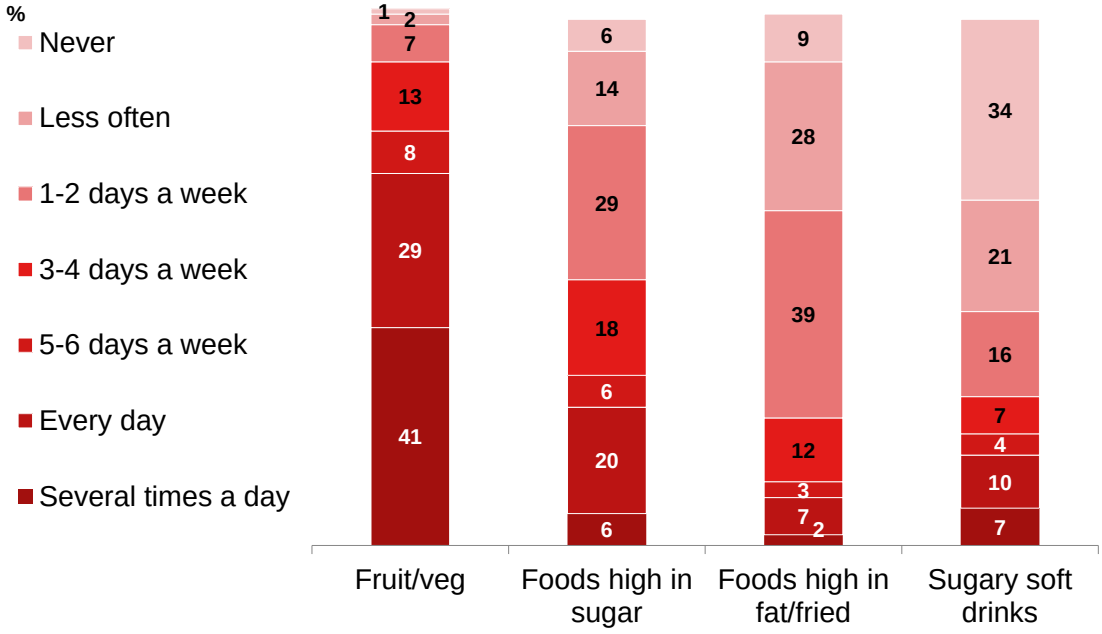
5.2 Frequency of eating fruit/veg and other foods

While the main nutritional indicator was whether respondents were eating five a day, the survey also looked at other nutritional behaviours, including consumption of foods high in fat/fried, foods high in sugar, and sugary soft drinks. All respondents were asked how often they eat each of the following types of food in a typical week:

- Fruit, vegetables or salad. These could be fresh, frozen, tinned, dried or juiced, but not including potatoes
- Foods that are high in sugar, such as cakes, puddings, pastries or biscuits, sweets or chocolate
- Foods that are high in fat or fried foods such as fried fish, chips, cooked breakfast, samosa, crisps or fatty meats, but not including oven chips
- Fizzy drinks or soft drinks like squash – not including diet or sugar free drinks, or sparkling water

Two fifths of adults said they ate fruit, vegetables or salad several times a day (41%), and seven in ten said they did so at least once a day (70% - either every day or several times a day). However, 1% said they never eat fruit, vegetables or salad, and 2% said they eat them less often than once a week (Figure 40).

Figure 40 **Frequency of consuming types of food/drinks**



Base: All 2012 adults (2029)

A quarter (26%) of all adults said they eat foods that are high in sugar daily (e.g. cakes, puddings, pastries or biscuits, sweets or chocolate). Daily consumption was somewhat higher amongst 18-24s (29%), though there were no differences in daily consumption levels by social grade or household type.

Similarly, 18-24s were more likely than other age groups to be daily consumers of high fat/fried foods (16% v 8% on average) and sugary soft drinks (33% v 18% on average). Levels of daily consumption of these food types were especially low amongst older people: only 3% of 55+s said they had high fat/fried foods daily, and 10% had sugary soft drinks daily.

In addition, C2DEs were more likely than ABC1s to report daily consumption of:

- Sugary soft drinks: 22% of C2DEs reported daily consumption (v 14% of ABC1s)
- High fat/fried food: 11% of C2DEs reported daily consumption (v 7% of ABC1s)

5.3 Other nutritional behaviours

To further explore nutritional behaviour, all were asked whether they limit some types of unhealthy foods in their diet. Three quarters (77%) of adults said they limit their diet in some way, including the following:

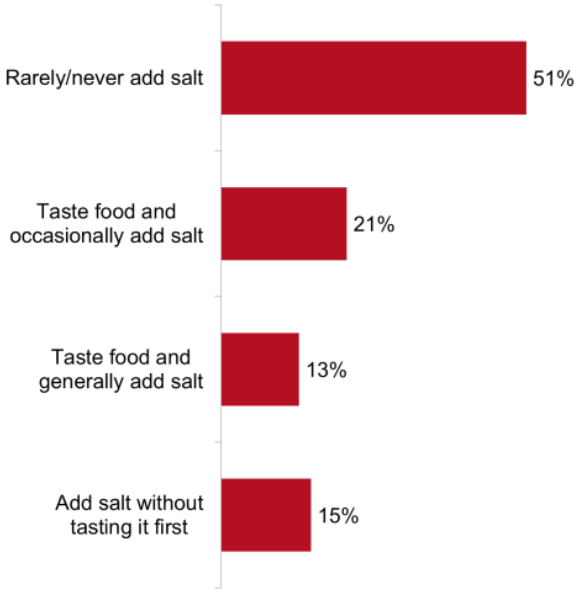
- 58% limit the number of unhealthy snacks they eat between meals
- 46% limit their salt/lo salt intake
- 35% limit the amount of high-calorie food they consume or limit their calorie intake

The following groups were less likely to limit their diet in any way: men (75% v 79% women), younger adults (73% 18-34s, v 80% 55+s) and C2DEs (74% v 80% ABC1s).

As well as being less likely to limit their salt intake, men and C2DEs were also more likely than average to say that they generally add salt to their food at the table without tasting it first. While one in seven (15%) of all adults said that they generally salt their food without tasting it, the proportion was as high as 18% amongst men (v 13% women) and 21% amongst C2DEs (v 11% ABC1s).

Amongst all adults, half (51%) said they rarely or never add salt to their food at the table, and a third (33%) taste their food before salting it (Figure 41).

Figure 41 **Whether add salt to food at the table**



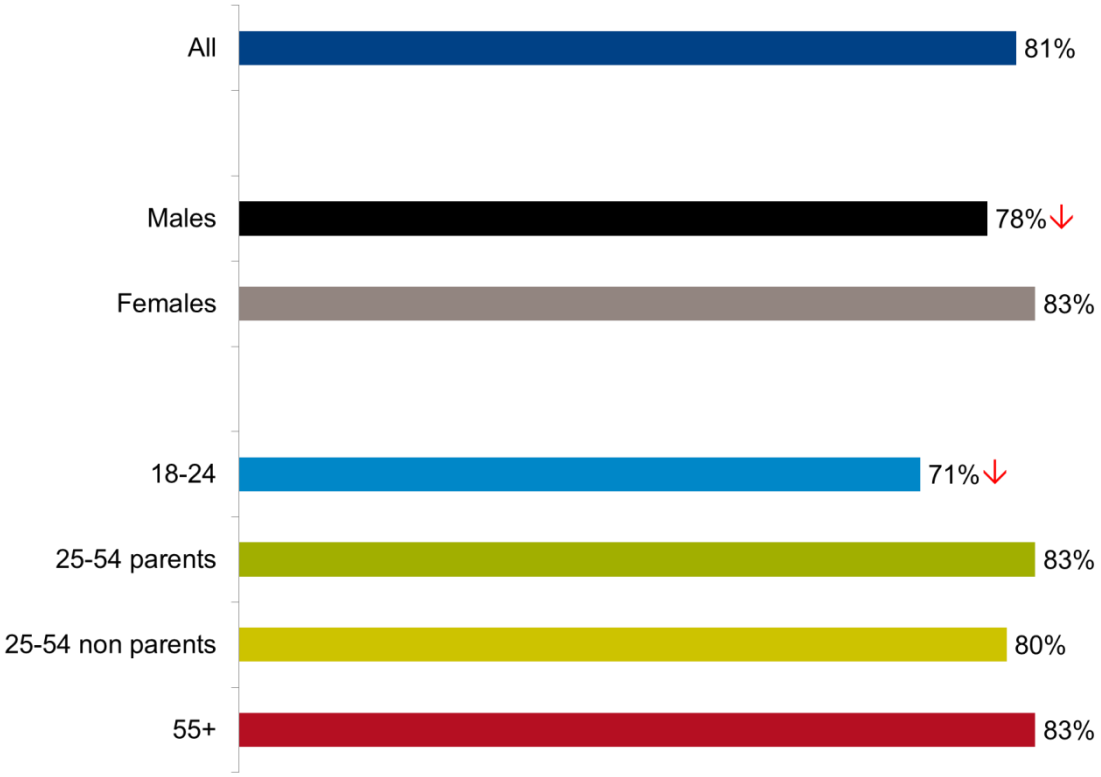
Base: All 2012 adults (2029)

5.4 Attitudes towards healthy eating

While four fifths of adults (79%) reported eating *fewer* than five portions of fruit or vegetables on the day before they were interviewed, a similar proportion (81%) said that healthy eating is a priority for them nowadays. Those who reported eating fewer than five portions of fruit/veg were less likely to say that healthy eating is a priority for them, though 78% said it is a priority, and 26% said it is a very high priority. In contrast, nine in ten (91%) of those who ate five or more portions of fruit/veg said that healthy eating is a priority, and 39% said it is a very high priority.

Figure 42 shows that men and 18-24s were less likely than their counterparts to say that healthy eating is a priority for them, and in addition, C2DEs (75%) were less likely than ABC1s (85%) to say that healthy eating is a priority. Daily consumers of foods high in sugar (73%), sugary soft drinks (71%) or high fat/fried foods (63%) were also less likely than average to say this.

Figure 42 **% thinking that healthy eating is a very or quite high priority nowadays**



Base: All 2012 adults (2029); Males (895), Females (1134), 18-24s (223), 25-54 parents (514), 25-54 non-parents (459), 55+s (833)
↑↓ Indicates a significant difference, compared with the corresponding sub-group

To investigate whether healthy eating is becoming the norm, all were asked the extent to which they agreed or disagreed with the statement '*most people I know eat healthily nowadays*'. Half (51%) of adults agreed that this was the case, though levels of agreement weren't strong with only 4% strongly agreeing. Compared to other behavioural norms included in the Lifecourse Tracker survey, eating healthily was fairly commonly perceived to be the norm, although not as commonly as stopping smoking (see section 3.4).

Levels of agreement that most people eat healthily rose strongly with age: while 40% of 18-34s agreed, this rose to 51% amongst 35-54s and 60% amongst 55+s. In addition ABC1s (54%) were significantly more likely to agree than C2DEs (48%).

There were no differences in perceptions that healthy eating is the norm between those who reported eating five or more portions of fruit/veg on the previous day (50% agreed) and those who ate fewer than five portions (51% agreed). Daily consumers of high fat/fried foods and/or sugary soft drinks did *not* however, appear to feel that healthy eating is the norm: half of these consumers *disagreed* that most people they know eat healthily (50%), compared with 35% on average.

All were also asked the extent to which they agreed or disagreed with a number of statements about healthy eating, including some key barriers to healthy eating. Responses are shown in Figure 43.

Figure 43 **% agreeing with statements about healthy eating**

	All (2029) %	Gender: Male (895) %	Gender: Female (1134) %	Age: 18-34 (559) %	Age: 35-54 (637) %	Age: 55+ (833) %	Social grade: ABC1 (853) %	Social grade: C2DE (1176) %
Healthy eating means giving up too many of the foods I enjoy	32	37↑	28↓	35	31	31	29↓	37↑
Healthy eating is only for those who can afford it	23	24	21	22	28↑	18↓	19↓	27↑

Base: All 2012 adults: as shown
↑↓ Indicates a significant difference, compared with the corresponding sub-group

A third (32%) of adults agreed that *healthy eating means giving up too many of the foods I enjoy*, with men (37%) and C2DEs (37%) more likely than average to agree. C2DEs were also more likely than average to agree that *healthy eating is only for those who can afford it*: 27% agreed, compared with 19% of ABC1s and 23% on average. It is notable, however, that despite their generally poorer nutritional behaviours, younger adults were no more likely than their older counterparts to agree with either of these statements; suggesting that enjoyment and affordability are not barriers to healthy eating for them.

There are, however, indications that these perceptions around affordability and giving up enjoyment are associated with consumption of high fat/fried food: 31% of daily consumers of high fat/fried food agreed that *healthy eating is only for those who can afford it* compared with 23% overall. Similarly, 48% of daily consumers of high fat/fried food agreed *healthy eating means giving up too many of the foods I enjoy* compared with 32% overall. There were, however, no associations with frequency of consumption of fruit/veg, high sugar foods or sugary soft drinks.

5.5 Worry about behaviour and intentions to change

All were asked the extent to which they worried about the impact of the things they do on their health. Only around one in ten said they were worried about the impact of the foods they eat or their salt intake on their health, and it is notable that these behaviours caused low levels of worry compared with other negative health behaviours, for instance smoking (see section 4.3).

As shown in Figure 44, younger adults were more likely than their older counterparts to say that they are worried about the impact of their diet on their health, and worry levels were highest amongst 18-24s and lowest amongst the 75+s: 35% of 18-24s were worried about the impact of the foods they eat on their health (v 3% 75+s), and 17% of 18-24s were worried about the impact of their salt intake (v 3% 75+s). This may reflect the generally poorer nutrition reported by younger adults and may also reflect the fact that people in older age groups may be less concerned about the longer-term impact of their behaviours.

Figure 44 **% worried about the impact of their diet on their health**

		Gender		Age						
	All (2029) %	Male (895) %	Female (1134) %	18-24 (223) %	25-34 (336) %	35-44 (327) %	45-54 (310) %	55-64 (300) %	65-74 (288) %	75+ (245) %
The foods you eat	15	15	16	35↑	17	19	12	10	9	3↓
The amount of salt you take in	11	10	11	17↑	12	11	12	12	4	3↓

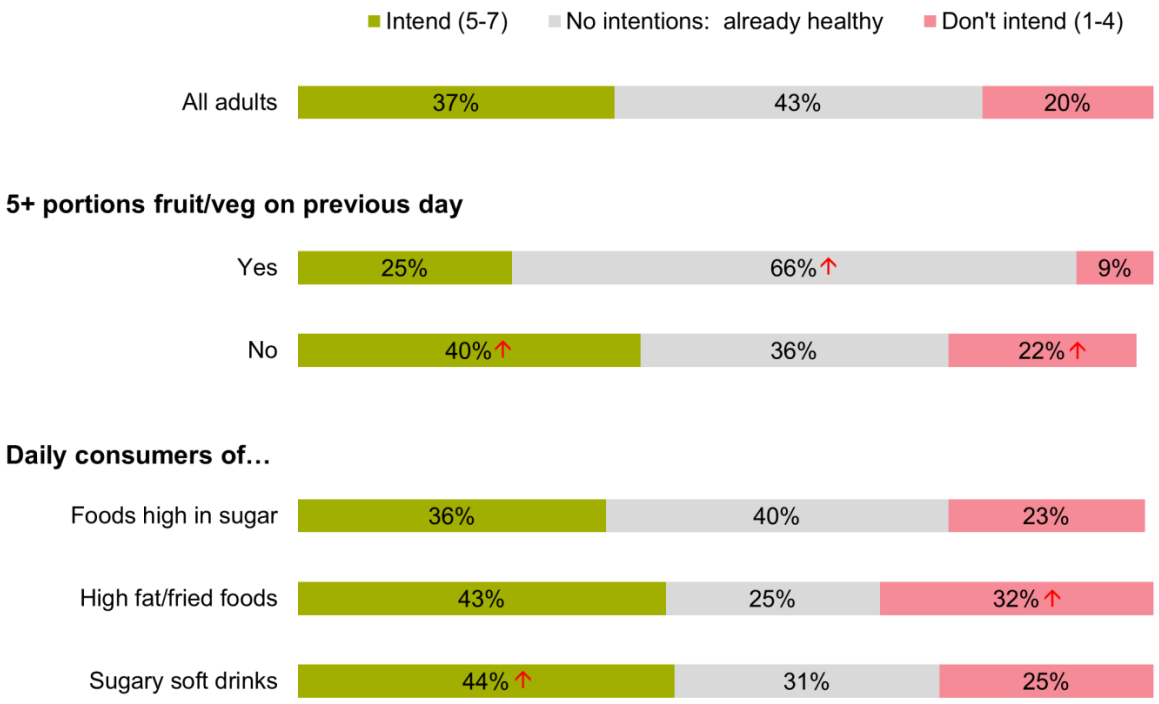
Base: All 2012 adults: as shown
↑↓ Indicates a significant difference, compared with the corresponding sub-group

There were no significant differences in levels of worry by gender or social grade, though behaviour did have a clear impact on worry levels. Those who reported eating fewer than five portions of fruit/veg on the previous day were more likely to be worried about the impact of the food they eat on their health (18% v 7% of those who had 5+ portions), and daily consumers of high fat/fried foods (27%) and sugary soft drinks (23%) were also more likely to be worried. However, daily consumers of foods high in sugar were no more likely than average to be worried about the impact of the foods they eat on their diet (14% v 15% average), perhaps suggesting that these types of food are not considered as unhealthy as other foods.

Those who say they generally salt their food were the most likely to say that they are worried about the amount of salt they take in: 17% of those who generally salt their food without tasting it and 16% of those who taste but then generally add salt said they were worried. Those who said they rarely or never add salt at the table were less likely to be worried about their salt intake (8%).

Worry about the impact of diet on health is closely associated with positive intentions to eat a healthier diet: two thirds (64%) of those who said they were worried about the impact of the foods they eat on their health, and 62% of those who said they were worried about the impact of their salt intake on their health said that they intended to start eating a healthier diet over the next three months. This compares with 37% on average (Figure 45).

Figure 45 **Intentions to start eating a healthier diet over the next three months**



Base: All 2012 adults (2029); 5 a day Yes (398) No (1631), Daily consumers of: Foods high in sugar (510), High fat/fried foods (175), Sugary soft drinks (383)
↑↓ Indicates a significant difference, compared with the corresponding sub-group (5 a day) or between sub-groups and the all adult average (daily consumers)

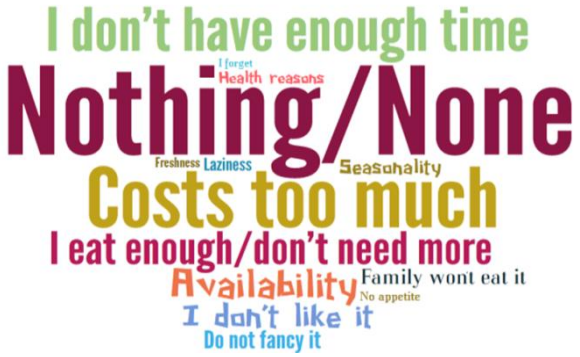
It is unsurprising to note that those who ate a less healthy diet were more likely than average to say they intend to eat a healthier diet over the next three months: two fifths of those who ate fewer than five portions of fruit/veg on the previous day (40%) and similar proportions of daily consumers of high fat/fried foods (43%) or sugary soft drinks (44%) said this. Those aged 18-24, who tended to have poorer diets, were more likely to say this. However, it is also notable that significant minorities of these groups said that they did not intend to eat a healthier diet because their diet is already healthy. This means that around three fifths of those who reported less healthy eating habits did not intend to start to eat a healthier diet over the next three months.

In addition, daily consumers of foods high in sugar were no more likely than average to say that they intend to eat a healthier diet. Once again, this may imply that for some consumers, daily consumption of high sugar foods may not be seen as unhealthy.

A sub-sample of those who reported eating fewer than five portions of fruit/veg on the previous day were asked what barriers prevent them from eating more fruit/veg . Figure 46 shows a word cloud of the main answers given, together with a table showing responses given by 5% or more.

The main reason given was inertia i.e. nothing prevents them from eating more fruit and veg: mentioned by a third (33%) of those asked. The main tangible barriers mentioned were cost (15%), time to prepare (12%) and not having fruit/veg in the house to eat (5%). Other barriers, such as not liking the taste (4%) or family members not liking fruit/veg (2%) were mentioned less frequently. These results suggest that continued interventions to encourage the consumption of fruit/veg may be useful, as only a minority specified tangible barriers to their consumption.

Figure 46 **Barriers to eating more fruit and vegetables**



What things prevent you from eating more fruit and veg?	%
Nothing	33
Costs too much	15
I don't have enough time to prepare/too busy	12
I don't need to eat more	11
Do not have it in the house	5

Base: All Autumn 2012 adults who reported eating fewer than five portions of fruit/veg on the previous day and not asked about other less prevalent health behaviours (207)
NB: Based on Autumn 2012 data only

5.6 Nutrition – summary

While the vast majority of adults say that healthy eating is a priority for them, in practice, eight in ten reported they ate *fewer* than five portions of fruit/veg on the day before they were interviewed. Only a minority were making positive and consistent decisions about their food choices - under half said that they limited salt whilst a third said they limit the amount of high calorie food they eat - and only half perceived healthy eating to be the norm amongst those they knew.

The following groups of adults tended to report poorer diets: 18-24s, C2DEs, smokers and men. Across nearly all nutritional measures, 18-24s tended to be eating more poorly than other adults (including being most likely to report eating fewer than five portions of fruit/veg a day) and were less likely to say that healthy eating is a high priority or the norm, despite there being no practical or financial barriers to healthy eating specific to this age group.

While some of those reporting a less healthy diet (including 18-24s) have acknowledged the impact of their diet on their health and intend to change, it is notable that those who said they consume high calorie/sugary foods were often no more likely than average to intend to make healthy changes to their diet. This may imply that for some, frequent consumption of high calorie/sugary foods may not be viewed as unhealthy.

6 Physical activity

Current physical activity guidelines for adults are that they should achieve a total of 150 weekly minutes of at least moderate activity[30]. Questions were included in the Lifecourse Tracker survey to understand the extent to which these guidelines for physical activity were being met.

This chapter includes the following:

- Respondents' own reports of their levels of physical activity and sedentary behaviour
- Attitudes to physical activity, including norms related to physical activity, barriers to change and intentions to change

6.1 150+ weekly active minutes

All adults were asked to think about moderate physical activity: that is activity that makes you breathe slightly faster than usual. Examples were given, which aimed to get people thinking about activity more broadly, rather than just considering sports or going to the gym. Examples included:

- Brisk walking
- Going to the gym
- Swimming
- Aerobics
- Sports
- Cycling
- Heavy gardening
- Physical activity as part of or getting to work/job

All were asked on how many days in the last seven they had done any moderate physical activity that makes them breathe slightly faster than usual, and how many minutes in total they had spent doing moderate physical activity in the past seven days[31]. Just under half (47%) reported that they had done 150 active minutes or more in the past seven days, but 53% said they had done fewer.

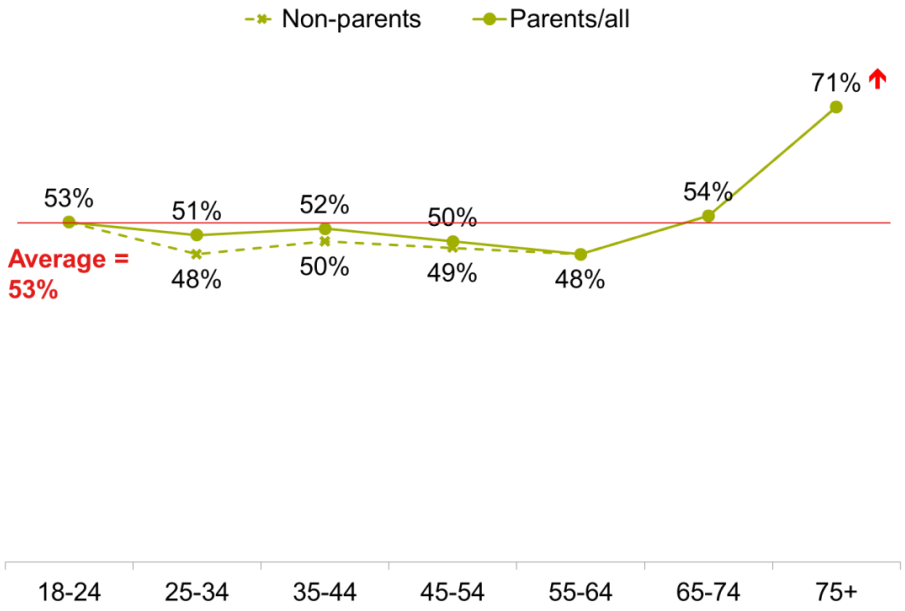
[30] Physical activity guidelines for adults: Factsheet 4. Department of Health, 2011. http://www.dh.gov.uk/publicationsandstatistics/publications/publicationspolicyandguidance/DH_127931

[31] Because respondents only answered about their activity in the past week it is acknowledged that these may not be typical of the respondent's usual activity levels.

Figure 47 details the proportions reporting *fewer* than 150 active minutes and shows that responses were fairly consistent across lifecourses, with the exception of those in the oldest age group: over seven in ten (71%) of those aged 75+ reported *fewer* than 150 active minutes in the past seven days. In addition, women were more likely than men to report *fewer* than 150 active minutes in the past seven days (56% women, 50% men).

Questions about physical activity have not been asked on the Health Survey for England since 2008, and the measure used differs[32], so direct comparisons are not possible. For similar reasons comparisons cannot be made with the Active People Survey 2010/2011[33]. However, patterns in response were similar, with women less likely than men to meet the physical activity guidelines, and people who were overweight or obese less likely to meet the recommendations than people who were a healthy weight.

Figure 47 **% who reported fewer than 150 active minutes in the previous seven days**



Base: All 2012 adults: 18-24 (223), parents/non-parents: 25-34 (185/151), 35-44 (228/99), 45-54 (101/209), 55-64 (300), 65-74 (288), 75+ (245)
↑↓ Indicates a significant difference compared with the all adult average or between corresponding parent/non-parent group

Respondents from the C2DE social grades (57%) were more likely than ABC1s (49%) to report *fewer* than 150 active minutes, and this rose to 66% amongst those in social grade E. In addition, those who reported eating *fewer* than five portions of fruit/veg on the previous day were more likely to have done *fewer* than 150active minutes (55% v 44% of those who had 5+ portions). There were, however, no other differences in activity levels by other health behaviours, with smokers or increasing/higher risk drinkers no more likely than average to say they had *not* met the activity guidelines in the past week:

- 51% smokers reported *fewer* than 150 active minutes (similar to 53% of non-smokers)
- 49% increasing/higher risk drinkers reported *fewer* than 150 active minutes (similar to 53% of others)

[32] In the 2008 Health Survey for England, the recommendations were defined as 20 or more occasions of moderate or vigorous activity of at least 30 minutes' duration in the past four weeks (i.e. at least five occasions per week on average). http://www.ic.nhs.uk/pubs/hse08physicalactivity

[33] The Active People Survey 2010/11, measures the number of adults aged 16+ in England who participate in at least 30 minutes of sport and active recreation at moderate intensity at least three times a week

It was, however, noted that respondents who considered themselves to be a healthy weight (49%) were less likely than those who considered themselves to be overweight/very overweight (54%), and in particular those who said they were very overweight (64%) to report *fewer* than 150 active minutes in the past week.

The average number of days in the past week on which respondents said they were active to the point where they were breathing faster than usual was 3.8: while a quarter (24%) said they were active on one day or fewer, a similar proportion (26%) said they were active on all seven days in the past week.

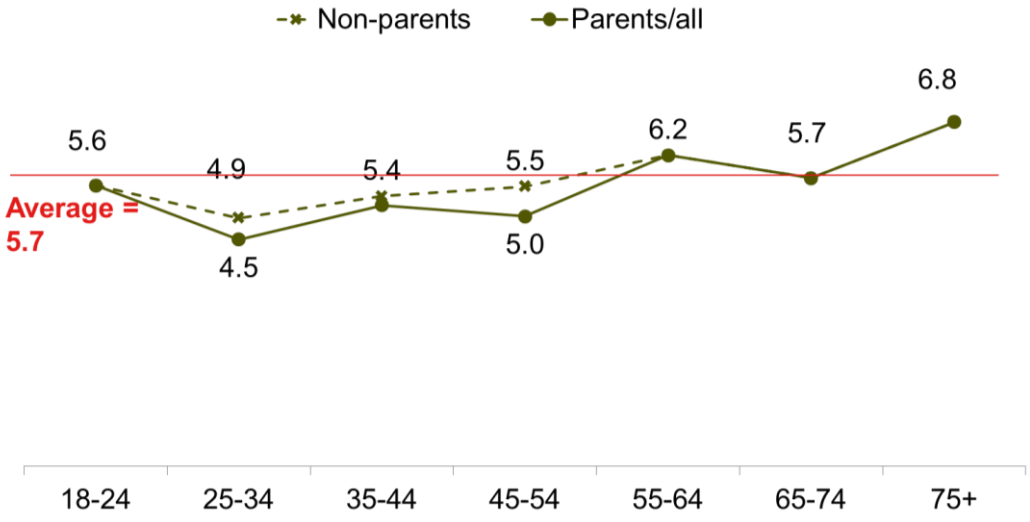
6.2 Sedentary behaviour

In addition to asking about active time, all respondents were also asked about sedentary time: that is time spent sitting down including at work, at home, on transport and in leisure time. They were asked to include time in cars, buses and trains, and time sitting at a desk, reading, or sitting or lying down to watch television, but not to include time spent asleep.

All were asked how many hours they spent sitting down on the day before they were interviewed. The mean average number of hours spent sitting down on the previous day was just under six (5.7), though sedentary behaviour was most commonly reported by men (6.0 hours v 5.2 hours for women) and those in social grade E (6.8 hours v 5.5 hours for ABC1s).

The average number of sedentary hours also varied considerably by lifecourse, with older people tending to spend longer on average sitting down (6.8 hours amongst 75+s) (Figure 48). Those living alone (5.9 hours) tended to be sedentary for an hour longer on average than those living with a partner and children (4.9 hours).

Figure 48 **Average number of hours spent sitting down on the day before the interview**



Base: All Autumn 2012 adults: 18-24 (109), parents/non-parents: 25-34 (95/76), 35-44 (88/51), 45-54 (48/107), 55-64 (157), 65-74 (154), 75+ (134)
↑↓ Indicates a significant difference compared with the all adult average or between corresponding parent/non-parent group
NB: Based on Autumn 2012 data only

6.3 Attitudes to physical activity

Two key attitudes to physical activity were explored in the tracker, which related to social norms around physical activity and barriers to being physically active.

To explore norms around activity, all were asked the extent to which they agreed or disagreed that *most people I know are active nowadays.* Just over half (55%) of all adults agreed, while three in ten (31%) disagreed. However, it was notable that there were very few differences in levels of agreement with the statement based on demographics, lifecourse or socio-economic factors (e.g. poverty, deprivation). In addition, those who reported 150+ active minutes in the previous week were no more likely to agree that *most people I know are active nowadays* than their less active counterparts.

Levels of agreement with the statement '*There are plenty of ways that I could be physically active without having to go to the gym or take part in organised sports*' were higher: almost nine in ten (88%) of adults agreed, with 28% strongly agreeing and only 7% disagreeing. While levels of agreement were higher amongst those aged 35-54 (92%), over four fifths of older (84% of 55+s) and younger adults (87% of 18-34s) agreed.

Those who reported 150+ active minutes in the previous week (95%) were unsurprisingly more likely to agree that *there are plenty of ways they could be physically active* than their less active counterparts (82%).

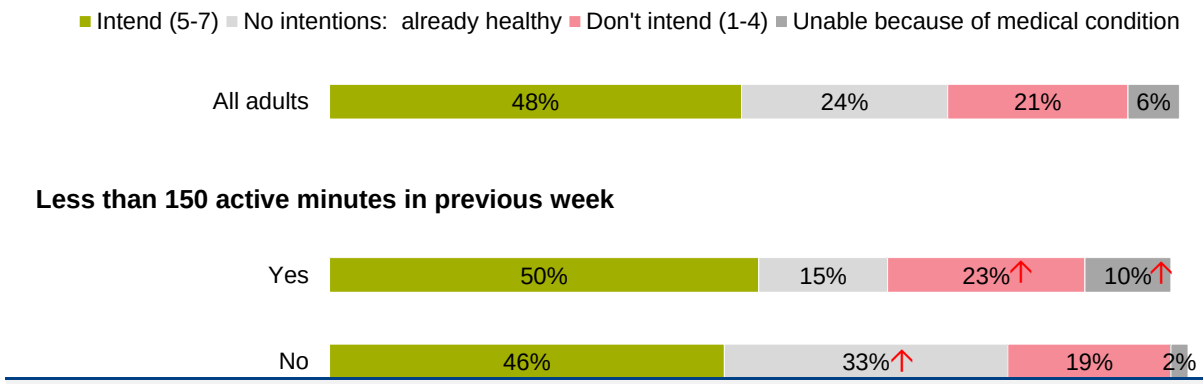
6.4 Worry about behaviour and intentions to change

All were asked the extent to which they worried about the impact of the things they do on their health. A quarter (26%) of all adults said that they were worried about the impact of their fitness levels on their health, and 28% of those reporting fewer than 150 weekly active minutes. However, respondents were less worried about the impact of their fitness on their health than they were about the impact of their weight on their health (see section 4.3 for comparisons of worries across behaviours).

Amongst all respondents younger people were more likely to be worried than their older counterparts; 31% of 18-34s said they were worried, compared with 25% of 35-54s and 22% of 55+s – worry levels were highest amongst 18-24s (40%) and lowest amongst 75+s (15%). Similar patterns were observed for worry about nutrition.

Worry about the impact of fitness on health is closely associated with positive intentions to be more physically active: two thirds (65%) of those who said they were worried about the impact of their fitness on their health said that they intended to start increasing the amount of physical activity they do over the next three months. This compares with 48% on average (Figure 49).

Figure 49 **Intentions to increase amount of physical activity over the next three months**



Base: All 2012 adults (2029), 150 active minutes last week Yes (1167) No (862)
↑↓ Indicates a significant difference, compared with the corresponding sub-group

Those who reported fewer than 150 active minutes in the past week were no more likely than average to say that they intended to increase the amount of physical activity they do over the next three months (50%), though they were more likely to say they do not intend to be more active (23%). In addition, one in ten of those who had done fewer than 150 active minutes in the past week said that they were unable to increase the amount of physical activity they do because of a medical condition (10%): most of those giving this answer were aged 55+ (77%) and eight in ten of those giving this answer reported a long term limiting illness later in the interview.

Amongst those who were already meeting the activity guidelines, just under a half (46%) said they intended to increase the amount of physical activity they do over the next three months.

A sub-sample of those who reported *fewer* than 150 active minutes in the previous week were asked to say what barriers prevented them doing more physical activity. Figure 50 shows a word cloud of the main answers given, together with a table showing responses given by 5% or more.

Figure 50 **Barriers to being more physically active**

What things prevent you from doing more physical activity?	%
Time constraints due to commitments	33
Poor health/physical limitations/medical conditions prevent me	29
Nothing – I don't want to/Personal choice	14
Age	8
Not motivated/laziness	8

Base: All Autumn 2012 adults who reported fewer than 150 active minutes in the previous week and not asked about other less prevalent health behaviours (415)
NB: Based on Autumn 2012 data only

The main reason given related to time constraints, mentioned by a third (33%), though 14% said that they simply didn't want to be more active and 8% said they were too lazy. While three in ten (29%) said that poor health or physical limitations prevent them from being more active, it is interesting to note that 8% said that age prevents them from being more active, and while this answer was almost exclusively given by those aged 55+, it is notable that a third of those giving this answer were aged under 75.

6.5 Physical activity – summary

Nearly all adults (9 in10) agreed that *there are plenty of ways to be physically active without going to a gym or taking part in organised sports*. Despite this, only half of adults reported levels of exercise sufficient to meet the current guidelines on physical activity (150 weekly minutes of moderate activity). C2DEs were also more likely to say they had done *fewer* than 150 weekly active minutes, and they were also less likely to acknowledge that it is possible to be active without going to the gym/playing organised sports. No particularly strong barriers to being more active were reported: lack of time was most commonly cited, though for many inertia was a key barrier. Poor health and age were also mentioned as barriers to being more active.

For adults the mean number of sedentary hours on the day before interview was just under six. Men, social grade Es and those aged 75+ tended to report more sedentary hours than average.

While half of those who were not being sufficiently active said that they intended to increase their activity levels in the next three months, respondents were less worried about the impact of their fitness levels on their health than they were about the impact of their weight.

7 Children's (2-11s) nutrition and physical activity

Health problems associated with being overweight or obese cost the NHS more than £5 billion every year. It is estimated that 30% of children aged between two and 15 are obese and for this reason the Government wants to see a sustained downward trend in the level of excess weight in children[34].

To achieve this, the Government is encouraging parents to get their children to eat and drink more healthily and be more active.

Current government recommendations are that everyone should eat at least 5 portions of fruit and vegetables a day, and that foods and drinks high in salt, fat and sugar should be consumed infrequently and in small amounts. This is represented by the eatwell plate[35], which aims to make healthier eating easier to understand. Although the NHS does not suggest using the eatwell plate as a guide for children under two years old, from this age onwards it recommends that they begin to regularly consume food in these proportions.

The Lifecourse Tracker survey aims to give a broad understanding of behaviours, attitudes and intentions related to nutrition. As with all other behaviours, the Lifecourse Tracker does not aim to replace other prevalence measures, but instead aims to add value by enabling analysis of nutritional attitudes and behaviours in comparison with other health behaviours (e.g. smoking, physical activity).

The Lifecourse Tracker adult survey included questions for parents of 2-11s about their child's nutritional behaviours and physical activity levels. For parents who had more than one child in this age range the questionnaire randomly picked one child for the parent to answer questions about.

7.1 Five a day (2-11s)

The core nutritional indicator for the survey was whether the respondent's child had eaten five or more portions of fruit or vegetables on the day before the interview. All were asked how many portions their child had eaten: they were asked to include fresh, frozen, tinned, dried or juiced fruit or vegetables, and were told that a portion is a medium sized piece of fruit such as an apple, a glass of 100% fruit juice, or 3 heaped tablespoons of cooked vegetables. They were asked not to include potatoes in their answer.

Across the sample of all parents with children aged 2-11 years, 20% said that their child had eaten five or more portions of fruit or vegetables the day before they were interviewed. These results are similar to those of the Health Survey for England (HSE) 2011 Child Trend Tables from 2010-2011, which found that 20% of girls and 16% of boys aged 5-15 ate five or more portions.

The fruit and veg consumption of parents and their 2-11 year olds were similar. A similar proportion of parents as 2-11s said that they had eaten 5+ portions of fruit and veg (23%) and the average number of portions consumed was also the same (3.1).

Parents who tended to be less healthy were more likely to have a child who eats fewer portions of fruit and veg on average or were not getting 5 or more portions of fruit/veg a day:

- Parents not eating 5 a day were more likely to say that their child had not eaten 5+ portions of fruit and veg yesterday (88% compared with 51% of those eating 5+ a day)

34 https://www.gov.uk/government/policies/reducing-obesity-and-improving-diet

35 http://www.nhs.uk/Livewell/Goodfood/Pages/eatwell-plate.aspx

- Parents who were less active (less than 150 weekly active minutes) reported that their children ate fewer portions of fruit and veg yesterday (2.8 portions compared with 3.4 amongst parents who reported 150+ weekly active minutes)
- Parents who thought that none/few of their friends/family lead a healthy lifestyle were more likely to say that their child ate fewer than five portions yesterday (94% v 76% who thought most/all of their friends/family lead a healthy lifestyle)

7.2 Frequency of eating fruit/vegetables and other foods (2-11s)

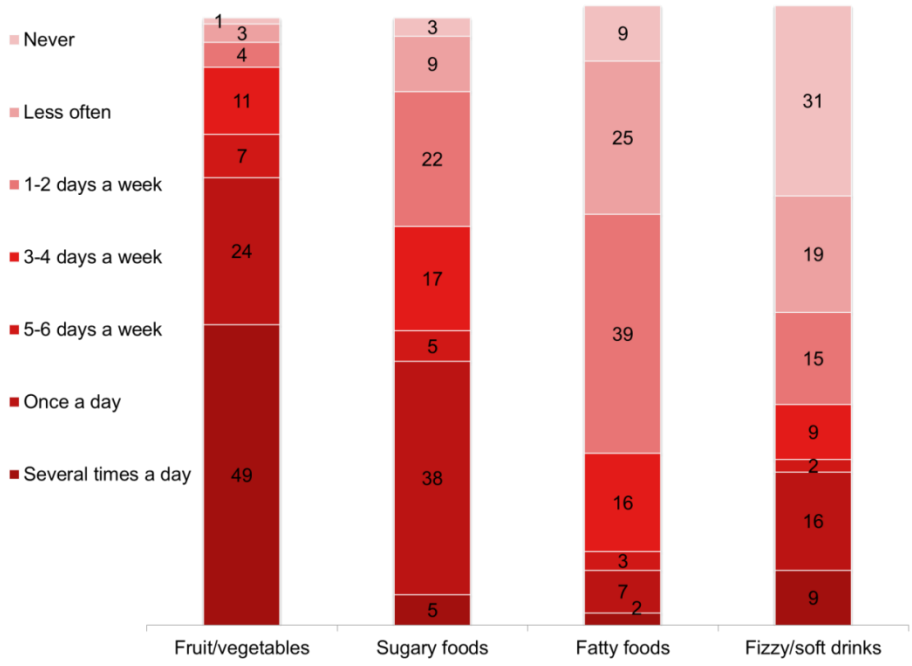
While the main nutritional indicator for 2-11s was whether they were eating 5 a day, the survey also looked at other nutritional behaviours, including consumption of high in fat/fried foods, high in sugar foods, and sugary soft drinks. All respondents were asked how often their child eats each of the following types of food in a typical week:

- Fruit, vegetables or salad. These could be fresh, frozen, tinned, dried or juiced, but not including potatoes.
- Foods that are high in sugar, such as cakes, puddings, pastries or biscuits, sweets or chocolate.
- Foods that are high in fat or fried foods such as fried fish, chips, cooked breakfast, samosa, crisps or fatty meats, but not including oven chips.
- Fizzy drinks or soft drinks like squash – not including diet or sugar free drinks, or sparkling water

On average, 73% of parents said that their child ate fruit/vegetables/salad daily, with 49% eating them several times a day, and 24% eating them once a day (Figure 51).

Daily consumption of high fat/fried foods seems to be at similar levels for children and adults, but children were more likely than adults to consume sugary soft drinks daily (24% v 18% amongst adults), and high calorie/sugary food daily (43% v 26% amongst adults).

Figure 51 **Frequency of consuming types of food/drinks - amongst 2-11s**



Base: All 2012 adults with children aged 2-11 (382)

There were a number of variations observed in the data. C2DEs were more likely to report negative nutritional behaviours for their 2-11s, though small base sizes mean that not all differences are significant. Similarly, those who said that none or few of their family/friends were leading a healthy lifestyle were also more likely to report this.

- Fruit and veg: C2DEs were less likely to say their child eats fruit and veg several times a day (44% v 54% of ABC1s), though the difference is not significant
- Foods high in sugar: C2DEs were more likely to say that their child eats high in sugar foods daily (46% v 40% of ABC1s), though again the difference is not significant. Those who thought that few or none of their friends/family lead healthy lifestyles were more likely to say that their child ate high in sugar foods daily (61% v 39% of those who said most or all led a healthy lifestyle)
- Sugary soft drinks: C2DEs were significantly more likely to report that their child consumes these daily (32% v 17% of ABC1s). Children of parents who thought that none or few of their friends/family lead healthy lifestyles were more likely to drink sugary soft drinks daily: 37% compared with 21% of those who said most or all led a healthy lifestyle

Another pattern that was evident was that the parent's diet tended to reflect the child's diet. For example, parents eating 5+ portions of fruit and veg yesterday were more likely to say that their child eats fruit and veg several times a day (67% v 44% of parents who eat fewer than five a day). Another example was that parents who consume sugary soft drinks daily themselves were significantly more likely to say that their child drinks them daily (58% v 24% average).

7.3 Other nutritional behaviours (2-11s)

To further explore nutritional behaviour among 2-11 year olds, all parents were asked about what kind of constraints they put on their child's diet. The most common constraint involved the parent making sure their child ate portion sizes appropriate to their child's age (71%) (Figure 52).

Figure 52 **Limits parents put on their child's diet**

	Parents of 2-11s (382) %
Make sure child eats age appropriate portions	71
Limit the amount of salt child consumes	55
Limit child to two unhealthy snacks between meals	36
All of the above	**18**

Base: All 2012 adults with children aged 2-11 years.
NB: Prefer not to say/Don't know not shown

Parents in DE households were less likely to limit their children's diet (7% did all of the above, compared to 22% of parents in ABC1C2 households).

7.4 Attitudes towards healthy eating (2-11s)

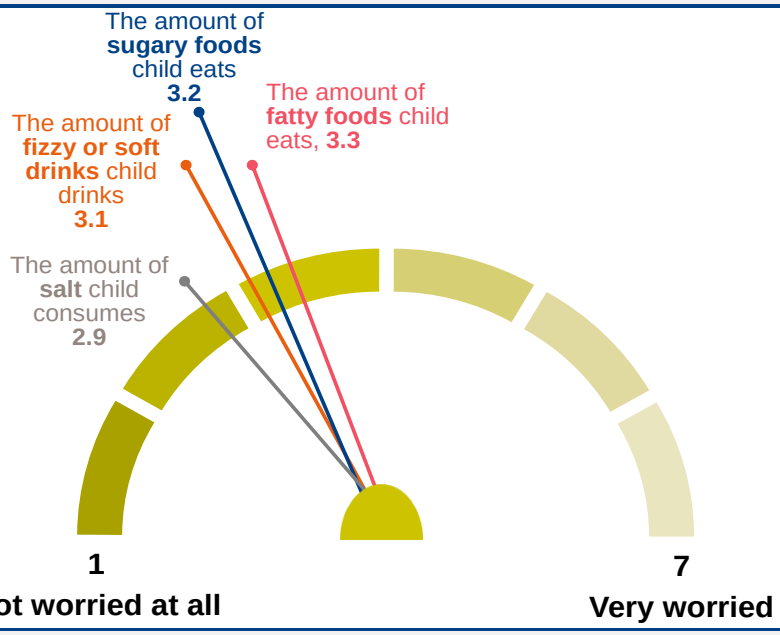
Most parents acknowledged that nutrition is about more than just maintaining a child's weight: as 81% disagreed that as long as a child is a healthy weight, parents don't need to worry about what they eat.

However, there was a potential mis-match between perceptions of a child's weight and actual weight: the vast majority (83%) of parents said their child was a healthy weight, with only 6% stating that their child was a little/very overweight. This is in contrast to the 2011 Health Survey for England's BMI estimates, which suggests that, actually, a quarter (26%) of 2-10 year olds are overweight/obese[36].

7.5 Worry about behaviour and intentions to change - nutrition (2-11s)

Parents of 2-11s were asked how worried they were about the impact of their child's diet on their child's health. Figure 53 shows the average worry score given by parents in relation to different aspects of their child's diet. Only parents reporting that their child had consumed each type of food/drink at least three times a week were included, to ensure a fair comparison. For all food types the level of worry was around the middle of the range but more towards the 'not at all worried' end of the scale than 'very worried' end.

Figure 53 **Mean worry score given by parents in relation to their child's consumption of high in sugar foods, high in fat/fried foods, salt and sugary soft drinks**



Base: All Autumn 2012 adults whose child eats/drinks each 3+ times a week – fatty foods (41*), sugary foods (109), fizzy/soft drinks (59*), all who do not limit child's intake of salt/lo-salt (83*), *Caution low bases. NB: Based on Autumn 2012 data only

Thirty-eight percent of parents intended to get their child to eat a more healthy diet over the next three months; and 49% felt their child already ate a healthy diet and did not intend to make any changes. An additional 13% did not intend to get their child to eat more healthily. The data suggest that parents who said that their child is not getting 5+ portions of fruit/veg a day (38%) are more likely to intend to make healthier changes than those who say their child eats 5+ portions of fruit/veg a day (27%) – however due to small sample sizes the difference is not significant.

[36] Methodological differences should be considered when comparing HSE and the Lifecourse Tracker survey. HSE uses height and weight measurements taken by interviewers to calculate the BMI whereas Lifecourse Tracker uses parents' perception of their child'

7.6 Physical activity (2-11s)

Parents were asked about how much time their child had spent the day before the interview being physically active not including any time within school/nursery hours. This was defined as being active to a point where the child is breathing slightly faster than usual. Parents were also prompted with a list of activities that this might include such as: active play, sports or exercise activities or walking for more than 10 minutes (including to and from school/nursery) and activity time during after school clubs.

Six in ten parents (61%) said that their child spends at least one hour a day being physically active outside of school / nursery hours. The behaviour of parents often mirrors that of their child: parents who do at least 150 minutes' activity per week themselves were more likely to say their child spends at least one hour a day being physically active (76% v 48% of those who don't).

The norm for parents increasing their child's activities was also measured. Just over half (54%) agreed that most of the parents they know are increasing the amount of physical activity that their child is doing nowadays.

In addition to active time, parents were also asked about their child's sedentary time: that is time spent sitting down, not including any time within school/nursery hours. A further prompt was provided to the parent to help them provide as accurate an answer as possible: this could be at home or on transport such as cars, buses or trains; e.g. this could be time spent in a buggy, sitting at a desk, reading, or sitting or lying down to watch television, DVDs, playing video games or using a computer. The definition did not include time spent asleep. According to their parents, children spent 2.5 hours sitting down, on average.

Four in ten parents (39%) said that they intended to increase the amount of physical activity their child does over the next three months. Parents who were less active themselves (fewer than 150 weekly active minutes) were more likely to say that they intend on getting their child to be more active in the next three months (46% v 32% who did 150+ active minutes in a week).

7.7 Children's (2-11s) nutrition and physical activity - summary

Eight in ten parents said that their child ate fewer than five portions of fruit/veg yesterday. Similar proportions of parents said this about their own consumption.

Whilst most parents claim to make sure their child eats child size portions, in practice, 2-11s were more likely to consume sugary foods and drinks on a daily basis than adults, and only a third of parents said they limit the number of snacks their child eats. This suggests that whilst portion size may be smaller for 2-11s, frequency of consumption of some unhealthy foods may be an issue.

Six in ten parents (61%) said that their child spends at least one hour a day being physically active and an average of 2.6 sedentary hours per day outside of school / nursery hours. While over half of parents (54%) agreed that most other parents are increasing their children's activity levels, fewer (39%) said they intend to increase their own child's activity levels.

Close links were noted between parents' and children's behaviour: parents eating 5 a day were more likely to have a child who does the same, and parents who reported 150+ weekly active minutes were more likely to have an active child.

8 Alcohol

The Chief Medical Officer's Annual Health Report (2012)[37] and the Government's 2012 Alcohol Strategy[38] highlighted the concerns of the harm caused by excessive drinking and published guidelines for safe drinking.

The Lifecourse Tracker provides topline information on attitudes and behaviours related to alcohol, which do not aim to replace other prevalence measures, but instead to add value to thinking by enabling analysis of attitudes and behaviours in comparison with other health behaviours (e.g. smoking, nutrition, physical activity).

Questions about alcohol were asked in the self-completion section of the questionnaire, to enable respondents to answer in privacy.

The key indicators related to alcohol consumption centred on whether respondents were classified as increasing or higher risk drinkers, which are defined based on the number of units of alcohol consumed in the seven days before the respondent was interviewed[39]. The definitions differ for men and women, as shown in Figure 54.

Figure 54 **Definition of alcohol consumption categories: number of units consumed in past seven days**

	Men	Women
Low risk	0-21	0-14
Increasing risk	22-49	15-35
Higher risk	50+	36+

This chapter includes the following:

- Respondents' own reports of their levels of alcohol consumption, enabling us to classify respondents by their alcohol consumption risk level
- Perceptions of their own alcohol consumption
- Whether respondents have cut back their alcohol consumption, and their views of doing so
- Attitudes to alcohol consumption, including norms related to alcohol, barriers to change and intentions to change

37 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/141769/CMO_Annual_Report_2011_Introduction_and_contents.pdf

38 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/98121/alcohol-strategy.pdf

39 Please note, respondents were not asked directly about the number of alcohol units consumed but instead about the number of drinks of different types consumed (e.g. pints of normal strength beer, bitter, lager or cider, glasses of wine, single measures of spirits). The number of units consumed was estimated based on responses given.
It is acknowledged that consumption levels in the past week may not be representative of respondents' typical consumption levels, but it was felt that it was more accurate to ask respondents about their consumption levels in a defined time period, rather than an average over time.

8.1 Prevalence of increasing/higher risk alcohol consumption

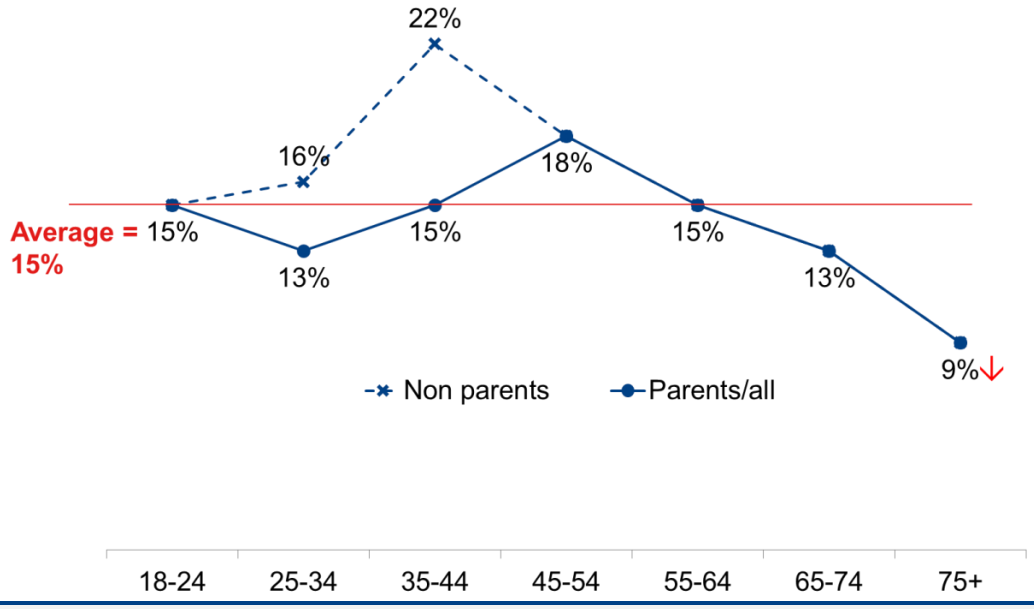
One in seven (15%) of all adults reported alcohol consumption in the previous week which would classify them as increasing or higher risk drinkers: 12% were classified as increasing risk drinkers, and 4% were classified as higher risk drinkers. It is notable that men were more likely to report consumption indicating that they were increasing or higher risk drinkers (19% men v 12% women), and they were more than twice as likely as women to be classified as higher risk drinkers (5% men v 2% women).

The question asked on the Health Survey for England looked at different types of drinks in more detail, so it is unsurprising that estimates of general consumption levels were slightly higher. However, patterns in response were similar: in 2011 HSE[40] found that 23% of men and 18% of women were increasing or higher risk drinkers, and this included 6% of men and 4% of women who were in the higher risk category.

Figure 55 details the prevalence of increasing or higher risk drinkers broken down by lifecourse, and shows that prevalence declines sharply after age 64: 13% of 65-74s and 9% of 75+s were classified as increasing/higher risk drinkers.

The chart also shows that prevalence of increasing/higher risk drinking amongst the youngest age group of 18-24s was in line with the average (15%). Amongst those aged 25-44, non-parents were more likely than parents to be increasing/higher risk drinkers, but there were no differences in prevalence between parents and non-parents aged 45+.

Figure 55 **% who were classified as increasing or higher risk drinkers**



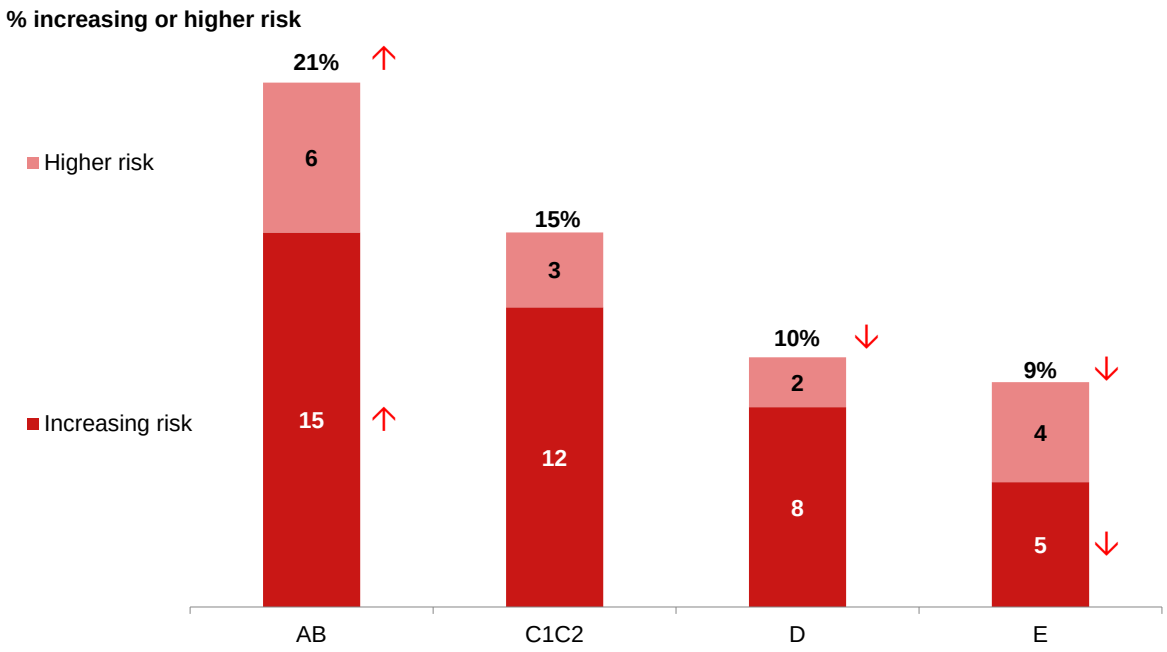
Base: All 2012 adults: 18-24 (223), parents/non-parents: 25-34 (185/151), 35-44 (228/99), 45-54 (101/209), 55-64 (300), 65-74 (288), 75+ (245)
↑↓ Indicates a significant difference compared with the all adult average or between corresponding parent/non- parent group

[40] https://catalogue.ic.nhs.uk/publications/public-health/surveys/heal-surv-eng-2011/HSE2011-Ch6-Drinking-Patterns.pdf

There were also clear trends in the prevalence of increasing/higher risk drinkers by social grade (Figure 56). While the prevalence of other negative health behaviours (e.g. smoking, eating fewer than five portions of fruit/veg) tends to be higher amongst the DE social grades, the opposite is true for increasing/higher risk drinking, with prevalence significantly higher amongst ABs. However, it is notable that the difference is mainly in the 'increasing risk' category, and there are no clear patterns in the prevalence of higher risk drinkers.

Similar patterns have been noted in other surveys, though other indicators of social grade are used (e.g. income). However, it is generally noted that, while people from lower social classes are less likely to be increasing/higher risk drinkers, they are more likely to have problematic drinking patterns, and to be admitted to hospital for conditions related to alcohol consumption[41].

Figure 56 **% who were classified as increasing or higher risk drinkers: by social grade**



Base: All 2012 adults; AB (384), C1C2 (852), D (317), E (476)
↑↓ Indicates a significant difference, compared with the all adult average

[41] For example http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review/fair-society-healthy-lives-full-report , p.57

8.2 Perception of own drinking

All those who said they ever drink alcohol were asked how they would describe themselves and most described themselves as very light (36%) or light (27%) drinkers (Figure 57). Increasing/higher risk drinkers were unsurprisingly less likely than average to describe themselves as light or very light drinkers, but it is notable that three fifths (62%) described themselves as moderate drinkers.

Even amongst the heaviest drinkers in the higher risk category (50+ units/week for men, 36+ units/week for women) only three in ten (31%) felt they were heavy or very heavy drinkers, with three fifths (59%) describing themselves as moderate drinkers. It therefore appears that there is a significant perception gap for this group.

Figure 57 **Perception of own drinking**

	All (1558) %	Not drunk in the last week (570) %	Risk			
			Low (643) %	Increasing (201) %	Higher (74) %	Increasing or higher (275) %
Very heavy	*	*	-	1	2↑	1↓
Heavy	4	2↓	1	8↑	29↑	13↑
Moderate	32	11↓	33	63↑	59↑	62↑
Light	27	18↓	37↑	22	6	18↓
Very light	36	69↑	28↓	6	4	5↓
Don't know/refused	1	*	*	1	-	1

Base: All 2012 adults who ever drink alcohol: as shown
↑↓ Indicates a significant difference, compared with the all adult average

8.3 Cutting back alcohol consumption

All were asked the extent to which they agreed or disagreed that more people are cutting back on the amount of alcohol they drink nowadays. Only a quarter (27%) agreed, with levels of agreement increasing significantly with age: just 19% of 18-34s agreed, which is far lower than the proportion of 55+s agreeing (35%).

Figure 58 **% agreeing more people are cutting back the amount of alcohol they drink nowadays**

	All (2027) %	Age			Social grade		
		18-34 (583) %	35-54 (719) %	55+ (725) %	AB (384) %	C1C2 (851) %	DE (792) %
% agreeing	27	19↓	26	35↑	19↓	30	30

Base: All adults 2012 using standard self-completion: as shown
↑↓ Indicates a significant difference between sub groups

There were also strong differences in perceptions based on level of alcohol consumption. Increasing risk drinkers were significantly more likely to agree that more people are cutting back than were higher risk drinkers (35% compared with 17%). It therefore appears that the norms for higher risk drinkers are somewhat different to the average.

In addition, respondents from the AB social grades, who were themselves more likely than average to be increasing/higher risk drinkers, were less likely than others to agree that more people are cutting back nowadays (19%, compared with 30% of those in other social grades).

Three in ten (30%) of those who drink alcohol at least once a month said that they had cut back the amount they drank over the past three months. There were no differences in the proportions saying they had cut back based on weight of drinking, though ABs (the social grades which were the most likely to be increasing/higher risk drinkers) were significantly less likely than other social grades to say they had cut back (24% v 33% of C1C2s and 35% of DEs).

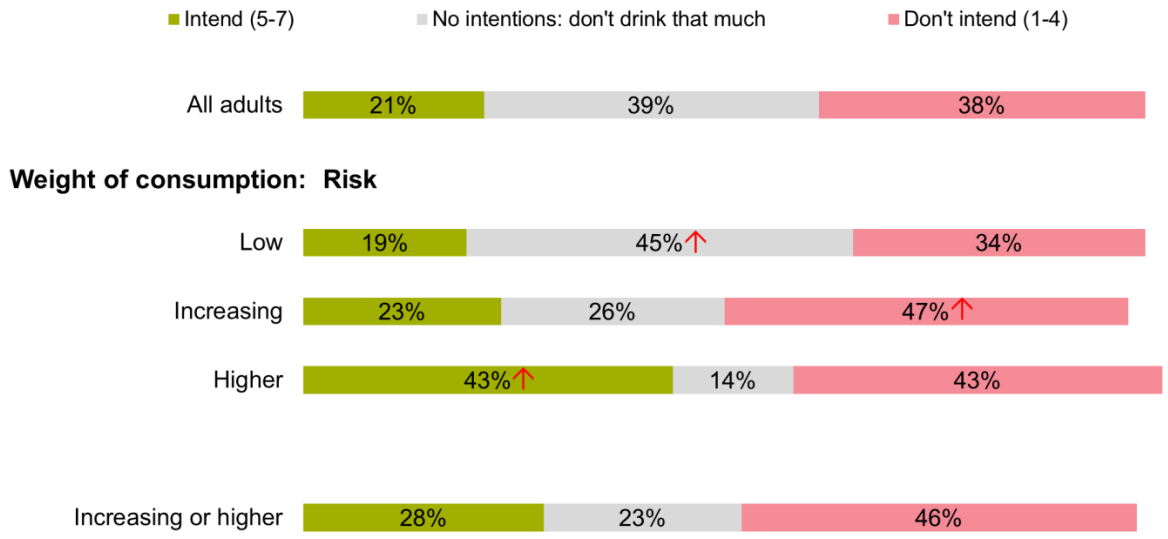
There were, however, no differences by social grade in the proportions saying that they *intend* to cut back the amount of alcohol they drink over the next three months: around a fifth of all those who drink alcohol at least monthly said that they intend to cut down (19% of ABs, 22% of C1C2s and 21% of DEs).

Figure 59 shows intentions to cut back alcohol consumption over the next three months, and shows that while a fifth of all adults who drink at least monthly said they intend to cut back (21%), almost twice this number (38%) said they don't intend to do so. A further four in ten (39%) did not intend to cut back because they feel they don't drink that much.

Those in the higher risk category were the most likely to intend to cut back (43% intended to do so), though it is notable that despite their higher consumption levels (50+ weekly units for men, 36+ for women) three fifths (57%) did not intend to cut back, either because they didn't think they drank that much (14%) or because they simply did not intend to do so (43%).

Levels of intention to cut back amongst increasing risk drinkers were similar to those of the low risk drinkers despite their higher consumption levels – 19% of low risk drinkers and 23% of increasing risk drinkers said that they intended to cut back over the next three months.

Figure 59 **Intentions to cut back amount of alcohol drunk over the next three months**



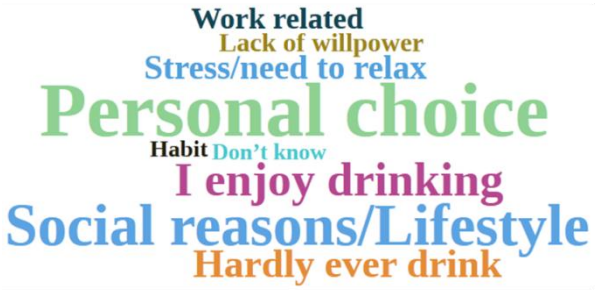
Base: All 2012 adults who drink alcohol at least monthly (1123); Risk: Low (585), Increasing (195), Higher (7273 Increasing or higher (268)
↑↓ Indicates a significant difference, compared with the all adult average

It is notable that, of all the behaviours included in the Lifecourse Tracker survey, alcohol consumption was the behaviour for which there was the most resistance to change: while 40% of smokers said they intend to give up and a similar proportion of those eating fewer than five portions of fruit/veg a day intended to eat a healthier diet, only three in ten (28%) of increasing or higher risk drinkers intended to cut back their consumption.

These lower levels of intentions may be linked with lower levels of worry about the impact of alcohol consumption on health: while two fifths (43%) of smokers said they were worried about the impact of their smoking on their health, only 20% of increasing or higher risk drinkers said they were worried about the impact of their alcohol consumption. Increasing risk drinkers (16%) were significantly less likely than higher risk drinkers (34%) to say they were worried. There were no significant differences in levels of worry by gender or social grade, despite higher prevalence of increasing/higher risk drinkers amongst men and those in the AB social grade.

A sub-sample of those who were classified as increasing or higher risk drinkers was asked to say what things prevent them from reducing their alcohol intake. As shown in Figure 60, the most common reasons given related to personal choice: either not wanting to reduce their intake (mentioned by 26% of those asked), enjoying drinking alcohol (17%), or for social reasons (16%). Increasing and higher risk drinkers mentioned similar barriers to cutting back in their responses.

Figure 60 **Barriers to reducing alcohol intake**



What things prevent you reducing your alcohol intake?	%
Nothing – I don't want to reduce	26
Enjoy/like drinking	17
Social reasons/lifestyle	16
Stress/need to relax	13
None/no reason	7
Hardly ever drink/don't drink enough to reduce it	6

Base: All Autumn 2012 adults who were classified as increasing/higher risk drinkers and did not report other less prevalent health behaviours (112)
NB: Based on Autumn 2012 data only

8.4 Attitudes to alcohol

In addition to asking about worry and intentions to cut back on alcohol consumption, all respondents were asked the extent to which they agreed or disagreed with two statements about drinking alcohol.

Three quarters (76%) agreed that *drinking more than the recommended limits can increase the risk of diseases such as mouth cancer, breast cancer, stroke and heart disease*. This is a specific message included in the Change4Life campaign, so it is positive to observe that the proportion agreeing is so high[42]. There were no strong differences in levels of agreement by respondent age or gender. Those in social grades DE (65%) were also significantly less likely to agree (compared with 86% of ABs and 77% of C1C2s).

While there were no significant differences in levels of agreement based on weight of alcohol consumption (69% of increasing/higher risk drinkers agreed), increasing/higher risk drinkers were significantly more likely to *disagree:* 15% disagreed, compared with 6% of those who were not increasing/higher risk drinkers.

[42] The question was only asked in Autumn 2012, so the base size for analysis is somewhat smaller (1,018 interviews in total).

In addition, increasing/higher risk drinkers were more likely to agree that *it's OK to drink alcohol every day as long as you're not getting drunk*: while 21% of all adults agreed with this statement, it rose to 34% amongst increasing/higher risk drinkers and as high as 42% amongst higher risk drinkers. Over half (55%) of increasing/higher risk drinkers aged 55+ agreed.

At an overall level, older people were more likely to agree that it's okay to drink every day as long as you're not getting drunk: 25% of 55+s agreed, compared with 18% of 18-54s, and in particular amongst men aged 55+ (31%).

The social grades with the highest proportions of higher risk drinkers (ABs and Es) were the most likely to agree that it's okay to drink alcohol every day as long as you're not getting drunk: 25% of ABs and 24% of Es agreed, compared with 18% of C1C2Ds.

8.5 Alcohol – summary

One in seven adults were classified as increasing or higher risk drinkers; prevalence was similar between the ages of 18 and 64 but from the age of 65 prevalence declined sharply. Non-parents aged 25-44 and ABs were the most likely to be classified as increasing or higher risk drinkers. It is notable that this is the only negative health behaviour which was more prevalent amongst the AB social grade.

The impact of alcohol consumption on health and intentions to change drinking habits were not particularly prominent in the minds of adults, particularly in comparison with other health behaviours. For instance, few thought that more people are cutting back their alcohol consumption nowadays, whilst future intentions to change and worry about the impact of drinking on health were not as strong as other health behaviours measured in the survey.

This may be linked to the fact that increasing/higher risk drinkers did not necessarily perceive themselves to be heavy drinkers. Whilst acknowledging that they drank more than other adults, these increasing/higher risk drinkers thought of their alcohol consumption as moderate, rather than heavy. They were also more likely to agree that it is ok to drink every day as long as you are not getting drunk, suggesting that they think that regular drinking, albeit at lower levels, is a less harmful way to drink. This may also suggest that they are not recognising the risks involved in their increasing tolerance of alcohol before becoming drunk.

Differences between increasing and higher risk drinkers were also noted, suggesting that this group cannot be treated homogenously. Increasing risk drinkers were more likely to think others were cutting back alcohol these days even though their own efforts to reduce consumption were no greater than lower risk drinkers (based on past behaviour and future intentions to change). Meanwhile, higher risk drinkers were less likely to feel that others are cutting back but were more likely to intend to cut back themselves, perhaps because they were the most worried about the impact of their drinking behaviour on their health.

9 Tobacco

The Lifecourse Tracker provides topline information on smoking attitudes and behaviours (including prevalence of smoking, and smoking in the home/car). As with all other behaviours, the Lifecourse Tracker does not aim to replace other tracking and prevalence measures, but instead to add value to thinking by enabling analysis of smoking attitudes and behaviours in comparison with other health behaviours (e.g. alcohol use, physical activity).

Questions about smoking tobacco were asked in the self-completion section of the questionnaire, to enable respondents to answer in privacy.

This chapter includes the following:

- Respondents' own reports of whether or not they smoke nowadays, including how much they smoke and when they started smoking
- Smoking behaviour in the household, including presence of other smokers, and whether smoking is allowed in the home/car
- Quit attempts, including norms related to smoking, barriers to quitting and intentions to quit
- Attitudes to smoking
- Smoking interacts with a number of other negative health behaviours, so those interactions are described in this chapter of the report
- One particular lifecourse group (non-parents aged 35-44) had a higher level of smoking prevalence than others, so a section at the end of this chapter looks at this group in more detail

9.1 Smoking prevalence by age and lifecourse

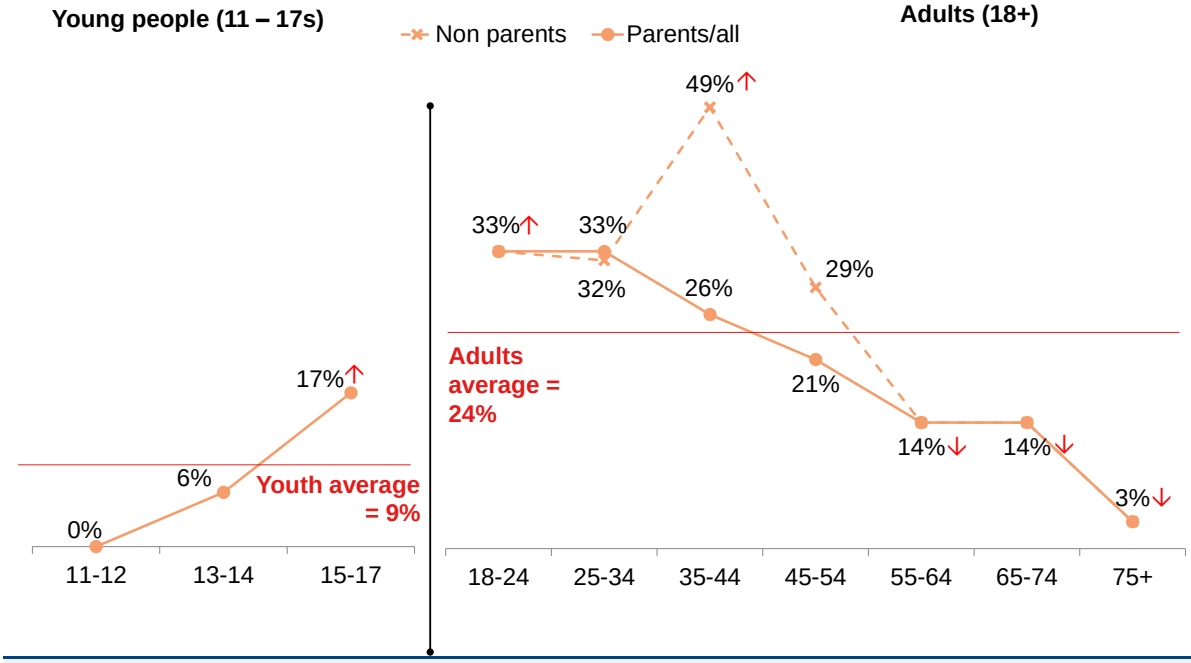
A quarter (24%) of adults aged 18+ interviewed in the Lifecourse Tracker survey said they smoke cigarettes nowadays. This is somewhat higher than the latest estimate reported in the General Lifestyle Survey (GLF)[43] (20%), though methodological differences between the two surveys should be noted.

Patterns in smoking prevalence by age were similar in the Lifecourse Tracker survey compared with GLF: under 35s were more likely to smoke, and prevalence fell off sharply amongst older age groups.

[43] General Lifestyle Survey, 2010. Office for National Statistics, 2012

Figure 61 shows smoking prevalence across all of the age groups included in the Lifecourse Tracker, including young people, and amongst adults breaks the sample down by whether or not respondents are parents of children aged 16 or younger.

Figure 61 **% who said they smoked cigarettes nowadays**



Base: All 2012 11-17s: 11-12 (370), 13-14 (394), 15-17 (433): For young people, the equivalent measure was smoking regularly
Base: All 2012 adults: 18-24 (223), parents/non-parents: 25-34 (185/151), 35-44 (228/99), 45-54 (101/209), 55-64 (300), 65-74 (288), 75+ (245)
↑↓ Indicates a significant difference compared with the all 11-17 or all adult average or with corresponding parent/non-parent group

It was also notable that non-parents were more likely than parents to smoke. In the Lifecourse Tracker survey, 35% of non-parents aged 25-54 were smokers, which is higher than their counterparts who were parents (27%).

This difference may in part be linked to the fact that many smokers give up while they are/their partner is pregnant. The Lifecourse Tracker survey found that pregnant women and mothers of 0-2s were much less likely to smoke than other women: only 4% of pregnant women and 18% of mothers of 0-2s said they smoked cigarettes nowadays. The latter can be compared with the broader sample of women aged under 45 who do not have children aged 0-2: 29% of these women said they smoked nowadays. More information on smoking amongst pregnant women and mothers of 0-2s can be found in section 12.8.5.

The smoking prevalence noted amongst 35-44 non-parents appears to be particularly high at 49%. Further details about this group, their profile and smoking habits are shown in section 9.6.

Amongst all adults, and reflecting findings in other surveys, smoking prevalence was considerably higher amongst those in social grades D and E. The proportions in each social grade who smoked cigarettes nowadays were as follows:

- 13% of ABs
- 25% of C1C2s
- 32% of Ds
- 36% of Es

Amongst children and young people, 9% of 11-17s said they smoked (including less frequently than once a week). The SDD survey[44] reports that 5% of 11-15s smoked at least one cigarette a week, and the equivalent proportion amongst 11-15s interviewed in the Lifecourse Tracker survey was similar at 4%.

The remainder of the information in this chapter focuses on smoking amongst the representative sample of adults aged 18+. For more information about smoking amongst 11-17s, please see section 14.6.

9.1.1 Amount smoked

Almost a quarter (22%) of adult smokers said they smoked five or fewer cigarettes a day. A fifth (21%) said they smoked 10 a day on average and a similar proportion (19%) said they smoked 20 a day. Only 5% of adult smokers said they smoked more than 20 cigarettes on an average day.

The mean average number of cigarettes smoked daily by adult smokers interviewed in the Lifecourse Tracker survey was 11.7: this is very similar to the average of 12.7 reported in the GLF.

All smokers aged 18-24 were asked when they started smoking regularly. Base sizes are small (88 respondents), so results should be treated with caution, but just over half (55%) said they started smoking regularly before the age of 16, 28% between 16 and 18 and 12% started after age 18.

9.2 Smoking in the household

A third (33%) of all adults said they lived in a household where at least one person smoked – either themselves or someone else. Half (48%) of smokers lived with another smoker, while 15% of non-smokers lived with a smoker[45].

Those from C2DE social grades were more likely to live in smoking households: 42% of C2DEs lived in a smoking household, compared with 27% of ABC1s. Amongst non-smokers, 15% of C2DEs lived in a smoking household, compared with 11% of ABC1s. Reflecting these results, it is unsurprising that C2DEs (19%) were more likely than average (15%) to say that smoking is allowed in their home.

Fifteen percent of all adults said that smoking is allowed in their home, and a further 4% said it was allowed when children were not present in the home (Figure 62). Around one in ten of those with a family car said that smoking is allowed in the car (8%) with a further 4% allowing it if children were not in the car.

Figure 62 **% who allow smoking in the house / car**

	In the house	In the family car
Yes - allow smoking	15%	8%
Yes – but only if children are not present	4%	4%
Do not allow it	80%	87%

Base: All 2012 adults (2027), those with a family car (1602)

[44] Smoking, drinking and drug use among young people in England in 2011. The Health and Social Care Information Centre (HSCIC), 2012

[45] Note: These figures are amongst those who live with others (i.e. not in single person households).

Younger people and ABC1s were more likely than average to say that they do not allow smoking in their home at all. These trends were evident even amongst smokers or those who lived in a smoking household, for example:

- 61% of under 35s living in a household with at least one smoker (themselves or another person) said that smoking is not allowed in their home, compared with only 47% of 55+s living in a smoking household
- 61% of ABC1s in a smoking household said that smoking is not allowed in their home, compared with 51% of their C2DE counterparts

9.3 Attitudes towards smoking

All were asked the extent to which they agreed or disagreed that the health risk from smoking is greatly exaggerated. Overall, smokers (37%) were more likely than non-smokers (17%) to agree that the health risk is exaggerated, and there were also strong differences in levels of agreement based on age and social grade.

Amongst all adults, those from the C2DE social grade (28%) and those aged 18-34 (28%) were more likely than average (22%) to agree that the health risk from smoking is greatly exaggerated. However, differences were stronger when looking at smokers and non-smokers within each age or social grade category (Figure 63).

Figure 63 **% agreeing 'The health risk from smoking is greatly exaggerated'**

	All	Smokers	Non-smokers
All	22%	37%↑	17%
18-34	28%	41%↑	22%
35-54	18%	29%↑	14%
55+	21%	52%↑	17%
ABC1	17%	30%↑	14%
C2DE	28%	42%↑	22%

Base: All 2012 adults (2027); All smokers (558), non-smokers (1442); Age 18-34 (558), 35-54 (636), 55+ (833); Social Grade ABC1 (852), C2DE (1175)
↑↓ Indicates a significant difference between smokers and non-smokers

Smokers aged 55+ were particularly likely to agree (52%) that the risks are greatly exaggerated; smokers aged 18-34 (41%) or from the C2DE social grades (42%) were also more likely to agree with the statement. Amongst non-smokers, 18-34s and C2DEs were the most likely to agree, though their levels of agreement were much lower than their smoking counterparts.

Despite scepticism amongst some smokers about the health risks of smoking, smoking was the negative health behaviour that those reporting the behaviour were most likely to say they were worried about. The average 'worry' score for smoking amongst smokers was 4.0[46], while the average 'worry score' amongst increasing/higher risk drinkers about their alcohol intake was lower at 2.9. Where smokers reported more than one negative health behaviour, they were still more likely to worry about the impact of smoking on their health than other behaviours. For example, smokers who were also increasing/higher risk drinkers gave a higher average 'worry score' to their smoking (4.1) than to their alcohol consumption (3.1).

Section 4.3 discusses worry about the impact of smoking and other behaviours on health in more detail.

[46] Worry was measured on a scale of 1 to 7 where 1 = not at all worried and 7 = very worried.

9.4 Quitting smoking

9.4.1 The social norm for quitting

Around three fifths (61%) of all adults agreed that more people are stopping smoking nowadays. Of all the behaviour change norms included in the Lifecourse Tracker survey, this was the most established (see section 3.4).

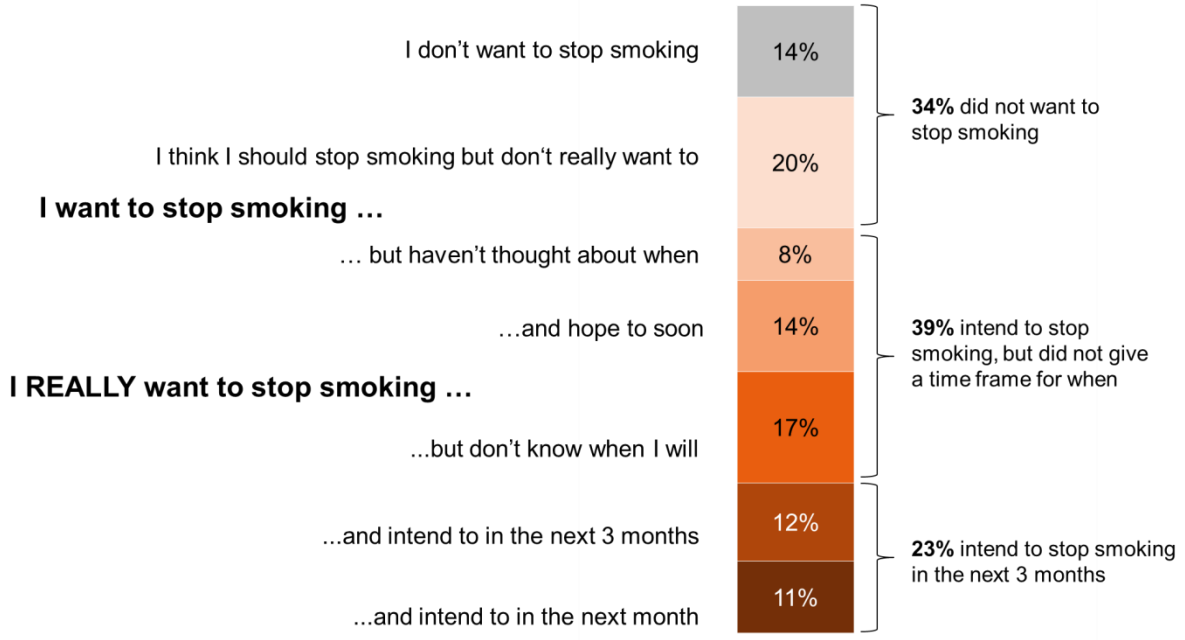
There were no significant differences in levels of agreement that more people are stopping smoking nowadays between smokers and non-smokers, which suggests that the norm is well established even amongst smokers. However, younger people were less likely to agree (48% of 18-34s agreed, compared with 66% of those aged 35 and over).

9.4.2 Intentions to quit

A quarter (23%) of smokers said that they really want to stop smoking and intend to do so in the next three months, and 39% said they want to stop but did not give a time frame for stopping (see Figure 64). The remaining third of smokers said they do not want to stop (34%): over 55s (55%) and in particular males over 55 (59%[47]) were more likely than average to say they do not want to stop.

Patterns in response are very similar to the intentions expressed by smokers in the Smoking Toolkit study[48]. In the Smoking Toolkit, 24% of smokers said they want to stop and intend to in the next three months and 33% said they don't want to stop.

Figure 64 **Intentions to give up smoking**



Base: All 2012 current smokers (558)

Intentions to quit did not vary by the number of cigarettes smoked, so smokers smoking 10 or fewer cigarettes daily (23%) were no more or less likely to intend to give up smoking in the next three months than heavier smokers (18%).

---

47 The low base size (58 respondents) should be noted.

48 West R, Brown J (2012) Smoking and Smoking Cessation in England 2011. London. www.smokinginengland.info, April 2012

9.4.3 Number of quit attempts

Around two fifths (41%) of current smokers said that they had made at least one serious attempt to stop smoking in the past 12 months. Three in ten (31%) had made one or two attempts, though one in ten (10%) had made three or more serious attempts in the past 12 months. The Smoking Toolkit survey asks similar questions about quit attempts and around a third of smokers on that survey said they had made at least one quit attempt over the same time period.

Recent[49] ex-smokers were also asked how many attempts they had made to quit in the past 12 months, and half (51%) said they had made one or two serious attempts to quit. However, 5% had made five or more attempts before they gave up.

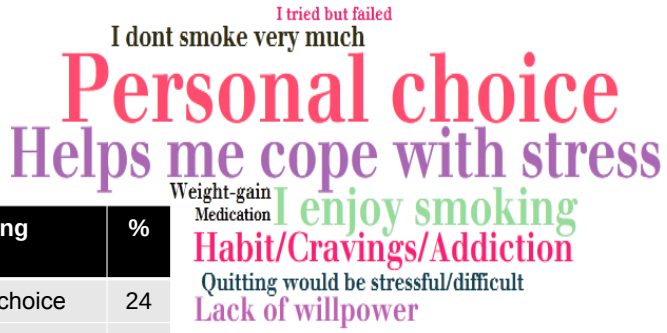
9.4.4 Reasons for not quitting

A sub-sample of current smokers were asked what prevents them from stopping smoking, and Figure 65 shows the most commonly mentioned reasons.

Personal choice (24%) and coping with stress (19%) were most commonly given as reasons for not stopping smoking: parents (30%) were more likely than non-parents (15%) to say that the need to smoke to cope with stress prevents them from stopping. Non-parents were instead slightly more likely than parents to say that personal choice and enjoyment of smoking prevent them from giving up.

Overall, one in ten of the smokers asked said that enjoyment (11%) or habit (9%) were reasons for not quitting. ABC1 smokers (13%) were more likely than C2DE smokers (2%) to say they don't need to quit because they don't smoke very much, perhaps linked to the fact that ABC1s (10) reported smoking fewer cigarettes on average per day than C2DEs (13).

Figure 65 **Reasons given by smokers for not quitting**



What things prevent you from stopping smoking?	%
Nothing – I don't want to stop/personal choice	24
Helps me cope with stress/family stress	19
I enjoy smoking/like it	11
Habit/cravings/addiction/I'm addicted	9
Willpower (lack of)	6
I don't need to stop/I don't smoke very much	6

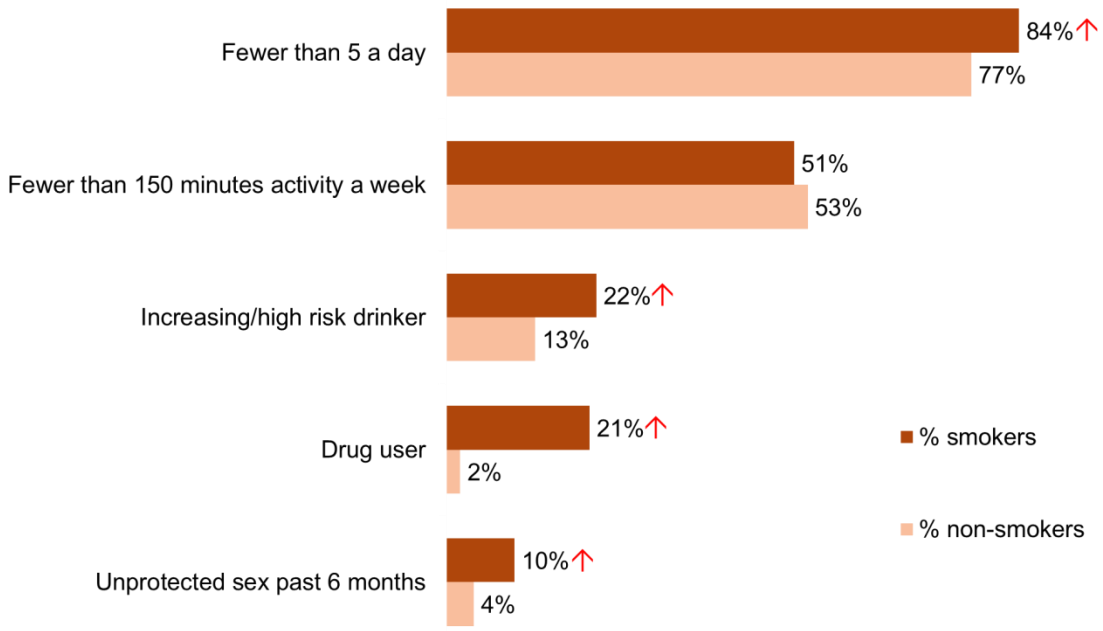
Base: All Autumn 2012 current smokers and did not report other, less prevalent, negative health behaviours (221)
NB: Only those mentioned by 5% or more shown in table
NB: Based on Autumn 2012 data only

[49] Recent is defined as within the last year

9.5 Smokers and other negative health behaviours

On average, smokers reported significantly more negative health behaviours than non-smokers (2.8 out of the five behaviours shown in Figure 66, compared with 1.5 amongst non-smokers). Smokers were more likely than non-smokers to report all negative health behaviours apart from physical activity (fewer than 150 minutes activity last week) for which there was no significant difference.

Figure 66 **Smokers and non-smokers: comparison of other negative behaviours**



Base: All 2012 current smokers (559), non-smokers (1442)
↑↓ Indicates significant differences between smokers and non-smokers

As well as being more likely than non-smokers to say that they ate fewer than five portions of fruit/veg on the previous day, other aspects of smokers' diets were also poorer compared with non-smokers (Figure 67).

Smokers were more likely than non-smokers to consume unhealthy foods on a daily basis and less likely to place restrictions on their snack and calorie consumption. Perhaps linked to the impact of their smoking on sense of taste, smokers were also more likely than non-smokers to add salt to their food without tasting it first.

Figure 67 **Negative nutritional health behaviours amongst smokers and non-smokers**

	Smokers	Non-smokers
Eat fatty or fried foods daily	10%	8%
Drink fizzy / soft drinks daily	25% ↑	15%
Not limit unhealthy snacks	55% ↑	38%
W1: Not limit calories	79% ↑	70%
W2: Not limit food/drink high in calories	67% ↑	55%
Add salt to food without tasting it	22% ↑	13%

Base: All current smokers (559), all non-smokers (1442)
↑ Indicates significant differences between smokers and non-smokers

9.6 Smoking amongst 35-44 non-parents

As already noted, smoking prevalence rates were particularly high amongst non-parents aged 35-44. As shown in Figure 68, 50% of non-parents aged 35-44 said they were current smokers: more than double the all adult average of 24%. While it is likely that smoking rates are so high amongst this group because they have not (yet) been pregnant/ experienced a partner's pregnancy[50], there are other factors which may also influence the high smoking prevalence amongst this group.

The profile of 35-44 parents and non-parents differed significantly, with 35-44 non-parents more likely to be male (66% were male, compared with 39% of 35-44 parents) and more likely to come from the DE social grade (29% of 35-44 non-parents were DEs, compared with 20% of 34-44 parents). Men and DEs were more likely than average to be smokers, so the higher smoking prevalence amongst this group may in some way be related to these profile differences.

However, it should be noted that within each social grade group non-parents were more likely than parents to smoke, so the higher smoking prevalence may be related to their status as non-parents as well as the social grade differences. The smoking prevalence amongst 35-44 non-parents in the C2DE social grade was particularly high at 74%, though the low base should be noted.

Figure 68 **% who smoke amongst 35-44 parents and non-parents**

	All 35-44s	35-44 non-parents	35-44 parents
All	(320) 36%	(97*) 50%↑	(223) 27%
ABC1s	(132) 26%	(41*) 34%↑	(91*) 21%
C2DEs	(188) 49%	(56*) 74% ↑	(132) 34%

Base: All 35-44s. Bases for each sub-group shown in parentheses in table. *Caution, low bases
↑ Indicates significant differences between parents and non-parents

[50] The definition of non-parent should be noted: these respondents do not have caring responsibilities for a child in their household. Some of these respondents may have ever had children (e.g. who live outside of the household), but the questionnaire does not ask about this subject. Later waves of the survey will enable their identification.
It should be noted that a quarter (24%) of 35-44 non-parents had divorced, separated or split up with a long-term partner over the past 12 months, compared with 7% of 35-44 parents.

The smoking behaviour of smokers in the 35-44 non-parents group was very similar to the all-smoker average (Figure 69, though the small base sizes should be noted). Non-parents aged 35-44 tended to smoke a similar number of daily cigarettes to the average, and were equally likely as the all-smoker average to have made any quit attempts in the past 12 months, or intend to do so in the next three months.

It is, however, notable that while 35-54 parents were slightly more likely than their counterparts without children to have made any serious quit attempts in the past 12 months, they were slightly less likely to intend to give up over the next three months. Once again, however, the small base sizes should be noted and this means that none of the differences shown in Figure 69 are significant.

Figure 69 **Smoking behaviours of 35-44 parents and non-parents**

	All smokers	35-44 non-parent smokers	35-44 parent smokers
Average number of cigarettes smoked per day	12	14	12
Whether have made any serious quit attempts in past 12 months	44%	43%	54%
Intend to give up in next three months	23%	32%	17%

Base: All current smokers (559), all 35-44 non-parent smokers (55*), all 35-44 parent smokers (67*). *Caution, low bases

9.7 Tobacco - summary

Smoking prevalence varied considerably by lifecourse. Whilst a quarter of adults said they smoked: under 35s and non-parents were the most likely to be current smokers, and prevalence tailed off sharply from age 65. However, older smokers tended to smoke more cigarettes on an average day.

Smoking prevalence was also particularly high amongst those from social grades D and E, people in poor households, and in deprived areas.

Lower prevalence levels amongst parents may be related to having a child – certainly pregnant women and mothers of 0-2s were less likely to smoke than other women their age and pregnancy was often cited as a reason for quitting. Exposure to smoking through other household members was also associated with smoking prevalence: half of smokers lived with a smoker, compared with 17% of non-smokers.

Eight in ten of all respondents said that smoking is not allowed in their home or the family car (where one is available), with younger people and ABC1s least likely to allow smoking in their home or family car.

Most adults acknowledged the harm smoking does to their health, but smokers were more likely to feel that the health risks from smoking are greatly exaggerated. Despite this scepticism, smoking was the negative health behaviour that most were worried about.

In addition, giving up smoking was a broadly perceived and well established social norm, with six in ten adults agreeing that more people are stopping smoking nowadays. A quarter of smokers said they really want to quit smoking and intend to do so in the next three months, and four in ten had made at least one serious quit attempt in the past 12 months. The main barriers to quitting related to just not wanting to quit, enjoying smoking and habit.

On average, smokers reported significantly more negative health behaviours than non-smokers, and they were also more frequent consumers of unhealthy foods.

10 Illegal drug use

The Lifecourse Tracker survey provides topline information about attitudes towards drugs and usage prevalence for PHE. The survey does not aim to replace other available estimates about prevalence: its aim is to provide a holistic picture of all behaviours and attitudes, how these compare, and any changes over time.

Questions relating to drug use were included in the self-completion section of the survey; this was to encourage respondents to provide honest answers to these potentially sensitive questions.

This chapter includes the following:

- Respondents' own reports of whether or not they have taken drugs in the past 12 months, including how frequently they do so and when they started
- Drug use in the household, including presence of other drug users
- Quit attempts, including norms related to drug use, barriers to quitting and intentions to quit
- Smoking interacts with a number of other negative health behaviours, so those interactions are described in this chapter of the report

10.1 Drug use prevalence

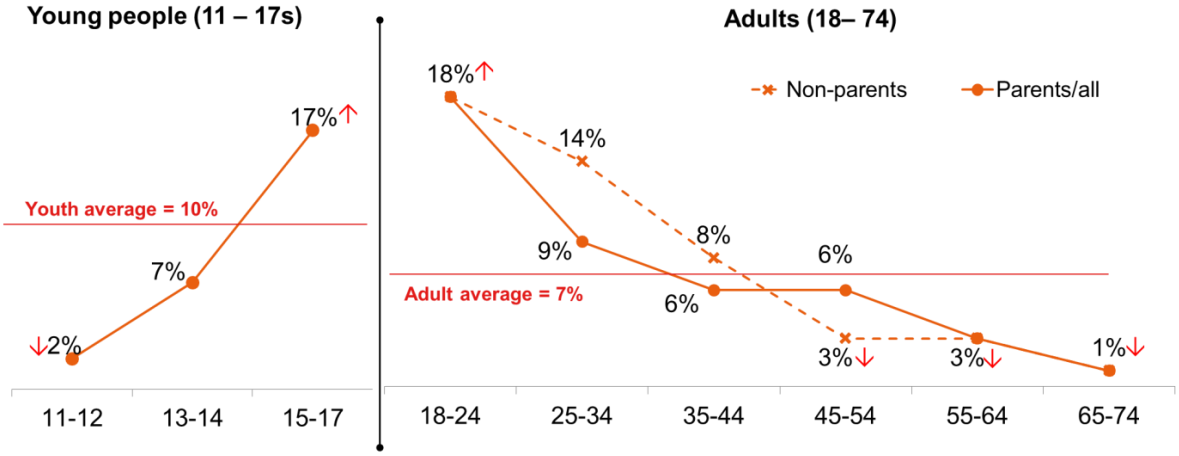
Those aged 18-74 in the Lifecourse Tracker survey were presented with a list of illegal drugs and legal highs[51] and asked if they had used any in the past 12 months. Seven percent said they had used any drugs in the past 12 months. This figure is similar to the 9% of 16-59s in England who reported that they used an illicit drug in the 2011/12 Crime Survey for England and Wales (CSEW[52]) in the last year.

[51] The full list can be found in the questionnaire – see section 19

[52] http://www.ons.gov.uk/ons/guide-method/surveys/list-of-surveys/survey.html?survey=Crime+Survey+for+England+and+Wales

Both the Lifecourse Tracker and CSEW show that younger adults were more likely to have used drugs: adults under 25 were more likely to have used drugs in last year (18% of 18-24s in the Lifecourse Tracker survey and 19% of 16-24s in CSEW) compared with 25+s (8% of 25-54s in the Lifecourse Tracker survey and 6% of 25-59s in CSEW). Figure 70 illustrates drug use by Lifecourse.

Figure 70 **% who had used drugs in the past 12 months**



Base: All 2012 11-17s; 11-12 (377), 13-14 (397), 15-17 (436)
Base: All 2012 adults; 18-24 (223), parents/non-parents: 25-34 (185/151), 35-44 (228/99), 45-54 (101/209), 55-64 (300), 65-74 (288)
↑↓ Indicates a significant difference compared with the all 11-17 or all adult average or between corresponding parent/non-parent groups

Figure 70 illustrates drug use prevalence amongst parents and non-parents by age group in the Lifecourse Tracker survey. There were no significant differences in prevalence between these groups (when comparisons are made within age group). However, those who were not living with a partner (10%) were twice as likely as those who were (5%) to say that they had used drugs last year. This pattern holds amongst the 18-34s who are less likely to live with a partner – 9% of those with a partner in this age group said they had used drugs in the last year compared with 20% of those not living with a partner.

Amongst 18-54s, people who said that they were homosexual or bisexual were more likely than those who identified themselves as heterosexual to say that they had used cannabis in the past 12 months (18% homosexual/bisexual respondents v 10% heterosexual respondents) but no other differences in prevalence of drug use were observed.

Drug use prevalence amongst 11 – 17s was measured in the youth survey of the Lifecourse Tracker. On average, 10% of this age group said they had used drugs in the past 12 months with 15-17s most likely to say this (17%) (Figure 70). The nearest comparable estimate for this age group is from the Smoking, Drinking and Drug Use Amongst Young People (SDD) survey[53]. In 2011 the SDD reported 12% of 11-15s used drugs in the past year. Six percent of 11-15s said the same in the Lifecourse Tracker – this difference may be due to methodological differences between the two surveys. For more details on drug use amongst 11-17s please see section 13.9.

[53] http://www.hscic.gov.uk/catalogue/PUB06921

10.2 Frequency of drug use

Four in ten cannabis users said that they had used it at least weekly in the past year (40%). One in six (17%) said that they had used it every day (this equates to 1% of all adults) over the last year. A third had used it once or twice in the past 12 months (33%).

Figure 71 **Frequency of cannabis use in the past year**

	All who have who have used Cannabis in the past 12 months (122) %
Every day	17
Five or six days a week	5
Three or four days a week	9
Once or twice a week	10
Two or three times a month	10
Once a month	8
Once every couple of months	8
Once or twice in the past 12 months	33
Prefer not to say	1
Base: Adult 2012 respondents using standard self-completion	

10.3 Drug use in the household

Only a small proportion of adults in the Lifecourse Tracker said that they knew that others in the household used illegal drugs or legal highs (3% of those who lived with at least one other person, 2% of all). It is notable that this was lower than the percentage who said that they used drugs – this potentially indicates that drug use is a hidden activity, away from other household members. Drug use was the least commonly reported risk behaviour observed in other household members (of those who lived with at least one other person: 23% said there was smoker in the household and 4% said there was a heavy drinker in the household).

Those who had used drugs in the last 12 months were more likely to report that someone they live with uses drugs (16% compared with 2% of those who had not used drugs in the last 12 months). Linked to this, 18-24s (7%) and those who were in social grade E (6%) were more likely to report that others in the household use drugs.

10.4 The social norm of drug use

Four in ten (43%) 18-34s thought that most people of their age use drugs nowadays (only this age group was asked this question). Section 3.4 compares this drug use norm with other behavioural norms.

Certain groups were more likely to say drug use was the norm, for example, those who had used drugs in the last 12 months were more likely to say that most people use drugs nowadays (72% versus 38% of those who had not). Groups who were more likely to use drugs were therefore more likely to think it is the norm - younger respondents (57% of 18-24s said most people of their age use drugs nowadays vs. 34% of 25-34s) and those who did not live with a partner (53% v. 32% of those who do live with a partner). There was also a strong social gradient evident; 23% of 18-34 ABs said that they thought most people take drugs compared with 45% of C1C2s and 61% of DEs.

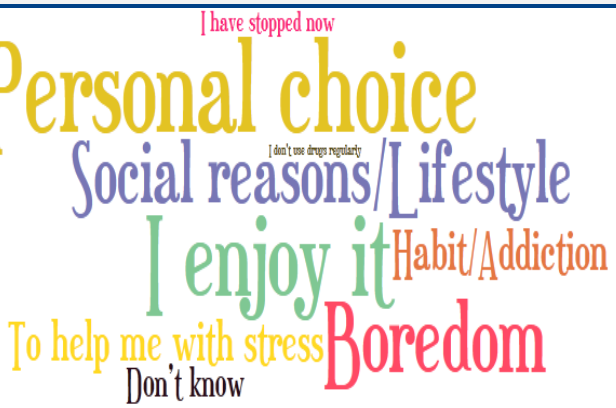
10.5 Worry about behaviours and intentions to change

Those who said that they had used drugs in the last year were asked how worried they are about the effect of their drug use on their health. They had to provide a rating on a scale from one to seven where one meant not at all worried and seven meant very worried. Drug users gave a score of 2.5 on average. Compared to other health behaviours measured in the survey, this was one of the lowest levels of worry (see section 4.3).

Amongst monthly cannabis users, intentions to give up were more towards the not wanting to give up end of the scale. A third said that they intended to give up in the next three months (33%). Cannabis users were least likely, compared with those reporting other negative behaviours, to say that they intend to change their behaviour in the next three months (for example, compared to smokers' intentions to quit smoking. This is discussed in more detail in section 4.4). Further analysis of the intentions to stop using drugs is limited by sample size available.

Adults who had used drugs in the past year were asked about what prevents them from stopping their drug use. Whilst no one reason was provided by the majority of drug users, many said that they actively chose to use drugs: a third said that it was their personal choice (32%) and one in ten said that they enjoy it (11%). Figure 72 provides a breakdown of reasons given by drugs users for not giving up – though results should be treated with caution because of low base sizes.

Figure 72 **Reasons given by drug users for not giving up**



What things prevent you from stopping drug use?	%
Nothing – I don't want to stop/personal choice	32
I enjoy it	11
Boredom	5
Social reasons/Lifestyle	4
Don't know	4

Base: All Autumn 2012 adults who have used drugs in the past 12 months and did not report other, less prevalent, negative health behaviours (61*). *Caution, low base
NB: Only those mentioned by 4% or more shown in table.
NB: Based on Autumn 2012 data only

10.6 Illegal drug use – summary

Use of illegal drugs/legal highs peaks between ages 15-24 (17% of 15-17s, 18% of 18-24s). However, the perception was that drug use is more prevalent than it actually is, as almost six in ten (57%) of 18-24s thought that most people of their age use drugs nowadays. This age group were also most likely to say that they live with other people who take drugs, further perpetuating the perception that usage is more prevalent.

Those not living with a partner were more likely to report drug use, even when age biases were controlled for. Parents and non-parents were equally likely to report drug use.

Relative to other negative health behaviours, drug users were the least likely to worry about their drug use or say they intend to give up in the next three months; with personal choice and enjoyment the main reasons for not wanting to stop using drugs.

11 Sexual health

The Government wants to improve the sexual health of the whole population and in March 2013 they published their 'Framework for Sexual Health Improvement in England'[54]. This document is intended for commissioners who will be in charge of commissioning sexual health services. The document states that support will be provided to commissioners by Public Health England (PHE). For example, PHE will provide evidence-based advice on how to improve sexual health and 'commission national level social marketing and behaviour change campaigns'[55].

The Lifecourse Tracker survey contains topline measures relating to sexual health and relationships. As well as providing information about behavioural prevalence it also allows sexual health measures to be compared with other health behaviours.

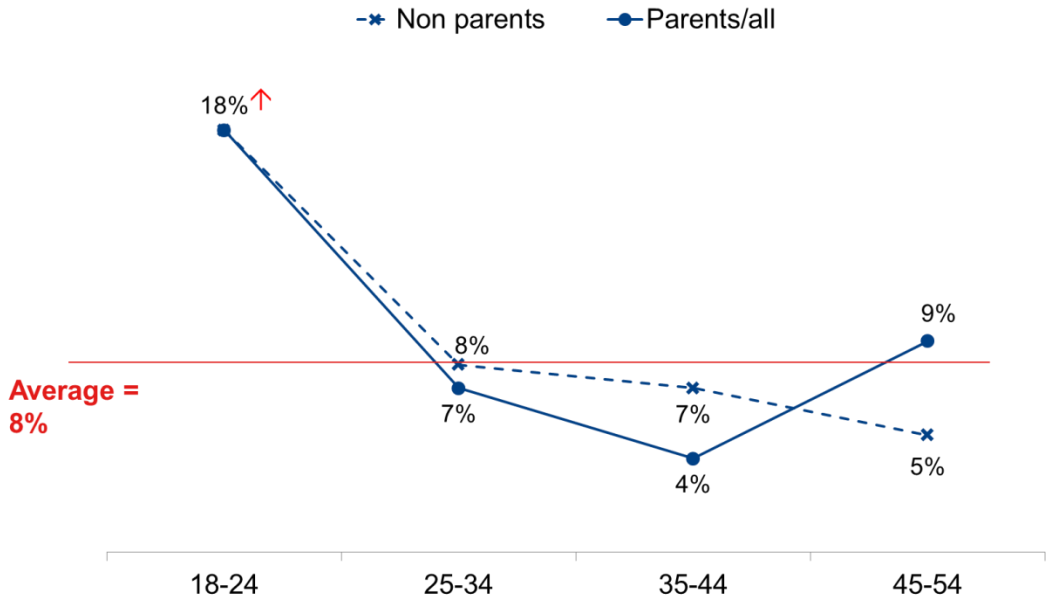
This chapter includes the following:

- Respondents' own reports of whether or not they have had unprotected sex in the past 6 months
- Reports of other potential risky sexual situations, including sex while drunk or under the influence of drugs, or one night stands

11.1 Prevalence of unprotected sex

The Lifecourse Tracker adult survey measured the level of unprotected sex[56] in 18-54s. Prevalence of unprotected sex was highest amongst 18-24s (Figure 73); 18% compared with 6% of 25-54s.

Figure 73 **% who reported unprotected sex in the last six months**



Base: All 2012 18-54s : 18-24 (223), parents/non-parents: 25-34 (185/151), 35-44 (228/99), 45-54 (101/209)
↑↓ Indicates a significant difference compared with the all adult average

[54] https://www.gov.uk/government/publications/a-framework-for-sexual-health-improvement-in-england
[55] https://www.gov.uk/government/publications/a-framework-for-sexual-health-improvement-in-england
[56] Unprotected sex is defined as sex without a condom amongst 18-54s who had had more than one partner or a new partner in the last six months

The Health Survey for England (HSE) in 2010[57] contained questions about sexual health, although comparisons with the Lifecourse Tracker must be made with caution. HSE found that, amongst those aged 16-69 who said that they had sex in the last four weeks, 78% of men and 82% of women said that they had not used a condom on every occasion. This prevalence figure is much higher than the Lifecourse Tracker measure – likely to be a result of the very different bases used in the two surveys (HSE also included those who are only in stable relationships and therefore less likely to use a condom, whereas the Lifecourse Tracker concentrated on those with more than one partner or a new partner in the past 6 months) as well as methodological and questionnaire differences between the two surveys.

The Lifecourse Tracker survey reported that amongst 18-54s the following groups were significantly more likely to report unprotected sex in the past six months:

- Males (11% v 6% females)
- C2DEs (11% v 6% ABC1s), with the highest prevalence in social grade D (16%)
- Those not living with a partner (14 v 5% of those with a partner)
- Smokers (12% v 7% non-smokers)
- Drug users (26% v 7% non-drug users)

It is worth noting that although the prevalence trend is downwards after the age of 24, there was an increase amongst 45-54 non-parents, which may be related to relationship breakdown.

The survey of 11-17s also included questions about sexual health and relationships – these are described in section 13.10.

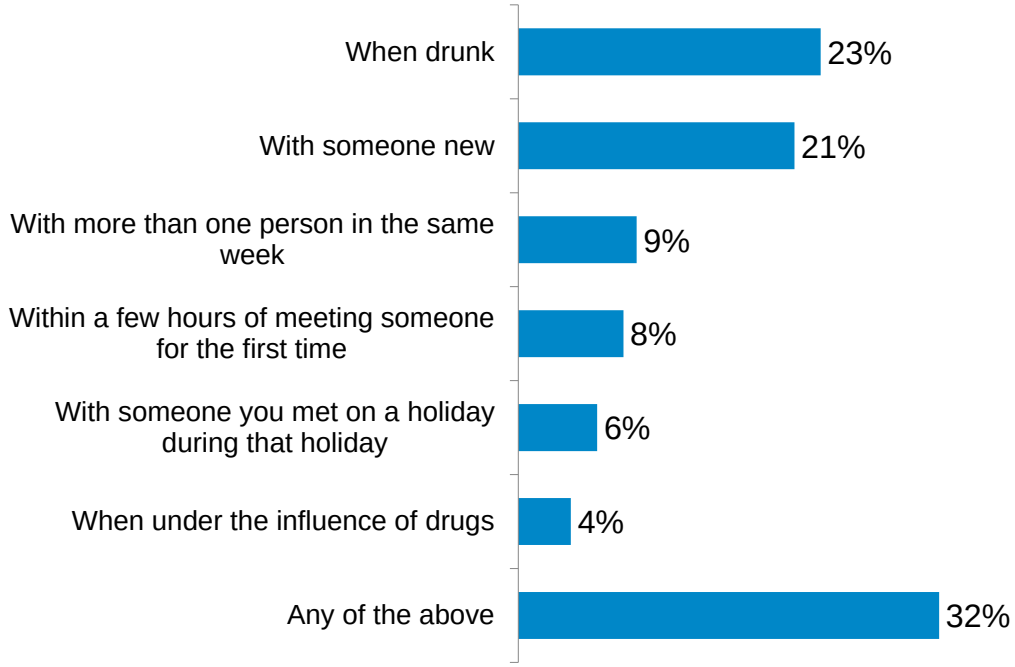
[57] https://catalogue.ic.nhs.uk/publications/public-health/surveys/heal-surv-resp-heal-eng-2010/heal-surv-eng-2010-resp-heal-ch6-sex.pdf

11.2 Potential risky sexual situations

The Lifecourse Tracker survey aims to establish the prevalence of sexual situations that may be considered risky. In the adult survey, 18-54s who had had unprotected sex with multiple partners or a new partner in the past 6 months were asked about their involvement in these situations (shown in Figure 74). Just over one in five said they had had unprotected sex whilst drunk (23%) or with someone new (21%). There were fewer mentions of: having sex with more than one person in the same week (9%), within a few hours of meeting someone for the first time (8%) and with someone they met on holiday (6%). Four percent said they had had sex under the influence of drugs.

Three in ten (32%) reported having unprotected sex in at least one of these situations. Men (47%) were more likely than women (16%) to report this, whilst non-parents (36%) were also more likely to report one of these situations (v 16% of parents).

Figure 74 **% who have had unprotected sex in the last six months in the following situations**



Base: All 2012 18-54s who have had unprotected sex within the last six months with two or more partners or a new partner (181)

At a total sample level, these figures represent 5% of 18-54s having had unprotected sex in at least one risky situation in the past six months; and 10% of 18-34s. Having sex when drunk (4%) or with someone new (3%) were the most frequently mentioned situations amongst all 18-54s; with all other situations mentioned by just one percent. Amongst all 18-34s less than one in ten said they had had unprotected sex whilst drunk (8%), and almost half as many with someone new (5%). All other risky sexual behaviours were mentioned by three percent or less of 18-34s.

11.3 Sexual health – summary

One in ten 18-54s had had unprotected sex (defined as sex without a condom) with multiple partners or a new partner over the past 6 months: perhaps unsurprisingly 18-24s and those who did not live with a partner were most likely to report this.

Males, those not living with a partner and drug users were the most likely to report unprotected sex in potentially risky situations, such as when drunk or within a few hours of meeting someone.

12 Pregnant women and mothers of 0-2s

The Lifecourse Tracker survey included pregnant women and mothers of 0-2s in a separate survey from the all adult population in order to allow for a detailed investigation of their views[58]. While interviews as part of the all adult survey were conducted face-to-face in respondents' homes, the pregnant women and mothers of 0-2s survey was conducted online with the sample sourced through Emma's Diary[59].

This chapter looks at pregnant women and mothers of 0-2s as distinct sub-groups to investigate where their attitudes and behaviours differ between them and their peers (women aged under 45 years without children 0-2 who were interviewed as part of the all adult survey).

The following terminology should be noted:

- **'Pregnant women'** refers to women interviewed as part of the online survey who were pregnant at the time they were interviewed. Some of these women also had other children, but questions were phrased specifically to encourage them to think about their current pregnancy
- **'Mothers of 0-2s'** refers to women interviewed as part of the online survey who had children aged up to 24 months at the time they were interviewed. Some of this group were also pregnant (79). If this was the case, the respondent was only asked questions about their child aged 0-2 rather than their pregnancy. If they had more than one child in this age group then the questionnaire picked one child at random and the respondent was only asked about their experiences with that particular child
- **'All women'** refers to pregnant women and mothers of 0-2 combined
- **'Other women'** refers to the comparison group of women interviewed face-to- face as part of the all adult survey. These women were all aged 18-45 (reflecting the age range of the vast majority of pregnant women and mothers of 0-2s interviewed online) and did not have any children aged 0-2 (some had older children). Some of these women may have been pregnant, but it was felt too sensitive to ask questions about current pregnancy in the face-to- face interview, so we are unable to identify which women would fall into this group

The Lifecourse Tracker survey does not aim to replace other available estimates about pregnant women and mothers of 0-2s, but provides a holistic picture of all behaviours and attitudes, how these compare and how these change over time.

This chapter examines the lives of pregnant women and mothers of 0-2s in the round, including looking at the following:

- Perceptions of their own health and well-being
- Availability of advice and support about pregnancy and parenting: where is such support sought, and whether enough support is felt to be available
- Use of health services and other services related to pregnancy and parenting
- A summary of pregnant women's health behaviours, and comparisons of these against other women
- Norms around health behaviours and intentions to change, as well as general attitudes towards health
- Detailed information about health behaviours

---

[58] Although it is worth noting that these groups were not excluded from the all adult survey and that this separate survey was conducted in order to provide a sufficiently large sample for separate analysis.

[59] Emma's Diary is an online and printed pregnancy guide produced in association with the Royal College of General Practitioners, which provides advice and guidance to mums-to-be about their pregnancy. Emma's Diary estimates that around 90% of pregnant women receive the publication, and almost all register with them.

- Nutrition, including nutritional behaviours specific to pregnancy and, for mothers of 0-2s, their child's nutrition
- Breastfeeding and introducing solid foods
- Physical activity: their own and, for mothers of 0-2s, their child's physical activity
- Smoking: prevalence of smoking, quit attempts
- Alcohol

12.1 Perceptions of health and well-being

The same core measures of well-being were measured amongst pregnant women and mothers of 0-2s as were used in the all adult survey. Although all women were generally positive about their lives nowadays, pregnant women reported higher levels of well-being than mothers of 0-2s. Pregnant women also reported higher levels than other women for all measures except the anxiety measure. Pregnant women were particularly likely to feel that the things they do are worthwhile (81% v 73% mothers of 0-2s and 66% other women) (Figure 75).

Figure 75 **Well-being measures**

	All pregnant women (594) %	All mothers of 0-2s (550) %	Other women* (370) %
Felt the things they do are **worthwhile** (top 4 boxes)	81	73↓	66↓
Felt **happy** yesterday (top 4 boxes)	74	64↓	65↓
Did **not** feel **anxious** yesterday (bottom 5 boxes)	66	59↓	64
Felt **satisfied** with life nowadays (top 4 boxes)	78	66↓	59↓

Base: All 2012 women in each group: as shown. *Taken from the all adult survey
↑↓ Indicates a significant difference, compared with pregnant women

Continuing with the pattern of pregnant women being generally more positive than mothers of 0-2s, pregnant women (80%) were significantly more likely to agree that they feel good about themselves than mothers of 0-2s (66%). The majority of both pregnant women (78%) and mothers of 0-2s (72%) felt that their health in general was good/very good. There were no significant differences in the proportion of pregnant women (61%) and mothers of 0-2s (56%) agreeing that *you need to take risks to lead a full life*, but both groups were significantly less likely than other women (69%) to agree.

In addition to the core well-being measures and attitudinal statements, pregnant women and mothers of 0-2s were also asked how often during the past four weeks they had had enough sleep to feel rested upon waking in the morning. Pregnant women also scored higher than mothers of 0-2s on this measure. Mothers of 0-2s were significantly more likely to report that they never felt rested in the last 4 weeks (19% v 9% of pregnant women)

As might be expected, first time mothers or those pregnant with their first child (11%) were less likely than those with other children (18%) to say they had not felt rested at all in the last four weeks.

Thinking about their experience of being a parent, mothers of 0-2s were asked how much they agreed or disagreed with each of the following statements: *I find being a parent rewarding* and *as a parent I find it difficult to cope*. The vast majority (95%) of mothers of 0-2s agreed that they find being a parent rewarding. A quarter (27%) of mothers of 0-2s agreed that they find it difficult to cope as a parent.

The amount of rest that women get appears be associated with their wider well-being. Women who reported feeling rested only a *little of the time* or *never* in the past four weeks generally reported lower well-being than those who reported feeling rested more often (Figure 76). The only well-being measures which the amount of rest did not associate with were: *finding being a parent rewarding* and *feeling you need to take risks to lead a full life*.

The most notable difference between those who felt rested *little/none of the time* and *at least some of the time* was in relation to life satisfaction (a 24 percentage point difference).

Figure 76 **The link between well-being and rest**

	All women who felt rested … in the past four weeks	
	…at least some of the time… (346) %	…little/none of the time… (247) %
Find being a parent rewarding [a]	96	95
Felt the things they do are **worthwhile** (top 4 boxes)	83	65↓
Health in general is good/very good	84	63↓
Felt good about themselves	83	61↓
Agree: you need to take risks to lead a full life	59	60
Felt **satisfied** with life nowadays (top 4 boxes)	82	58↓
Felt **happy** yesterday (top 4 boxes)	77	54↓
Did **not** feel **anxious** yesterday (bottom 5 boxes)	66	51↓
Agree: as a parent find it difficult to cope[a]	19	34↑
Had/might have post-natal depression [a]	8	20↑

Base: All Autumn 2012 women: as shown, expect for those marked with 'a' which are based on mothers of 0-2s only (152 (sleep at least some of time) / 149 (sleep little/none of the time))
↑↓ Indicates a significant difference, compared with corresponding sub-group
NB: Based on Autumn 2012 data only

When presented with a list of health problems, around three in ten (29%) of all women said they had any of the health problems listed; in line with other women (31%). All were also asked if they had any long standing illness, disability or infirmity that limits their day to day activities[60]. One in ten (11%) women said they did; with 8% (of all) saying this affected their day to day activities some (6%) or all (2%) of the time.

Pregnant women (6%) were significantly less likely than both mothers of 0-2s (11%) and other women (13%) to report stress or depression for which they are receiving treatment. When asked directly whether they had or thought they might have post-natal depression 14% of mothers of 0-2s said yes; including 7% saying this had been diagnosed by a health professional.

[60] Further detail was given in the question to clarify concepts for respondents. Long standing was defined as something which has troubled them over a period of time or that is likely to affect them over a period of time. Normal day to day activities were defined as everyday things like eating, washing, walking or going shopping.

12.2 Support and advice about pregnancy and parenting

A series of questions was asked relating to support and advice about pregnancy and parenting. Mothers of 0-2s were asked about the support they received from friends and family, as well as about their wider sources of support and advice on parenting. They were also asked to rate how supported they felt overall in their role as a parent. These questions were only asked of mothers of 0-2s, but all women were asked about their views of support for new mothers in breastfeeding and introducing solid foods.

12.2.1 Friends and family as support for mothers of 0-2s

Mothers of 0-2s were asked a series of questions about the support they receive from their friends and family. Presented with a list of statements, they were asked how much they agreed or disagreed with each.

Most mothers of 0-2s indicated that they had a good support network of friends/family around them. The majority (74%) agreed that they had the opportunity to share their problems and experiences of being a parent with others.

Around two thirds (64%) agreed that they lived close enough to friends to be able to see them as often as they would like, with just slightly fewer (61%) saying the same about family members. However, only half (54%) said that they actually see their friends/family as often as they would like. For mothers of 0-2s who said they found it difficult to cope, levels of agreement dropped to 51% for living close to friends, and 46% for living close to family – perhaps suggesting that these support networks play an important role in helping mothers cope with early parenthood.

The majority (86%) of mothers of 0-2s said that if there was an emergency and they needed someone to look after their child for a few hours, there was someone who they could trust to do that. Those who agreed that they lived close enough to family to see them as often as they liked were more likely to say they had someone they could trust to look after their child in an emergency (94% v 75% of those who disagreed). The same was true for those who said they lived close enough to friends (94% said yes v 73% who disagreed).

There appears to be an association between the extent to which mothers of 0-2s feel supported by friends and family and their likelihood to say they had post-natal depression. Mothers of 0-2s who reported post-natal depression were significantly less likely to agree that they had the support of family and friends (Figure 77); though it should be noted that these figures are based on a very small number of mothers of 0-2s (n=45 who had/thought they might have post natal depression) and so should be treated as indicative only.

Although there were no differences in terms of having someone trusted to look after their child in an emergency, on all other aspects mothers of 0-2s reporting post-natal depression had significantly lower levels of agreement – most notably in relation to living close enough to friends to be able to see them as often as they liked (23 percentage points lower than those not reporting post-natal depression) (Figure 77).

Figure 77 **Association between family/friend support and depression**

	All mothers of 0-2s who had/thought they might have post-natal depression	
	Yes (45*) %	No (258) %
Have someone they trust to look after their child if there was an emergency	86	87
Had the opportunity to share their problems and experiences of being a parent with others	49↓	79
Live close enough to **friends** to be able to see them as often as they like	44↓	67
Live close enough to **family** to be able to see them as often as they like	48↓	63
See friends/ family as often as they would like	36↓	57

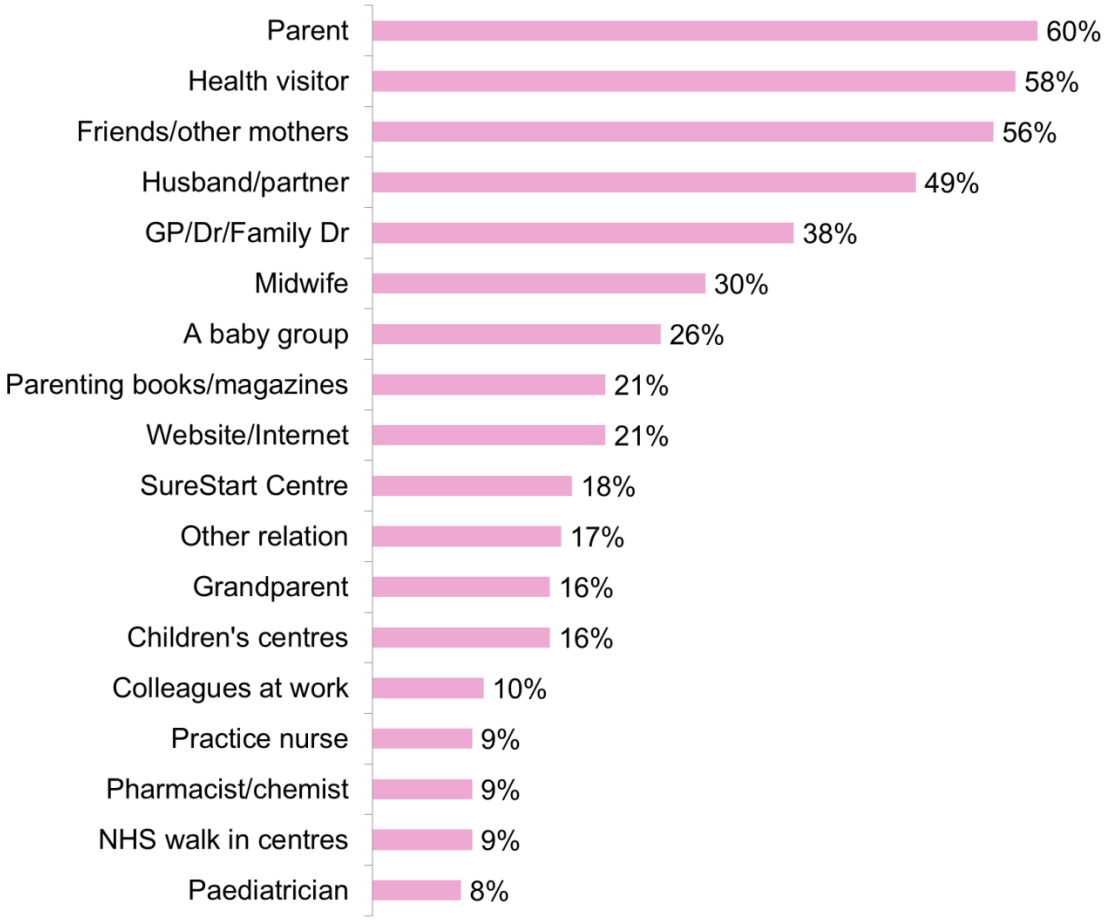
Base: All Autumn 2012 mothers of 0-2s. *Caution low base
↑↓ Indicates a significant difference, compared to mothers of 0-2s who did not think they had/might have post-natal depression
NB: Based on Autumn 2012 data only

In addition to this, there was also evidence to show that the amount of rest mothers of 0-2s get appears to be associated with how supported they feel. This was observed especially in relation to levels of agreement that they see friends or family as often as they would like (64% who felt rested at least some of the time in the past four weeks agreed with this v 44% who felt rested a little or none of the time).

12.2.2 Who mothers of 0-2s turn to if they need support

Mothers of 0-2s were asked about their current sources of advice or support about parenting, for example if they had a specific problem with breast feeding, weaning or potty training. Parents (60%), health visitors (58%), and friends/other mothers (56%) were most commonly mentioned as potential sources of advice/support on parenting issues. Half (49%) also mentioned their husband or partner (Figure 78).

Figure 78 **% saying they would turn to the following for parenting advice/support**



Base: All Autumn 2012 mothers of 0-2s (303)
NB: Sources mentioned by more than 5% shown on chart
NB: Based on Autumn 2012 data only

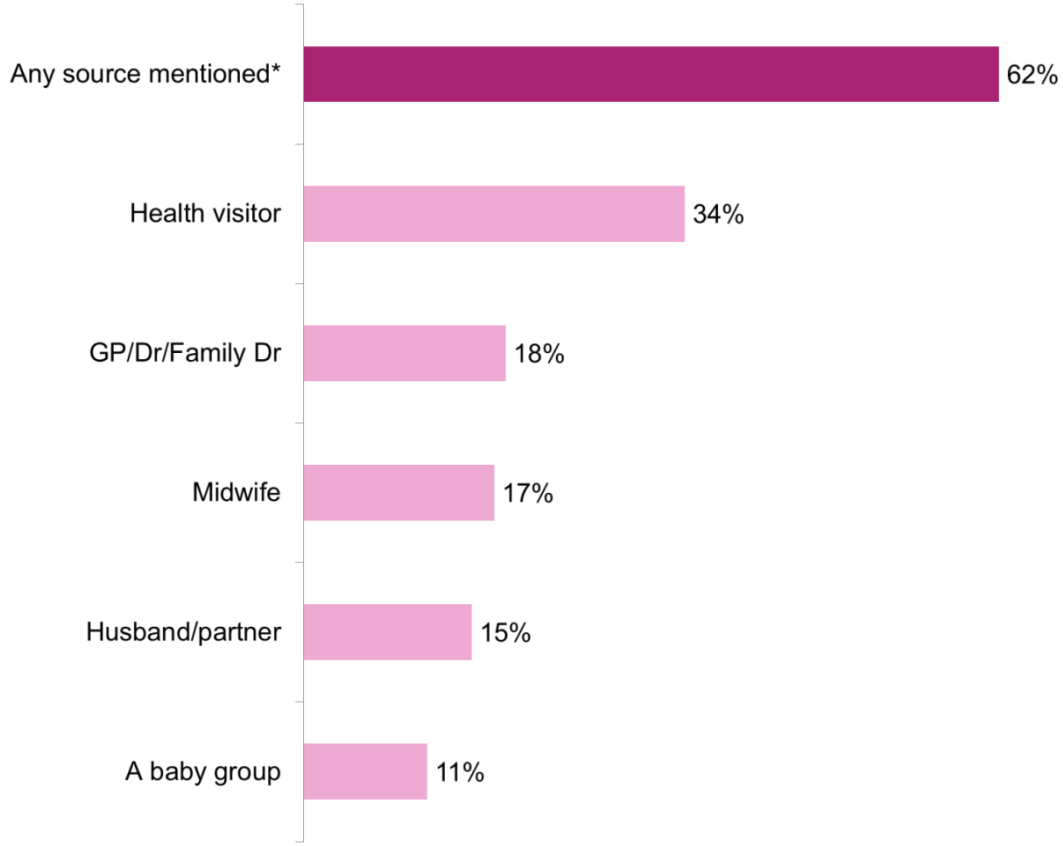
Overall, 21% of mothers of 0-2s mentioned websites as a source of parenting advice/support. The most common mentions were for BabyCentre (8%), Google (5%), Mumsnet (2%), Bounty (2%) and Emma's Diary (1%). Mothers of 0-2s who were in some way isolated from their friends or family were more likely to say they used websites for advice or support:

- 28% of **mothers of 0-2s** who disagreed that they see friends/family as often as they would like (v 18% who agreed)
- 31% of **mothers of 0-2s** who disagreed that they are close enough to family to see them as often as they would like (v 16% who disagreed)

12.2.3 Where would mothers of 0-2s like more support from

After listing their current sources of advice/support, mothers of 0-2s were asked from where they would like to receive more advice or support. Almost two thirds (62%) of mothers of 0-2s said they would like to receive more advice or support from at least one source: mainly from health professionals. A third (34%) would like to receive more advice or support from a health visitor and one in six would like more support from a GP (18%) or midwife (17%) (Figure 79).

Figure 79 **From where mothers of 0-2s would like to receive more advice/support**



Base: All Autumn 2012 mothers of 0-2s (303)
NB: Sources mentioned by 10% or more shown on chart
*Any source mentioned net includes sources not listed on this chart that were mentioned by less than 10%
NB: Based on Autumn 2012 data only

Single mothers (76%) were more likely than mothers living in multi-adult households (59%) to say they wanted more advice or support, especially from baby groups (23% of single mothers v 8% of mothers in multi-adult households) or Children's Centres (22% of single mothers v 6% of mothers in multi-adult households).

12.2.4 Support for breastfeeding and introducing solid foods

All women were asked how much they agreed or disagreed that *there is enough support available to help new mothers breastfeed*. Almost six in ten (59%) women agreed, with a fifth (18%) disagreeing and around a quarter (23%) unable to give an opinion. Levels of disagreement were higher amongst mothers of 0-2s (27%) than pregnant women (9%), suggesting that whilst pregnant women feel there is enough support in this area, in reality some mothers do not feel they get enough support when it comes to breastfeeding. First time mothers or those pregnant with their first child (14%) were less likely to *disagree* than those with other children (23%).

Mothers with children under one year who had eaten solid foods were also asked how much they agreed or disagreed that *there is enough support available to help mothers with weaning/ introducing solid foods into their baby's diet*. Around half (51%) agreed, with two in five (39%) disagreeing and just one in ten (10%) unable to give an opinion. There were no differences in levels of overall disagreement based on social grade, education, income or deprivation.

12.2.5 How much mothers of 0-2s feel supported overall

After considering the different aspects of advice and support, mothers of 0-2s were asked to think generally about all sources of support and to rate to what extent they felt supported in their role as a parent (on a seven point scale where one meant they did not feel supported at all and seven meant they felt fully supported). Overall, the majority (79%) of mothers of 0-2s said they felt supported in their role as a parent (scoring five to seven on the seven point scale). Just a third (33%) said they felt fully supported (scoring seven on the scale).

Support was highly correlated with how well mothers of 0-2s feel they were coping as parents – only 12% of those who felt fully supported said they found it difficult to cope (v 27% overall).

There were associations between levels of perceived support and emotional well-being: mothers of 0-2s who reported post-natal depression (11% said they felt fully supported v 36% who did not report post-natal depression) and those who felt they did not have the opportunity to share their problems (9% v 38% who agreed that they had the opportunity to do so) were less likely to feel fully supported. In addition, mothers of 0-2s who felt rested a little or none of the time over the past four weeks (72%) were significantly less likely than those who felt rested at least some of the time (88%) to feel supported overall (scoring 5 to 7 on the scale).

12.3 Interactions with health and other services

12.3.1 Activities in the past four weeks

All women were asked about the activities they had taken part in over the past four weeks. Presented with a list of activities they were asked to say which they themselves had done over the past four weeks. Mothers of 0-2s (81%) were more likely than pregnant women (67%) to have done any of the listed activities in the past four weeks. Figure 80 shows the top four mentions amongst each group.

Figure 80 **Top four activities in the past four weeks**

All pregnant women (594)		All mothers of 0-2s (550)	
Gone to a cinema etc.	32%	Used a Surestart Centre	38%
Used a Surestart Centre	15%	Gone to a playgroup	36%
Taken part in any kind of sport	12%	Gone to a soft play centre	35%
Gone to a soft play centre	10%	Gone to other classes e.g. tumble tots, baby yoga etc.	30%

Base: All 2012 women in each group: as shown

Overall, mothers of 0-2s (71%) were significantly more likely than pregnant women (25%) to mention having done any pregnancy or baby-related activities; whilst pregnant women were more likely to mention non-baby related activities (57% v 49% of mothers of 0-2s).

12.3.2 Activities to prepare for the birth

As well as general activities, all women were asked whether they had attended (or planned to attend) any antenatal classes/workshops/ sessions or hospital tours in preparation for the birth of their child.

Overall, three fifths (60%) of all women had attended or planned to attend any antenatal classes to help them prepare for the birth of their child. However, the proportion of pregnant women planning to attend antenatal classes (67%) was significantly higher than the proportion of mothers of 0-2s who reported actually attending (52%). This difference is explained by higher proportions of mothers of 0-2s saying classes were not available to them (12% v 6% pregnant women) or that they were available but they had chosen not to attend (34% v 20% of pregnant women).

Overall, half (51%) of all women had attended/planned on attending antenatal classes run by the NHS, a fifth (21%) by the NCT/ABC[61] and one in six (17%) some other sort of antenatal class.

First time mothers or those pregnant with their first child were more likely to say they attended or planned to attend antenatal classes (78% v 33% of those with other children). ABC1 mothers were also more likely to say they attended/planned to attend - in particular, NCT/ABC classes (27% v 17% of C2DE mothers).

The overall proportion of all women that had attended, or planned to attend, a tour of hospital facilities was slightly lower than for antenatal classes at 43%. This difference is explained by higher proportions saying that a tour was not available to them (21% v 9% for antenatal classes). Again, pregnant women were more likely to say they planned to attend a hospital tour (54%) than mothers of 0-2s were to say they had attended one (33%). As with antenatal classes, first time mothers or those pregnant with their first child were more

[61] NCT (National Childbirth Trust) (also referred to as ABC (Antenatal, Babies & Children) is the UK's largest charitable organisation for parents. It aims to give parents accurate, impartial information and to introduce them to local support networks; including running antenatal classes.

likely to say they attended or planned to attend such a hospital tour (53% v 29% of those with other children).

12.3.3 Satisfaction with health services

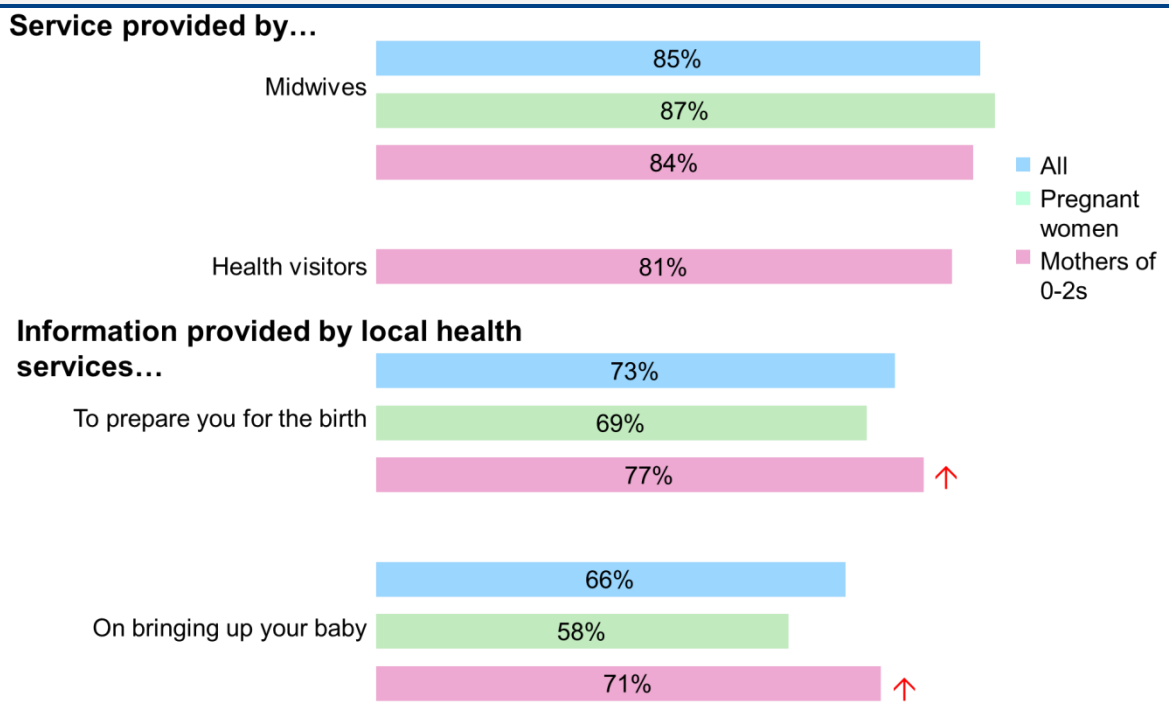
Focusing on the health services they had used and information with which they had been provided during their pregnancy, women were asked to rate their satisfaction with each on a seven point scale. Pregnant women were asked in the context of services they had used so far in their pregnancy; and mothers of 0-2s in the context of during their pregnancy and after the birth of their child. They were asked to specifically consider each of the following in turn:

- The service received from…
  - … midwives
  - … health visitors
- The amount of information provided by local health services…
  - … to prepare them for the birth
  - … on bringing up their baby

Almost all (98%) women had used the services provided by midwives and only 1% of mothers of 0-2s had not seen a health visitor. The majority had also received information from local health services to help prepare for the birth (88%) or bring up their baby (83%).

Satisfaction varied amongst those who had said they had used/seen each health service or information source. Most women (85%) who had used services provided by midwives were satisfied with the service they had received. Satisfaction levels were slightly lower in relation to health visitor services (81% amongst mothers of 0-2s only), information provided by local health services on preparing for the birth (73%) and bringing up a baby (66%). Figure 81 shows the proportion of those who had used each service and said they were satisfied with it.

Figure 81 **% satisfied with each health or information service – amongst those who have used each**



Base: All 2012 women using each service: (703-1126), All pregnant women using each service (158-578), All mothers of 0-2s using each service (545-548)
↑↓ Indicates a significant difference, compared with pregnant women

Satisfaction with the services provided by midwives was similar amongst both pregnant women (87%) and mothers of 0-2s (84%) who had used these services. Amongst those who had used the services provided by midwives, those not living in poverty (90%) were more likely to be satisfied than those who were living in poverty (81%).

Amongst those who had used health visitor services eight in ten mothers of 0-2s (81%) were satisfied with the service they had received.

Amongst those who had received information from local health services, mothers of 0-2s were more likely to be satisfied, with around three in four satisfied with the information provided to prepare them for the birth (77% v 69% of pregnant women) and on bringing up their baby (71% v 58% of pregnant women). First time mothers or those pregnant with their first child (61%) were less likely than those with other children (71%) to be satisfied with the information they had received on bringing up their baby.

12.4 Health behaviours

Although the same core measures of negative health behaviours for nutrition, physical activity (for mothers of 0-2s only) and smoking were used amongst these women as amongst the all adult population, there were some differences in the measures used for alcohol. Pregnant women and mothers of 0-2s were not asked about their behaviours and attitudes in relation to drugs and sexual health. Figure 82 details the core measures of negative health behaviours used for pregnant women, mothers of 0-2s and other women (in the all adult survey).

Figure 82 **Core measures of negative health behaviours**

	All pregnant women	All mothers of 0-2s	Other women*
Nutrition	Fewer than five portions of fruit/veg on day before interview	Fewer than five portions of fruit/veg on day before interview	Fewer than five portions of fruit/veg on day before interview
Physical activity	N/A	Fewer than 150 active minutes in past week	Fewer than 150 active minutes in past week
Smoking	Smoke nowadays	Smoke nowadays	Smoke nowadays
Alcohol	Drunk alcohol in the last week	Drunk alcohol in the last week	Increasing/higher risk drinker
Drugs	N/A	N/A	Used illegal drugs/legal highs in the past 12 months
Sexual health	N/A	N/A	Had unprotected sex with a new/ multiple partners in the past 6 months

*Taken from the all adult survey

12.4.1 Prevalence of negative health behaviours - women

Prevalence of negative health behaviours varied between pregnant women, mothers of 0-2s and other women, with pregnancy strongly associated with healthy behaviour changes (Figure 83).

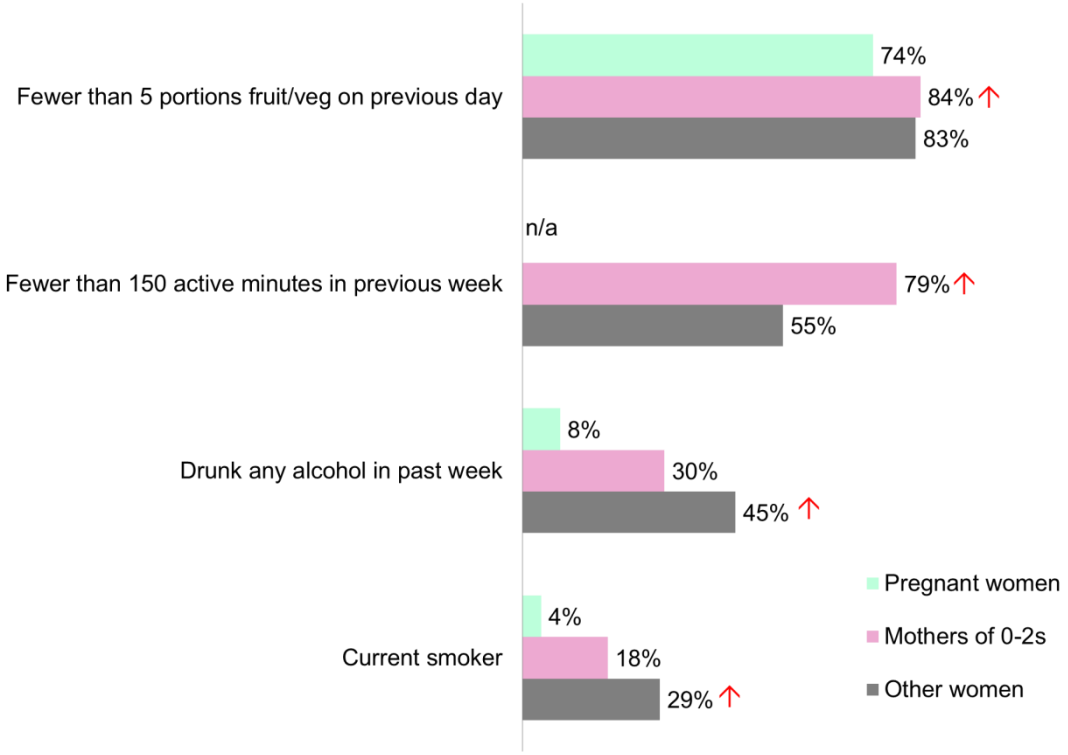
Pregnant women were significantly less likely than the other groups to have consumed fewer than five portions of fruit/veg on the day before they were interviewed (74% v 84% of mothers of 0-2s and 83% of other women).

Levels of physical activity were not measured amongst pregnant women as there are not comparable guidelines for levels of physical activity during pregnancy. Although no comparison of physical activity can be made between pregnant women and mothers of 0-2s, compared with other women in the all adult survey (55%) mothers of 0-2s (79%) were significantly more likely to report doing fewer than 150 active minutes in the past week.

Pregnant women (8%) were the least likely to report having drunk alcohol in the past seven days. Although mothers of 0-2s (30%) were more likely than pregnant women to have drunk alcohol in the past seven days, they were less likely than other women (45%) to have done so.

The same is true of smoking, with just 4% of pregnant women reporting to be a current smoker; compared with 18% of mothers of 0-2s and 29% of other women. Figure 83 shows the prevalence of negative health behaviours amongst these three groups.

Figure 83 **% reporting each negative health behaviour**



Base: All 2012 women (587), All 2012 mothers of 0-2s (557), All 2012 other women (370)
*taken from the all adult survey
↑↓ Indicates a significant difference, compared with pregnant women

12.4.2 Prevalence of negative health behaviours – other household members

Women were also asked about the prevalence of negative health behaviours (smoking cigarettes, drinking heavily or taking illegal drugs) amongst other members of their households. A quarter (27%) of women (who lived with someone else) said they lived with someone who did at least one of these things nowadays. This was most likely to be a smoker (25%). Very small proportions of women reported living with a heavy drinker (4%) or someone who took illegal drugs/legal highs (2%).

The 2010 Infant Feeding Survey[62] reported that a quarter (23%) of mothers had a partner who smoked before or during their pregnancy; in line with the 26% of pregnant women in the Lifecourse Tracker survey who said they lived with a smoker.

12.4.3 Impact of pregnancy/parenthood on behaviour - mothers of 0-2s

The Lifecourse Tracker survey also looked at the changes women had made to their behaviour as a result of pregnancy. In order to fully assess the impact of pregnancy/parenthood it is important to consider behaviour changes in the context of the guidelines that are given to women. The Start4Life guidelines[63] state that, during pregnancy, women should:

- "Eat for you, not for two" – sticking to the recommended calorie intake of 2000 calories, only adding an extra 200 per day in the final trimester
- Take vitamin D and folic acid supplements during pregnancy
- Maintain levels of physical activity as before they got pregnant, with the recommendation that 150 minutes walking each week can be of benefit
- Stop smoking
- Avoid alcohol

Around a third (35%) of all women said they ate more during the first trimester of their pregnancy than they did before they were pregnant. In the later stages of pregnancy food consumption increased further, with half (51%) eating more in the second trimester and nearly two thirds (62%) in the third trimester[64]. During the third trimester 41% said they ate a little more, and 21% a lot more. This suggests that although some women are acting in accordance with the Start4Life guidelines and only upping their calorie intake during the final trimester, substantial proportions are not picking up on this message and are consuming more in the earlier stages of pregnancy too. However, we cannot imply links with Start4Life communications here. See section 12.6.3 for more details on diet during pregnancy.

As physical activity was not measured in the same way amongst pregnant women as amongst mothers of 0-2s and other women it is difficult to draw direct comparisons. Although around six in ten (58%) women said they were less active during pregnancy compared to pre-pregnancy, three in ten (29%) said they did the same amount of physical activity during their pregnancy as they had done beforehand. Amongst pregnant women levels of physical activity appeared to reduce as the pregnancy progressed. See 12.8.2 for more details on physical activity during pregnancy.

Whilst smoking prevalence was under a third (29%) amongst other women (taken from the adult survey), 18% of mothers of 0-2s and just 4% of pregnant women reported to be current smokers. Twelve percent of allwomen said they had smoked during *some* or *all* of their pregnancy, although almost seven in ten (69%) of these said they had made at least one serious attempt to quit. In addition, 13% of pregnant women/mothers of 0-2s gave up when they found out that they were pregnant. However, there is evidence that around half

[62] http://data.gov.uk/dataset/infant-feeding-survey-2010 Chapter 11 tables, Table 11.21
[63] http://www.nhs.uk/start4life/Pages/healthy-pregnancy-baby-advice.aspx
[64] The second and third trimester figures are based only on women who are at that stage of pregnancy (in addition to mothers of 0-2s)

of mothers of 0-2s who gave up smoking during their pregnancy started smoking again within the first two years after the birth of their child. See section 12.8.6 for more details on smoking during pregnancy.

Alcohol consumption levels were lowest amongst pregnant women, with around one in ten (8%) reporting to have drunk any alcohol in the last week. This compares with 30% of mothers of 0-2s and 45% of other women. Two in five (41%) women said they had given up alcohol altogether when they found out they were pregnant, with a further one in five (19%) saying they had cut down on the amount they drank for some (2%) or all (18%) of their pregnancy. See section 12.9 for more details on alcohol consumption during pregnancy.

12.4.4 Impact of life events on behaviour - other family members

As well as asking women about changes to their own health behaviours, the survey also looked at whether other people in the household had made changes to their lifestyle because of the woman's pregnancy/since the birth of their baby.

As well as triggering positive behaviour changes in women, pregnancy was also a trigger for healthy behaviour changes in some other household members. Amongst those women living with someone participating in any negative health behaviours, six in ten said that person had stopped/cut down smoking (61%) or drinking alcohol (59%) as a result of the pregnancy/having a baby.

12.4.5 Norms around health behaviours

As in the all adult survey, in order to measure norms around health behaviours women were also asked to what extent they agreed or disagreed that more/most of the people they know are behaving in a healthy manner nowadays.

Overall, a third (35%) of all women thought that all/most of their friends and family lead a healthy lifestyle nowadays. In relation to nutrition, two in five women (42%) agreed that *most people I know eat healthily nowadays*, in line with the views of other women (41%). However, mothers of 0-2s were significantly less likely than pregnant women or other women to agree that *most people I know are physically active* nowadays. Figure 84 shows the proportions agreeing amongst pregnant women, mothers of 0-2s and other women.

Figure 84 **% agreeing that more/most people they know … nowadays**

	All pregnant women (594) %	All mothers of 0-2s (550) %	Other women* (370) %
Are physically active	54	46↓	52
Are stopping smoking	52	54	47
Eat healthily	42	41	44

Base: All 2012 women in each group: as shown. *Taken from the all adult survey
↑↓ Indicates a significant difference, compared with pregnant women

Around half (53%) of all women felt that *more people are stopping smoking nowadays*. There were no significant differences in levels of agreement between pregnant women and mothers of 0-2s (52% v 54%). Disagreement with this statement was higher amongst non-smoking women (20% v 11% of women smokers). There was a similar pattern amongst smokers and non-smokers in the all adult survey.

12.4.6 Intentions to change each behaviour

As in the all adult survey, all women were asked about intentions to change their diet, whilst those who smoked nowadays or had drunk alcohol in the past 7 days were asked about their intentions to stop or cut down on those behaviours. Mothers of 0-2s were also asked about their intentions to be more physically active.

Pregnant women (62%) and mothers of 0-2s (64%) were more likely than other women (49%) to say they intend on starting to eat a healthier diet over the next three months[65]. A fifth (21%) of all women did not intend to change their diet because they felt they already ate healthily (v 35% of other women). Pregnant women (25%) were more likely than mothers of 0-2s (18%), but less likely than other women (35%) to feel that their current diet was healthy enough not to warrant any changes.

There was no significant difference in intentions to increase levels of physical activity in the next three months between mothers of 0-2s (66%) and other women (61%). Levels of physical activity were not measured amongst pregnant women, so no comparison can be drawn there. See 12.8.1 for further discussions of the intentions of mothers of 0-2s to increase their levels of physical activity over the next three months.

The data indicates that pregnant women who smoke (46%) were more likely to intend to give up in the next three months than mothers of 0-2s who smoked (29%) or other women who smoked (24%). However, the small base size for pregnant smokers (n = 22) means that these differences are not significant and should be treated with caution.

12.5 Attitudes towards health

As in the all adult survey, women were also asked a series of questions to establish their opinions and attitudes related to the constructs of health fatalism, health locus of control, response efficacy and self-efficacy (see section 3.3 for a detailed description of each). In order to establish these constructs, women were presented with a number of statements about health attitudes and asked how much they agreed or disagreed with each.

As amongst the all adult sample, opinions amongst women were divided related to health fatalism: pregnant women (33%) were significantly less likely than both mothers of 0-2s (40%) and other women (46%) to agree that *if a person is meant to get ill, they will get ill anyway, regardless of whether they lead a healthy lifestyle*.

Fifty eight percent of pregnant women agreed that *the main thing which affects my health is what I personally do*, similar to mothers of 0-2s (64%) and other women (68%).

[65] They gave a score of five to seven out of seven where one meant they definitely did not intend to and seven meant definitely intend to.

As a measure of response efficacy and self-efficacy women were asked how easy or difficult they would find it to lead a healthy lifestyle over the next three months; and how much control they believed they had over doing so. On both measures mothers of 0-2s were the least likely to agree (Figure 85). Six in ten (60%) of mothers of 0-2s said they would find it easy to lead a healthy lifestyle over the next three months, compared with seven in ten pregnant women (71%) and other women (74%). Although mothers of 0-2s were more likely to think that a healthy lifestyle would be in their control than thought it would be easy (76% felt they would have complete control), pregnant women (83%) and other women (85%) were still more likely to say so.

Figure 85 **Leading a healthy lifestyle over the next three months**

	All pregnant women (594) %	All mothers of 0-2s (550) %	All other women * (370) %
Response efficacy: Easy (top 3 box)	71	60↓	74
Self-efficacy: Complete control (top 3 box)	83	76↓	85

Base: All 2012 women: as shown. *Taken from the all adult survey
↑↓ Indicates a significant difference, compared with pregnant women

Almost all (98%) women agreed that it *is important for you to set your child a good example through the things that you do* – with 83% strongly agreeing. Despite overall high levels of agreement there were some groups of women who were less likely to *strongly* agree with this:

- C2DE women (78% v 88% ABC1s)
- Single parents (75% v 84% in multi-adult households)
- Those eating fewer than five portions of fruit/veg a day (81% v 90% eating 5+)

Asked to think about their weight at the moment, more than half (58%) of mothers of 0-2s described themselves as overweight. A third (36%) described themselves as a healthy weight and 5% felt they were underweight. Despite their recent pregnancy, mothers of 0-2s were not significantly more likely than other women to describe themselves as overweight (51% of other women said this).

Measures of current weight were not applicable to pregnant women because of their current pregnancy, so they were instead asked to think about their weight before they became pregnant. Two fifths (39%) of pregnant women described themselves as overweight (39%); half (51%) said they were a healthy weight and one in ten (9%) felt they were underweight before they became pregnant.

12.5.1 Attitudes towards leading a healthy lifestyle

When women were asked to describe a 'healthy lifestyle' in their own words the most frequently mentioned elements, by a fair way, were a healthy/balanced diet (75%) and regular exercise or keeping fit (69%). The only other elements mentioned by one in ten women or more were:

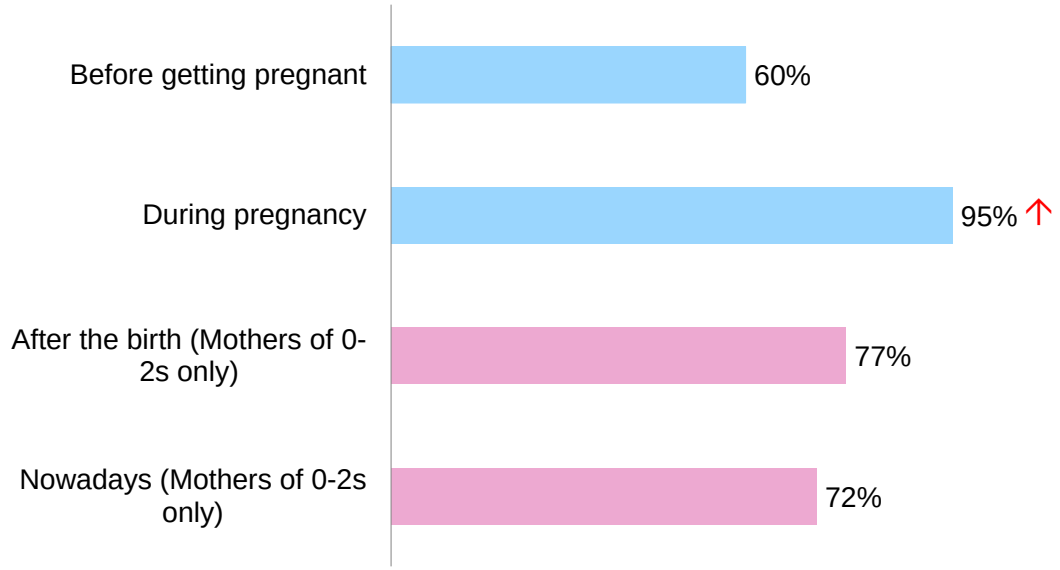
- Not drinking too much alcohol (15%)
- Not smoking (14%)
- Getting enough sleep/rest/relaxation (10%)

There were few significant differences between the descriptions given by pregnant women and mothers of 0-2s. Only a small number of all women (n=9) mentioned taking vitamins or supplements: and 8 out of these 9 were pregnant women. Mothers of 0-2s (6%) were more likely than pregnant women (3%) to mention fresh air as part of a healthy lifestyle.

Women were asked about the priority of leading a healthy lifestyle both before and during pregnancy. Mothers of 0-2s were also asked the same question in relation to the priority of leading a healthy lifestyle immediately after the birth of their child, and nowadays.

Again, pregnancy appears to be a key event for changes in perceptions, with the proportion of all women saying that leading a healthy lifestyle is a very/quite high priority increasing significantly from six in ten (60%) for before pregnancy to more than nine in ten (95%) during pregnancy. Figure 86 shows the proportions saying that leading a healthy lifestyle is a priority at different stages of pregnancy.

Figure 86 **% saying leading a healthy lifestyle is a very/quite high priority at each stage**



Base: All 2012 women (1144), All 2012 mothers of 0-2s (550)
↑↓ Indicates a significant difference

Pregnant women were significantly more likely than mothers of 0-2s to say that leading a healthy lifestyle was a very/quite high priority before they got pregnant (65% v 55% of mothers of 0-2s); whilst the vast majority in both groups said this is/was the case during pregnancy (95% of pregnant women and 94% of mothers of 0-2s). Although it still remained a higher priority than it was before pregnancy, leading a healthy lifestyle appeared to become less of a priority for mothers of 0-2s after the birth of their child, with around three in four saying it was a very/quite high priority either immediately after the birth of their child (77%) or nowadays (72%).

12.6 Nutrition

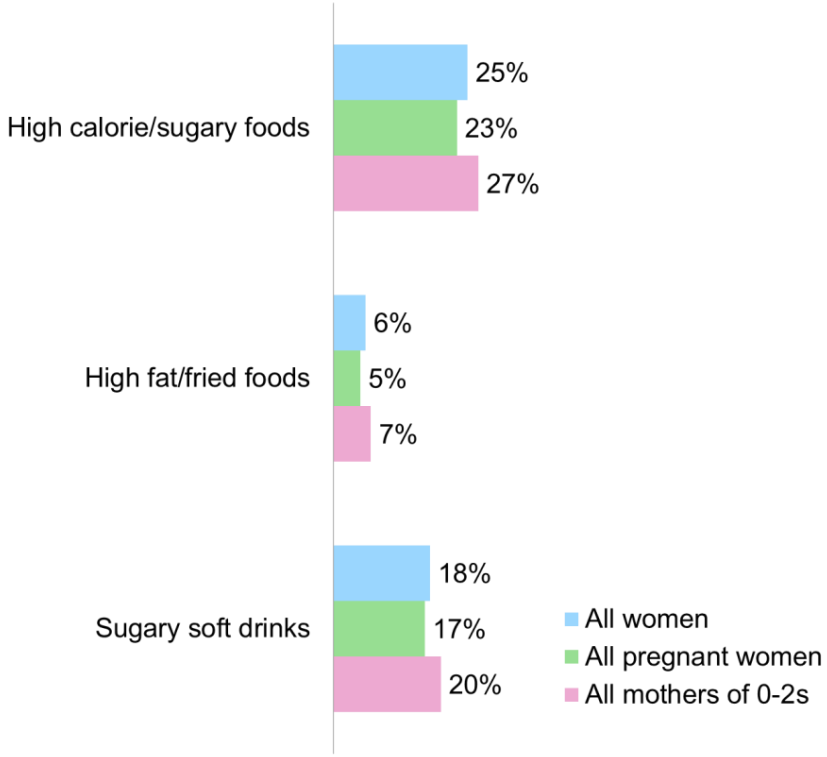
As in the all adult survey, the core measure for nutrition for women was whether respondents had eaten fewer than five portions of fruit/veg on the day before they were interviewed. Women were also asked about their other nutritional behaviours in relation to consumption of certain food types over a normal week and whether they limit any unhealthy elements in their diet.

In terms of the core nutritional measure, pregnant women (74%) were less likely than mothers of 0-2s (84%) to have eaten fewer than five portions of fruit/veg the day before they were interviewed. The proportion of other women who had done so (83%) was very similar to that of mothers of 0-2s and significantly higher than pregnant women.

12.6.1 Consumption of other types of foods

One third (36%) of all women reported at least one negative nutritional behaviour. Daily consumption of high calorie/sugary foods, high fat/fried foods and sugary soft drinks was similar amongst the two groups (Figure 87).

Figure 87 **% consuming each daily**



Base: All 2012: women (1144), pregnant women (594), mothers of 0-2s (550)

Other women generally reported similar nutritional behaviours, although they (10%) were significantly more likely than pregnant women (5%) and mothers of 0-2s (6%) to consume high fat/fried foods daily.

C2DE women were more likely than ABC1 women to consume sugary soft drinks daily (20% v 15%). Daily consumption of high calorie/sugary foods (23% C2DEs v 27% ABC1s) and high fat/fried foods (7% C2DEs v 4% ABC1s) did not vary significantly by social grade. Similar patterns were also observed in the all adult sample

12.6.2 Other nutritional behaviours

As in the all adult survey, women were asked whether they limit certain types of unhealthy foods in their diet. Overall, two thirds (63%) of all women reported limiting the number of unhealthy snacks they eat between meals, three in ten (35%) reported limiting the amount of calories/food and drink that is high in calories they consume and a similar proportion reported (31%) limiting the amount of salt/low salt they consume. One in five (19%) women said they did not put any of these limits on what they eat nowadays.

Pregnant women (67%) were significantly more likely than mothers of 0-2s (60%) and other women (57%) to limit unhealthy snacks. In contrast, pregnant women (30%) were less likely than mothers of 0-2s (40%) and other women (39%) to limit calorie intake.

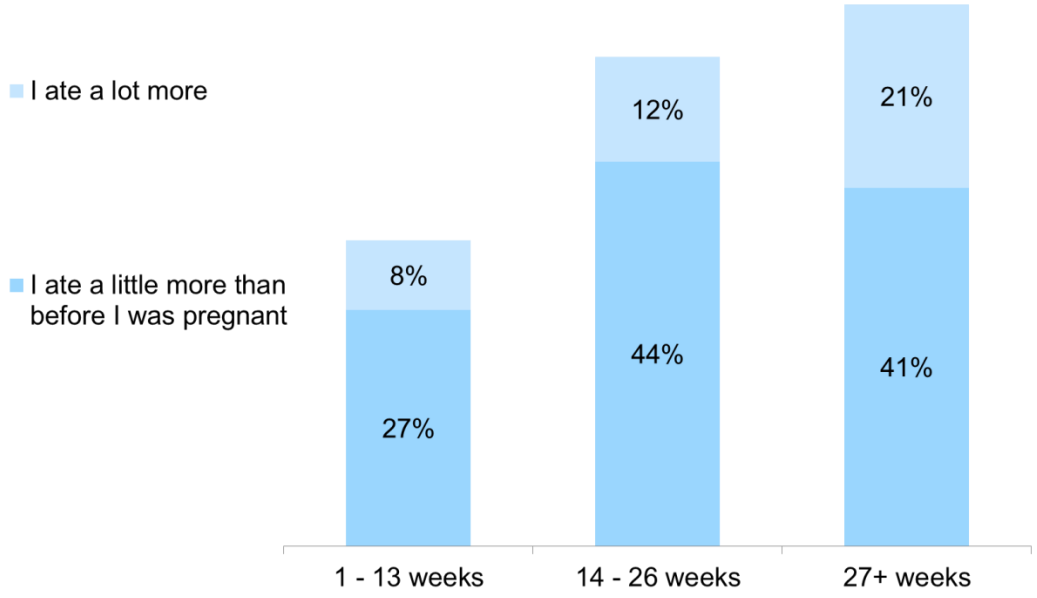
It is worth noting, however, that there were no differences in the proportions of pregnant women saying they limit their calorie intake based on their stage of pregnancy: 29% in their first or second trimester said they did so, compared with 31% of those in their third trimester. This may suggest that pregnant women are perhaps not picking up on the Start4Life recommendations that calorie intake should remain the same during the first two trimesters, and only be increased to take in an additional 200 calories per day during the third trimester[66].

12.6.3 Diet during pregnancy

In order to gauge eating patterns throughout pregnancy, all women were asked to evaluate the amount they eat/ate during each trimester of their pregnancy compared to what they ate before their pregnancy.

Women reported that they tended to eat more as their pregnancy progressed. While three in ten (35%) said they ate more in the first 13 weeks of their pregnancy, this proportion rose to 56% in the second trimester and 62% in the third trimester (Figure 88).

Figure 88 **Eating patterns throughout pregnancy**



Base: One to 13 weeks: all 2012: women (1144)
14 – 26 weeks: all 2012: at least 15 weeks pregnant or mother of 0-2 (1024)
27+ weeks: all at least 28 weeks pregnant or mother of 0-2 (728)

[66] http://www.nhs.uk/start4life/Pages/healthy-eating-during-pregnancy.aspx

In addition to maintaining a healthy diet, the Start4Life guidelines state that during pregnancy women should take vitamin D and folic acid supplements to help their baby develop healthily[67]. Asked directly whether they had taken or planned to take these supplements during their pregnancy the majority (97%) of all women said they had taken/planned to take folic acid. A significantly lower proportion (51%) of all women said they had taken/planned to take vitamin D. Pregnant women were significantly more likely than mothers of 0-2s to say they had taken or planned to take vitamin D supplements during their pregnancy (57% v 44%), but there were no significant differences in relation to taking folic acid (97% pregnant women v 96% mothers of 0-2s).

The 2010 Infant Feeding Survey[68] also reported that the vast majority (94%) of women took folic acid supplements at some stage during their pregnancy: 37% before, 79% during the first trimester and 23% later on in their pregnancy. This same survey reported a significantly lower proportion of women taking vitamin D supplements during pregnancy (just 3%). However, it also reported that a third (29%) took some form of multi-vitamins, either with (18%) or without (11%) iron, which could go some way towards making up the discrepancy between the two surveys here.

12.6.4 Nutritional guidelines

After talking about different aspects of their own nutritional behaviours women were asked to say, without prompting, what they thought were the food and nutrition guidelines for women during pregnancy. The most commonly recalled guidelines were 'balanced diet' (30%) and '5 a day' (28%), but a quarter (26%) couldn't think of any guidelines. Around one in ten mentioned drinking plenty of water (10%), limiting calorie intake (10%), avoiding alcohol (9%) or avoiding certain cheeses (8%).

Despite the majority (97%) of all women reporting to have taken/planning to take folic acid during their pregnancy just 3% mentioned this as a guideline. Likewise, where half (51%) reported taking or planning to take vitamin D during their pregnancy just 1% mentioned this as a guideline.

The following groups were more likely to say they could not recall any guidelines for food and nutrition for women who are pregnant, though it is worth noting that many of these groups are linked:

- Younger women (43% 18-24 v 27% 25-29 v 18% 30+)
- C2DEs (34% v 17% ABC1s)
- Those living in poverty (31% v 18% not in poverty)
- Single parents (37% v 25% in multi-adult households)
- Those eating fewer than five portions of fruit/veg a day (30% v 12% those eating 5+)
- Smokers (44% v 24% non-smokers)

12.6.5 Attitudes towards nutrition

The same attitudinal statements about nutrition that were included in the all adult survey were also presented to women. Around a third (34%) of all women agreed that *healthy eating means giving up too many of the foods I enjoy*, with mothers of 0-2s (40%) more likely to agree than pregnant women (28%). There were no significant differences between the two groups in agreement that *healthy eating is only for those that can afford it* (26% pregnant women v 30% mothers of 0-2s).

[67] http://www.nhs.uk/start4life/Pages/vitamin-supplements-folic-acid-pregnant.aspx
[68] http://data.gov.uk/dataset/infant-feeding-survey-2010

12.7 Breastfeeding and introducing solid foods

The Start4Life guidelines encourage mothers to breastfeed, focusing on the many benefits it provides both for them and their baby[69]. Pregnant women were asked to what extent they intended to try breastfeeding their baby, whilst mothers of 0-2s were asked if they had ever done so. The majority (79%) of pregnant women said they intended to breastfeed their baby; with 70% definitely intending to do so. Likewise, the majority (85%) of mothers of 0-2s said they had ever breastfed/given breast milk to their child, even if this was only once.

The Start4Life guidelines state that the longer a mother feeds their baby breast milk, the more they help to protect their health and suggest exclusively breastfeeding until the baby is aged about six months, at which stage combining breast milk with solid foods is ideal[70]. Despite this recommendation, it is acknowledged that few mothers will be able to adhere to exclusive breastfeeding for this length of time. With this in mind, the Lifecourse Tracker survey looks at exclusive breastfeeding up to six weeks.

A series of questions were asked of mothers of 0-2s to ascertain whether they breastfed exclusively beyond six weeks. Half (47%) of mothers of 0-2s said they had done so.

The 2010 Infant Feeding Survey[71] reports on this slightly differently, detailing the proportion of mothers exclusively breastfeeding at different ages from birth up to six months. It reported that a quarter (23%) of mothers were exclusively breastfeeding at six weeks, with this proportion reducing steadily thereafter (21% at two months, 17% at three months, 12% at four months, 5% at five months) through to just 1% exclusively breastfeeding at six months.

The Lifecourse Tracker survey shows that in terms of demographics, younger mothers (67% 18-24s v 50% 25+s) and those from C2DE social groups (58% v 48% ABC1s) were least likely to have breastfed exclusively beyond six weeks. The Infant Feeding Survey also reported similar patterns in response, despite using a different measure.

The Lifecourse Tracker also reported some notable differences by health behaviours; with mothers of 0-2s who smoked, who ate a less healthy diet and who were less active more likely to say they did *NOT* breastfeed exclusively beyond six weeks:

- Smokers (72% v 49% non-smokers)
- Those eating fewer than five portions of fruit/veg a day (56% v 36% 5+)
- Those doing fewer than 150 active minutes (56% v 41% 150+)

The Start4Life guidelines state that introducing solid foods at the right time is important for a baby's health. They recommend that around six months is a good time to introduce solid foods into a baby's diet as before this their digestive system is still developing and may not be able to fully process solid foods[72]. Mothers of 0-2s were also asked whether they had or intended to introduce their baby to solid foods at or before the age of six months. The majority of mothers of 0-2s said they had given, or intended to give, solid foods to their baby for the first time at six months or earlier. This broke down as 69% saying they had done so and 13% saying they intended to do so. There were no notable demographic differences in response.

In line with this, the 2010 Infant Feeding Survey[73] also reported that the vast majority (94%) of mothers had introduced solid foods into their child's diet by the age of six months.

[69] http://www.nhs.uk/start4life/Pages/breastfeeding-benefits.aspx
[70] http://www.nhs.uk/start4life/Pages/breastfeeding-duration.aspx
[71] http://data.gov.uk/dataset/infant-feeding-survey-2010 Chapter 2 tables, Table 2.19
[72] http://www.nhs.uk/start4life/Pages/babies-introducing-solid-food.aspx
[73] http://data.gov.uk/dataset/infant-feeding-survey-2010 Chapter 2 tables, Table 2.19

12.7.1 Attitudes towards breastfeeding

During the survey women were asked a number of questions related to their attitudes towards breastfeeding. These covered the issues of breastfeeding versus formula, breastfeeding out and about and the norms around how many mothers breastfeed/have breastfed. Overall, pregnant women and mothers shared similar attitudes towards breastfeeding (Figure 89).

Around three in four (77%) women agreed that while their baby was still young it was worth sticking with breastfeeding for as long as possible. In addition, almost half (47%) saw breastfeeding as the norm, agreeing that most of the mothers they know breastfeed/have breasted. Despite recognising the benefits of breastfeeding and viewing it as a norm, around half (49%) agreed that they would feel uncomfortable breastfeeding out and about.

Positively, women were least likely to agree with the negative statement, *Formula is as good for your baby as breast milk*, with only three in ten (29%) of all women agreeing. This is the one attitude on which the views of pregnant women and mothers of 0-2s differed significantly. Pregnant women (25%) were less likely than mothers of 0-2s (33%) to agree that formula is as good for a baby as breast milk.

Figure 89 **% who agreed with each**

	All women (1144) %	All pregnant women (594) %	All mothers of 0-2s (550) %
While your baby is still young, it is worth sticking with breastfeeding for as long as you can	77	76	78
Would feel uncomfortable breastfeeding when out and about	49	50	49
Most of the mothers you know breastfeed/have breastfed	47	46	47
Formula is as good for your baby as breast milk	29	25	33↑

Base: All 2012 women in each group: as shown
↑↓ Indicates a significant difference, compared with pregnant women

First time mothers or those pregnant with their first child had a more positive view of breastfeeding than those with other children (Figure 90). They were more likely to agree that it is worth sticking with breastfeeding for as long as possible (80% v 74% with other children), and less likely to agree that formula is as good as breast milk (26% v 33% with other children). Although they were more likely to agree they would feel uncomfortable breastfeeding out and about (52% v 44% with other children), they were also more likely to be surrounded by the breastfeeding norm, as they were more likely to agree that most of the mothers they know breastfeed/have breastfed (50% v 43% with other children).

Figure 90 **% who agreed with each – first time/with other children**

	All first time mothers/pregnant with first child (697) %	All with other children (447) %
While your baby is still young, it is worth sticking with breastfeeding for as long as you can	80	74↓
Would feel uncomfortable breastfeeding when out and about	52	44↓
Most of the mothers you know breastfeed/have breastfed	50	43↓
Formula is as good for your baby as breast milk	26	33↑

Base: All 2012 women in each group : as shown
↑↓ Indicates a significant difference, between groups

Single parents and those living in multi-adult households also had some differing attitudes towards breastfeeding. Single parents (39%) were more likely than those in multi-adult households (27%) to agree that formula is as good as breast milk. In addition, single parents (34%) were less likely to agree that most of the mothers they know breastfeed/have breastfed than those living in multi-adult households (49%).

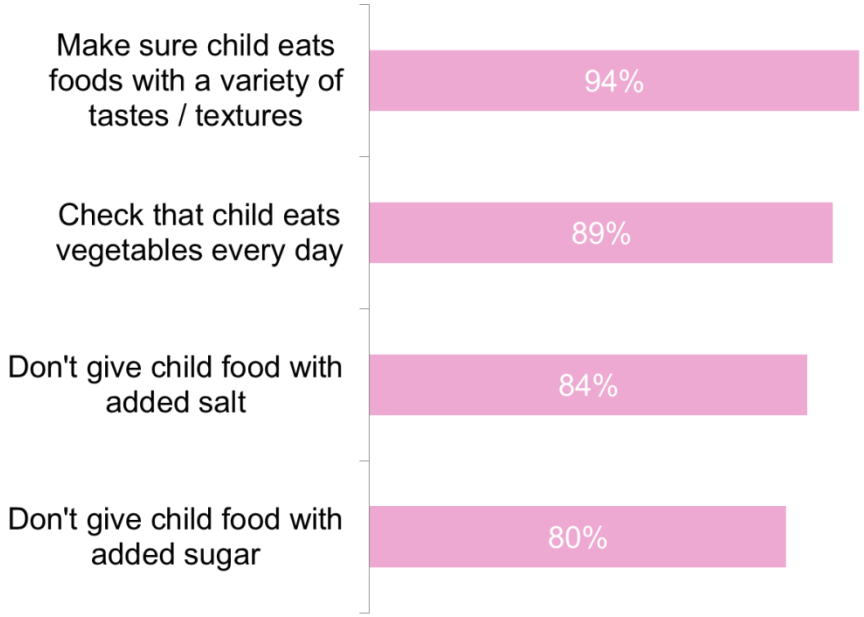
Younger women were less likely to agree that it is worth sticking with breastfeeding for as long as possible (73% under 30s v 82% 30+s). This may in part be linked to their increased likelihood of agreeing that they would feel uncomfortable breastfeeding out and about (55% under 30s v 44% 30+).

12.7.2 Child's nutrition

Following on from questions about their own nutrition, mothers of children aged four months or over were also asked a series of questions about the nutrition of their child. The Start 4Life guidelines state that establishing a healthy diet for babies from around the age of six months means they will eat well later on. They recommend giving babies different healthy foods, flavours and textures to encourage a healthy and varied diet from the start[74].

Those mothers of 0-2s who had already given their child solid foods were asked a series of questions about the things they do regarding their child's diet. In line with the Start4Life guidelines, almost all (94%) said they make sure their child eats foods with a variety of tastes and textures. The majority also said that they always or mostly make sure their child eats vegetables every day (89%) and avoid giving them food with added salt (84%) or added sugar (80%) (Figure 91).

Figure 91 **% who always/mostly do each for their child**



Base: All 2012 mothers of 0-2s who have given child solid food (451)

[74] http://www.nhs.uk/start4life/Pages/babies-food-variety.aspx

12.7.3 Attitudes towards child's nutrition

When asked how much they agreed or disagreed, the vast majority (95%) of all women agreed that *setting healthy eating habits when they are young will impact on their child's health later*.

Mothers of 0-2s were also asked how much they agreed or disagreed that *as long as a child is a healthy weight, parents needn't worry about what the child eats*. Eight in ten (80%) disagreed with this, suggesting that the majority of mothers place importance on other factors besides their child's weight.

There appears to be a link between mother's attitudes towards their child's nutrition and their own health behaviours. Those who ate 5+ portions of fruit/veg a day (99% v 93% fewer than 5 a day) and those who did 150+ active minutes (99% v 93% fewer than 150) were more likely to agree that *setting healthy eating habits when they are young will impact on their child's health later*. These same groups were also more likely to disagree that *as long as a child is a healthy weight, parents needn't worry about what the child eats*, as shown below*:*

- 89% of those who ate 5+ portions of fruit/veg v 78% who ate fewer than five
- 88% of those who did 150+ active minutes v 77% who did fewer than 150

ABC1 mothers were more likely to agree that *setting healthy eating habits when they are young will impact on their child's health later* (97% agreed v 93% C2DEs), and more likely to disagree that *as long as a child is a healthy weight, parents needn't worry about what the child eats* (87% v 74% C2DEs).

Two new questions were added at wave two to look at the perception mothers had of the weight of their child aged 0-2. When asked to think about the weight of their child at the moment the majority (89%) of mothers of 0-2s said they felt their child was a healthy weight. Just 1% of mothers of 0-2s thought their child was overweight and 8% underweight. Mothers who thought their child was either under or overweight were asked how worried they were about the effect of this on the child's health: around half (46%) were worried, although it should be noted that this was amongst a very small base (n=31) and so should be treated with caution.

12.8 Physical activity

As in the all adult survey the core measure of physical activity amongst mothers of 0-2s was whether they did fewer than150 minutes of moderate activity in the week prior to interview. The Start4Life guidelines around physical activity during pregnancy are not comparable with those of the wider adult population, so pregnant women were not asked about their current levels of physical activity in the same way. Instead, the survey looked on a more basic level at the types of physical activities they had participated in over the past seven days and at differences between their levels of physical activity before and during pregnancy (see 12.8.2).

12.8.1 Amount of exercise/type of exercise

As pregnant women were not asked about physical activity in relation to the 150+ weekly active minute guidelines, the only comparison that can be made here is between mothers of 0-2s and other women (taken from the all adult survey). Overall, mothers of 0-2s reported lower levels of physical activity than other women. Whilst almost eight in ten (79%) mothers of 0-2s reported doing fewer than 150 active minutes in the past seven days, this proportion fell to around half (55%) amongst other women.

When asked whether they intended to increase the amount of physical activity they do over the next three months two thirds (66%) of mothers of 0-2s said they intend to do so. A further 7% said they did not intend to do so because they already did enough exercise.

This compares to six in ten (61%) other women intending to increase their physical activity over the next three months, and almost one in five (17%) saying they did not need to because they were already active enough.

Increasing physical activity over the next three months had the highest reported intention rates amongst mothers of 0-2s; with 64% intending to eat a healthier diet, 29% of mothers who smoke intending to stop/cut down and 11% of mothers who drink alcohol intending to stop/cut down over the next three months. The same pattern was evident amongst other women, with 49% intending to eat a healthier diet, 26% who drink alcohol intending to stop/cut down and 24% who smoke intending to stop/cut down over the next three months.

Pregnant women were not asked about their intentions towards increasing physical activity over the next three months as it was not felt that this was relevant in relation the Start4Life guidelines, or in the context of the constraints that pregnancy may have on their abilities to be physically active. See section 12.4.6 for further discussion of intentions to change behaviours.

All women were asked about the types of activities they had done in the past seven days to the point of breathing faster than usual due to physical exertion. Pregnant women (93%) were more likely than mothers of 0-2s (88%) to say they had done any such activities. When looking at the individual types of activity mentioned, mothers of 0-2s were more likely than pregnant women to have participated in physical exercise of some sort (24% v 17%), dancing (18% v 6%) or heavy gardening (9% v 5%) in the past seven days.

12.8.2 Physical activity during pregnancy

All women were asked about their levels of physical activity during pregnancy. Pregnant women were asked to compare the amount of physical activity they do nowadays with the amount they did before they were pregnant; whilst mothers of 0-2s were asked to do the same with regards to during and before their pregnancy with the child they were talking about during the survey.

Around six in ten (58%) women said they were less active during pregnancy compared to pre-pregnancy. Around three in ten (28%) said they did the same amount of physical activity during their pregnancy as they had done beforehand.

Amongst pregnant women levels of physical activity appeared to reduce as pregnancy progressed. Those in their third trimester were significantly more likely to say that they did less exercise nowadays compared with before they were pregnant (71% v 55% in the first or second trimester); whilst those in their first or second trimester were significantly more likely to say they did about the same amount (33% v 20% in their third trimester). This is in line with the Start4Life guidelines which state that women should maintain similar levels of pre-pregnancy activity during their pregnancy to keep both them and their baby growing healthily, suggesting that walking for 150 minutes a week can help keep them and their growing baby healthy[75].

12.8.3 Attitudes towards physical activity

In terms of their attitudes towards physical activity, pregnant women (90%) and mothers of 0-2s (87%) were fairly similar, with the majority agreeing *there are plenty of ways that I could be physically active without having to go to the gym or take part in organised sport*. The responses from other women were similar (92% agreed).

[75] http://www.nhs.uk/start4life/Pages/walking-activity-during-pregnancy.aspx

12.8.4 Child's physical activity

Following on from questions about their own physical activity, mothers of children aged 4-24 months were asked a series of questions about their child's physical activity levels. The majority (81%) said they encourage their child to be physically active as part of a normal day; either by playing on the floor (if not walking) or being active for at least three hours a day (if walking). In addition, two thirds (63%) of mothers of children aged 4-24 months said they make sure their child is not sitting still for more than an hour at a time during the day, and ABC1 mothers were more likely to say this (68% v 58% C2DEs).

12.8.5 Smoking

As in the all adult survey, women were asked whether they smoke cigarettes nowadays. Overall, smoking prevalence was lower amongst pregnant women and mothers of 0-2s than amongst other women in the all adult survey: whilst three in ten (29%) other women were current smokers, this fell to two in ten (18%) amongst mothers of 0-2s and fewer than one in twenty (4%) amongst pregnant women.

The numbers of pregnant smokers and mothers of 0-2 who smoke were too small for separate analysis, so for the remainder of this section these two groups will be reported on together and referred to as 'women smokers'.

Women smokers tended to smoke less than other women (in the all adult survey): the mean average number of cigarettes smoked in an average day by women smokers was 8.7, compared with 11.8 amongst other women in the all adult survey.

Living with a smoker had the strongest association to smoking amongst women smokers – 61% of them said they lived with another smoker (v 21% of all women who were non-smokers). A similar pattern was seen amongst other women in the adult survey.

The vast majority (93%) of all women (including smokers and non-smokers) did not allow smoking in the house, even if children were not present; although this proportion fell significantly, to 77%, amongst women smokers. Overall, there were no significant differences in allowing smoking in the house between pregnant women (91%) and mothers of 0-2s (94%), but a significantly lower proportion of other women (77%) said they did not allow smoking in the house at all.

Likewise, the majority (91%) of all women (including smokers and non-smokers) said they did not allow smoking in the family car, even if children were not present; although this level fell significantly to 61% amongst women smokers. Overall, there were no significant differences between the proportions of pregnant women (90%), mothers of 0-2s (92%) and other women (87%) saying that they do not allow smoking in the family car at all.

12.8.6 Smoking and quit attempts during pregnancy

Twelve percent of all women reported having smoked during some/all of their pregnancy (the same proportion as reported by the 2010 Infant Feeding Survey[76]).

The Lifecourse Tracker survey showed that pregnancy acts as a trigger for quitting smoking, with almost seven in ten (69%) of those who smoked during their pregnancy having made at least one serious attempt to quit during their pregnancy. When asked about whether they had made any serious quit attempts in the past 12 months, half (50%) of other women said they had done so.

In around two thirds (62%) of serious quit attempts women (pregnant women and mothers of 0-2 who smoked) had used some sort of support in their efforts. The most common forms of support were nicotine replacement products, either on prescription/from a health professional (24%) or not (23%). One in five (20%) had also attended a special stop

[76] http://data.gov.uk/dataset/infant-feeding-survey-2010

smoking group/one-to-one service for pregnant women. In the majority (79%) of cases, they had been prompted to attempt to quit smoking due to concerns about the health of their baby. Just a third said they attempted to quit because of concerns for their own health (34%) or following advice from a midwife (33%).

Despite low bases, there is evidence that around half of mothers of 0-2s who gave up smoking during their pregnancy started smoking again within the first two years after the birth of their child.

12.8.7 Attitudes towards smoking

Seven in ten (70%) women (pregnant women and mothers of 0-2s) disagreed that *the health risks from smoking are greatly exaggerated*. Non-smokers (73%) were more likely than smokers (46%) to disagree. Perhaps linked to their lower smoking prevalence and heightened importance given to health during pregnancy, pregnant women and mothers of 0-2s (70%) were more likely to disagree than other women (62%).

Almost two in five (39%) women agreed that *fewer pregnant women smoke these days compared with five years ago*; though a similar proportion (43%) did not express an opinion and a fifth (19%) disagreed. There were no differences in levels of agreement between smokers (44%) and non-smokers (38%).

12.9 Alcohol

The Start4Life guidelines recommend that women cut out alcohol altogether during pregnancy. As a baby's liver does not fully develop until the last month of pregnancy, they warn that even a little alcohol can be damaging and that avoiding alcohol will help to ensure that the baby grows properly[77]. With this in mind pregnant women and mothers of 0-2s were not asked about alcohol consumption in the same ways as in the all adult survey. Instead, the key alcohol measure amongst women was whether they had drunk any alcohol in the past seven days.

Alcohol consumption levels tended to be very low amongst the women interviewed, with lower levels amongst pregnant women than mothers of 0-2s; in turn mothers of 0-2s presented lower levels of alcohol consumption than other women.

Less than one in ten (8%) pregnant women had drunk any alcohol in the past seven days, compared with 30% of mothers of 0-2s and 45% of other women. Around half (55%) of pregnant women said they never drink nowadays, and this compares with 28% of mothers of 0-2s and 18% of other women.

Because the numbers of pregnant women and mothers of 0-2s who were weekly drinkers was low, base sizes are too small for separate reporting. Instead they are reported on together and referred to as 'women drinkers'.

The majority of women drinkers (82%) summarised themselves to be light drinkers; with 53% describing themselves as 'a very light drinker'. Looking at this against reported consumption it appears that women had an accurate image of their drinking. Those women who had not drunk any alcohol in the past week (87%) were more likely to describe themselves as light drinkers than those who had drunk alcohol in the past week (72%).

In line with low levels of alcohol consumption amongst women, three in four (76%) said they did not intend to reduce the amount they drink – half (51%) because they felt they did not drink that much anyway. Intention to cut down on alcohol consumption was similar amongst other women (72% did not intend to - 36% because they felt they did not drink that much anyway).

[77] http://www.nhs.uk/start4life/Pages/alcohol-pregnant.aspx

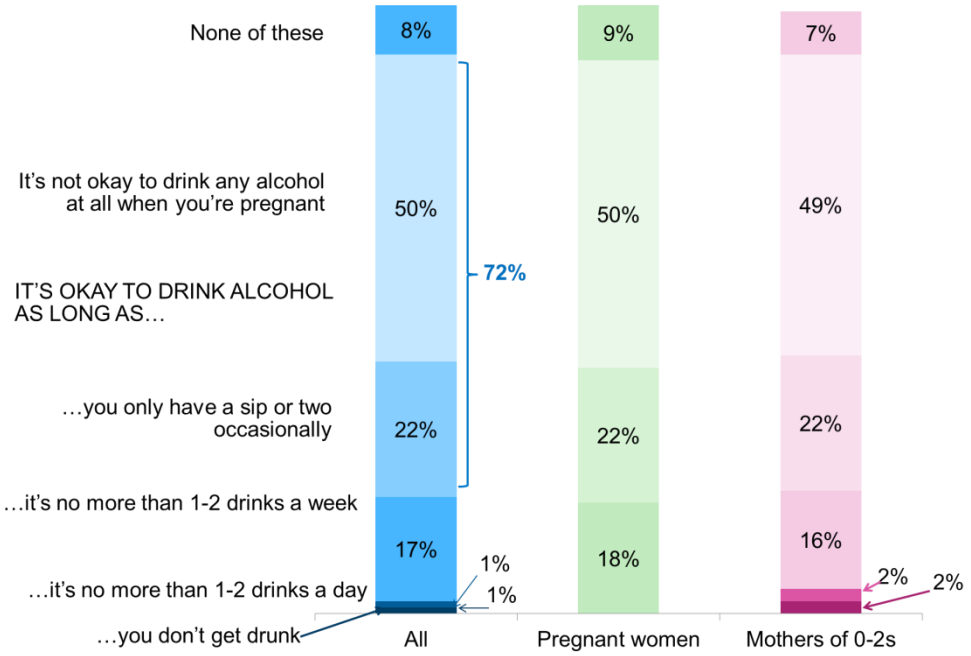
As discussed in section 12.4.3, pregnancy appears to act as a trigger for positive changes in the health behaviours of women. Two in five (41%) women said they had given up alcohol altogether when they found out they were pregnant. A further one in five (20%) said they had cut down on the amount they drank for some (2%) or all (18%) of their pregnancy, and a third (32%) said they did not drink alcohol at all at the time they found out they were pregnant. Those groups also more likely to say that they did not drink alcohol at all at the time they found out they were pregnant included:

- C2DEs (36% v 27% ABC1s)
- Those living in households in poverty (39% v 26% not)

The 2010 Infant Feeding Survey[78] reported a slightly higher proportion (49%) of women giving up drinking altogether during pregnancy and a much higher proportion (46%) cutting down on the amount they drank. It is worth noting here that this is set in a slightly different context, as the Infant Feeding Survey questionnaire asked women about their alcohol consumption in a lot more detail than the Lifecourse Tracker survey.

The Lifecourse Tracker survey also asked women for their thoughts about drinking alcohol when pregnant. They were presented with a scale of varying levels of drinking (from 'it's ok to drink alcohol as long as you don't get drunk' through to 'it's not okay to drink any alcohol at all when you're pregnant') and asked which best described their view. Most women (72%) thought that the maximum amount women should drink during pregnancy is a sip or two occasionally, with one in five (22%) saying an occasional sip or two was ok, and half (50%) that it was not okay to drink at all during pregnancy (Figure 92). Opinions were consistent between pregnant women and mothers of 0-2s.

Figure 92 **Thoughts about drinking when pregnant**



Base: All 2012 women (1144), All pregnant women (594), All mothers of 0-2s (550)

ABC1 women and mothers of one to two year olds were more likely to think that moderate drinking during pregnancy is okay:

- 1-2 drinks a week: 22% ABC1 women v 14% C2DE women and 21% mothers of one to two year olds v 12% mothers of under ones
- A sip or two occasionally: 27% ABC1 women v 18% C2DE women and 28% mothers of one to two year olds v 17% mothers of under ones

[78] http://data.gov.uk/dataset/infant-feeding-survey-2010

It is worth noting here that these groups were also more likely to report having drunk alcohol in the past seven days. ABC1 women overall were more likely to have drunk alcohol in the past seven days (25% v 15% C2DE women).

12.10 Pregnant women and mothers of 0-2s - summary

This section summarises the findings from the pregnant women and mothers of 0-2s survey.

Although both groups reported generally positive frames of mind, pregnant women report higher levels of well-being than mothers of 0-2s and other women on all of the key measures. In addition, pregnant women were more likely to report getting enough sleep to feel rested at least some of the time in the past four weeks. There were some apparent links between the amount of rest women were getting and how they felt generally, with those who felt rested at least some of the time in the past four weeks reporting significantly better well-being, better general health and lower prevalence of post-natal depression.

Most mothers of 0-2s indicated that they had good support networks of family/friends around them, living close enough and being able to see each other as often as they wanted. Parents, health visitors and friends were the most common sources of support for mothers of 0-2s, the majority of whom felt supported overall in their role as a parent. The impact of these support networks can be seen in that mothers of 0-2s who felt more supported were also more likely to report that they were coping well with parenthood.

Pregnancy appeared to act as a trigger for healthy behaviour changes – not only for women themselves, but also amongst other members of their households. Pregnant women were significantly less likely than mothers of 0-2s to report eating fewer than five portions of fruit/veg a day, less likely to have drunk alcohol in the past seven days and less likely to smoke. Amongst those who did report negative health behaviours, pregnant women generally stated stronger intentions to make healthy changes over the next three months. In addition, leading a healthy lifestyle was a higher priority for women during pregnancy and pregnant women were more likely to feel that achieving a healthy lifestyle would be easy and in their control.

The majority of mothers of 0-2s said they had breastfed/given breast milk to their baby, and the majority of pregnant women intended to do so. Around half of mothers of 0-2s had breastfed exclusively at six weeks or beyond. Women overall held positive attitudes towards breastfeeding – understanding the benefits of breast milk and recognising that it is better for a baby than formula milk. However, almost half of all women said they would feel uncomfortable breastfeeding “out and about”.

The majority of mothers of 0-2s had/intended to introduce solid foods into their baby’s diet before the age of six months. The majority of mothers who had already given their baby solid foods appeared to have picked up on the Start4Life guidelines around child nutrition – varying tastes and textures, including vegetables every day and avoiding salt and sugar.

Mothers of 0-2s were more likely than other women to say they had not been sufficiently physically active in the past week (doing fewer than 150 active minutes). A third of all women said they were as active during pregnancy as they had been before, but most said they were less active; with levels of physical activity reducing as pregnancy progressed.

Smoking prevalence and alcohol consumption were lower amongst pregnant women and mothers of 0-2s than other women – and lower amongst pregnant women than mothers of 0-2s.

13 Young people (11-17s)

13.1 Lifecourse tracker: young people survey

A bespoke survey of young people aged 11 to 17 was conducted to enable analysis of this group in more detail. Where possible, questions were kept the same as those used in the adult survey, although it was not appropriate for some behavioural measures. The survey method and the interviewing period were kept as similar as possible to the adult survey to maximise comparability.

A nationally representative sample of 11-17s in England[79] were interviewed at both waves one (spring 2012) and two (autumn 2012) of the survey. In order to track changes, the majority of the questions were kept the same at both waves. The survey method used was identical: the sample was selected using random location methods and interviews took place face-to-face in respondent's homes using Computer Aided Personal Interviewing (CAPI). Any sensitive questions were asked in a self-completion section of the questionnaire to elicit honest responses. The data was weighted to known estimates; further details of the survey method can be found in the appendices.

This chapter examines the lives of 11-17s in the round, including looking at the following:

- Perceptions of their own health and well-being, including how they feel about their family, school and teachers, what worries them, and whether they are getting enough sleep
- Conversations: whether young people feel they have people they can talk to, and prevalence and reasons for having conversations about health with parents
- Prevalence of negative health behaviours
- Norms around health behaviours and intentions to change, as well as general attitudes towards health
- Detailed information about health behaviours
    - Nutrition
    - Physical activity
    - Risk behaviours, including sexual intercourse, drug use, alcohol use and smoking

[79] Plus a boost of interviews in deprived areas – see section 15.3.3 for more details

13.1.1 Young people – core behavioural indicators

A range of health behaviours was measured and six core indicators were selected in conjunction with the young people's policy team.

Indicators represented **negative** health behaviours and are shown in Figure 93. They differed slightly from the adult indicators to reflect policy priorities:

Figure 93 **Behavioural indicators, young people survey**

Behaviour	Indicator
Nutrition	Ate fruit/veg (fruit, vegetables or salad - fresh, frozen, tinned, dried or juiced) less often than several times a day in a normal week
Physical activity	Did any moderate physical activity (physical activity that makes you breathe slightly faster than usual) on 0-6 days in the seven days prior to interview
Smoking	Currently smokes cigarettes (and this may be less than once a week). Described as 'youth smokers' in this chapter
Alcohol consumption	Usually drinks at least monthly. Described as 'monthly drinkers' in this section
	Had first proper alcoholic drink (not just a sip) before 15
Drug use	Used cannabis, ecstasy or cocaine in past 12 months
Sexual intercourse	Ever had sexual intercourse
	First had intercourse before 15

These indicators were self-reported, i.e. based on respondents' reports of their own behaviour.

13.2 Young people's lives

A range of questions in the Lifecourse Tracker young people survey explored how young people felt about themselves, their family life and their school life. Generally, young people said that they feel happy and healthy although some groups, such as those who reported risk behaviours and girls aged 13+, were less positive. Whilst most were generally positive, many had specific worries and these mainly related to pressures at school.

13.2.1 How young people are feeling

Young people were asked about how they feel through a series of statements in the questionnaire. Nearly all young people said that they feel very or quite happy (97%) with 56% saying that they feel very happy.

The majority of young people agreed that they feel good about themselves (86%) and most said that their health is very good or good (80%). Seven in ten (68%) said that they remain calm when facing difficulties. A lower proportion (though still a majority) agreed that they like to take risks (63%).

Young people who reported risk behaviours (those classified as youth smokers, monthly drinkers or who had used drugs in the past year or ever had intercourse) tended to be less positive than young people not reporting these risk behaviours. Youth smokers tended to be less positive about ALL of these things. Likewise, young people who lived with a smoker, heavy drinker or drug user and those who get less sleep (defined as not getting 8+ hours sleep every/most nights) reported less positive outlooks on average. Figure 94 summarises these findings.

Figure 94 **How 11-17s feel (1)**

	All 11-17s (1210) %	Youth smokers (103) %	Monthly drinkers (214) %	Used drugs past year (93) %	Ever had inter-course (130) %	Live with a negative household influence[80] (597) %	Do not get 8+ hrs. sleep every/most nights (470) %
Feel very happy with their life today	56	44↓	49↓	42↓	46	55	46
Agree they feel good about themselves	86	82↓	82↓	84	84	83↓	83↓
Feel their health in general is very good or good	80	64↓	78	72↓	69↓	77↓	78↓
Agree that they can remain calm when facing difficulties	68	47↓	63	67	62	64↓	63↓
Agree that they like to take risks	63	74↑	70	82↑	78↑	63	69

Base: All 2012 11-17 year olds in each group: as shown
↑↓ Indicated significant differences between corresponding sub-groups (e.g. comparing youth smokers with non-smokers)

Social grade differences were also evident. Those in C1C2DE households were less positive than those in AB households. For example, they were less likely to say that:

- Their health is very good or good (79% C1C2DEs v 87% of those in AB households)
- Agree that they can remain calm when facing difficulties (66% C1C2DEs v 78% of those in AB households)

[80] A smoker, heavy drinker and/or drug user, as reported by the young person

The survey also aimed to understand young people's levels of confidence and self-esteem. A fifth of 11-17s said they always feel confident in themselves (22%) and a similar proportion said that they never feel low (23%). Three in ten said they never feel left out (32%). Girls aged 13-17 were less likely to be positive about these aspects of mental well-being compared with other young people (Figure 95).

Figure 95 **How 11-17s feel (2)**

	All 11-17s (1210) %	13 – 17 girls (418) %	11-17 boys / 11-12 girls (792) %
Always feel confident in yourself	22	13↓	27
Never feel low	23	15↓	27
Never feel left out of things	32	19↓	39

Base: All 2012 11-17 year olds using standard self-completion: as shown
↑↓ Indicates a significant difference between groups

Young people who reported that they smoked or were monthly drinkers were less likely to say that they *never* feel low (15% of monthly drinkers v 25% of other young people, and 15% of youth smokers v 23% of non-smokers).

13.2.2 Sleep

Just over half (55%) of young people reported that they get 8+ hours of sleep every/most nights in a week. The oldest age group were the least likely to say they got 8+ hours sleep every/most nights (44% 15-17s, 58% 13-14s, 71% 11-12s). As reported in Figure 94, getting sufficient sleep appears to be associated with measures of mental well-being. Furthermore, there are a number of positive associations between getting sufficient sleep and positive health behaviours amongst young people such as consuming fruit/veg more than once a day or drinking less frequently than once a month. It is noted that 15-17s were the least likely to report 8+ hours sleep every/most nights, and were also more likely to report many negative health behaviours. However, the positive associations between sleep and health behaviours/outcomes are still evident, even when age is taken into account. Figure 96 summarises these findings – the figures are based on 15-17s only to control for age biases.

Figure 96 **Level of sleep by reporting of health behaviours and other outcomes**

	Base	%	% of 15-17s reporting that they get 8+hrs of sleep every / most nights
All 15-17s	(436)	%	44%
Consume fruit/veg once a day or less frequently			
No	(103)	%	56↑
Yes	(330)	%	40
Youth smoker			
No	(357)	%	47↑
Yes	(76)*	%	28
Monthly drinkers			
No	(274)	%	51↑
Yes	(159)	%	34
Used cannabis, cocaine or ecstasy in last 12 months			
No	(365)	%	47↑
Yes	(68)*	%	27
Ever had intercourse			
No	(315)	%	48↑
Yes	(118)	%	35
Self-reported health			
Good/very good	(337)	%	46↑
Fair/bad/very bad	(96)*	%	34
Obey family rules			
Agree	(244)	%	51↑
Not agree	(102)	%	34

Base: All 2012 15-17 year olds using standard self-completion: as shown
↑↓ Indicates a significant difference between corresponding sub-groups. *Caution: low bases
NB: Table shows horizontal percentages

Given that those who report negative health behaviours/outcomes are generally less positive and tend to get less sleep, on average, it does appear that these three things are linked.

13.2.3 Attitudes towards family

The Lifecourse Tracker survey explored young people's attitudes towards their family life; most young people agreed that they really enjoy spending time with their family (83%) whilst six in ten (60%) agreed that they always obey the rules in their family (Figure 97). Enjoyment of family life varied with age whilst obeying family rules varied by social grade of household:

- 15-17s were less inclined to say that they really enjoy spending time with their family (92% of 11-12s agreed compared with 83% of 13-14s and 76% of 15-17s). There were no differences in the proportions agreeing that they enjoy spending time with their family by social grade
- Young people in ABC1 households were more likely to say that they obey the rules in their family (65% agreed v 56% of those in C2DE households). There were no differences by age on this measure

Figure 97 **Attitudes towards family**

	I really enjoy spending time with the family All (1197) %	I always obey the rules in this family All (1197) %
Agree	83	60
Neither agree nor disagree	8	15
Disagree	8	21

Base: All 2012 11-17 year olds using standard self-completion: as shown

Those reporting risk behaviours (monthly drinkers, youth smokers or those who have used drugs in the last year or ever had intercourse) were generally less likely to agree that they always obey family rules or that they enjoying spending time with their family. These differences were evident within age group so this suggests that differences were driven by behaviour rather than age.

13.2.4 Attitudes towards school and teachers

Most young people interviewed in the survey attended school or college (96%). These young people were asked about their attitudes towards school and their teachers. The vast majority (91%) agreed that they feel safe in their school or college whilst a slightly lower proportion agreed that their teachers treat them fairly (77%) (Figure 98).

Figure 98 **Attitudes towards school/teachers**

	I feel safe in my school/college All (1173) %	Our teachers/tutors/ lecturers treat us fairly All (1173) %
Agree	91	77
Neither agree nor disagree	6	9
Disagree	4	14

Base: All 2012 11-17s who attend school or college: as shown

Youth smokers were more likely to feel negative about both of these things. They were less likely to agree they feel safe in their school (77% compared with 92% of non-smokers) and that their teachers treat them fairly (54% compared with 79% of non-smokers). Young people who have used cannabis, ecstasy or cocaine were also less likely to agree that their teachers treat them fairly (62% compared with 79% of non-drug users)

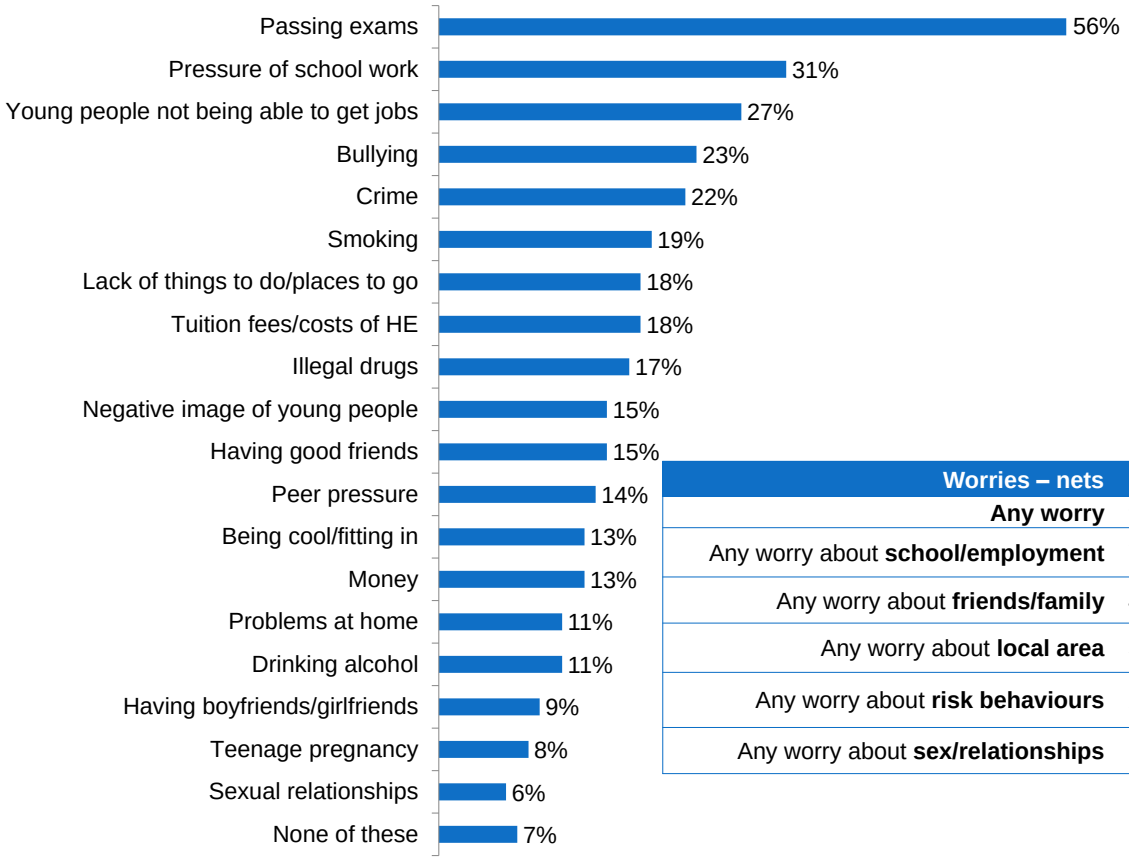
13.2.5 Young peoples' worries

The Lifecourse Tracker investigated specific issues that worried young people: they were prompted with a list of issues they might face and asked which worried them. They were also given an opportunity to tell the interviewer about anything else that worried them that did not appear on the list.

School-related worries were most commonly mentioned by young people. Over half of young people worried about passing exams (56%) - this had nearly twice as many mentions as the next most prevalent worry: 'the pressure of school work' (31%). A quarter (27%) of all young people said that the lack of availability of jobs for young people was a concern (Figure 99).

Overall, 73% of young people mentioned at least one worry related to school or employment, and 48% mentioned at least one worry related to friends or family. Worries about the local area (37%), risk behaviours (28%) and sex/relationships (18%) were also commonly mentioned.

Figure 99 **The issues that young people worry about**



Worries – nets	%
Any worry	91
Any worry about **school/employment**	73
Any worry about **friends/family**	48
Any worry about **local area**	37
Any worry about **risk behaviours**	28
Any worry about **sex/relationships**	18

Base: All 2012 11-17 year olds (1210)

For many issues, the level of worry varied by age. Bullying, for instance, was the most common worry for 11-12s, but it was the fourth most commonly mentioned issue amongst 13-14s, and did not feature at all in the top eight worries for 15-17s (Figure 100). Similarly, risk behaviours (smoking, drug use and drinking alcohol) were in the top eight worries for 11-12s but not for 15-17s, whose worries instead centred on school/education and employment issues.

Figure 100 **The top eight issues that young people worry about by age**

	Age				
	11-12 (377) %		13-14 (397) %		15-17 (436) %
Bullying	38	Passing exams	58	Passing exams	69
Passing exams	34	Pressure of school work	34	Young people not being able to get jobs	38
Smoking	30	Young people not being able to get jobs	26	Pressure of school work	37
Crime	26	Bullying	25	Tuition fees/costs of HE	25
Illegal drugs	23	Crime	25	Lack of things to do/places to go	22
Pressure of school work	19	Smoking	22	Negative image of young people	20
Drinking alcohol	18	Illegal drugs	20	Crime	19

Base: All 2012 11-17 year olds: as shown

There were also variations by social grade. Those living in ABC1 households were more likely to worry about school/ employment issues than those living in C2DE households (although this was still the top worry for both groups). Those living in C2DE households were more likely to worry about issues relating to risk behaviours and their local area than those living in ABC1 households (Figure 101).

Figure 101 **The issues that young people worry about by social grade**

Any worry about…	All (1210) %	ABC1 (490) %	C2DE (720) %
…school/employment	73	78↑	68
…friends/family	48	46	50
…local area	37	31	43↑
…risk behaviours	28	24	33↑
…sex/relationships	18	17	18
…any listed	**91**	**93**	**90**

Base: All 2012 11-17 year olds: as shown
↑↓ Indicates a significant difference, between corresponding sub-groups

13.2.6 Talking to adults: who young people feel comfortable talking to

The Public Health England marketing plan 2013 – 2014[81] states that the overall marketing objective for young people is:

> "to catalyse positive conversations about health between peers and between parents and their children"

In order to understand more fully the issues around conversations generally, the Lifecourse Tracker explored who young people would turn to about issues that concerned them.

Young people were asked to select, from a list of adults they may come in contact with, who they felt comfortable talking to about things that really bother them. Parents were most frequently mentioned: two thirds said mother/stepmother/father's partner (67%) and just under half said father/stepfather/mother's partner (46%). The figure for fathers rose to 53% for young people in two parent families (30% in single parent households). Other family members also ranked highly; around a quarter said they could talk to an older sibling (28%), grandparents (25%) or aunt/uncle (21%). Non-family members were also mentioned; most notably teachers (20%), adults in youth/sports/other clubs (8%) and religious/faith leaders (5%) (Figure 102).

Figure 102 **Adults that young people feel comfortable talking to about things that really bother them**

	All (1197) %	11-12 (370) %	15-17 (433) %
Mother/stepmother/father's partner	67	76↑	61
Father/stepfather/mother's partner	46	53↑	39
Older brother/sister	28	22	32↑
Grandmother/grandfather	25	27	21
Aunt or uncle	21	18	20
Teacher	20	25↑	17
Adult at youth / sports / other club	8	6	8
Religious or faith leader	5	4	6
Another adult	4	3	4
Friends	2	2	4
I don't have an adult I can talk to	4	1	6↑
Any family member	**86**	**91↑**	**81**
Any non-family member	**30**	**28**	**30**

Base: All 2012 11-17 year olds using standard self-completion: as shown
Don't know and prefer not to say not shown on table
↑↓ Indicates a significant differences between age groups

[81] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/186957/PHE_Marketing_Plan_2013-14_1651.pdf

Boys were more likely to say that they would feel comfortable speaking to their father (57% v 34% of girls). Boys and girls were equally likely to say that they would feel comfortable speaking to their mother.

With age, young people are less likely to rely on their parents to discuss issues that concern them. Figure 102 shows that 11-12s were more likely to say that they would feel comfortable speaking to their parents or teachers than 15-17s, whilst 15-17s were more likely to say they would speak to older siblings.

15-17s in C2DE households were less likely than other young people to say that they would feel comfortable talking to parents and teachers (although parents were still the most mentioned adults by all groups). In addition, this group were more likely than other young people to say they would feel comfortable talking to non-family members such as adults at youth clubs or religious leaders:

- mother/stepmother/father's partner: 52% v 72% of other age/social grades
- father/stepfather/mother's partner: 30% v 50% of other age/social grades
- teachers: 13% v 22% of other age/social grades
- adults at youth clubs: 13% v 7% of other age/social grades
- religious or faith leader: 8% v 4% of other age/social grades

Those aged 15-17 (6%) and living in single parent households (7%) were more likely to say that they did not have an adult that they can talk to (compared with 1% of 11-12s and 2% of those living in two parent households). Youth smokers (11%) and those who have had sexual intercourse (10%) were also more likely to say this (compared with 3% of non-smokers and 3% of those who have not had intercourse) – although this may be a function of age (i.e. older respondents were more likely to report these behaviours).

13.2.7 Self-harm

Other aspects of young people's lives were explored in the Lifecourse Tracker survey including whether they had self-harmed.

A fifth (21%) of young people said that they had, at some point, deliberately tried to hurt themselves in some way and 13% (of all young people) said that this was in the last 12 months. A further 9% said that they had not self-harmed but had seriously thought about doing so.

Those providing less positive responses on mental well-being questions, those who reported risk behaviours and also those who lived with a smoker, heavy drinker or drug user were more likely to say that they had ever self-harmed. For example, the following groups were more likely to say this:

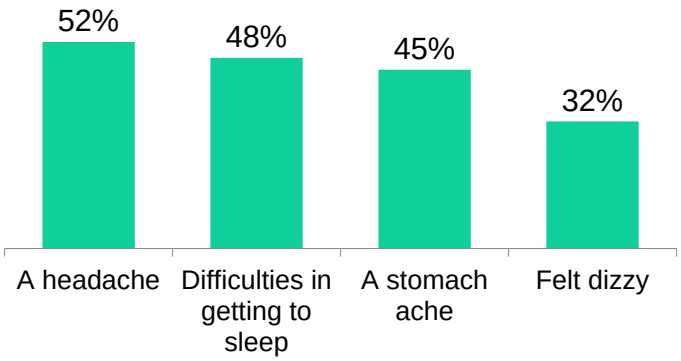
- Those who said they always/often feel low (54% v 16% of those who do not always/often feel low)
- Those who said they do not feel good about themselves (43% v 17% of others)
- Youth smokers (54% v 17% of non-smokers)
- Monthly drinkers (31% v 18% of non-drinkers)
- Those who live with someone who is a smoker/drinker/ drug user (31% compared with 11% of other households)

13.2.8 Health problems experienced in the last six months

Health Behaviour in School aged Children survey or HBSC[82] measures prevalence of certain health symptoms amongst young people as they 'present a non-clinical measure of mental health reflecting two facets of health, one psychological and one somatic'[83]. Wave 2 of the Lifecourse Tracker youth survey included a subset of these questions. These measured the occurrence of certain health symptoms in the past six months.

Around half of young people said that they had had a headache at least once a month (52%) and a similar proportion had had difficulties getting to sleep (48%) in the last 6 months. A slightly lower proportion said they had had a stomach ache (45%), whilst a third said they had felt dizzy (32%) at least monthly (Figure 103) in the last 6 months.

Figure 103 **% who have had the following at least once a month in the last six months**



Base: All Autumn 2012 11-17s using standard self-completion (600)
NB: Based on Autumn 2012 data only

Over half (54%) of young people reported having at least two of these problems once a month or more often in the past six months. Those providing less positive responses on mental well-being questions were more likely to report this, such as older girls and those who report risk behaviours. Groups more likely to report this included the following:

- Girls (66% compared with 43% boys) especially those aged 13+ (75%)
- Those who drink at least once a month (61% compared with 52% of those who do not drink that often)
- Youth smokers (75% compared with 52% of non-smokers)

Moreover, those providing less positive responses on mental well-being questions were much more likely to report that they had suffered from two or more symptoms at least monthly:

- Those who always/often feel low (89% compared to 49% of those who said sometimes or never)
- Those who disagree that they feel good about themselves (87% compared with 49% of those who do agree)

[82] http://www.hbsc.org/
[83] http://www.euro.who.int/__data/assets/pdf_file/0003/163857/Social-determinants-of-health-and-well-being-among-young-people.pdf

13.2.9 Weight and diet

Young people were asked about their weight in the Lifecourse Tracker survey. To measure this, self-perception of weight was collected to explore young people's view of body image (rather than collecting height and weight to derive a young person's BMI). The question was included in the self-completion section of the survey to encourage honest responses.

Perceptions varied; half said they thought they were about the right size (53%) whilst 33% thought they were too fat and 11% thought they were too thin (Figure 104).

Figure 104 **Perception of weight**

	All (1210) %
Too thin	11
About the right size	53
Too fat	33

Base: All 2012 young people 11-17: as shown

Evidence as to whether these perceptions reflect the true weight of the young person is mixed. The Health Survey for England estimates that 34% of 11-15s were overweight or obese[84] in 2010 – this is based on BMI derived from height and weight measurements. A similar proportion of 11-15s in the Lifecourse Tracker said that they thought they were too fat – 30%. Whilst it is hard to draw firm conclusions about the comparability of these two groups, the similarity of these figures suggests that young people's perceptions are in line with measured BMI estimates.

Despite this, diet and physical activity amongst 11-17s did not vary by perception of weight – one would expect that those who said they were too fat to report poorer diets or less physical activity. Instead, those who said they were too fat reported roughly equivalent diets and activity levels to those who said they were about the right weight or too thin (Figure 105).

Figure 105 **Perception of weight, by negative health behaviours**

	All (1210) %	Too thin (121) %	About right (652) %	Too fat (390) %
Consume fruit/veg once a day or less frequently	73	74	72	73
Daily consumption of fizzy drinks	42	40	39	46
Daily consumption of fatty foods	18	20	17	18
Daily consumption of sugary foods	39	44	38	39
Active less than 7 days a week	68	59	67	72
Monthly drinkers	23	23	17	32 ↑
Youth smoker	10	16↑	6	14 ↑
Used cannabis, ecstasy or cocaine in the last year	7	17↑	5	8
Breakfast not eaten every day	46	37↓	42	56

Base: All 2012 11-17 year olds: as shown
↑↓ Indicates a significant difference between too thin or too fat groups with about right group

[84] http://www.hscic.gov.uk/pubs/hse10trends23

Figure 105 also includes other negative behaviours: young people who thought they were too thin or too fat were more likely to report risky health behaviours than those who said they were about the right weight. For example, those who said they were too thin (16%) or too fat (14%) were more likely to be smokers than those who said they were about right (6%).

There was an association between more negative responses on mental well-being questions and the perception of being too fat:

- 60% of those saying that they always/often feel low said they felt too fat (v 29% of those who do not feel low always/often)
- 53% of those who do not feel good about themselves said they felt too fat (v 30% of those who feel good about themselves)

The associations between perception of weight, mental well-being and risk behaviours are all likely to be linked, given that those who reported risk behaviours were more likely to respond negatively to questions about mental well-being.

Other variations in perception were evident by gender and age, with 13-17 girls more likely to perceive themselves as too fat:

- 11-12s were more likely to say that they are too thin or about the right size (75% compared with 60% of 13-17 year olds)
- 13-17 year olds were more likely to say that they are too fat (37% compared with 21% of 11-12 year olds) and a disproportionate number of girls aged 13-17 thought they were too fat (48% compared with 25% of other age/gender groups)
- Boys were more likely to say that they think they are too thin or about the right size (74% compared with 53% of girls) and girls were more likely to say that they are too fat (42% compared with 24% of boys)

Young people were also asked whether they were on a diet in the self-completion section of the wave 2 survey. Half of those interviewed thought their weight was fine (51%). A quarter of 11-17s thought they should lose weight (but were not on a diet) (24%), whilst one in eight said they were on a diet or doing something else to lose weight (12%). Less than one in ten felt they need to put weight on (7%) (Figure 106).

Figure 106 **Dieting**

	All (600) %
Thought their weight is fine	51
Not on a diet but think they should lose some weight	24
On a diet or doing something else to lose weight	12
Thought they need to put some weight on	7

Base: All Autumn 2012 11-17s using standard self-completion: as shown
NB: Based on Autumn 2012 data only

Patterns observed were similar to those found in relation to perception of weight. Older girls and those who had a more negative outlook were more likely to say that they were on a diet (these points are likely to be linked as girls in this age group tended to have a slightly more negative outlook). The following groups were more likely to say they were on diet or doing something to lose weight

- 13-17 girls (16% v 7% of 13-17 year old boys)
- Those saying that they always/often feel low (25% v 10% of those who do not feel low always/often)
- Those who do not feel good about themselves (27% v 9% of those who feel good about themselves)

Some variations by diet and activity levels were observed. Those who were not on a diet but thought they should lose weight were more likely to report negative behaviours relating to nutrition and activity than those who said their weight was fine:

- Active less than 7 days a week – 77% of those who said they should be on a diet said this compared with 62% of those who said their weight was fine
- Consume fruit and veg less often than several times a day - 82% of those who said they should be on a diet said this compared with 69% of those who said their weight is fine

13.3 Healthy eating and physical activity

The Lifecourse Tracker measured fruit and veg consumption and physical activity levels amongst young people.

The key indicators used for healthy eating and physical activity were different to those used in the adult survey - the questions were designed to be age appropriate for the 11-17 age bracket. These are described in more detail in this section.

13.3.1 Fruit and vegetable consumption – key indicator

The key indicator for healthy eating amongst young people in the Lifecourse tracker survey was the proportion of young people who said that they did not eat fruit, vegetables or salad several times a day in a normal week. A definition was provided which told the respondent to include fresh, frozen, tinned, dried or juiced fruit, vegetables or salad but not potatoes. Seven in ten (73%) 11-17s said that they did not eat fruit and veg several times a day.

A similar question is included on the Heath Behaviour in School aged Children (HBSC) survey[85], however, publicly available results from this survey splits out fruit consumption from vegetable consumption. Comparing consumption of fruit from HBSC with fruit **or** veg consumption from the Lifecourse Tracker, the Lifecourse Tracker figures are higher, as expected (Figure 107). However, the broad consumption patterns are similar between the two surveys – girls are more likely to eat fruit (HBSC) / fruit or veg (LCT) daily than boys, and consumption decreases amongst girls between the ages of 11 and 15 but it does not decline amongst boys.

Figure 107 **Comparing survey estimates for fruit/veg consumption**

	HBSC[86] - daily fruit consumption	Lifecourse Tracker - daily fruit and veg consumption
11 year old girls %	46	64
11 year old boys %	34	47
15 year old girls %	40	54
15 year old boys %	33	46

Base: Lifecourse tracker: all 2012 11 and 15 year olds (336); 11 year old girls (76); 11 year old boys (104); 15 year old girls (79); 15 year old boys (77)
NB: Table shows horizontal percentages

In terms of the key indicator used for nutrition in the Lifecourse Tracker survey (not eating fruit and vegetables several times a day) the following groups were more likely to report this:

- Those living in C2DE households (77% compared with 64% of young people in AB households)

[85] http://www.hbsc.org/publications/international/
[86] http://www.euro.who.int/__data/assets/pdf_file/0003/163857/Social-determinants-of-health-and-well-being-among-young-people.pdf

- In particular, 15-17 years olds in C2DE households (80% compared with a 73% average)
- Young people who do not get 8+ hours of sleep every/most nights (79% compared with 67% who get 8+ hours sleep every/most nights)

Fruit and veg consumption does not appear to be associated with prevalence of risk behaviours such as smoking, drinking alcohol etc. in young people.

13.3.2 Prevalence of other healthy eating measures

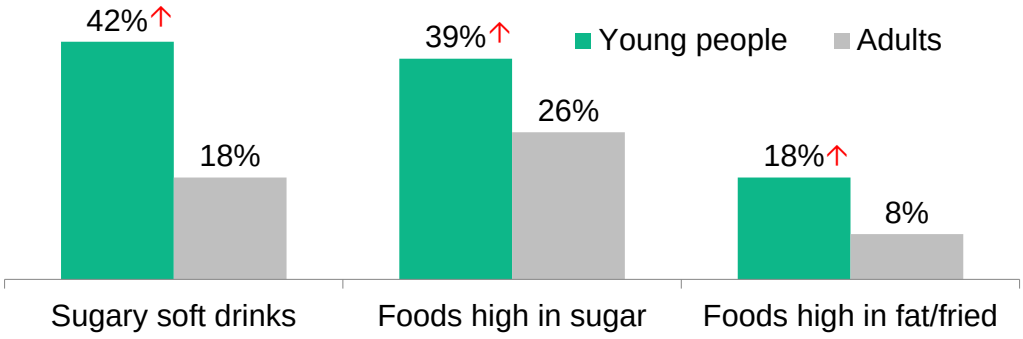
Consumption levels of other types of food and drink were also measured. All young people were asked how often they eat each of the following types of food in a normal week:

- Foods that are high in sugar, such as cakes, puddings, pastries or biscuits, sweets or chocolate
- Foods that are high in fat or fried foods such as fried fish, chips, cooked breakfast, samosa, crisps or fatty meats, but not including oven chips
- Fizzy drinks or soft drinks like squash – not including diet or sugar free drinks, or sparkling water

Four in ten young people reported that they consume sugary soft drinks on a daily basis (42%) and a similar proportion said they consume high foods high in sugar daily (39%). A fifth said they consume high fat/fried foods daily (18%) (Figure 108).

Comparing these results with the adult survey, daily consumption levels for each of these food types/drinks were higher amongst 11-17s compared with 18+s: the proportions of young people saying they were daily consumers of sugary soft drinks and/or high fat/fried food were double those reported by adults.

Figure 108 **Daily consumption of various types of food/drinks compared with adults**



Base: All 2012 11-17s (1210), All 2012 adults (2029)
↑↓ Indicates a significant difference between groups

Young people in C2DE households were more likely to say that they consumed high fat/fried foods daily (23% v 13% young people in ABC1 households), and sugary soft drinks daily (48% v 35% young people in ABC1 households). There were no social grade differences for consumption of foods high in sugar. There were no notable differences in the proportions saying they are daily consumers by age or gender.

13.3.3 Meal routines

The literature[87] indicates some links between family mealtime routines and resilience amongst young people, and this issue was investigated in the Lifecourse Tracker, with a focus on eating breakfast, and eating regular meals with parents or carers.

Half of young people reported that, in a usual week, they had had **breakfast** every day (54%). This was defined as more than a glass of milk or fruit juice.

A similar proportion (50%) reported that they eat an **evening meal with parents or carers** every day in a usual week. An evening meal was defined as a meal in which the young person sits and talks rather than watches the TV while eating.

Girls, older respondents and those living in C2DE households were less likely to say that they eat breakfast daily (Figure 109). Young people aged 15-17 in C2DE households were particularly unlikely to say they eat breakfast daily (33% compared with 60% of all other young people).

Boys were less likely to say that they eat an evening meal with their parents every day in a usual week. Whilst there were no social grade differences in levels of daily consumption of an evening meal with parents/carers, looking across the full scale of responses, young people in ABC1 households tended to have more evening meals with parents/carers in a usual week than those in C2DE households (5.1 days a week on average compared with 4.5 days a week for those living in C2DE households).

Figure 109 **Meal routines**

		Gender		Age		Live in... household	
	All (1210) %	Boys (607) %	Girls (603) %	11-12 (377) %	13-17 (833) %	ABC1 (490) %	C2DE (720) %
Consume breakfast **every day** in a usual week	54	58	50↓	71	47↓	63	46↓
Consume an evening meal with parents **every day** in a usual week	50	45↓	55	52	49	53	47

Base: All 2012 11-17s: as shown
↑↓ Indicates a significant difference between corresponding sub-groups

[87] For example, Williams LK, Veitch J and Ball K, What helps children eat well? A qualitative exploration of resilience among disadvantaged families, Health Educ. Res. (2011) 26 (2): 296-307

The data indicate that those reporting negative health behaviours, such as eating fruit/veg once a day or less frequently and youth smokers, were less likely to eat breakfast or consume a family meal every day (Figure 110). Figures are shown amongst 15-17s only to control for age differences in the data.

Figure 110 **Daily consumption of breakfast / evening family meal by health behaviours amongst 15-17s**

	Base	%	15-17s reporting that they…	
			… consume breakfast daily	… consume an evening family meal daily
All 15-17s	(436)	%	47	49
Consume fruit/veg once a day or less frequently				
No	(103)	%	65	61
Yes	(333)	%	41↓	45↓
Youth smoker				
No	(358)	%	50	52
Yes	(78)*	%	31↓	35↓
Monthly drinkers				
No	(277)	%	47	53
Yes	(159)	%	46	43
Used cannabis, cocaine or ecstasy in last 12 months				
No	(382)	%	48	50
Yes	(54)*	%	41	37
Ever had intercourse				
No	(318)	%	50	53
Yes	(118)	%	39	38↓

Base: All 2012 15-17 year olds using standard self-completion: as shown
↑↓ Indicates a significant difference between groups *Caution: low bases
NB: Table shows horizontal percentages

13.3.4 Physical activity – key indicator

The key indicator used to measure levels of physical activity was the proportion of young people who said that they were *not* at least moderately active every day in the last week. Moderate physical activity was defined as activity that at least makes the young person breathe slightly faster than usual. Two thirds (67%) reported that that were not physically active every day over the last seven days. Older girls were more likely to say this (77% of girls aged 13-17 said this compared with 61% of other age/gender groups).

The mean average number of days in which young people had done moderate physical activity in the last week was 4.6.

Physical activity did not appear to be associated with risk behaviours such as smoking and drinking alcohol. For example, youth smokers were no less likely to be active every day than non-smokers.

13.4 Risk behaviours – prevalence of key indicators

A number of measures were chosen as key indicators for risk behaviour prevalence amongst young people (Figure 111). These were developed in conjunction with the Department of Health and relevant policy teams; they were different to key indicators used in the adult survey because the questions used were designed to be age-appropriate for 11-17 year olds.

A quarter (23%) of 11-17s said they drink alcohol at least monthly, and 14% said they had ever had sexual intercourse. Less than one in ten were current smokers or had used cannabis, ecstasy or cocaine in the past 12 months.

Figure 111 **Risk behaviours - key indicators, young people survey**

Behaviour	Indicator	Prevalence
Alcohol consumption	Usually drinks at least monthly. Described as 'monthly drinkers'	23
	Age of first proper alcoholic drink (not just a sip) before 15	37*
Sexual intercourse	Ever had sexual intercourse	14
	Age of first intercourse before 15	7*
Smoking	Currently smokes cigarettes (and this may be less than once a week). Described as 'youth smokers'	9
Drug use	Used cannabis, ecstasy or cocaine in past 12 months	7

Base: All 2012 respondents (1210) *amongst 15-17s only (436)

Comparisons with other estimates are shown in Figure 112 – these other estimates are similar to those used in Lifecourse tracker but not the same, and this should be considered when making comparisons (as well as the methodological differences between the surveys).

Figure 112 **Comparing risk behaviour prevalence estimates: Lifecourse Tracker and other surveys**

Behaviour	Comparison with other surveys
Alcohol consumption	The 2012 SDD [88] survey reports that 6% of 11-15s usually drink once a week. Amongst 11-15s interviewed in the Lifecourse Tracker survey 5% said they drink once a week or more often
Sexual intercourse	Natsal (from 2000)[89] estimated that 30% of males and 26% of females aged 16-19 said that they had had sex before 16. Although this measure cannot be exactly replicated in the Lifecourse Tracker, looking at 16 year olds **only**: 30% of both males and females said that they had ever had intercourse
Smoking	The SDD survey reports that 5% of 11-15s smoked at least one cigarette a week, and the equivalent proportion amongst 11-15s interviewed in the Lifecourse Tracker survey was 4%
Drug use	The proportion who said they had taken any drugs in the last year was 12% of 11-15s in the SDD survey. For Lifecourse Tracker, the equivalent figure was 6% of all 11-15s.

Base: All 2012 respondents (1210)

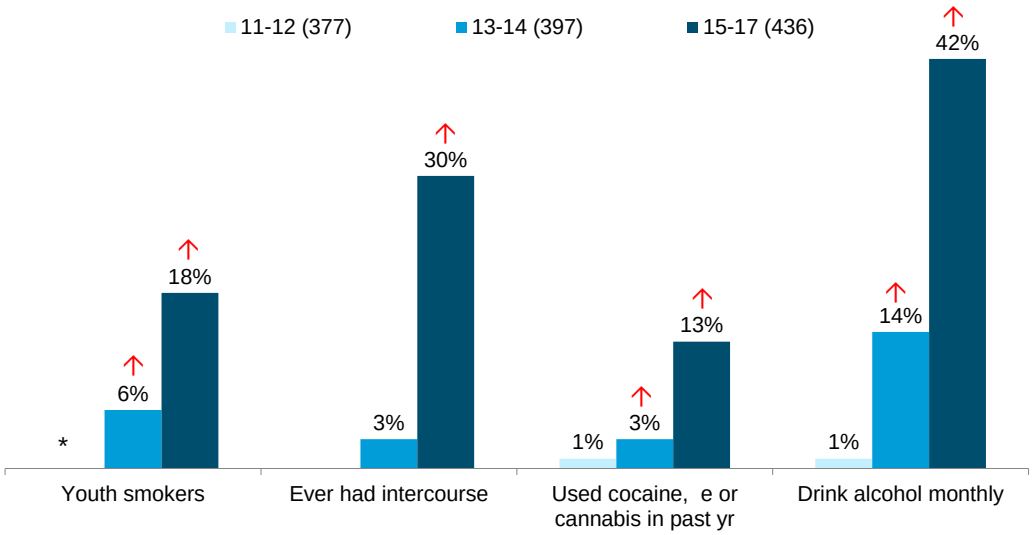
88 Smoking, drinking and Drug use among young people in England 2012: http://www.hscic.gov.uk/catalogue/PUB11334

89 http://www.fpa.org.uk/professionals/factsheets/sexualbehaviour

Patterns in response in the Lifecourse Tracker survey were similar to the other surveys shown above. There were strong variations in the prevalence of risk behaviours based on age; 15-17s were more likely than 11-14s to report each risk behaviour (Figure 113). While there was a jump in prevalence in the 15-17 age group for each behaviour, this was particularly marked for intercourse (a 27 percentage point increase from the 13-14 age group) and drinking alcohol monthly (a 28 percentage point increase).

It is notable that the proportions of 13-14s saying they had ever had intercourse or had used drugs in the past 12 months were very similar to those of 11-12s. While 13-14s were significantly more likely than 11-12s to say they smoked or drank monthly, their levels of reported behaviour were still significantly below those of 15-17s.

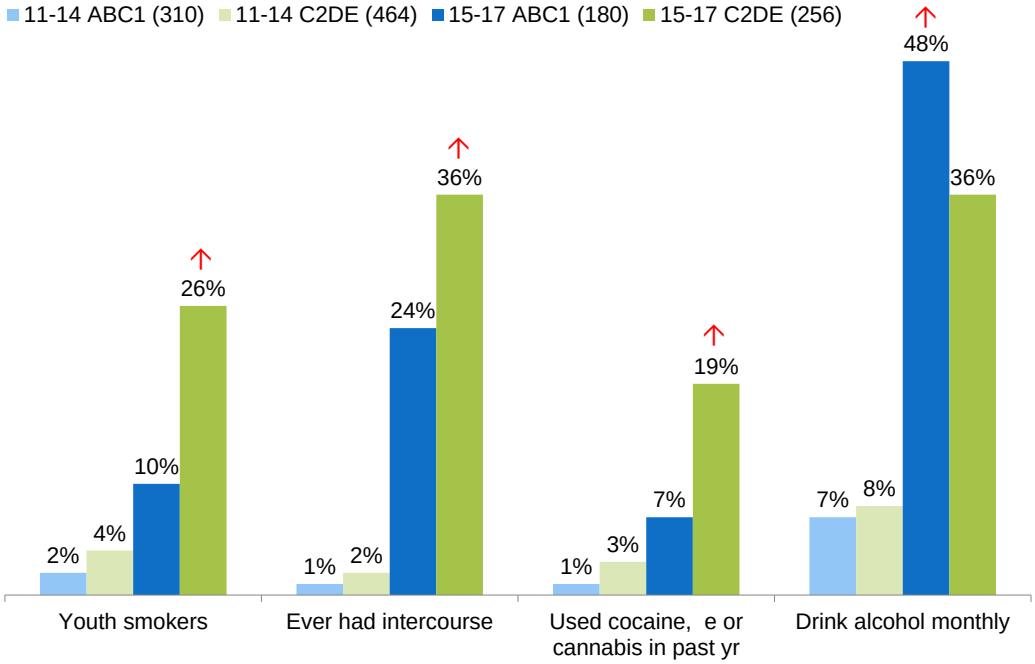
Figure 113 **Prevalence of key indicators for risk behaviours, by age**



Base: All 2012 11-17s in each group: as shown
↑↓ Indicates a significant difference between age groups * indicates less than one percent

Differences were more marked when socio-economic grade was taken into account: 15-17s living in C2DE households were more likely than their ABC1 counterparts to report that they are youth smokers, had ever had intercourse or used cocaine, ecstasy or cannabis in the past 12 months (Figure 114). The reverse was true for drinking: 15-17 ABC1s were more likely to be monthly drinkers (48% v 36% of 15-17 C2DE). There were no significant differences in prevalence by social grade amongst 11-14s.

Figure 114 **Prevalence of key indicators for risk behaviours, by social grade/age**



Base: All 2012 11-17s in each group: as shown
↑↓ Indicates a significant difference between social grade within age

Boys aged 15-17 were the most likely to report that they used cannabis, ecstasy or cocaine in the last year (17% v 8% of females aged 15-17). There were no other differences in the proportions reporting each risk behaviour by gender.

13.5 Risk behaviours – comparisons

The Lifecourse Tracker provides an opportunity to examine young people holistically, through comparisons across risk behaviours. This section, therefore, draws together common measures, relating to motivations and experiences, from the Tracker.

13.5.1 Age of first time experience

It is important to understand the age at which young people first adopt health behaviours. For instance, the white paper Smoking Kills[90] suggests that people who smoke from an earlier age are more likely to smoke for a longer period or die from smoking related diseases.

[90] http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4006684

The Lifecourse Tracker survey provides an overview of when risk behaviours were first experienced and adopted regularly. Around a third of 15-17s said they were aged 14 or younger when they first drunk a proper alcoholic drink (not just a sip) (37%) or smoked a cigarette (including just one puff) (31%). A quarter said the first time they got drunk was at age 14 or younger (24%, see Figure 115).

A minority of 15-17s said they started smoking cigarettes regularly or using cannabis at age 14 or younger (9% and 4% respectively) and 7% said that they first had intercourse at age 14 or younger.

Figure 115 **Age first experienced / started risk behaviours**

			Age 14 or younger
First drank alcohol (a whole drink, not just a sip)	15-17s, (436)	%	37
First smoked (including only one puff)	15-17s, (436)	%	31
First got drunk	All wave 2 15-17s, (223)	%	24
Started smoking regularly	15-17s, (436)	%	9
Started using cannabis	15-17s, (436)	%	4
First had intercourse	15-17s (436)	%	7

Base: All 2012 15-17s: as shown
NB: Table shows horizontal percentages

13.5.2 Perception of risk behaviours – perceived risks to health

Young people were asked about their perceptions of risks to their health from negative health behaviours. At least three quarters of 11-17s agreed that smoking (84%) and using cannabis (75%) are very bad for your health and eight in ten agreed that regularly drinking alcohol can slowly damage your body in ways that cannot be seen (80%) (Figure 116).

Comparing smoking and cannabis use, using the same question wording, smoking was most likely to be identified as a risk by young people. This was mirrored by the level of worry attached to each of these behaviours by adults in the adult survey (adults were more likely to worry about the impact of smoking on health than the use of drugs - see section 4.3 for more details).

Figure 116 **Perception of the health risks from negative health behaviours**

	All (1197) %
Agree that smoking is very bad for your health	84
Agree that regularly drinking alcohol can slowly damage your body in ways you cannot see and may not realise	80
Agree that using cannabis is very bad for your health	75

Base: All 2012 11-17s using standard self-completion: as shown

There were varying perceptions of risks by gender. Whilst boys were more likely than girls to agree that smoking is very bad for your health (87% v 80% girls), boys aged 15-17 were least likely to think that using cannabis is very bad for your health (59% v 79% of the rest of the sample).

Those reporting each risk behaviour were less likely to perceive it as bad for their health, for instance:

- Youth smokers were less likely to feel that the smoking is very bad for your health (75% v 84% of other young people)
- Cannabis users were less likely to agree that cannabis use is bad for your health (35% of those who have used cannabis in the last year compared with 78% of those who have not)

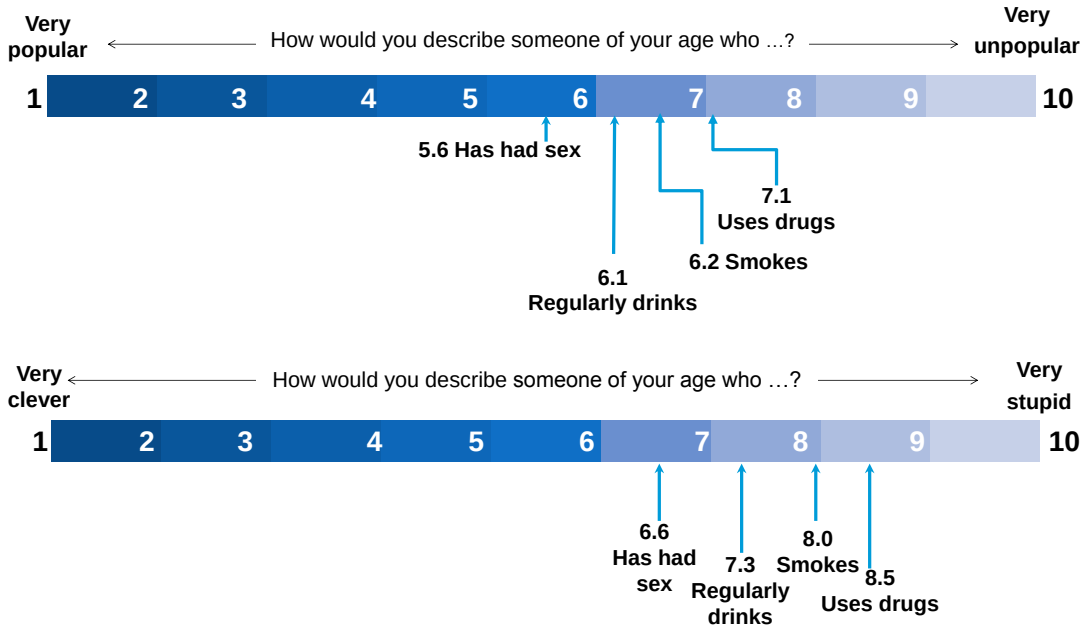
Linked to this, those living in C2DE households (a group who were also more likely to report using drugs) were also less likely to agree that cannabis is very bad for your health (70% v 79% of those who live in ABC1 households).

13.5.3 Perception of risk behaviours – 'brand image'

The Lifecourse Tracker youth survey investigated what young people thought about others who engaged in risk behaviours. This provides an indication of perceived 'brand image' of each behaviour and how they compare. The questions about each behaviour were spread throughout the questionnaire rather than being asked all in one section.

Using two scales: popular/unpopular and clever/stupid, young people rated others their age who participated in risk behaviours. Overall, drug users were perceived most negatively whilst young people who had had sex were perceived more positively (although still more negatively than positively on the overall scale) (Figure 117). For example, drug users were given a score of 7.1 on the popularity scale (where 1 is very popular and 10 is very unpopular) whilst those who had had sex were given a score of 5.6 on the same scale (Figure 117).

Figure 117 **Perception of peers engaging in risk behaviours**



Base: All 2012 young people using standard self-completion (1197) (Sex only: and answered questions about sex – see section 13.10 for definition) (931)

Young people who reported each risk behaviour were more likely to perceive others who engaged in that behaviour positively. Linked to this, groups with higher prevalence of risk behaviour were also more likely to be positive about others who did these things:

- 15-17s were more likely to be positive about all behaviours than 11-14s
- Those who lived in ABC1 households were more likely to perceive regular drinkers their age as positive

Boys were more likely to have a positive perception of those who had had sex than girls (though they were no more likely than girls to say that they had ever had sex).

13.5.4 Perception of risk behaviours - acceptability of risk behaviours

Young people were asked about their views on the acceptability of risk behaviours even with certain caveats (for example, it's okay to drink alcohol as long as you are not getting drunk all the time).

Generalising across behaviours, drug use was deemed to be less acceptable than drinking alcohol and having sex (Figure 118).

- Nearly eight in ten disagreed that it's okay to use drugs, so long as you're not doing it all the time (77%), and a slightly smaller proportion agreed that people should never use drugs (70%)
- Fewer agreed that young people aged under 18 should not drink any alcohol at all (44%), or disagreed that it's okay for people their age to drink alcohol, so long as they are not getting drunk (43%)
- Similar proportions (43%) of young people asked (see Figure 118 for base definition), disagreed that it's okay for people their age to have sex

Figure 118 **Acceptability of risk behaviours**

Drinking alcohol	All (1197) %	11- 12s (370) %	15-17s (433) %
Agree that young people aged under 18 should not drink any alcohol at all	44	64↑	32
Disagree that it's okay for people of my age to drink alcohol, so long as they are not getting drunk	43	73↑	25
Drug use	All (1197) %	11- 12s (370) %	15-17s (433) %
Disagree that it's okay to use drugs, so long as you are not doing it all the time	77	83↑	73
Agree that people should never use drugs	70	78↑	64
Sex	All (931) %	11- 12s (104) %	15-17s (433) %
Disagree that it's okay for people my age to have sex	43	97↑	60

Base: All 2012 young people using standard self-completion (1197) (Sex only: and answered questions about sex – see section 13.10 for definition) (931)
↑↓ Indicates significant difference between corresponding sub-groups

Because prevalence of risk behaviours varied strongly by age, analysis of perceived acceptability amongst young people reporting each risk behaviour was limited to the oldest age group (15-17s). Within the 15-17 age group those reporting each risk behaviour were more likely to think that each behaviour is acceptable than their counterparts not reporting risk behaviours. The following differences were observed:

- Monthly drinkers were more likely than average to feel drinking is acceptable (11% of monthly drinkers thought that young people aged under 18 should not drink any alcohol at all, and 14% disagreed that it's okay for people of my age to drink alcohol, so long as they are not getting drunk)
- 43% of cannabis, cocaine and ecstasy users disagreed that it is okay to use drugs (compared with 82% non-drug users); 40% of cannabis, cocaine and ecstasy users agreed that people should never use drugs (compared with 71% non-drug users and 69% of non-smokers)
- 5% of those who had had sex disagreed that it's okay for people my age to have sex (compared with 28% of those who had not had sex)

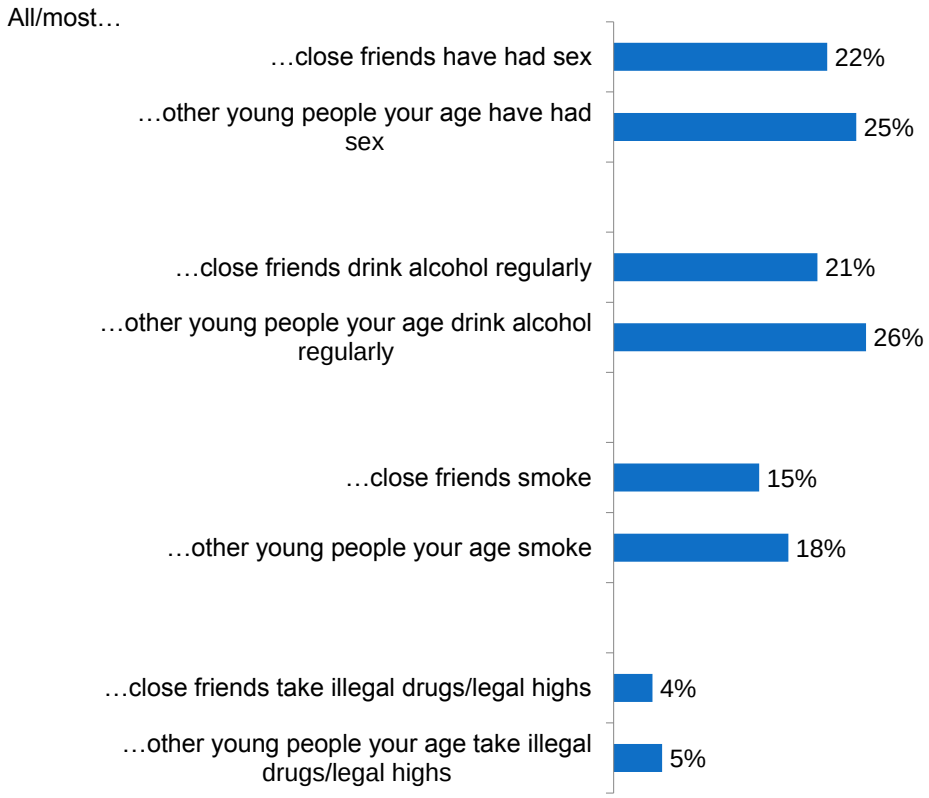
13.5.5 Perception of risk behaviours – norms amongst peers

Perceptions of behavioural prevalence amongst friends and the wider peer group provides a measure of behavioural norms. The Lifecourse Tracker survey asked 11-17s how many friends or young people their age were engaging in each risk behaviour, answering on a scale from 'all of them' to 'none'. These questions were spread throughout the questionnaire and sat within the relevant behavioural section of the questionnaire.

Having sex and drinking alcohol were perceived to be the most widespread behavioural norms. Over a fifth thought that all or most of their close friends or peers were having sex (22% close friends/ 25% other peers) or regularly drinking alcohol (21% / 26%). Fewer thought that all or most of their close friends or other peers smoked (15% / 18%) and only a small minority thought all or most of their close friends or other peers were using illegal drugs/legal highs (4% / 5%) (Figure 119).

For most behaviours, young people were somewhat more likely to think that their wider peer group had engaged in that behaviour, compared with their close friends. For example, while 21% of young people thought that all or most of their close friends drink alcohol regularly, 26% thought that all or most of other young people of their age (i.e. excluding their close friends) did so. While differences were not strong, they were consistent across all behaviours with the exception of drug use: perhaps linked to the fact that few young people thought that drug use was common.

Figure 119 **% who said all or most of their close friends / wider peer group had engaged in each behaviour**



Base: All 2012 11-17s using standard self-completion (1197) (Sex only: and answered questions about sex – see section 13.10 for definition) (931)

Looking within age groups, 15-17s were more likely than 11-14s to think that all/most close friends and peers were engaging in each behaviour; this is perhaps not surprising given that prevalence of these behaviours is higher amongst 15-17s.

If a young person reported a particular risk behaviour themselves, they were significantly more likely than non-reporters to say their close friends or other peers were engaging in that behaviour. This applies even when age is taken into account - Figure 120 only includes data for 15-17s to control for age related differences. The only behaviour for which the difference is not significant is drug use, and this may be related to the very low base size of young people who had used drugs in the past 12 months.

Figure 120 **% who said all / most of their close friends / wider peer group had engaged in each behaviour, by whether reported that behaviour or not (15-17s only)**

	Had sexual intercourse (118) %	Not had sexual intercourse (318) %
All/most…		
…close friends have **had sex**	68↑	23
…other young people your age have had sex	71↑	27
	Monthly drinkers (159) %	Not monthly drinkers (277) %
All/most…		
…close friends **drink alcohol** regularly	59↑	24
…other young people your age **drink alcohol** regularly	62↑	38
	Youth/former smoker (118) %	Non youth /former smoker (318) %
All/most…		
…close friends **smoke**	62↑	13
…other young people your age **smoke**	55↑	19
	Used cannabis/ecstasy/ cocaine in the last year* (54) %	Not used cannabis/ecstasy/ cocaine in the last year (382) %
All/most…		
…close friends take illegal **drugs**/legal highs	27	3
…other young people your age take illegal **drugs**/legal highs	23	6

Base: All 2012 young aged 15-17: as shown
*Caution small base size – figures should be treated with caution
↑↓ Indicates significant difference, between corresponding sub-groups

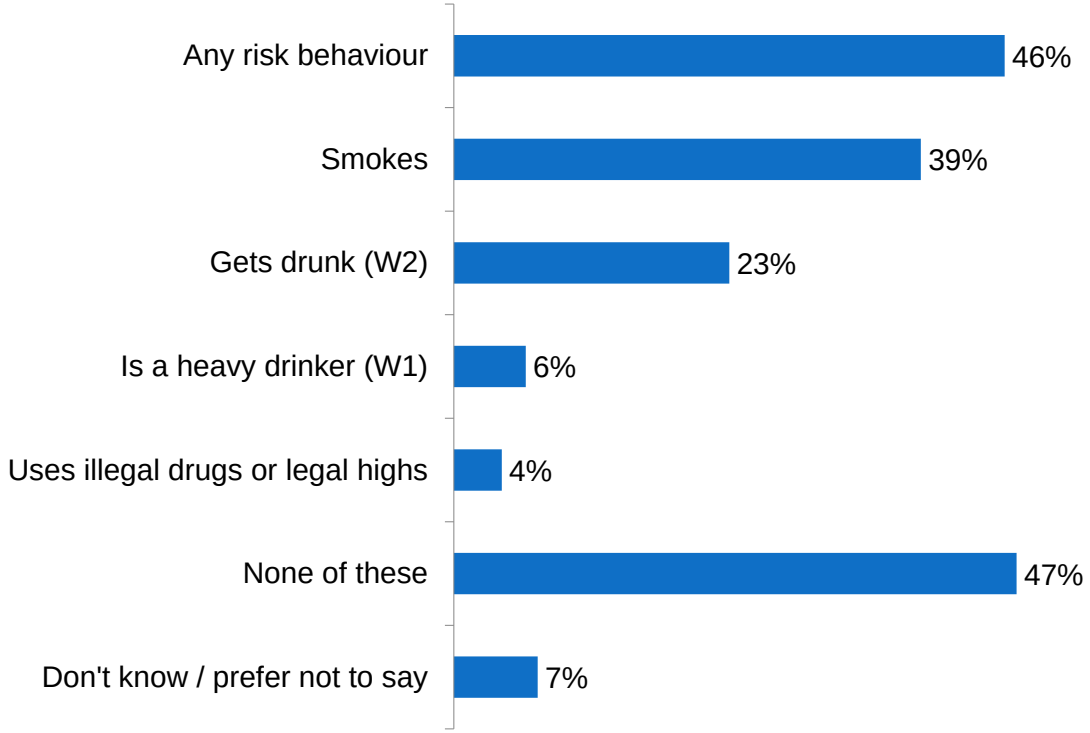
13.5.6 Household norms / influences

In addition to measuring norms amongst peers, the Lifecourse Tracker included questions to estimate household behavioural norms.

Almost half of young people (46%) said that they live with someone who they think smokes, gets drunk[91] and/or uses illegal drugs or legal highs (Figure 121).

Smoking was the most common risk behaviour noted with four in ten young people reporting that someone in their household smoked (39%). Nearly a quarter said that someone else in their household gets drunk (23%) whilst 4% said someone in their household uses illegal drugs or legal highs (Figure 121).

Figure 121 **Behaviours of others in the household**



Base: All 2012 young people (1210) except for: 'gets drunk' – Autumn 2012 data only (608) and 'is a heavy drinker' – Spring 2012 data only (602)

If a young person reported a risk behaviour themselves they were more likely to say that they live with someone who also does that particular behaviour. For example, 64% of youth smokers said they live with a smoker compared with 36% of non-smokers.

[91] At wave two the wording was changed to 'gets drunk' from 'is a heavy drinker'; this was because it was felt that heavy drinking was too hidden and 'getting drunk' would be more likely to be reported

13.6 Conversations and risk behaviours

The Lifecourse Tracker explores young people's experiences of conversations and information provision concerning risk behaviours, both in the home and school setting.

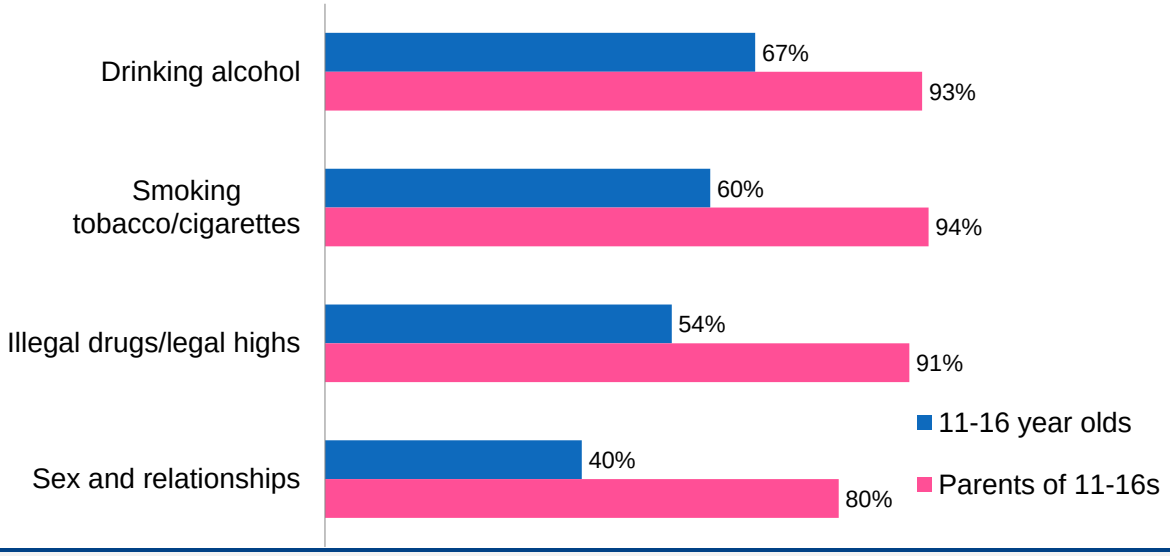
13.6.1 Ease of parental conversations about risk behaviours

Questions about parental conversations were asked of young people aged 11-16 in the youth survey, and of parents of 11-16s in the adult survey. All were asked how easy they thought it would be to talk to their parent/child about each risk behaviour: the question was asked irrespective of whether or not they had already had a conversation about each behaviour.

For both parents and young people, drinking alcohol was the behaviour most likely to be considered easy to discuss, whilst sex and relationships was least likely to be considered easy (Figure 122).

Parents were more likely than young people to say that they think that conversations would be easy. For example, nine in ten parents said they would find conversations about drinking alcohol easy (93%) compared with 67% of 11-16s. The greatest difference between parents and young people was for sex and relationships – nearly twice as many parents said they would find it easy as young people (80% of parents compared with 40% of 11-16s).

Figure 122 **% who thought it would be easy to talk about each of these topics with their parent/child**



Base: All 2012 11-16s using standard self-completion (1073) / Base: All Autumn 2012 parents of child aged 11-16 (89)
NB: Parents figures based on Autumn 2012 data only

While 15-16s were more likely than their younger counterparts to think that conversations about drinking alcohol were easy (74% compared with 60% of 11-12s), there were no other age differences in perceived ease of conversations.

Perceptions of how easy or difficult questions would be were also related to whether a conversation had happened or not. Young people who had had a conversation about a particular risk behaviour were more likely than those who had not to say that they thought those conversations were/would be easy. This applied to all risk behaviours measured. For example, 11-16s who said that they had had a conversation about sex and relationships were more likely to say that conversations with parents on this topic were easy (60% compared with 23% of those who had not had a conversation on this subject).

13.6.2 Prevalence of parental conversations about risk behaviours

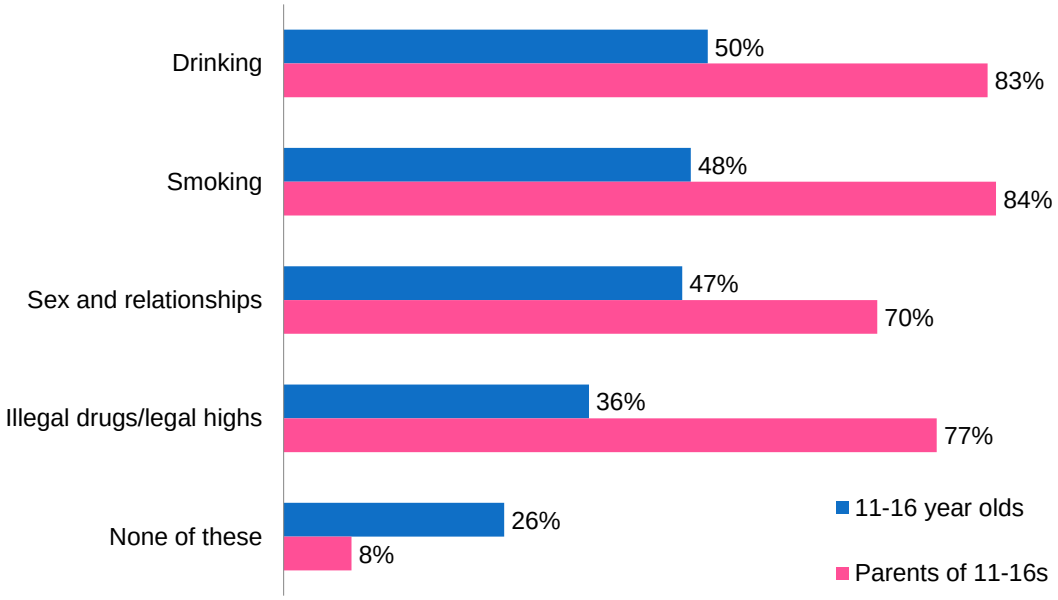
Young people were asked whether they had ever discussed risk behaviours with their parents, and a similar question was posed to parents in the adult survey (about their child aged 11-16). Shown a list of risk behaviours, the young person /parents in the adult survey were asked which ones they had talked to their parents/child about.

Figure 123 compares responses from 11-16s in the young people's survey and from parents of 11-16s in the adult survey.

Parents were more likely than 11-16s to say that conversations about risk behaviours had occurred. The largest mismatch in reporting was for conversations about illegal drugs/legal highs – 77% of parents reported that they had had a conversation about this with their child whilst only 36% of young people said that they had had a conversation about this with their parent. On average, the difference was 33 percentage points across all four behaviours demonstrating the large gap in recall between parents and children.

The most commonly discussed behaviours, according to both parents and young people, were drinking alcohol and smoking.

Figure 123 **% who had talked to their parent/child about each topic**



Base: All 2012 11-16s (1086) / All 2012 Parents of child aged 11-16 (210)

Amongst young people, 15-16s were more likely than younger respondents to say they have had conversations about each of the listed risk behaviours with their parents (Figure 124). Girls were more likely to report that they had had conversations about sex and relationships (54% v 41% of boys) and drinking alcohol (54% v 46% of boys) but boys and girls were equally likely to report conversations about smoking and drugs.

Figure 124 **% who had talked to their parent**

	Gender		Age	
	Boys (547) %	Girls (539) %	11-12 (377) %	15-16 (312) %
Drinking alcohol	46	54↑	30	67↑
Smoking tobacco	47	50	31	58↑
Sex and relationships	41	54↑	31	59↑
Illegal drugs/legal highs	33	38	23	46↑
None of these	29	23	42↑	15

Base: All 2012 11-16s: as shown
↑↓ Indicates a significant differences between groups

Behaviours within the household, seem to be associated with conversations about risk behaviours between parents and young people. For instance, young people reporting a risk behaviour were more likely to say that they have discussed that behaviour with their parents than other young people (figures shown in Figure 125 are only based on 15-17s data to account for variations in age).

Figure 125 **% who discussed each behaviour and whether reported that behaviour (15-17s only)**

	Youth smoker		Monthly drinker		Used cannabis, ecstasy or cocaine past 12 months	
	Yes	No	Yes	No	Yes	No
	(78) %	(358) %	(159) %	(277) %	(54) %	(382) %
Have discussed relevant behaviour with parent	80↑	56	84↑	53	80↑	42

Base: All 2012 15-17 year olds: as shown
↑↓ Indicates a sub group difference

A possible explanation for this variation is that parents are more likely to initiate a conversation if their child is exhibiting those behaviours. The data indicates that, amongst those reporting risk behaviours, young people were more likely to have talked to their parent about the relevant risk behaviour if their parent knew about their behaviour than if they did not know. This finding is only indicative due to small sample sizes; this pattern will be examined at future waves when the sample size is larger.

Young people who said that they live with someone who smokes, gets drunk or uses illegal drugs were more likely to say that they had had a conversation about that behaviour with their parents than those in other households. Those who reported that they live with…

- …smokers were more likely to have had a conversation with their parents about smoking (60% v 45% of those not living with a smoker[92])

[92] These figures are based on 11-17s rather than 11-16s

- …those who get drunk were more likely to have had a conversation with their parents about drinking alcohol (68% v 47% of those not living with someone who gets drunk)
- … illegal drug/legal high user(s) were more likely to have had a conversation with their parents about illegal drugs/legal highs (63% v 37% of those not living with someone who uses drugs)

13.6.3 Age of first conversation about risk behaviours

Young people who had discussed risk behaviours with their parents were asked what age they were when this first happened. This was to explore the potential impact that age of initial conversation may have on prevalence of risk behaviours.

Amongst those who had discussed each behaviour **only**: a third of 15-17s said that smoking was discussed before the age of 13 (34%) and three in ten said that they had had a conversation about sex and relationships before the age of 13 (31%). A quarter said that illegal drugs/legal highs (25%) and drinking alcohol (24%) were discussed before the age of 13 (Figure 126).

Figure 126 also shows the percentages broken down by risk behaviours to see if age of first conversation has any bearing on prevalence. The data suggests that, for some behaviours (smoking and sex/relationships) those reporting the relevant behaviour were less likely to have had the conversation before 13 than those who did not report it. However, the small sample sizes mean that these differences are not significant and firm conclusions cannot be drawn at present. This pattern will be monitored at future waves to see if it holds true with a larger base size.

Figure 126 **Age first discussed risk behaviour with parent/carer, 15-17s only**

		Had first conversation before the age of 13
First conversation about…		
…smoking		
All	(132) %	34
Youth smoker	(31*) %	29
Not youth smoker	(101) %	35
… sex and relationships		
All	(134) %	31
Those who have had sexual intercourse	(47*) %	21
Those who have not	(87*) %	38
…illegal drugs/ legal highs		
All	(104) %	25
Used cannabis, ecstasy or cocaine	(21*) %	33
Not used cannabis, ecstasy or cocaine	(83*) %	23
… alcohol		
All	(136) %	23
Monthly drinker	(60*) %	27
Not monthly drinker	(76*) %	19

Base: All Autumn 2012 15-17s who discussed each behaviour. *Caution – small base size
NB: Based on Autumn 2012 data only

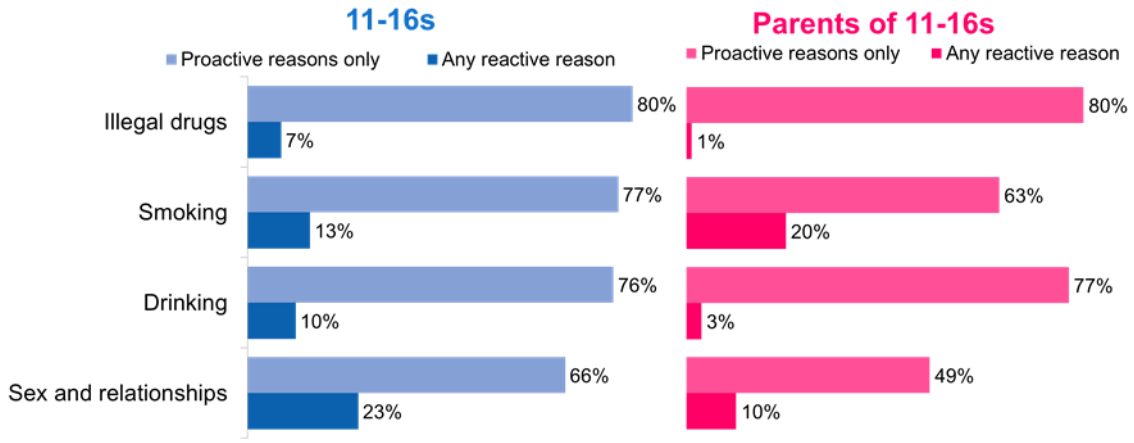
13.6.4 Reasons for first conversation about risk behaviours

The survey included questions for parents (in the adult survey) and young people about how the first conversation came about. The majority of parents and 11-16s reported that the reason for the first conversation was proactive rather than reactive e.g. a conversation about smoking arose from something seen on television about smoking rather than as a result of the parent discovering that the young person was smoking.

According to young people, proactive conversations about illegal drugs and smoking were the most prevalent. Of those who had had a conversation 80% said the first conversation about illegal drugs was proactive 77 76% said the first conversation about smoking was proactive (Figure 127). The subject about which conversations were most likely to be reactive was sex and relationships: 23% of young people said their first conversation about sex and relationships was reactive.

Parents' responses are also shown in Figure 127 and patterns in response are similar, though the small base size should be noted. Their responses will be monitored at future waves when larger sample sizes are available.

Figure 127 **Reasons for first conversation about negative risk behaviours**



Base: All Autumn 2012 11-16s/parents of 11-16s using standard self-completion who talked to their parent/child about each behaviour (base: young person/parents – smoking 253/75, drinking 245/75, illegal drugs 187/67, sex and relationships 246/56)
NB: Base sizes for the parent survey are small and should be treated as indicative
NB: Based on Autumn 2012 data only

13.7 School lessons that discuss risk behaviours

The Lifecourse Tracker survey asked young people whether negative risk behaviours had been covered as a topic in school lessons. Eight in ten or more young people said that each behaviour had been covered in lessons in school:

- Smoking – 83%
- Drug use – 83%
- Sex and relationships – 82%
- Drinking alcohol – 80%

Seven in ten (69%) said *all four* topics had been covered and a fifth (24%) said between one and three topics had been covered. Only 6% said none of the topics had been covered in school lessons, with younger respondents more likely to say this (13% of 11-12s compared with 4% of 13-17 year olds).

Those living in ABC1 households were more likely to say that drug use and sex/relationships had been covered in school lessons (for drugs 86% v 80% of those living in C2DE households; for sex/relationships 85% v 80% of those living in C2DE households). Coverage of smoking and drinking in lessons was similar across social grade.

The impact of school lessons appears to be mixed. Comparing only 15-17s in order to control for age biases, youth smokers were less likely to say smoking had been covered as a topic in school (79% v 89% of non-smokers). Monthly drinkers were more likely to say that drinking alcohol had been covered in school lessons (94% compared with 83% of those who do not drink as regularly). There were no differences amongst those reporting drug use and sexual intercourse.

13.8 Individual health behaviours – drinking alcohol

The key indicator for drinking behaviour was the proportion of young people who said that they usually drank alcohol at least once a month – 23% of 11-17s said this.

13.8.1 Drinking behaviour

Nearly half of 11-17s (46%) said that they had ever had a proper alcoholic drink – this was defined as a whole drink, not just a sip.

Those who had ever drunk alcohol were asked about the circumstances in which they usually drink. Half said it was usually with their parents or another responsible adult at home (49%) whilst four in ten said that they usually drink at a party with friends (45%) and a third said someone else's house (34%) (Figure 128).

Figure 128 also shows the results based on all 11-17s and shows that only a small proportion of young people (4%) have ever drunk alcohol and usually drink out in the street or in another public area.

Figure 128 **Where young person usually drinks**

	All 11-17s (1197) %	All who have ever had a proper alcoholic drink (495) %
At home with parents/carer/ other responsible adult	23	49
At party with friends	21	45
At someone else's home	16	34
At a party with parents/carers/ other responsible adult	14	30
At home with friends/someone else	14	30
In a pub or bar	6	14
In a restaurant	6	12
Out in the street/public area	4	9
In a club or disco	3	7
Never had a proper alcoholic drink	49	-
Don't know / refused to say if had proper alcoholic drink	5	
Any with parents/adults	**28**	**60**
Any with friends	**27**	**58**

Base: All 2012 11-17s using standard self-completion: as shown
NB: Only mentions of 3% or more are shown (based on all 11-17s)

Amongst those who have ever had an alcoholic drink, 15-17s were more likely than younger respondents to say that they drink away from their parents; they were more likely to:

- Drink at home with friends or someone else (33% compared with 12% of 11-12s)
- At someone else's house (39% compared with 12% of 11-12s)
- At a party with friends (55% compared with 10% of 11-12s)

13.8.2 Getting drunk

Young people who said that they had ever had a proper alcoholic drink were asked how often they got drunk when they drank alcohol.

Two thirds of those who said that they had had a proper alcoholic drink said that they had been drunk at least once (63%) – this equates to 29% of all 11-17s (Figure 129). Older respondents and those reporting risk behaviours (even when age is controlled for) were more likely to say that they had been drunk at least once:

- Amongst all 11-17s: 15-17s were more likely to say that they have been drunk at least once (53% compared with 17% of 13-14s and 3% of 11-12s)
- Amongst 15-17s being drunk is associated with other risk behaviours: youth smokers (84% compared with 46% of non-smokers), used cannabis, cocaine or E in the last year (89% compared with 47% of others) and those who had had intercourse (82% compared with 40% of those who had not had intercourse) were more likely to say that they had been drunk at least once

Those who were regularly getting drunk were in the minority; of those who had ever had a proper alcoholic drink only 16% said that they got drunk almost every time or most times that they drink alcohol (which equates to 7% of all 11-17s). Those aged 15-17 in ABC1 households were the most likely to say that they got drunk every/most times when drinking (21% compared with 8% of other groups).

Figure 129 **Frequency of getting drunk**

	All 11-17s (1197) %	All who have ever had a proper alcoholic drink (495) %
Almost every time I drink alcohol	2	5
Most of the times I drink alcohol	5	11
Now and again when I drink alcohol	15	32
Only once	7	15
Ever been drunk (net)	**29**	**63**
I have never been drunk	15	33
Never had a proper alcoholic drink	49	-
Don't know / refused to say if had proper alcoholic drink	5	

Base: All 2012 young people using standard self-completion: as shown
NB: Don't know and prefer not to say not shown

The Lifecourse Tracker also explored positive drinking habits (measures taken by young people to diminish the impact of their drinking) and negative habits (measures taken to accelerate the impact of drinking, or excessive drinking that led to negative outcomes). Over half (56%) of those who had ever drunk alcohol said that they did something positive to lessen the impact of drinking alcohol; for example: making sure they don't drink until they are sick/ill (30%) and pacing themselves with non-alcoholic drinks (26%). Just under a quarter said that before they start drinking they plan how much they are going to drink or spend on alcohol (23%) (Figure 130).

A lower proportion reported negative habits, though 14% of those who had had a drink said they did at least one negative thing. For example, 6% said they got so drunk that they can't remember what happened at the end of the night and the same proportion felt sick or ill because of the amount they drank (6%).

Around a third (35%) said they did not usually do any of those things – positive or negative.

Figure 130 **Positive and negative drinking habits**

	All who have ever had a proper alcoholic drink (495) %
Make sure I don't drink until I am sick	30
Pace myself with water/soft drinks	26
Before I start drinking I plan how much I am going to drink or spend on alcohol	23
Any positive drinking habits	**56**
Get so drunk that I can't remember what happened at the end of the night	6
Feel sick or ill because of the amount I have drunk	6
Deliberately don't eat before I go out so that I can get drunk more easily	4
Deliberately get drunk at home before a night out	3
Any negative drinking habits	**14**
None of these	35
Base: All 2012 young people using standard self-completion: as shown	

Older drinkers were more likely than their younger counterparts to mention both positive and negative drinking habits: this is likely to reflect their higher levels of drinking:

- 65% of 15-17s mentioned at least one positive habit and 17% at least one negative habit
- 22% of 11-12s mentioned at least one positive habit and 5% at least one negative habit

Those who reported certain risk behaviours were also more likely to report negative drinking habits (but were no more likely to report positive drinking habits):

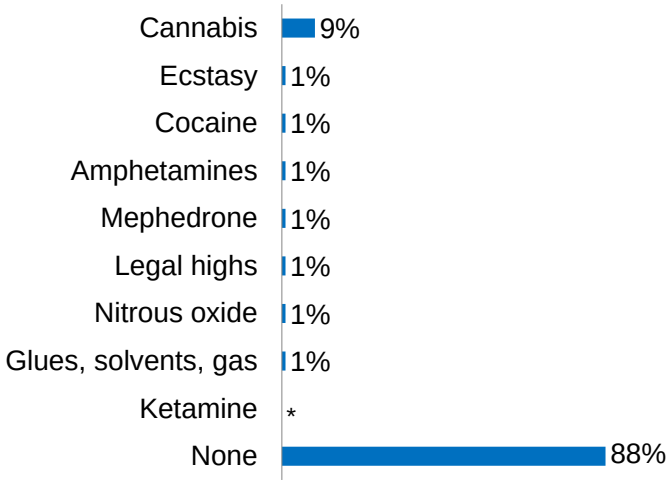
- 36% of youth smokers mentioned at least one negative drinking habit (v. 9% of non-smokers who had ever drunk alcohol)
- 28% of cannabis, ecstasy and cocaine users (v. 10% of non-drug users who had ever drunk alcohol)

13.9 Individual health behaviours – illegal drug use and legal highs

13.9.1 Drugs used in the past 12 months

Respondents were shown a list of illegal drugs and legal highs and were asked which they had used in the last 12 months. The majority (88%) said that they had not used any and 2% said that they preferred not to answer the question or did not know how to answer. Ten percent said they had used at least one drug over the past 12 months: most commonly cannabis (9%), with all other drugs mentioned by 1% or less (Figure 131).

Figure 131 **Drug use in the past 12 months**



Base: All 2012 young people using standard self-completion (1197) * mentioned by less than 0.5% of the sample

Boys aged 15-17 and 15-17s living in C2DE households were particularly likely to say they had used at least one drug in the past 12 months:

- Boys aged 15-17 (21% v. 6% of other young people)
- 15-17s living in C2DE households (22% v. 6% of other young people)

Hence, a disproportionate number of boys aged 15-17 living in C2DE households said that they had used drugs: around two in three (28%) this equates to 35% of all drug users (despite making up 12% of the sample)

Around one in ten young people who said that they had used cannabis in the past 12 months said that they did so every day (12%), whilst a third said that they had used it once or twice in the past 12 months (34%).

13.10 Individual health behaviours – sexual health

The Government wants to improve sexual health amongst the whole population and in March 2013 they published their 'Framework for Sexual Health improvement in England'[93]. This document sets out the importance of sexual health across lifecourse and the need for "age-appropriate education, information and support to help [individuals] make informed and responsible decisions". One of the ambitions listed is to "build knowledge and resilience among young people".

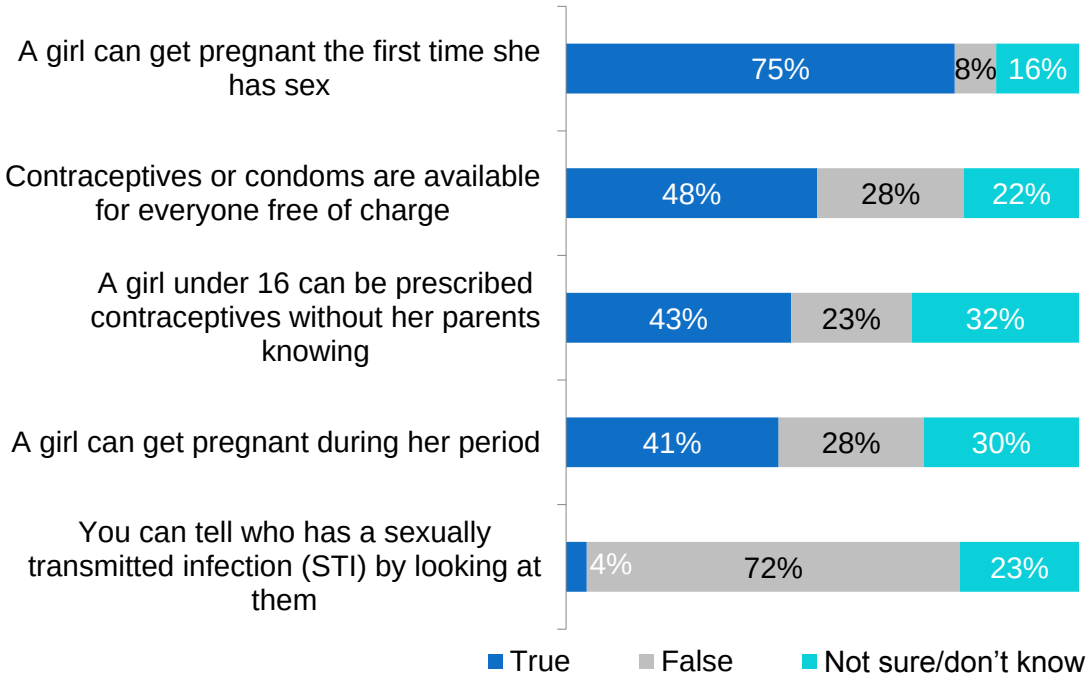
The Lifecourse Tracker young people survey contains a module of questions about sex and relationships to investigate how young people feel about sex and their experiences. The sensitive nature of this topic meant that questions were only asked of 11-12s in secondary school who said that they had thought about sex and relationships before the interview (28% of 11-12s), but asked of all 13-17s. All results in this section, therefore, are based on these respondents only.

13.10.1 Knowledge about sexual health

Respondents were asked whether they would know where to go if they needed more information about contraception, sex and relationships. Eight in ten said that they knew where to go for more information (80%), though 9% said they did not know where to go. Five percent felt that they did not want any more information about sex and relationships.

To measure young people's knowledge of sexual health issues a number of statements relating to sex and contraceptives were put to respondents and they were asked to say whether they thought each was true or false. The statements were structured around common myths about sex (Figure 132).

Figure 132 **Proportions thinking myths are true or false**



Base: All 2012 11-17s who answered sexual health questions (931)

[93] https://www.gov.uk/government/publications/a-framework-for-sexual-health-improvement-in-england

The majority correctly thought that a girl *can* get pregnant the first time she has sex (75% thought this was true).

Half thought that contraceptives or condoms were available for everyone free of charge (48%) though 28% thought this was false and 22% weren't sure/did not know. Similar patterns in response were observed related to knowledge of whether a girl under 16 can be prescribed contraceptives without her parents knowing, and whether a girl can get pregnant during her period. All of these statements are true, so there appears to be an information gap here, which is particularly evident amongst 11-14s (36% thought contraceptives or condoms were available for everyone free of charge v 59% 15-17s; 33% that girls under 16 can be prescribed contraceptives without her parents knowing v 51% 15-17s and 65% that a girl can get pregnant during her period v 84% 15-17s).

Most young people correctly thought the statement 'you can tell who has a sexually transmitted infection (STI) by looking at them' is false (72%). Only 4% thought it was true, though some uncertainty was evident as 23% were not sure/said don't know.

Older respondents, in particular, girls aged 15-17 were most likely to correctly know whether a statement was true or false when compared with most other age/gender groups (Figure 133).

Figure 133 **Proportions thinking myths are true or false – age within gender**

	Boys			Girls		
	11-12 (57*) %	13-14 (205) %	15-17 (207) %	11-12 (47*) %	13-14 (189) %	15-17 (226) %
% thinking it is true that…						
Contraceptives or condoms are available to everyone, free of charge	11↓	37↓	58	18↓	46↓	60
A girl under 16 can be prescribed contraceptives without her parents knowing	27↓	37↓	46↓	15↓	34↓	58
A girl can get pregnant the first time she has sex	48↓	64↓	81	62↓	71↓	87
A girl can get pregnant during her period	30↓	31↓	44	38	34↓	53
% thinking it is false that…						
You can tell who has a sexually transmitted infection (STI) by looking at them	39↓	58↓	80	57↓	66↓	85

Base: All 2012 young people using standard self-completion, aged 13-17 (or 11 in secondary school or 12 who have thought about sex and relationships before): as shown
* Caution – small base size
↑↓ Indicates a significant difference, compared with girls aged 15-17

Those who said that they had ever had sexual intercourse were also more likely to know statements were true or false compared with those who have not had sex – this applies even when looking only at the 15-17 age group only, thereby minimising any age biases (Figure 134).

Figure 134 **Proportions thinking myths are true or false – whether ever had intercourse**

	Ever had sexual intercourse	
	No (315) %	Yes (118) %
% thinking it is true that…		
Contraceptives or condoms are available to everyone, free of charge	53	73↑
A girl under 16 can be prescribed contraceptives without her parents knowing	47	61↑
A girl can get pregnant the first time she has sex	79	95↑
A girl can get pregnant during her period	46	53
% thinking it is false that…		
You can tell who has a sexually transmitted infection (STI) by looking at them	79	89↑

Base: All 2012 15-17s using standard self-completion: as shown
↑↓ Indicates a significant difference between sub-groups

13.10.2 Preparatory behaviours

Young people were asked how easy they thought it would be to take specific actions which could be preparations for safer sex. Because the question was hypothetical it was asked of all 13-17s and 11-12s in secondary school who said they had thought about sex before the interview - whether or not they had ever had sexual intercourse.

Seven in ten young people thought that it would be easy to make sure a condom is used when having sex (70% of 11-17s and 67% of 18-24s (taken from the all adult survey)). Just over half of 11-17s thought that talking about condoms with someone they might have sex with would be easy (53%) whilst 7 in 10 of 18-24s thought that talking about contraceptives would be easy (71%) (Figure 135).

Figure 135 **Preparatory behaviours (1)**

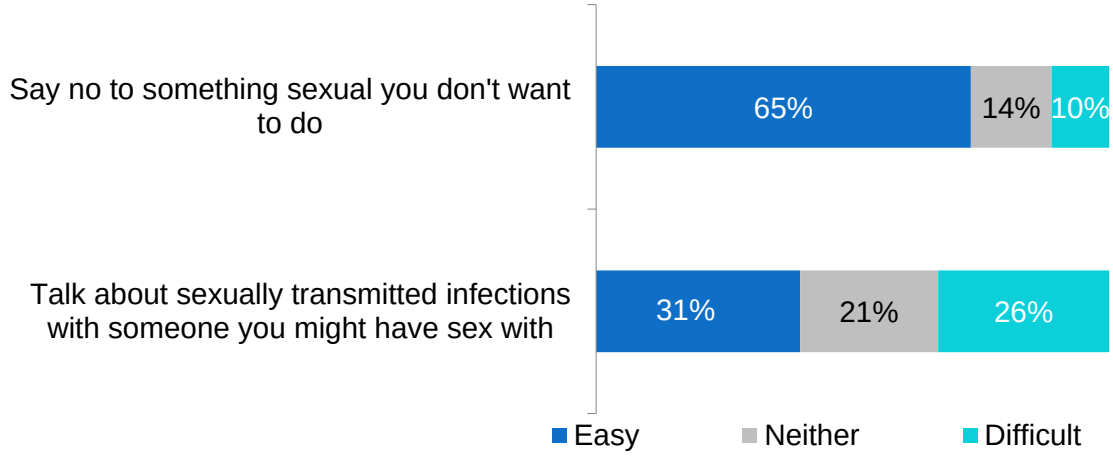
	11-17 (931) %	18-24s (223) %
Make sure you use a condom when having sex		
Easy	**70**	**67**
Neither	**7**	**13**
Difficult	**4**	**12**
Don't know	**13**	**3**
Talk about using condoms (11-17s) / contraceptives (18-24s) with someone you might have sex with		
Easy	**53**	**71**
Neither	**15**	**16**
Difficult	**10**	**6**
Don't know	**17**	**3**

Base: All 2012 11-17s who answered sexual health questions; All 2012 18-24s from adult survey

Two thirds of young people felt that it would be easy to say no to something sexual they don't want to do (65%), and there were no notable differences in response to this statement by age, gender or social grade (Figure 136).

Responses were more mixed in relation to discussions about sexually transmitted infections. Three in ten (31%) said they would find it easy to talk about sexually transmitted infections but 26% thought they would find it difficult.

Figure 136 **Preparatory behaviours (2)**

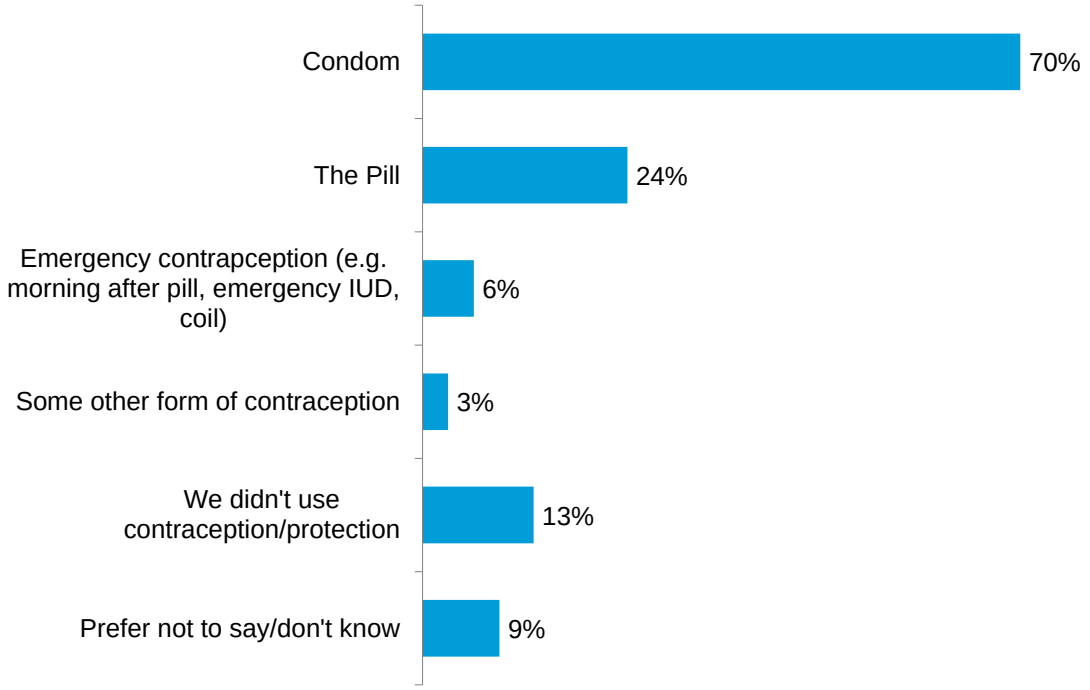


Base: All 2012 11-17s who answered sexual health questions (931)

In terms of whether discussions were actually happening, those who had ever had sexual intercourse were asked whether they had discussed contraception or protection with their partner the first time they had intercourse: seven in ten (71%) said that they had had this discussion, but 20% had not . Boys (80%) were more likely than girls (60%) to say that this was discussed, whilst girls (30%) were more likely to say this was NOT discussed (v 11% of boys).

Those who had ever had sexual intercourse were asked what contraception they used the first time they had intercourse. Most said they had used a condom (70%) whilst a quarter had used the pill (24%). There were fewer mentions of emergency contraception (6%) or other forms of contraception (3%). However, around one in eight said that they had not used any form of protection (13%) the first time they had intercourse (Figure 137).

Figure 137 **Type of contraception used the first time had sexual intercourse**



Base: All 2012 11-17s who have had sexual intercourse (130)

The only notable sub-group difference observed was that youth smokers were more likely to say that they had not used any form of contraception the first time they had intercourse (24% compared with 4% of non-smokers).

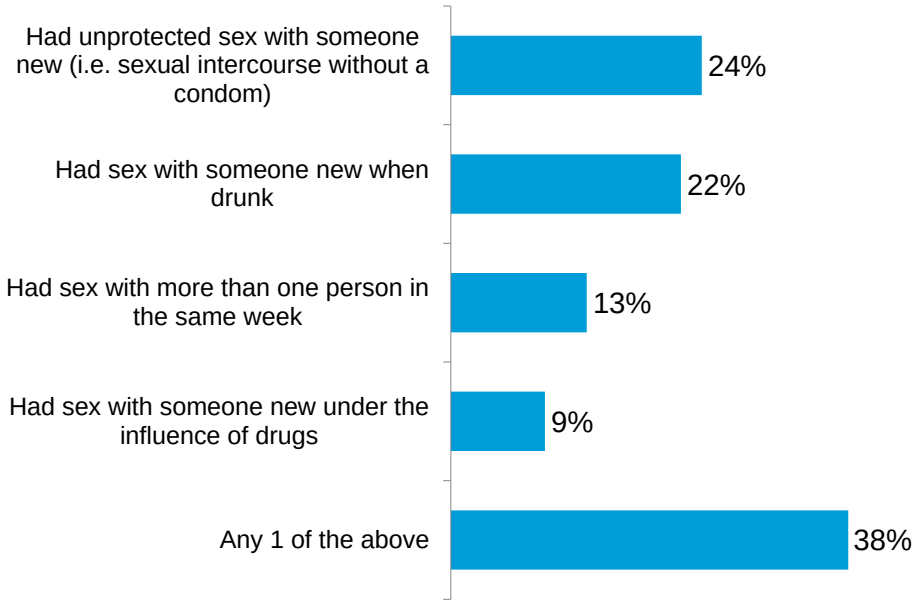
13.11 Risky sexual situations

The Lifecourse Tracker aims to establish the prevalence of sexual situations which may be considered risky for young people. Young people who had ever had sex were asked about certain situations in which they may have had unprotected sex in the last 12 months.

Figure 138 shows that around one in four (24%) said they had had unprotected sex (i.e. sexual intercourse without a condom) with someone new in the past 6 months and a similar proportion (22%) said they had had sex with someone new while drunk.

Overall, four in ten (38%) of those who had ever had intercourse said that they had sex in any of the situations shown in Figure 138 in the past 6 months.

Figure 138 **% who have had sex in the last six months in the following situations**



Base: All 2012 11-17s who have had sexual intercourse (130)

Again there were few differences in response based on socio-demographics. Youth smokers were more likely than other groups to say that they had had sex in any of these situations in the past 6 months (59% compared with 20% of non-smokers). There are indications that monthly drinkers and drug users were more likely to have had sex in these situations, but due to the small sample size we cannot be more conclusive about this.

13.12 Young people (11-17s) - summary

This section summarises the findings from the young people's survey.

Young people (11-17s) generally felt happy and healthy. Some groups (for example girls aged 13-17 and those reporting risk behaviours) were more likely to report a negative mindset and say that they have self-harmed, feel that they are not the right weight or report health conditions such as dizziness or tiredness.

As they get older, young people's priorities change. While most young people were close to their parents, the oldest age group were less likely to say that they enjoyed spending time with family or feel comfortable talking to their mum and dad about things that bother them. In terms of specific worries, pressures related to school were the most common and were the predominant concern for 15-17s whilst worries were more mixed for 11-12s: as well as school pressures, other common concerns for this age group were bullying and risky health behaviours (e.g. people smoking, drinking alcohol and taking drugs).

Most young people were not eating fruit and veg several times a day and/or were not moderately active on a daily basis. Other measures of diet showed that, in comparison with adults, young people reported poorer diets. Young people in C2DE households tended to have poorer diets than average and girls aged 13-17 were not as physically active as other 11-17s. There was no evidence to suggest that there was an association between diet and prevalence of risk behaviours amongst young people.

Prevalence of all negative behaviours was generally lower amongst 11-17s, with much higher levels amongst 15-17s: particularly amongst those living in C2DE households (except for monthly drinking which was more prevalent amongst those living in ABC1 households). In addition, young people who were exposed to risk behaviours in the home (e.g. smoking, heavy drinking) were more likely to report those risk behaviours themselves.

11-17s tended to perceive risk behaviours as bad for health and viewed peers who engaged in these behaviours more negatively than positively. Drug use amongst peers was judged most negatively and perceived to be the least prevalent, whilst having sex was perceived to be the least negative and most prevalent risk behaviour. Those reporting risk behaviours and 15-17s (these groups do overlap) tended to view each risk behaviour more positively and to think that it is acceptable to engage in these behaviours.

Parents and young people had varying perceptions of conversations with one another about risk behaviours. Young people were less inclined to say that conversations about risk behaviours had happened and less likely than parents to think such conversations would be easy. The most commonly discussed behaviours, and also most likely to be deemed easy to talk about, were drinking alcohol and smoking.

For all behaviours, the first conversation was predominantly a proactive conversation (rather than as a reaction to the parent discovering their child was engaging in that behaviour).

14 Older people (55+)

The UK has an ageing population. There are already more people over State Pension age than children and the Office for National Statistics (ONS) predicts that by 2020 a third (32%) of the UK workforce and almost half (47%) of the adult population will be aged over 50[94].

Government policies are now beginning to focus on a broader understanding of older people as they enter and progress through the different stages of old age[95]. The emphasis of government health and social policies is to promote and extend health and well-being into old age and to encourage older people to take responsibility for their own health behaviours.

The Lifecourse Tracker survey included older people (55+s) as part of a wider all adults (18+) survey population. This chapter looks at older people as a distinct sub-group to investigate where their attitudes and behaviours differ from the all adult average. Bearing in mind that 55+ is a diverse age group, this group has been broken down further to also examine any significant differences between 55-64s, 65-74s and 75+s.

The core health behaviour indicators for older people are largely similar to those for the wider adult population – although older people were not asked about sexual health behaviours and attitudes. Taking into consideration issues of relevance to older people, some additional questions were also asked relating to mental well-being and interactions/conversations with people outside of the household.

The Lifecourse Tracker survey does not aim to replace other available estimates about older people but provides a holistic picture of all behaviours and attitudes, how these compare and how this changes over time.

This chapter examines the lives of older people aged 55+ in the round, including looking at the following:

- Perceptions of their own health and well-being
- Norms around health behaviours and intentions to change, as well as general attitudes towards health
- Prevalence of negative health behaviours and detailed information about health behaviours including:
    - Nutrition
    - Physical activity
    - Alcohol
    - Smoking
- Interactions with health services and friends/family, including questions about conversations about health with friends and family

[94] https://www.gov.uk/government/policies/improving-opportunities-for-older-people
[95] http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/browsable/DH_4901314

14.1 Well-being

Against the core measures, older people generally reported similar levels of well-being to the all adult average. However, they were significantly more likely to feel satisfied with life nowadays (72% scoring 7-10 on a 10 point scale v 67% all adult average).

As Figure 139 shows, despite higher levels of life satisfaction, older people reported lower levels of well-being against other measures more directly linked to their health. Older people were less likely than the all adult average to feel their health is very good/good (53% v 68% all adult average) and for many (62%) poor health was felt to be an unavoidable part of ageing, as they agreed that as they get older their health is going to get worse, regardless of whether they lead a healthy lifestyle.

Figure 139 **Other well-being measures**

	All adults (2029) %	All 55+s (833) %
I feel good about myself	82	78↓
Good health in general (very good/good)	68	53↓
The main thing which affects my health is what I personally do	67	62↓
As I get older my health is going to get worse, regardless of whether I lead a healthy lifestyle	N/A	62
If a person is meant to get ill, they will get ill anyway, regardless of whether they lead a healthy lifestyle	43	45
There is little I can do to change my life	31	41↑

Base: All 2012 adults, All 2012 55+s: as shown
↑↓Indicates a significant difference

Those aged 75+ who reported fair/bad/very bad general health were more likely to agree that their health will get worse as they get older regardless of their lifestyle: 76% agreed compared with 58% of those reporting very good/good health . Agreement that *there is little I can do to change my life* increased with age (27% 55-64s v 41% 65-74s v 63% 75+s), but there were no other differences by age.

In addition, older people were more likely than the all adult average to agree that *I generally focus on the here and now rather than worry about the future* (63% v 58%), but no more/less likely to agree that *I believe you need to take risks to lead a full life* (63% v 65% all adult average). Those aged 75+ were more likely to agree with the former statement (74% v 59% 55-74s).

As well, and perhaps in relation to, reporting lower levels of general well-being, older people were more likely than the all adult average to report any of a number of potential lifestyle-related health problems (66% v 41% all adult average), and more likely to report having a long standing illness, disability or infirmity (44% v 27% all adult average).

All adults were asked to describe their weight at the time they were interviewed. Overall, older people were no more/less likely than the all adult average to describe themselves as overweight (55% v 52%).

14.2 Prevalence of negative health behaviours

The same core indicators of negative health behaviours were analysed amongst older people as the wider adult population. Overall, older people were less likely than the all adult average to report all of the core negative health behaviours apart from fewer than 150 active minutes, which they were more likely to report, and alcohol consumption in the last week that would classify them as increasing/higher risk drinkers, for which they were in line with the all adult average.

As Figure 140 shows, older people were significantly less likely than the all adult average to have eaten fewer than five portions of fruit/veg the day before they were interviewed (74% v 79% all adult average), to smoke nowadays (11% v 24% all adult average) and to have taken any illegal drugs in the past 12 months (1% v 7% all adult average).

Figure 140 **Prevalence of negative health behaviours**

	All Adults (2029) %	All 55+ (833) %	All 55-64s (300) %	All 65-74s (288) %	All 75+s (245) %
Fewer than five portions fruit/veg yesterday	79	74↓	69	71	84↑
Fewer than 150 active minutes last week	53	57↑	48	54	71↑
Smoke nowadays	24	11↓	14	14	3↓
Increasing/higher risk drinker	15	13	15	13	9
Any illegal drugs in past 12 months	7	1↓	3	1	-

Base: All 2012 adults, All 2012 adults in each age group: as shown
↑↓ Indicates a significant difference, between 55+s and the all adult average or between the three older age groups

Figure 140 also shows 75+s were significantly more likely than older people on average to report negative health behaviours against the core measures for fruit/veg consumption (84% v 69% 55-64s and 71% 65-74s) and physical activity (71% v 48% 55-64s and 54% 65-74s). However, they were significantly less likely to say they smoke nowadays (3% v 14% 55-74s). There were no significant age differences on the core measures of drinking and drug use amongst the three age groups.

In line with these findings, older people reported fewer negative health behaviours than the all adult average (1.5 v 1.8 all adult average). Again, 75+s differed from 55-74s – reporting a greater number of negative health behaviours on average (1.7 v 1.5 55-74s).

14.3 Nutrition

The core measure for nutrition was whether respondents had eaten fewer than five portions of fruit and/or vegetables on the day before they were interviewed. Frequency of consumption of foods high in sugar, high fat/fried foods, and sugary soft drinks within a typical week was also examined. In addition, respondents were asked whether they limited their intake of salt or low salt and calories in their diet.

14.3.1 Five a day

There was a mixed picture for daily fruit and veg consumption amongst older people. Three quarters (74%) said that they had consumed fewer than five portions of fruit or veg on the day before they were interviewed; significantly lower than the all adult average (79%). However, this rose to 84% amongst 75+s, significantly higher than amongst 55-74s (70%).

As discussed in the all adult section above, similar questions were asked on the Health Survey for England in 2011[96]. Largely in line with findings on the Lifecourse Tracker, the Health Survey for England reported that 70% of 55+s did not consume five or more portions of fruit or veg a day. It also showed a higher proportion of 75+s not eating five portions of fruit or veg a day (74% v 67% of 55-64s and 70% of 65-74s).

14.3.2 Other nutritional behaviours

As Figure 141 shows, although older people's daily consumption of foods high in sugar was in line with the all adult average (27% v 26%), they were significantly less likely than the all adult average to be daily consumers of high fat/fried foods (3% v 8%) or sugary soft drinks (10% v 18%).

Figure 141 **Daily consumption of other foods**

	All adults (2029) %	55+ (833) %
Foods high in sugar	26	27
High fat/fried foods	8	3↓
Sugary soft drinks	18	10↓

Base: All 2012 adults, All 55+s: as shown
↑↓ Indicates a significant difference, compared with the all adult average

Daily consumption of high fat/fried foods and sugary soft drinks was fairly similar across all older age groups, whilst reported daily consumption of foods high in sugar was significantly higher amongst 75+s (34% v 24% of 55-74s).

To further explore nutritional behaviour, all were asked whether they limit some types of unhealthy foods in their diet. Older people were significantly more likely than the all adult average to limit their intake of salt or low salt (54% v 46%) and calorie intake (39% v 35%), though 75+s were significantly less likely to do this (27% v 43% of 55-74s).

Intentions to eat a healthier diet were significantly lower amongst older people than the all adult average (this is discussed in more detail in section 14.7.3).

Older peoples' attitudes to healthy eating were generally in line with the all adult average, with the majority agreeing that healthy eating is a (very/quite high) priority nowadays (83% v 81% all adult average). However, older people were significantly less likely to agree that *healthy eating is only for those that can afford it* (18% v 23% all adult average).

[96] http://www.hscic.gov.uk/catalogue/PUB09300

14.4 Physical activity

The core measure of physical activity was whether a respondent did fewer than 150 minutes of moderate activity in the week before they were interviewed. A measure of sedentary behaviour the day before they were interviewed was also taken to provide further insight.

Around half (48%) of 55-64s and 65-74s (48%) reported doing *fewer* than 150 active minutes in the past seven days. Whilst these age groups were in line with the all adult average (53%), 75+s were significantly more likely (71%) than the all adult average to report *fewer* than 150 active minutes in the past seven days, making them the least likely of all age groups to meet the activity guidelines.

The Health Survey for England in 2011[97] reported that 54% of 55+s have 'low' levels of physical activity – doing less than 30 minutes of moderate or physical activity on 1 to 4 days a week.

Older people's intentions to be more physically active were significantly lower than the all adult average (this is discussed in more detail in section 14.7.3).

As well as reporting differing behaviours around physical activity, older people also differed from the all adult average in their attitudes on this subject. Compared with the all adult average (88%), there was a significant difference in the proportion of older people (84%) agreeing that *there are plenty of ways they could be physically active without having to go to the gym or take part in organised sports*. Those aged 75+ were the least likely to agree (76% v 87% of 55-74s).

Older people reported a greater than average number of hours spent sitting down the day before they were interviewed (6.2 hours v 5.7 hours all adult average). In line with other behaviours, 75+s reported significantly higher average levels of sedentary behaviour than older people on average (6.8 hours v 6.2 hours 55+ average).

14.5 Alcohol

Older people reported similar levels of alcohol consumption to the all adult average (13% were classified as increasing/higher risk drinkers v 15% all adult average).

In line with lower levels of alcohol consumption than the all adult average, older drinkers were more likely to describe themselves as a light drinker (70% v 63% all adult average); with 44% describing themselves as a very light drinker (v 36% all adult average).

Amongst those who drink at least once a month, older people were less likely than the all adult average to say they had cut back the amount of alcohol they drink in the *past* three months (22% v 30%). Intentions to cut back in the *next* three months amongst this group were also significantly lower than the all adult average (13% v 21%). However, it is worth bearing in mind that this may be linked to their lower consumption levels. This is discussed in more detail in section 14.7.3.

Asked how much they agreed or disagreed that *drinking more than the recommended limits can increase the risk of diseases such as mouth cancer, breast cancer, stroke and heart disease*, older people were close to the all adult average in levels of agreement (78% v 76% all adult average).

However, older people were significantly more likely than the all adult average to agree that *it's ok to drink alcohol every day, so long as you're not getting drunk* (25% v 21%). This was significantly higher amongst 75+s (35%). Older increasing/higher risk drinkers were also more likely to agree with this statement (55% of increasing/higher risk drinkers aged 55+).

[97] http://www.hscic.gov.uk/catalogue/PUB09302

14.6 Smoking

The core measure for smoking was whether a respondent smoked cigarettes/hand-rolled cigarettes nowadays. Older people were significantly less likely than the all adult average to smoke nowadays (11% v 24% all adult average), with 75+s reporting the lowest smoking prevalence (3%). Similar questions were asked on the Health Survey for England in 2011[98], which found that 12% of over 55s were current smokers.

Despite lower prevalence of smoking amongst older people in the Lifecourse Tracker survey, older smokers smoked a greater average number of cigarettes/hand-rolled cigarettes a day than the average adult smoker (14 for smokers aged 55+ v 12 for smokers aged 18+).

Older smokers were no more or less likely than the adult smoker average to say they had made any serious attempts to quit smoking over the past 12 months (42% v 44%); or that they intended to stop smoking in the next three months (20% v 23%). See section 14.7.3 for more details on intentions to change behaviours.

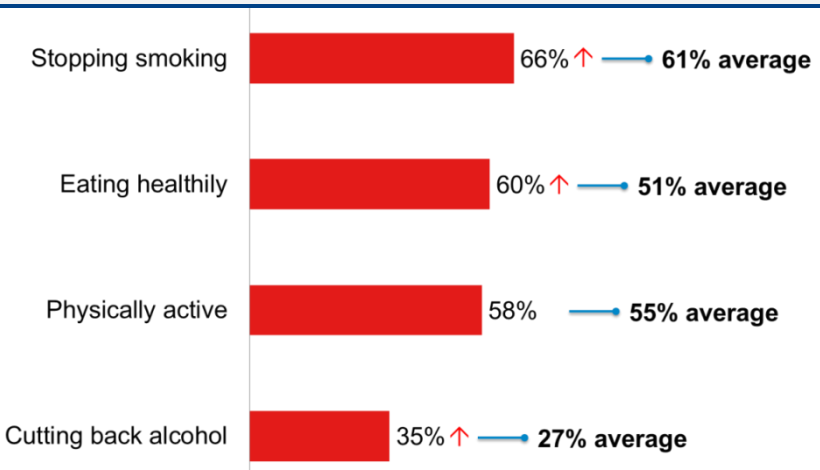
Older people were significantly more likely than the all adult average to disagree that *the health risks from smoking are greatly exaggerated* (72% v 68% all adult average). There were no significant differences in levels of agreement amongst the three age groups of older people.

14.7 Norms, worry and intentions to change

14.7.1 Norms around health behaviours

In order to understand norms around health behaviours the survey asked whether respondents agreed that more/most of the people they know are making healthy behaviour changes nowadays. Older people were significantly more likely than the all adult average to think that positive health behaviours are the norm for all behaviours except physical activity (Figure 142). Older people were most likely to agree that more/most people are stopping smoking nowadays (66%), whilst the biggest difference between them and the all adult average was agreement that more/most people eat healthily (60% v 51%). Although only a third (35%) of older people agreed that more/most people are cutting back on alcohol nowadays, they were still significantly more likely than the all adult average (27%) to agree.

Figure 142 **% of 55+s who agreed that more/most people I know are … nowadays**



Base: All 2012 adults (2029), all 55+s (833)
↑↓ Indicates a significant difference

[98] http://www.hscic.gov.uk/catalogue/PUB09302

Older people were also more likely than the all adult average to say that most/all of their friends and family lead a healthy lifestyle nowadays (64% v 51% all adult average).

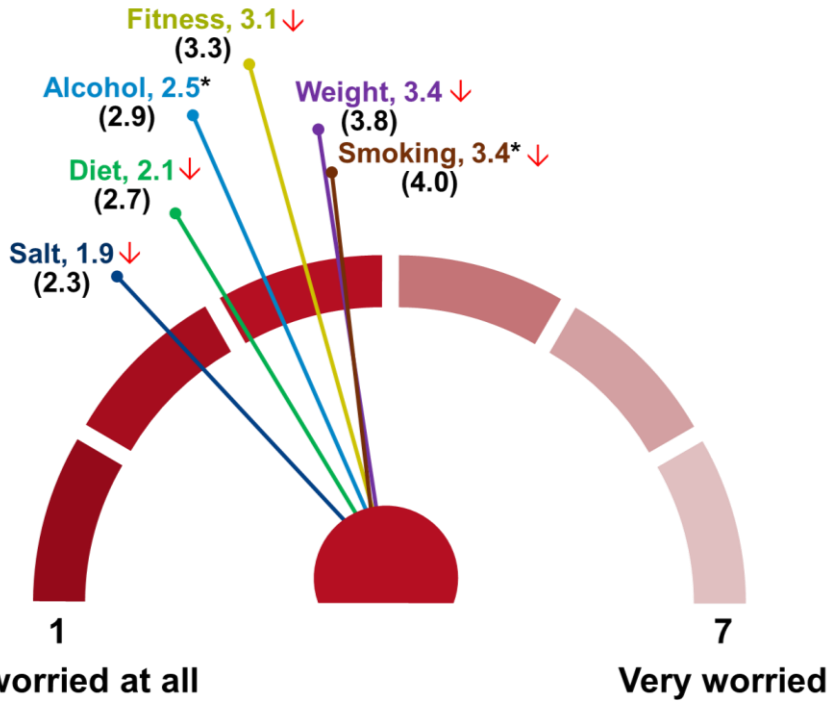
14.7.2 Worry about negative health behaviours

Respondents were asked how worried they felt about the effect of the things they do on their health. All were asked about the effect of the foods they eat, the amount of salt they consume and how fit or unfit they are; whilst those reporting the relevant negative behaviour were asked about the effect of smoking, alcohol and drugs. In addition, those who felt they were under/overweight were asked how worried they are about the effect of their weight on their health.

Overall, older people were less worried than the all adult average about the effect of the things they do on their health. This was true in all cases, except for the amount of alcohol they drink where worry was closer to the all adult average (2.5 v 2.9 all adult average worry score). Smoking (3.4) and weight (3.4) caused the most concern amongst both older people and the average adult population.

Figure 143 details the average worry scores amongst older people. The lines mark the mean average worry scores for each behaviour amongst older people reporting negative health behaviours. The top figures for each show the mean average worry score amongst older people, whilst the figures in the brackets show the all adult average. Significant differences between the worry rating for older people and the all adult average are marked with an arrow.

Figure 143 **Mean average worry amongst those reporting negative health behaviours**



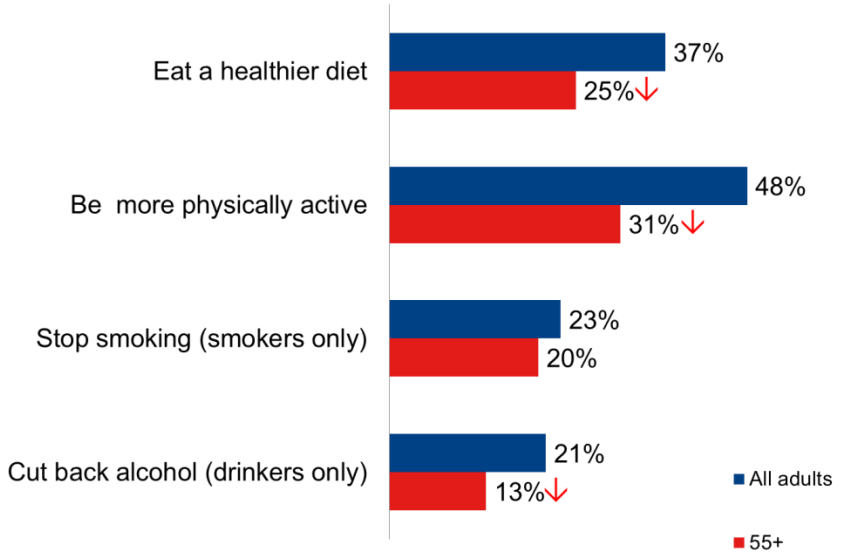
Base: All 2012 increasing/higher risk drinkers (55+ 94, ave. 275), all who do not limit intake of salt/lo-salt (55+ 384, ave. 1102)all who ate fewer than five portions of fruit/veg yesterday (55+ 637, ave. 1631), all who do fewer than 150 active minutes (55+ 508, ave. 1167), all who describe themselves as overweight (55+ 459, ave. 1085), all current smokers (55+ 128, ave. 559). * Caution low base(s)
NB: Top figures refer to mean average scores amongst 55+s. (Figures in brackets refer to mean average scores amongst all adults)
↑↓ Indicates a significant difference, compared to the all adult average

14.7.3 Intentions to change negative health behaviours

Older people reporting negative health behaviours were less likely than the all adult average to intend to make healthy changes (with the exception of giving up smoking, where there was no difference: 20% for older people v 23% for the all adult average). The most common intention amongst older people, though significantly lower than the all adult average (48%), was to improve their physical activity levels – with around a third (31%) intending to be more active within the next three months.

Figure 144 shows intentions to change amongst older people, compared with the all adult average. It shows the percentage giving an intention score of 5-7 out of 7, where 1 means they definitely don't intend to change and 7 that they definitely do.

Figure 144 **% saying they intend to make healthy changes within the next three months**



Base: All 2012 adults (2029), All 2012 55+s (833), all adult smokers (558), all 55+ smokers (128), all 2012 adult drinkers (1558), all 55+ drinkers (451).
↑↓ Indicates a significant difference

Those aged 75+ (68%) were significantly more likely than older people on average (46%) to have consumed fewer than five portions of fruit/veg the day before they were interviewed and not to intend to eat a healthier diet in the next three months.

The same was true in relation to physical activity; with 28% of 75+s having done fewer than 150 active minutes in the past seven days and not intending to be more physically active, compared with 20% of older people on average.

14.7.4 Attitudes towards a healthy lifestyle

When asked how they would personally describe a *'healthy lifestyle'* older people were significantly less likely than the all adult average to mention a number of key aspects including *'have a healthy diet'* (71% v 79%), *'don't smoke'* (35% v 43%) and *'do regular exercise'* (68% v 73%). However, they were significantly more likely than the all adult average to mention '*keep your mind active'* (21% v 15%). It is worth noting that, although statistically significant, these differences are not very large and the rankings amongst older people were similar to the all adult average.

Once they had been asked about what they considered a *'healthy lifestyle'* to be, all adults were asked a series of questions about leading a 'healthy lifestyle' themselves over the next 12 months. Older people were just as likely as the all adult average to say they would find it easy to lead a healthy lifestyle over the next 12 months (71% v 73%) and to believe that they had complete control over whether or not they lead a healthy lifestyle over the next 12 months (81% v 82% all adult average).

14.7.5 Barriers to a healthier lifestyle

In relation to fruit/veg consumption, around two in five older people said there was no specific reason for them not eating more fruit/veg (45%, significantly higher than the 33% all adult average). The next most common reason given was that they felt they already ate enough and did not need to increase their fruit/veg consumption (17%, significantly higher than the 11% all adult average). Figure 145 shows the top three mentions by older people, compared with those of the all adult average.

Figure 145 **Top three barriers to eating more fruit/veg**

All Adults (2029) %	All 55+s (833) %
Nothing/None 33% ↓	Nothing/None 45% ↑
It costs too much/money 15% ↑	I eat enough/don't need to eat more 17% ↑
I don't have enough time to prepare 12% ↑	It costs too much/money 9% ↓

Base: All 2012 adults, All 2012 55+s: as shown
↑↓ Indicates a significant difference between 55+s and the all adult average on given barrier

The main barriers preventing older people from reducing their alcohol intake were personal choice (45%, significantly higher than the 37% all adult average), feeling that they don't drink enough to warrant cutting down (19%) and enjoying drinking (17%, significantly higher than the 9% all adult average).

Personal choice was also the main barrier preventing older people from stopping smoking (34%) and one of the main reasons for not doing more physical activity (13%). The top two barriers to older people increasing their levels of physical activity were perceived poor health (48%) and thinking they are too old (17%) - both significantly higher than the all adult average (29% and 8% respectively).

14.8 Interactions and conversations about health

14.8.1 Interactions with health services

All adults were asked about their interactions with health services in the context of health check-ups within the past two years. Although the majority of all 18+s (80%) had had at least one type of health check in the past two years[99], and perhaps unsurprisingly, older people (94%) were significantly more likely than the all adult average to have done so.

The most frequently mentioned check-ups amongst older people were eye tests (68% v 53% all adult average) and tests for high blood pressure (67% v 45% all adult average) and high cholesterol (56% v 34% all adult average). The only tests/check-ups which older people were significantly less likely than the all adult average to have had were those related to sexual health:

- HIV test (1% v 5% all adult average)
- Chlamydia test (1% v 6% all adult average)
- Cervical smear test (8% v 16% all adult average)

Overall, older people were no less likely than the all adult average to report regular self-health checks (56% reported doing any regularly v 58%). However, older males were significantly less likely than the all-male average to say they regularly check their testes/balls for lumps or changes (38% v 44% all male adult average).

14.8.2 Interactions with friends and relatives

In order to understand the role of other interactions on older peoples' health they were asked about how often they interact with relatives or other adults outside of their households, and about conversations they may have had about health with friends or family. These questions were not asked of 18-54s and so no comparisons can be drawn between older people and the all adult average. Where notable differences exist within the older age group these have been noted.

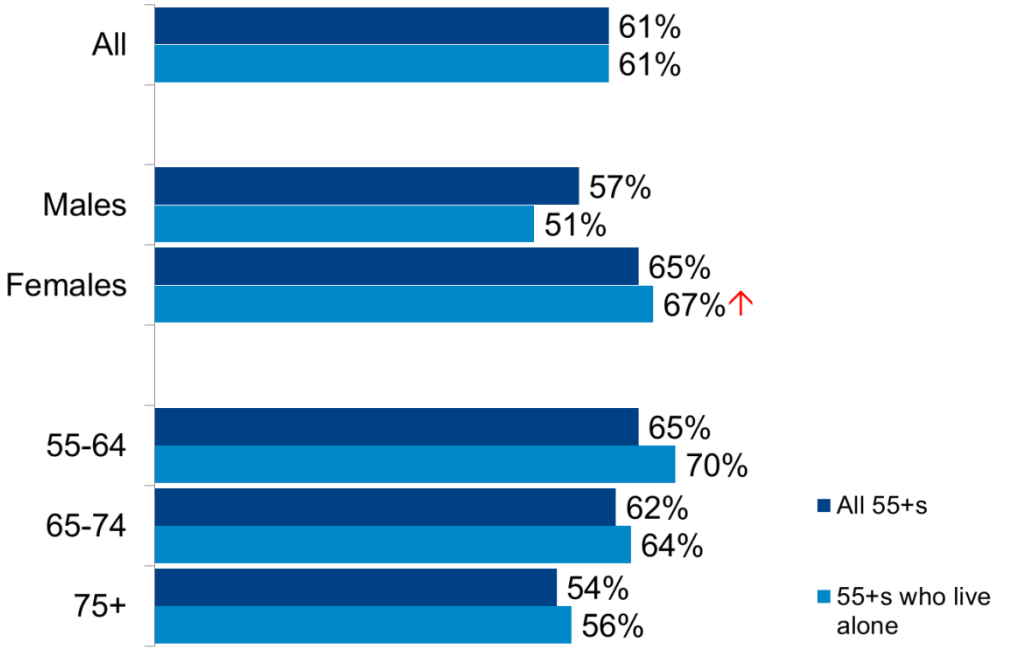
Six in ten (61%) older people said they see or speak to a relative or other adult outside of their household every day. This equates to two in five (39%) not seeing or speaking to an adult outside of their household every day.

[99] All were asked if they had had any of a number of health checks in the past 2 years. The checks could have been conducted by a doctor or pharmacist. The health checks were Test for diabetes, Memory test (55+s only), Eye test, Skin check (e.g. moles/skin cancer), Bowel cancer screening, Test for high blood pressure, Test for high cholesterol, Testicular cancer check, Prostate check, Cervical smear test, Breast cancer check e.g. mammogram, Chlamydia test, HIV test, Full health check

Amongst those who live alone there were no overall differences in interactions compared with older people on average, though older females (67%) who live alone were significantly more likely than older males who live alone (51%) to say they see or speak to a relative or other adult outside of their household every day (Figure 146).

It is also interesting to note that, regardless of whether or not they live alone, the proportion of older people saying they see or speak to a relative or other adult outside their household every day declines with age (Figure 146).

Figure 146 **% who said they see or speak to a relative or other adult outside their household every day**



Base: All 55+s (833), 55+s who live alone (309)
↑↓ Indicates a significant difference, compared with the corresponding sub-group

In addition amongst those who live alone, ABC1s (71%) were significantly more likely than C2DEs (56%) to see or speak to a relative or other adult outside of their household every day. Twelve percent of all older people live alone *and* do not see or speak with someone every day. This proportion increases with age: 5% of 55-64s, up to 13% of 65-74s and 23% of 75+s.

In addition to the six in ten (61%) who see or speak to a relative or other adult outside of their household every day, around one in ten do so five or six days a week (10%), three or four days a week (13%) or once or twice a week(12%). Just 2% of older people said they see or speak to a relative or other adult outside of their household less often than once a week, or never.

Although the Lifecourse Tracker survey cannot provide a comparison to 18-54s here, a 2011 Department for Environment, Food and Rural Affairs (Defra) survey of public attitudes and behaviours towards the environment[100] can be used as a comparator. The Defra survey asked respondents how often in the previous two weeks they had spent time together with family and friends. It reported that 67% of respondents spent time with friends

100 http://webarchive.nationalarchives.gov.uk/20130123162956/http://www.defra.gov.uk/statistics/files/Statistical-Release-13-April-2011-well-being.pdf section 4: Engagement in positive activities

and family on most or every day during this period; with over 65s significantly less likely to have done so: 35% v 67% of 16 to 24 year olds.

14.8.3 Conversations about health with friends and family

The Lifecourse Tracker also asked older people whether they had had a conversation with a friend or family member about health-related subjects in the past three months. They were first asked about the subject of this conversation and then about who had raised the subject on the last occasion. Nearly six in ten (56%) older people had had some sort of conversation about their health with a friend or family member in the past three months. These included conversations about:

- Health in general (35%)
- A specific health problem (26%)
- A sign or symptom which had just become apparent (9%)
- A sign or symptom which had changed/got worse (7%)

Over 65s (6%) were much less likely than 55-64s (14%) to have discussed signs and symptoms including those which had just become apparent.

Amongst those who had had a conversation about specific health concerns, the last conversation had more often been initiated by the older person (39%) than by the friend or family member to whom they were speaking (25%). In most other cases the topic simply came up in conversation (28%).

14.9 Older people – summary

This section summarises the findings from the adult survey and is specifically about 55+s.

Overall, older people reported lower levels of well-being than the all adult average in relation to the ONS well-being measures, self-reported health and attitudes towards their own health now and in the future.

Older people's health behaviours were generally better than the all adult average. They were less likely to report all negative health behaviours with two exceptions: physical activity and alcohol consumption. Over 55s were more likely than the all adult average to say that they were active for fewer than 150 minutes in the previous week. In addition, a similar proportion as the all adult average reported alcohol consumption which classified them as increasing/higher risk drinkers.

The over 75s, in comparisons with the 55-74s, were more likely to consume fewer than five portions of fruit/veg a day and were less likely to be physically active, but also were less likely to be smokers.

Perhaps linked to their lower prevalence of negative health behaviours , 55+s were significantly more likely than the all adult average to think that positive health behaviours are the norm for all behaviours except physical activity. Amongst those who did report each negative health behaviour, older people were generally less likely than the all adult average to worry about the effect of this on their health and less likely to intend to change these behaviours over the next three months.

Older people were significantly more likely than the all adult average to have had at least one health-check with a health professional in the past two years, but no more likely to report regular self-health checks

Most older people reported seeing or speaking to a relative or other adult outside of their household every day. Regardless of whether or not they live alone, the proportion of older people saying they see or speak to a relative or other adult outside their household every day declines with age. Most had had some sort of conversation with a friend or family member about health-related subjects in the three months prior to interview, with over 65s more likely to have done so than 55-64s.

Appendices

15 Methods

The main audience for the Lifecourse Tracker research was adults aged 18+ in England. Two further key groups were identified: young people aged 11-17 and pregnant women and mothers of 0-2 year old babies. Separate surveys were conducted with 11-17s and pregnant women/mothers of 0-2s because of their relatively low penetration in the general population.

The adult and young people surveys were conducted face-to-face in respondents' homes, but the survey of pregnant women/mothers of 0-2s was conducted online. Further details of the survey method for each group are described in sections 15.3.1 and 15.4.1.

15.1 Survey development and piloting

Before conducting the survey, the Lifecourse Tracker had an extensive development stage to ensure that the questionnaire met the needs of the Department and other users of the data as well as ensuring that appropriate harmonised questions from established surveys were used where possible.

The processes of scoping and piloting the survey are detailed below.

15.1.1 Scoping stage

The first stage of development was the scoping stage and consisted of an initial knowledge review, followed by stakeholder interviews amongst key Department staff and academic advisors. Finally a stakeholder workshop was conducted to help to prioritise the questions that should be included in the survey. These are described in more detail as follows:

Knowledge review

The first stage of the scoping exercise reviewed what was already known and included the following:

- Further discussion of tracking survey objectives
- Review of existing strategic materials
- Review of existing literature on motivations
- A review of existing questionnaires looking at issues relating to health behaviour measurement
- A review of behaviour change journeys across the marketing strands

Stakeholder interviews

Ten interviews were carried out by GfK NOP executives amongst Department stakeholders and academic experts. The interviews provided an in-depth understanding of information and tracking needs, and how these interact with their strategic objectives. The interviews covered the following topics:

- Youth issues
- Older people
- Pregnant women and mothers of young children
- Alcohol
- Tobacco control
- Physical activity
- Diet and nutrition
- Other strategic health surveys carried out for the Department (such as the Health Survey for England)

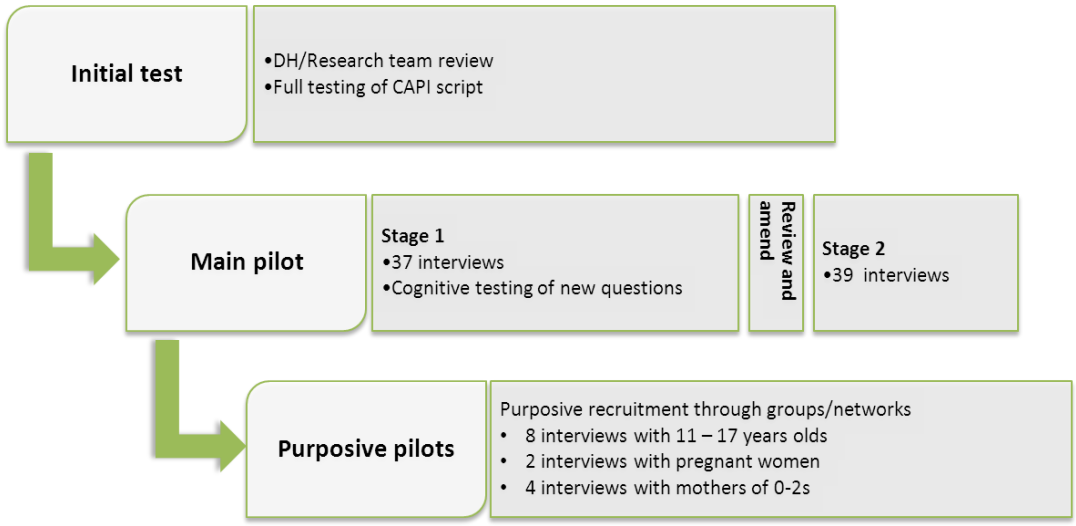
Stakeholder workshop

Once all the possible avenues for survey topic areas had been explored then the next task was to decide what went into the first draft of the questionnaires. A stakeholder workshop was therefore carried out to inform the focus of the questionnaires. Prioritisation of attitudinal and behavioural measures were discussed; following the workshop a list of questions which were considered 'must haves' were produced which fed into the development of the first questionnaires.

15.2 Questionnaire design and piloting

Following the scoping stage the questionnaire was piloted. Figure 147 gives an overview of the piloting stage.

Figure 147 **Overview of the piloting stage**



After the stakeholder workshop a number of meetings between GfK NOP, academic advisors and the Department were held to further refine and agree on the content for the pilot questionnaires. Where possible, questions were harmonised across the questionnaires. Once agreed, the CAI (Computer Aided Interviewing) script was programmed based on the pilot questionnaires. These programmed questionnaires were tested extensively before the fieldwork pilot to ensure that the correct questions were being asked and that the question wording exactly matched that of the agreed pilot questionnaire.

15.2.1 Fieldwork pilot

The three audiences were piloted separately:

Adults – this was a two stage piloting exercise which was conducted face-to-face. The aim of the first stage of the pilot was to cognitively test the questionnaire, measure the questionnaire length and test the fieldwork procedures. Interviewers were provided with briefing notes to familiarise themselves with the survey and were briefed verbally by GfK NOP executives on the aims and objectives of the pilot test. Interviewers worked in different areas across the country to get a spread of responses. GfK NOP executives watched a number of interviews to understand how well the questionnaire was working. This feedback, along with any feedback from interviewers was collated and discussed with the Department. The questionnaire was amended accordingly for stage 2 of the pilot. The purpose of the second stage was to check that any amendments to the questionnaire were working correctly and to re-check the timing of the questionnaire.

At the first stage 37 interviews were carried out, with a further 39 at the second stage. Interviewers carried out the interviews with a mix of different types of adults including parents to ensure that all routes through the questionnaire were thoroughly tested. After the pilot, changes were agreed and signed off. Any changes to questions that also appeared in the young people and pregnant women/mothers of 0-2s survey were carried over.

Young people and pregnant women/mothers of 0-2s - due to the lower incidence of these groups a purposive pilot was carried out to specifically find these respondents. These interviews were carried out face-to-face as normal to test the interview length and some cognitive questions were included. After the feedback was collated changes were agreed with the Department.

15.3 Adult (18+) survey and young people survey (11-17s) – main stage

15.3.1 Method

Both of these surveys were conducted face-to-face in respondents' homes. Interviews were conducted using Computer Assisted Personal Interviewing (CAPI) which means that the interviewers used a laptop which controlled the questionnaire, order of presentation of questions and routing based on answers given. The questionnaire used Computer Assisted Self Interviewing (CASI) for the most sensitive elements of the questionnaire – these meant respondents were given the CAPI laptop and answered the questions themselves. Respondents who were not comfortable using the CAPI laptop were given the option of listening to a selection of the CASI questions through headphones and then selecting the answers on the laptop touch screen.

A nationally representative sample was targeted in both the adult and young people surveys with a skew towards the 10% most deprived areas of the country. The rationale for this skew was to ensure there were adequate sub samples in deprived areas; these are areas that often have a strong policy focus and a nationally representative sample does not necessarily deliver sufficient sub sample sizes in such areas. This skew was corrected in the final figures through weighting, to produce a nationally representative picture.

It should be noted that the adult and young people surveys were completely separate, that is, adult respondents and young people respondents did not live in the same household.

15.3.2 Sampling – adult survey

The sample was drawn using a random location sampling method. Fieldwork was completed across 103 sampling points in England and each sampling point took the form of one Output Area[101] (OA). Interviewers were instructed to work for two days, with the aim of achieving an average of 10 interviews per sampling point.

The sample was matched at each wave to produce a profile consistent in terms of regional distribution, neighbourhood types, working status, age and gender, to ensure comparability over time. The sampling procedure at each wave was as follows:

1. **Selection of Output Areas from the chosen constituencies**: OAs were selected following stratification by region, unitary authority or equivalent and Index of Multiple Deprivation (IMD) rank. The selection was made with probability in proportion to size of the number of adults aged 18+. In order to obtain a boost of respondents in the 10% most deprived areas: 26 OAs were drawn from the 10% most deprived constituencies and 77 OAs were drawn from the full stratified list of all OAs in England. Once drawn, the profile of the selected OAs was checked against the national profile to ensure that it was representative by the key variables noted above as well as age, gender and working status. An equal number of substitute points were selected at the same time to be used if any of the original sample was ineligible for any reason (e.g. inaccessible gated communities, military housing within closed bases).

2. **Selection of addresses within each sampling point**: Interviewers were provided with lists of residential addresses which they could approach for interview, and they recruited respondents based on the quota provided to them.

Quotas were set on age and interlocked gender and working status (more specifically men working full-time, men not working full-time, women working, women not working). Quotas varied by sampling point to reflect the census profile of the area in which interviewers were working.

15.3.3 Sampling – young people survey

The young people's survey sample was also drawn using random location sampling methods, with a consistent sampling design from wave to wave to enable comparisons to be made over time. At each wave fieldwork was completed at 103 sampling points in England, with each sampling point taking the form of one OA. The sample was drawn in the following stages:

1. **Selection of OAs from chosen constituencies**: Initially, for fieldwork efficiency, the OAs with populations containing greater than 8% 11-17s were selected. The sampling procedures were then identical to those described for the adult survey: stratification by region, unitary authority and IMD rank and selection of sampling points (OAs) with probability in proportion to the number of 11-17 year olds present. An additional boost sample was selected to boost the number of interviews with those in the 10% most deprived areas.

---

[101] An Output Area (OA) is the smallest area for which detailed 2001 Census results are available. OAs were created specifically for statistical purposes on the basis of data from the 2001 Census. OAs contain an average of 125 households and around 300 residents: the minimum size is 100 residents or 40 households. Where possible, OA boundaries were drawn to contain populations with homogenous characteristics, and around small, free-standing settlements. For more information on Output Area geography, please see http://www.statistics.gov.uk/census2001/geo_methods.asp

2. **Selection of areas**: Interviewers were provided with lists of addresses which they could approach for interview, and they recruited respondents to quota.

   Interlocking quotas were set on gender and age of the young person. Quotas were based upon profile information from the 2001 Census.

15.3.4 Fieldwork

Figure 148 shows fieldwork dates and the number of interviews achieved at each stage:

Figure 148 **Key fieldwork figure for adult and young people surveys**

	Adult		**Young people**	
	Wave 1	Wave 2	Wave 1	Wave 2
Fieldwork dates	12th – 31st March 2012	17th September - 17th October 2012	14th March- 9th April 2012	17th Sept - 17th October 2012
Number of interviews	1010	1019	608	602

To acquaint interviewers with the background to and objectives of the research, written briefing instructions were provided to all interviewers working on the survey. Interviewers were instructed to familiarise themselves with the objectives of the survey as well as the topics covered. Specific briefing points about question administration and points of clarification were provided via a marked up questionnaire to ensure consistency and high quality information was collected. Interviewers were invited to contact members of the research team if they had any queries specific to the survey or subject matter.

When completing fieldwork, interviewers adhered to the following rules to maintain fieldwork quality. They:

- Only completed one interview per household
- Completed no interviews with people known to them
- Registered at a local police station before starting work, to enable them to provide reassurance to respondents if needed

The survey introduction was carefully worded to encourage as wide a range of respondents as possible to take part – not only those interested in health issues.

A contact screener card was provided to interviewers which included all questions required to enable interviewers to establish eligibility. For the young people survey permission to interview the young person was sought from a parent or carer before the interview took place.

Upon concluding the interview all respondents were handed a sources of information leaflet. The leaflets contained a list of contacts to go to for help and support regarding the issues which were covered in the survey. The purpose of the leaflet was to provide the respondent with a mechanism for accessing support if necessary and was part of GfK NOP's duty of care to respondents. In addition to the information leaflet, a thank you leaflet was also provided. This contained contact details for GfK NOP in case there were any later queries. A large print version of this leaflet was also made available, if required.

15.3.5 Weighting and analysis

The achieved samples were weighted to the known profile of adults and young people in England with establishment profiles taken from the Census. Minor rim weighting was required to correct for minor imbalances in the age, gender, social grade and regional profiles of the achieved samples. Before this, pre-weights were applied to correct for the sample skew towards more deprived areas, as described above.

Full weighting matrices are appended and the effective sample sizes were generally around 62% of the achieved sample for the adult survey and 65% for the youth survey.

The data were tabulated and analysed by key groups such as lifecourse, gender and social grade. The data were also produced in SPSS for bespoke analysis.

Indicators across the two surveys were closely examined, and it became clear that there was a high degree of consistency of response between the two waves of research. In order to deliver sufficiently large samples within key sub-groups for robust analysis, the decision was taken to combine the samples across the two waves. Data are therefore shown based on all adults or young people interviewed as part of the Lifecourse Tracker during 2012 (i.e. across the two waves), though where there were significant differences in response between the two waves, this is noted in the commentary.

15.4 Pregnant women and mothers of 0-2s

15.4.1 Method

Due to the relatively low penetration of pregnant women and mothers of 0-2s in the general population, the optimal method for interviewing this group was through an online survey. Respondents were contacted through the Emma's Diary database. Emma's Diary is an online and printed pregnancy guide produced in association with the Royal College of General Practitioners, which provides advice and guidance to pregnant women about their pregnancy. Emma's Diary estimates that around 90% of pregnant women receive the publication, and almost all register with them. The survey only included mothers of babies who were aged up to 24 months as this was the limit of the database.

15.4.2 Sampling

A representative random sample was drawn from the Emma's Diary database. The sample was drawn following stratification of the database by region, age of mother and stage of pregnancy / age of child.

15.4.3 Fieldwork

Fieldwork was conducted as shown in Figure 149.

Figure 149 **Key fieldwork figures for pregnant women and mothers of 0-2s**

	Wave 1	**Wave 2**
Fieldwork dates	21st – 31st March 2012	28th September - 5th October 2012
Number of interviews	300 with pregnant women 247 with mothers of 0-2s	294 with pregnant women 303 with mothers of 0-2s

15.4.4 Weighting and analysis

The achieved samples were weighted to the known profile of pregnant women and mothers of 0-2s in England with establishment profiles taken from GfK NOP's Financial Research Survey (itself weighted to the profile of the National Readership Survey). Minor rim weighting was required to correct for minor imbalances in the age, social grade and regional profiles of the achieved samples.

Full weighting matrices are appended in section 18 and the effective sample sizes for each survey were as follows.

- Adult: 62% of the achieved sample
- Youth: 65% of the achieved sample
- PW02: 84% of the achieved sample

The data were tabulated and analysed by key groups such as age, social grade, whether or not a first time mum and (for pregnant women) trimester. The data were also produced in SPSS for bespoke analysis.

Indicators across the two waves of the survey were again closely examined, and it became clear that there was a high degree of consistency of response between the two waves of research. In order to deliver sufficiently large samples within key sub-groups for robust analysis, the decision was taken to combine the samples across the two waves. Data are therefore shown based on all mothers of 0-2s and pregnant women interviewed as part of the Lifecourse Tracker during 2012 (i.e. across the two waves), though where there were significant differences in response between the two waves, this is noted in the commentary.

16 Definitions

This section fully defines key behavioural indicators used, other survey sources, and other terms used in the lifecourse tracker survey.

16.1.1 Key indicators of negative health behaviours

Figure 150 **Key indicators of negative health behaviours**

Behaviour	Survey audience	Key indicator definition
Nutrition	Adults	Ate fewer than five portions of fruit/veg (fruit, vegetables or salad - fresh, frozen, tinned, dried or juiced) on the day prior to interview
	Youth	Ate fruit/veg (fruit, vegetables or salad - fresh, frozen, tinned, dried or juiced) less often than several times a day in a normal week
	Pregnant women	Adult measure used
	Mothers of 0-2s	Adult measure used
Physical activity	Adults	Did fewer than 150 minutes of moderate physical activity (physical activity that makes you breathe slightly faster than usual) in the seven days prior to interview
	Youth	Did any moderate physical activity (physical activity that makes you breathe slightly faster than usual) on 0-6 days in the seven days prior to interview
	Pregnant women	N/A: Pregnant women not questioned about levels of moderate physical activity
	Mothers of 0-2s	All adult measure used
Alcohol	Adults	Consumed alcohol to a level that would classify them as increasing/higher risk drinkers (22+ units a week for men and 15+ units a week for women)
	Youth	Usually have an alcoholic drink at least once a month Had first proper alcoholic drink (not just a sip) before 15
	Pregnant women	Had drunk any alcohol in the seven days prior to interview
	Mothers of 0-2s	Had drunk any alcohol in the seven days prior to interview
Smoking	Adults	Currently smokes cigarettes/hand-rolled cigarettes
	Youth	Currently smokes cigarettes (and this may be less than once a week). Described as 'youth smokers'
	Pregnant women	Adult measure used
	Mothers of 0-2s	Adult measure used
Drugs	Adults	Used any illegal drugs/legal highs in the 12 months prior to interview
	Youth	Used cannabis, ecstasy or cocaine in the 12 months prior to interview
	Pregnant women	N/A: Pregnant women not questioned about drug use
	Mothers of 0-2s	N/A: Mothers of 0-2s not questioned about drug use
Sex	Adults	Unprotected sex (defined as sex without a condom) amongst 18-54s with more than one partner or a new partner in the six months prior to interview
	Youth	Ever had sexual intercourse First had intercourse before 15

16.2 Other surveys sources used in the report

Figure 151 **Other surveys sources used in the report**

Survey name	Abbreviation (where applicable)	Source
Infant Feeding Survey		IFF Research, in partnership with Professor Mary Renfrew of the University of Dundee, on behalf of the Health and Social Care Information Centre (HSCIC)
Health Survey for England	HSE	NatCen Social Research and the Research Department of Epidemiology and Public Health at UCL (University College London), on behalf of Health and Social Care Information Centre (HSCIC)
The Healthy Foundations Lifestages Segmentation		GfK NOP Social Research, on behalf of Social Marketing and Health Related Behaviour Team of the Department of Health
Subjective Well-being survey		Office for National Statistics
General Lifestyle Survey	GLF	Office for National Statistics
Smoking, drinking and drug use among young people in England in 2011	SDD	Health and Social Care Information Centre (HSCIC)
Smoking and Smoking Cessation in England - 2011		West R, Brown J, on behalf of Health and Social Care Information Centre (HSCIC)
Crime Survey for England and Wales	CSEW	Office for National Statistics
Survey of public attitudes and behaviours towards the environment		Department for Environment, Food and Rural Affairs

16.2.1 Glossary of other terms used in this report

Figure 152 **Definitions for other terms used in this report**

Term	Explanation
Department of Health (the Department)	Department with responsibility for government policy for health and social care matters and for the National Health Service (NHS). The Department commissioned the Lifecourse Tracker. From 1st April 2013 the responsibility for government policy for health became the remit of Public Health England (PHE) (see below).
Indices of Multiple Deprivation (IMD)	The English Indices of Deprivation 2010 provide a relative measure of deprivation at small area level across England. Areas are ranked from least deprived to most deprived on seven different dimensions of deprivation and an overall composite measure of multiple deprivation. The domains used in the Indices of Deprivation 2010 are: income deprivation; employment deprivation; health deprivation and disability; education deprivation; crime deprivation; barriers to housing and services deprivation; and living environment deprivation[102]. Based on this addresses in the Lifecourse tracker have been put into quintiles of deprivation: 1: 10% most deprived 2 3 4 5: 10% least deprived These quintiles are often simplified to look at whether or not respondents live within the 10% most deprived areas.
Locus of control	Agreement/disagreement with “There is little I can do to change my life” (Agree strongly – disagree strongly).
Other women	Women aged under 45 years of age and without children aged 0-2 who were interviewed as part of the all adult survey. This group is used a comparator for pregnant women and mothers of 0-2s.
Parents	Those in the adult survey with dependent children aged 0-16 (defined as children who live in their household and for whom they are the main parent/guardian).
Poverty Status	Based on 60 per cent relative poverty measure (defined as individuals living in households with incomes below 60 per cent of the median income). The definition of median income was taken from the May 2011 version of the DWP Households Below Average Income report[103].
Public Health England (PHE)	An executive agency of the Department of Health in the United Kingdom established in April 2013 as a result of reorganisation of the National Health Service (NHS) in England outlined in the Health and Social Care Act 2012.
Risk taking	Agreement/disagreement with “I believe you need to take risks to lead a

[102] http://data.gov.uk/dataset/index-of-multiple-deprivation
[103] https://www.gov.uk/government/publications/households-below-average-income-hbai-199495-to-201112

	full life" (Agree strongly – disagree strongly).
Self esteem	Agreement/disagreement with "I feel good about myself" (Agree strongly – disagree strongly).
Short termism	Agreement/disagreement with "I generally focus on the here and now rather than worry about the future" (Agree strongly – disagree strongly).
Social Grade	Respondents were classified into broad social grade groupings based on the chief income earner in the household. These groups are based on the following: • A - Higher managerial, administrative or professional • B - Intermediate managerial, administrative or professional • C1 - Supervisory or clerical and junior managerial, administrative or professional • C2 - Skilled manual workers • D - Semi and unskilled manual workers • E - Casual or lowest grade workers, pensioners and others who depend on the welfare state for their income
Short termism	Agreement/disagreement with "I generally focus on the here and now rather than worry about the future" (Agree strongly – disagree strongly).
Statistical significance	The non-random survey method employed on the Lifecourse Tracker means that true statistical significance cannot, strictly speaking, be calculated but, in practice, this sampling method implies a level of randomness in the overall sampling process that allows us to use it to make some inferences about the survey estimates. However, the results should be treated as indicative rather than conclusive. When data collected is based on a sample the estimates are subject to sampling error. A statistical test allows us to calculate whether a difference between two survey estimates is more likely to be a reflection of a real difference in the population or simply a result of sampling error. Differences highlighted in this report are, generally, significant at the 95% confidence level. This means that there is probability of 5% or less that the observed difference is a result of sampling error and, hence, a probability of 95% or more that the difference is due to a real difference between the populations.

17 Source of constructs used in the Lifecourse Tracker

The table below shows the original papers from which the constructs to be included in the questionnaires were derived. It should be noted that the number of question items within each scale was reduced and refined through the Healthy Foundations piloting phase (include HF reference here) so the list below should be taken as indicative.

Figure 153 **Provenance of constructs used in the Lifecourse Tracker**

Scale	Source
Health Fatalism	Powe BD (1995) Fatalism among elderly African Americans. Effects on colorectal cancer screening, Cancer Nursing, 18 (5): 385-92
Self-positivity	Raghubir P and Menon G (1998) AIDS and Me, Never the Twain Shall Meet: the effects of information accessibility on judgements of risk and advertising awareness, Journal of Consumer Research, 25 (June): 52-63
Health Locus of Control	Wallston KA, Wallston BS and Devellis RF (1978) Development of the Multidimensional Health Locus of Control (MHLC) Scale, Health Education Monographs, 6 (1): 160-70
Response Efficacy	Ajzen I (2006) Constructing a TpB Questionnaire: Conceptual and methodological considerations. Accessed 6 July 2007: www.people.umass.edu/ajzen/pdf/tpb.measurement.pdf
Self-Efficacy	Ajzen I (2006) Constructing a TpB Questionnaire: Conceptual and methodological considerations. Accessed 6 July 2007: www.people.umass.edu/ajzen/pdf/tpb.measurement.pdf
Self Esteem	Rosenberg M (1965) Society and the Adolescent Self-Image. Princeton, NJ: Princeton University Press
Attitudes to Risk	Rohrman B (2004) Risk Attitude Scales: Concepts and Questionnaires, Project Report, University of Melbourne

Other constructs (Locus of control and Short Termism) were developed without reference to the literature.

18 Data

The achieved samples were weighted to the known profile of adults / young people / pregnant women/mothers of 0-2s from sources such as the Office of National Statistics. Figure 154 through to Figure 156 show what the data was weighted by.

Figure 154 **Profile of adults interviewed –before and after weighting has been applied**

	Weighted	Unweighted		Weighted	Unweighted
Gender and age			**IMD grouping**		
18-24 Male	6%	5%	10% most deprived	10%	34%
25-34 Male	9%	8%	10%-20%	10%	7%
35-44 Male	9%	6%	20%-40%	20%	16%
45-54 Male	9%	7%	40%-60%	10%	16%
55-64 Male	7%	6%	60%-80%	20%	17%
65-74 Male	5%	7%	80%-100% least deprived	20%	10%
75+ Male	4%	5%			
18-24 Female	6%	6%	**Ethnicity**		
25-34 Female	8%	9%	White	89%	87%
35-44 Female	9%	10%	Asian	4%	6%
45-54 Female	9%	8%	Black	3%	4%
55-64 Female	8%	9%	Other	5%	2%
65-74 Female	6%	7%			
75+ Female	5%	7%	**Working Status**		
			Working	59%	44%
Government office region			Not working	18%	26%
North East	5%	6%	Retired	23%	29%
North West	13%	19%			
Yorkshire And The Humber	10%	13%			
East Midlands	9%	9%	**Children in the household**		
West Midlands	10%	13%	Children under 16	73%	70%
Eastern	11%	9%	None under 16	21%	3%
London	15%	13%			
South East	16%	10%			
South West	10%	7%			

Figure 155 **Profile of young people interviewed – before and after weighting has been applied**

	Weighted	Unweighted		Weighted	Unweighted
Gender and age			**IMD grouping**		
11-12 year old Male	14%	16%	10% most deprived	10%	35%
13-14 year old Male	15%	17%	10%-20%	10%	10%
15-17 year old Male	23%	17%	20%-40%	20%	16%
11-12 year old Female	13%	15%	40%-60%	20%	12%
13-14 year old Female	14%	16%	60%-80%	20%	12%
15-17 year old Female	21%	19%	80%-100% least deprived	20%	14%
Government office region			**Ethnicity**		
North East	5%	6%	White	83%	81%
North West	14%	19%	Asian	7%	9%
Yorkshire And The Humber	10%	13%	Black	6%	5%
East Midlands	9%	10%	Other	4%	5%
West Midlands	11%	12%			
Eastern	11%	9%	**Social grade of head of household**		
London	13%	13%	ABC1	47%	40%
South East	17%	11%	C2DE	53%	60%
South West	10%	6%			

Figure 156 **Profile of pregnant women and mothers of 0-2s interviewed – before and after weighting has been applied**

	Weighted	Unweighted		Weighted	Unweighted
Age and social grade			**Government office region**		
18-24 ABC1s	5%	7%	North East	4%	4%
25-29 ABC1s	12%	16%	North West	13%	13%
30-34 ABC1s	15%	24%	Yorkshire and the Humber	9%	10%
35+ ABC1s	12%	12%	East Midlands	8%	11%
18-24 C2DEs	18%	11%	West Midlands	10%	9%
25-29 C2DEs	16%	13%	Eastern	11%	12%
30-34 C2DEs	13%	10%	London	19%	12%
35+ C2DEs	8%	7%	South East	17%	18%
			South West	9%	10%

19 Questionnaires

The following pages show the final Wave 2 questionnaires used in each survey: adults (18+), youth (11-17s) and pregnant women and mothers of 0-2s.

452676 Lifecourse Tracker Questionnaire ADULT WAVE 2 FINAL

A Who are you? (intro and demographics)

Firstly, I would like to ask you a few questions about this household and the people you live with

A 1 To start, can I just ask you how old you are?

Enter actual age
If refused: use bands below
18-24
25-34
35-44
45-54
55-64
65-74
75+

A 2 CODE RESPONDENT GENDER

Male
Female
Other

A 3 Which of these categories best describes what YOU personally do at the moment?

SHOWSCREEN
CODE MAIN ACTIVITY ONLY

Working full time as an employee or on a self-employed basis (30+ hours)
Working part time as an employee or on a self-employed basis (8-29 hours)
Unemployed and actively seeking work
On a special government training or employment scheme
A full time student or pupil
Looking after the family or home
Not working because temporarily sick or injured
Not working because long-term sick or disabled
Retired from paid work
None of these

A 4 Who do you live with in this household?

SHOWSCREEN
CODE ALL MENTIONED

Spouse/civil partner/partner
Parent (including in-law or step parent)
Grandparent (including in-law or step)
Son/daughter (including in-law, adopted, step or foster)
Brother/sister (including in-law, adopted, step or foster)
Other relative
Friend
Personal assistant/paid carer
Other person (specify)
No-one/I live alone

A 5 How many children or young people aged under 17 live in this household? This could include other people's children who usually live in this household, as well as your own children.

Enter Number
None

IF MORE THAN ONE CHILD (A 5>0), OTHERS GO TO SECTION B

A 6 COLLECT AGES OF ALL CHILDREN/YOUNG PEOPLE AGED UNDER 17 WHO LIVE IN THE HOUSEHOLD

A 7 Enter ages

A 8 And are you the parent or main or joint carer for any of the children or young people you have told me about?

CAPI show ages of children. Ask respondent to code all children for whom they are the parent or main carer
None

IF PARENT/MAIN/JOINT CARER TO ANY CHILDREN AGED 2-16: CAPI TO MAKE RANDOM SELECTION OF CHILD

A 9 You've told me that you are the parent or main/joint carer to a child aged <age>. I will be asking you some questions about them later in the interview, and to make sure that I ask you about the right person, could I take their name

Enter name which the parent usually calls child (first name only)

B General motivations

The first section is about the way you think and feel about things. Throughout this interview there are no right or wrong answers - we are interested in your views and opinions.

B 1 How much you agree or disagree with these things?

SHOWSCREEN

PROBE: Do you agree/disagree strongly or slightly, or just agree/disagree?

Disagree strongly
Disagree
Disagree slightly
Neither agree nor disagree
Agree slightly
Agree
Agree strongly

ROTATE

- I feel good about myself (SELF ESTEEM)
- There is little I can do to change my life
- I believe you need to take risks to lead a full life (RISK TAKING)
- I generally focus on the here and now rather than worry about the future (SHORT TERMISM)

C General views on health

READ OUT
The next few questions ask you about your feelings about health in general.

C 1 How is your health in general? Would you say it was ...

SHOWSCREEN

1 …very good
2 good
3 fair
4 bad, or
5 very bad?

C 2 How much do you agree or disagree with these things?

SHOWSCREEN

Disagree strongly
Disagree
Disagree slightly
Neither agree nor disagree
Agree slightly
Agree
Agree strongly

ROTATE
HEALTH LOCUS OF CONTROL

- The main thing which affects my health is what I personally do

HEALTH FATALISM

- If a person is meant to get ill, they will get ill anyway, regardless of whether they lead a healthy lifestyle

IF AGED 55 OR OLDER

- As I get older my health is going to get worse, regardless of whether I lead a healthy lifestyle

READ OUT
People think differently about their health and how it might change in the future, and the next few questions are about that subject.

C 3 Compared with other people of your age, how likely do you think it is that you will get seriously ill at some point over the next few years?

SHOWSCREEN

I am much MORE likely to get seriously ill than other people of my age
I am a little more likely
No more or less likely
I am a little less likely
I am much LESS likely to get seriously ill than other people of my age
Not applicable/Already have a serious illness

INT SCREEN: PLEASE TURN SCREEN AWAY FROM RESPONDENT

C 4 Next I'd like you to think about healthy lifestyles. What things do you think you need to do or avoid doing as part of a healthy lifestyle? DO NOT PROMPT. CODE ALL MENTIONED

DO NOT SHOW SCREEN
INTERVIEWER: PROBE FULLY: what else do you think you need to do or avoid doing to have a healthy lifestyle?

Have a healthy diet
Drink lots of water
Maintain low cholesterol
Reduce salt in diet
Take vitamins/supplements
Reduce fat
Don't use illegal drugs
Don't smoke
Don't drink too much alcohol
Practise safer sex/look after your sexual health (e.g. using condoms)
Do regular exercise
Have regular health checks
Get enough sleep
Reduce stress
Feel happy
Keep your mind active
Have good relationships
Have a decent environment to live in
Everything in moderation
Other (specify)
None of these

READ OUT

C 5 For you, how easy or difficult would it be to lead a healthy lifestyle over the next 12 months? (RESPONSE EFFICACY)

SHOW SCREEN

Extremely difficult 1 … 7 Extremely easy

C 6 How much control do you believe you have over whether or not you lead a healthy lifestyle over the next 12 months? (SELF EFFICACY)

SHOW SCREEN

No control 1 … 7 Complete control

C 7 Next I would like you to think about your friends and family. How many of them do you think lead a healthy lifestyle nowadays?

SHOW SCREEN

All of them
Most of them but not all
About half
Some of them but less than half
Only a few
None of them

D Now part of section C

E Healthy Eating

READ OUT
Next I would like to ask you some questions about food and what you eat. There are no right or wrong answers here, so please be as honest as possible.

E 1 To what extent would you agree or disagree with these things about healthy eating?

SHOW SCREEN

Disagree strongly
Disagree
Disagree slightly
Neither disagree nor agree
Agree slightly
Agree
Agree strongly

ROTATE

- Healthy eating means giving up too many of the foods I enjoy
- Most people I know eat healthily nowadays
- Healthy eating is only for those that can afford it

E1a How high a priority for you is healthy eating nowadays?

SHOW SCREEN

Very high
Quite high
Not very high
Not a priority at all

E 2 How often do you eat each of these things in a normal week?
SHOW SCREEN

Several times a day
Once a day
5 or 6 days a week
3 or 4 days a week
Once or twice a week
Less often
Never

ROTATE

- Fruit, vegetables or salad . These could be fresh, frozen, tinned, dried or juiced, but don't include potatoes
- Foods that are high in sugar, such as cakes, puddings, pastries or biscuits, sweets or chocolate
- Foods that are high in fat or fried foods such as fried fish, chips, cooked breakfast, samosa, crisps or fatty meats but not including oven chips
- Fizzy drinks or soft drinks like squash – not including diet or sugar free drinks, or sparkling water

E 3 DELETED

E3a At the table do you….READ OUT…
CODE ONE ONLY. TREAT LO-SALT AS SALT
SHOW SCREEN

Generally add salt to your food without tasting it first
Taste the food, but then generally add salt
Taste the food, but only occasionally add salt
Rarely, or never, add salt at the table

E 4 Thinking just about YESTERDAY how many portions of fruit, vegetables or salad did you eat- fresh, frozen, tinned, dried or juiced?

NOTE: A portion is a medium sized piece of fruit such as an apple, a glass of 100% fruit juice or 3 heaped tablespoons of cooked vegetables. It does not include potatoes.

ENTER NUMBER
None

E4a And which of these things apply to the way you personally eat nowadays, as part of a normal day?

SHOW SCREEN

You limit the number of unhealthy snacks you eat between meals
You limit the amount of food and drink you consume that is high in calories
You limit the amount of salt or lo salt you take in
None of these

E 5 To what extent do you intend to start eating a healthier diet over the next 3 months?

SHOW SCREEN

Definitely don't intend to 1 … 7 Definitely intend to
I don't intend to eat a healthier diet – I already eat healthily

IF PARENT OF CHILD AGED 2-11
Next I would like to ask you some questions about <child>.

E 6 To what extent would you agree or disagree with this statement?

SHOWSCREEN
ROTATE

Disagree strongly
Disagree
Disagree slightly
Neither disagree nor agree
Agree slightly
Agree
Agree strongly

- As long as a child is a healthy weight, parents needn't worry about what the child eats

E 7 How often does <child> eat each of these things in a normal week?

ROTATE

Several times a day
Once a day
5 or 6 days a week
3 or 4 days a week
Once or twice a week
Less often
Never

- Fruit, vegetables or salad . These could be fresh, frozen, tinned, dried or juiced, but don't include potatoes
- Foods that are high in sugar, such as cakes, puddings, pastries or biscuits, sweets or chocolate
- Foods that are high in fat or fried foods such as fried fish, chips, cooked breakfast, samosa, crisps or fatty meats but not including oven chips
- Fizzy drinks or soft drinks like squash – not including diet or sugar free drinks

E 8 Thinking just about YESTERDAY how many portions of fruit, vegetables or salad did <child> eat- fresh, frozen, tinned, dried or juiced?

NOTE: A portion is a medium sized piece of fruit such as an apple, a glass of 100% fruit juice or 3 heaped tablespoons of cooked vegetables. It does not include potatoes.

ENTER NUMBER
None

E 9 And which of these things do you do nowadays for <child>, as part of a normal day?

CODE ALL THAT APPLY

Limit <him/her> to a maximum of 2 unhealthy snacks a day between meals (IF CHILD AGED 5-11)
Make sure <he/she> eats food portions appropriate for <his/her> age
Limit the amount of salt or lo-salt <he/she> takes in
None of these

FOLLOW ROUTING IN RESPONSES

E9b How worried are you about the impact of each of the following on <child>'s health?

Not at all worried 1 … 7 Very worried

- IF FATTY FOODS CODES 1-6 AT E7 The amount of fatty or fried foods such as fried fish, chips, cooked breakfast, samosa, crisps or fatty meats that <child> eats - not including oven chips
- IF SUGAR CODES 1-6 AT E7 The amount of sugar and foods containing a lot of sugar, such as cakes, puddings, pastries or biscuits, sweets or chocolate that <child> eats
- IF FIZZY DRINKS CODE 1-6 AT E7 The amount of fizzy drinks or soft drinks like squash that <child> consumes- not including diet or sugar free drinks
- ASK ALL The amount of salt <child> consumes

E 10 To what extent do you intend to get <child> to eat a healthier diet over the next 3 months?

SHOW SCREEN

Definitely don't intend to 1 … 7 Definitely intend to
I don't intend to change <child>'s diet – <he/she> already eats healthily

F Physical activity

READ OUT
Next I would like you to think about exercise and physical activity.

F 1 To what extent would you agree or disagree with these things?

SHOW SCREEN
ROTATE

Disagree strongly
Disagree
Disagree slightly
Neither disagree nor agree
Agree slightly
Agree
Agree strongly

- Most people I know are physically active nowadays
- There are plenty of ways that I could be physically active without having to go to the gym or take part in organised sports

READ OUT
The next few questions are about MODERATE PHYSICAL ACTIVITY that is activity that at least makes you breathe slightly faster than usual. For example:

- brisk walking
- going to the gym
- swimming
- aerobics
- sports
- cycling
- heavy gardening
- physical activity as part of or getting to work/job

F 2 Thinking about the last 7 days, on how many days have you done *any* moderate physical activity? This is any physical activity that makes you breathe slightly faster than usual

Write in (0-7)

IF DOES MODERATE PHYSICAL ACTIVITY (IF 1-7 OR VARIES AT F 2), OTHERS (NONE AT F 2) GO TO F4A

F 3 Across the last 7 days, how many minutes in total have you spent doing moderate physical activity?
IF NECESSARY – This is any physical activity that makes you breathe slightly faster than usual

Write in minutes

ASK ALL

F4a Now thinking about YESTERDAY, how many HOURS did you spend sitting down? This could be at work, at home, on transport such as cars, buses or trains, and in your leisure-time for example sitting at a desk, reading, or sitting or lying down to watch television. This does not include any time spent asleep

Write in hours

F 4 DELETED

F 5 Do you intend to increase the amount of physical activity you do over the next 3 months?
SHOWSCREEN

Definitely don't intend to 1…7 Definitely intend to
Unable to because of a medical condition
I don't intend to increase the amount of physical activity – I already do enough

IF PARENT OF CHILD AGED 2-11, OTHERS GO TO SECTION G
READ OUT
For the next few questions I'd like you to think about <child>.

F 6 To what extent would you agree or disagree with this statement?

SHOW SCREEN
ROTATE

Disagree strongly
Disagree
Disagree slightly
Neither disagree nor agree
Agree slightly
Agree
Agree strongly

- Most parents I know are increasing the amount of physical activity that their child is doing nowadays

F 7 Thinking about YESTERDAY, how much time, in total, did <child> spend being physically active, not including any time within school/nursery hours?
This means that <he/she> was active to a point where <he/she> was breathing slightly faster than usual.
Physical activity can include active play, sports or exercise activities or walking for more than 10 minutes, including walking to and from school/nursery. This includes after school clubs

Write in minutes

F7a Again thinking about yesterday, how many HOURS did <CHILD> spend sitting down, not including any time within school/nursery hours? This could be at home or on transport such as cars, buses or trains. For example this could be time spent in a buggy [FILTER on 2-3 year olds], sitting at a desk, reading, or sitting or lying down to watch television, DVDs, playing video games or using a computer. This does not include any time spent asleep

Write in hours

F 8 Do you intend to get <child> to be more active over the next 3 months?

SHOW SCREEN

Definitely don't intend to 1…7 Definitely intend to
Unable to because of child's medical condition
I don't intend to increase the amount of physical activity
<Child> does – <he/she> already does enough

G Self-completion section

READ OUT
I'd now like you to answer some questions on the laptop. The reason I am asking you to complete this section yourself is that some of the questions are personal to you and doing it this way means you can answer them in private.

Please remember, you do not have to answer any questions you do not want to, but this is a serious survey which will help the government to plan health services.

G 1 Would you prefer to answer the questions by reading them on the laptop screen, or by listening to them through the headphones?

IF NECESSARY: If you read the answers on the screen, the questions are a little quicker to answer

Read on screen and enter answers by themselves (continue)
Listen through headphones (start audio interview)
Prefer interviewer to read questions from screen
(INTERVIEWER: some of the questions are quite personal, so it may be worthwhile to move to another room or ask others to leave the room while you are completing the questions)
Other (discuss requirements with respondent and type in how the questions will be answered)

INTERVIEWER: HAND RESPONDENT THE CAPI MACHINE AND DEMONSTRATE USE BY ASSISTING RESPONDENT TO COMPLETE THE EXAMPLE QUESTIONS.

INTERVIEWER: MAKE SURE YOU SHOW ALL THREE EXAMPLES SO THE RESPONDENT IS USED TO THE DIFFERENT QUESTION TYPES

If audio selected
INTERVIEWER: SHOW RESPONDENT HOW TO LISTEN TO THE ANSWERS AND USE THE ANSWER BUTTONS INCLUDING THE 'PREFER NOT TO SAY' AND 'DON'T KNOW' BUTTONS

EXAMPLE 1: SINGLE RESPONSE:
How much do you agree or disagree that… I like football

Disagree strongly
Disagree
Disagree slightly
Neither disagree nor agree
Agree slightly
Agree
Agree strongly

EXAMPLE 2: MULTIPLE RESPONSE
Which types of pets do you have?

Cats
Dogs
Hamsters
Gerbils
Rabbits
Fish
Other type of pet (type in your answer)
None

EXAMPLE 3: TYPED IN RESPONSE:
Please type in the name of your pet. If you have never had a pet, type in the name you would give a pet if you had one.

Type in

READ OUT
Please answer the next questions in your own time. If you have any problems please ask me and I will be happy to help you.

G 2 Thinking about your weight at the moment which of the following best describes you?

I think I am….

Very overweight
A little overweight
Healthy weight
A little underweight
Very underweight

IF PARENT OF CHILD AGED 2-11

G2a And now thinking about the weight of <child> at the moment, which of the following best describes <him/her>?

Very overweight
A little overweight
Healthy weight
A little underweight
Very underweight

H Tobacco

ASK ALL
The next few questions are about smoking. Please try to answer as honestly as possible

H 1 To what extent would you agree or disagree with these things about smoking and tobacco?

ROTATE

Disagree strongly
Disagree
Disagree slightly
Neither disagree nor agree
Agree slightly
Agree
Agree strongly

- More people are stopping smoking nowadays
- The health risk from smoking is greatly exaggerated

H 2 Which of the following best applies to you? Please think about both ready-made and hand-rolled cigarettes

PLEASE CHOOSE ONE ONLY

I smoke cigarettes every day
I smoke cigarettes, but not every day
I have stopped smoking completely in the last year
I stopped smoking completely more than a year ago
I have never been a smoker

IF CURRENT OR RECENT EX-CIGARETTE SMOKER AT H 2 (CODES 1-3), OTHERS GO TO H 7

ASK UNDER 25S ONLY OTHERS GO TO H 4

H 3 At what age did you start to smoke regularly? Please think about both readymade and hand rolled cigarettes.

PLEASE CHOOSE ONE ONLY
Before age 11
11-12
13-15
16-18
19-21
After age 21

ASK ALL CURRENT SMOKERS (CODES 1 OR 2 AT H 2)
OTHERS GO TO H 5

H 4 On average, how many cigarettes or hand rolled cigarettes do you usually smoke a day?

IF THE NUMBER VARIES BETWEEN WEEKDAYS AND WEEKENDS, PLEASE ENTER AN AVERAGE FOR EACH DAY. ENTER 0 IF SMOKE LESS THAN 1 CIGARETTE PER DAY.

PLEASE ENTER NUMBER

Enter number

H 5 How many serious attempts to stop smoking have you made in the last 12 months, if any? By serious attempt I mean you decided that you would try to make sure you never smoked again. Please include any attempt that you are currently making and please include any successful attempt made within the last year.

PLEASE ENTER NUMBER

Enter number
None

H 6 Which of these best describes you?

PLEASE CHOOSE ONE ONLY

I REALLY want to stop smoking and intend to in the next month
I REALLY want to stop smoking and intend to in the next 3 months
I REALLY want to stop smoking but I don't know when I will
I want to stop smoking and hope to soon
I want to stop smoking but haven't thought about when
I think I should stop smoking but don't really want to
I don't want to stop smoking

ASK ALL

H 7 Is smoking allowed in the house?

PLEASE CHOOSE ONE ONLY

Yes
Only when children are NOT in the house
No – not at all

H 8 Is smoking allowed in the family car?

PLEASE CHOOSE ONE ONLY

Yes
Only when children are NOT in the car
No – not at all
Not applicable – do not have a family car

I Alcohol

ASK ALL
READ OUT
The next few questions are about drinking alcohol.

I 1 To what extent would you agree or disagree with these things about drinking alcohol?

ROTATE

Disagree strongly
Disagree
Disagree slightly
Neither disagree nor agree
Agree slightly
Agree
Agree strongly

- More people are cutting back the amount of alcohol they drink nowadays
- Drinking more than the recommended limits can increase the risk of diseases such as mouth cancer, breast cancer, stroke and heart disease
- It's okay to drink alcohol every day, so long as you're not getting drunk

I 2 Thinking now about all kinds of alcoholic drinks, how often have you had an alcoholic drink of any kind during the last 12 months?

This could be drunk in your own home, in someone else's home or out of the home in pubs, bars or restaurants

PLEASE SELECT ONE ANSWER.

Every day
5 or 6 days a week
3 or 4 days a week
Once or twice a week
Once or twice a month
Once every couple of months
Once or twice a year
Less than this or never*

THOSE WHO DRINK (CODES 1 – 7 AT I 2) IF LESS OFTEN/NEVER (*) AT I 2 GO TO SECTION J

I 3 When did you last have an alcoholic drink?

PLEASE CHOOSE ONE ANSWER

Today
Yesterday
Some other time during the last 7 days
More than 1 week but less than 2 weeks ago
More than 2 weeks but less than 4 weeks ago
More than 1 month but less than 6 months ago
More than 6 months ago

IF HAVE HAD AN ALCOHOLIC DRINK IN PAST 7 DAYS (CODES 1-3 AT I 3), OTHERS GO TO I 5

I 4 In the last 7 days, how many of each of these types of drink have you had? Please include drinks that are drunk in or out of the home.

ENTER THE NUMBER OF DRINKS YOU HAD:

Enter number
Less than one
None

- Pints or bottles of NORMAL STRENGTH beer, bitter, lager or cider (less than 6% alcohol)
- Pints or bottles of STRONG BEER bitter, lager or cider (6% or more alcohol)
- Glasses of wine
- Glasses of martini, sherry or port (not wine)
- Single measures of spirits or liqueur such as whiskey, gin, vodka, etc.
- Bottles of premixed drinks such as WKD, Reef, Bacardi Breezer, Smirnoff Ice, Crabbies etc.

UNLESS LESS OFTEN/NEVER (*) AT I 2

I 5 Thinking about the amount of alcohol that you usually drink how would you describe yourself?

A very light drinker
A light drinker
A moderate drinker
A heavy drinker
A very heavy drinker

CODES 1-5 AT I 2 OTHERS GO TO SECTION J

I 6 Have you cut down the amount you drink in the past 3 months?

Yes
No

I 7 To what extent do you intend to cut down the amount of alcohol you drink over the next 3 months?

Definitely don't intend to 1…7 Definitely intend to
Don't intend to – I don't drink that much

J Drugs

ASK ALL
The next questions are about drugs. This includes illegal drugs, other than those you get from the doctor, and also includes drugs called 'legal highs'.

Please answer honestly. The answers you give are completely confidential.

ASK UNDER 35S ONLY

J 1 To what extent would you agree or disagree that **most people of your age take drugs nowadays**?

Remember to only think about illegal drugs or legal highs, not drugs given to you by the doctor.

Disagree strongly
Disagree
Disagree slightly
Neither disagree nor agree
Agree slightly
Agree
Agree strongly

ASK ALL

J 2 Have you used any of these drugs in the past 12 months?

PLEASE SELECT ALL THAT APPLY

Cannabis (marijuana, grass, hash, ganja, blow, skunk, draw, weed, spliff)
Ecstasy (E, MDMA)
Cocaine (coke)
Amphetamines (speed, whiz, uppers, billy)
Mephedrone (M-cat or Miaow)
Ketamine (special K)
Legal Highs (e.g. Ivory Wave, Bubble)
Nitrous oxide (laughing gas)
Glues, solvents, gas or aerosols (to sniff)
None of these

FOR EACH OF CANNABIS, ECSTASY, COCAINE USED IN THE PAST 12 MONTHS OTHERS GO TO SECTION K

J 3 How often have you used <drug> in the past 12 months?

CHOOSE ONE ONLY

Every day
5 or 6 days a week
3 or 4 days a week
Once or twice a week
2 or 3 times a month
Once a month
Once every couple of months
Once or twice in the past 12 months

FOR EACH OF CANNABIS, ECSTASY, COCAINE AT LEAST MONTHLY (CODES 1 – 6) AT J 3

J 4 To what extent do you intend to stop using <drugs> in the next 3 months?

Definitely don't intend to 1…7 Definitely intend to

K Sexual health

ASK ALL AGED 18-54
The next questions are about other matters. We would like to get a picture of people's health, including sexual health, and therefore need to ask you a small number of questions about the subject. Once again, your answers are confidential, so please be as honest as you can.

K 1 Which of these best describes your sexual orientation?

Heterosexual (that is attracted to <women/men>)
Gay/lesbian (that is attracted to <women/men>)
Bisexual (that is attracted to both women and men)
Other

K 2 How many sexual partners have you had in the past 6 months?

None
One
More than one

IF ONE AT K2
K2a Is the partner you just told us about a new partner in the past 6 months?

Yes
No

IF AGED UNDER 25 AND NONE AT K 2). OTHERS GO TO ROUTE BEFORE K 7
K 3 Have you ever had sexual intercourse?

Yes
No

IF AGED UNDER 25 AND HAD SEXUAL INTERCOURSE (1 OR MORE AT K2 OR K 3 = CODE 1)
K 4 How old were you when you first had sexual intercourse?

TYPE IN

ASK -
- UNDER 25S WHO HAVE EVER HAD SEX (1 OR MORE AT K2 OR K 3 CODE 1)
- THOSE WITH MORE THAN ONE PARTNER IN THE LAST 6 MONTHS (2 OR MORE AT K2)
- THOSE WHO HAVE A NEW PARTNER IN THE LAST 6 MONTHS (YES AT K2a)
  UNDER 25S WHO HAVE NEVER HAD SEXUAL INTERCOURSE GO TO K7. ALL OTHERS GO TO NEXT SECTION

K 5 Have you had sexual intercourse without a condom within the past 6 months?

Yes
No

IF YES AT K5

K 6 And have you had sex without a condom in any of these situations in the past 6 months?

SET UP ON A GRID WITH YES/NO FOR EACH CODE

…With someone new
…Within a few hours of meeting someone for the first time
…With someone I met on a holiday during that holiday
…When I was drunk
…When I was under the influence of drugs
…With more than one person in the same week

ASK ALL UNDER 25S ONLY

K 7 How easy or difficult would you find it to….?

ROTATE

- Say no to something sexual you don't want to do
- Talk about contraception with someone you might have sex with
- Talk about sexually transmitted infections (STIs) with someone you might have sex with
- Make sure you use a condom when having sex

Very easy
Fairly easy
Neither easy nor difficult
Fairly difficult
Very difficult

L Other views

Now that you have told us about the things you do, we'd like to know how you feel about it.

L 1 How worried are you about the effect of the things you do on your health…

SHOW AS GRID, RANDOMISE ORDER
SHOW RELEVANT BEHAVIOURS

- The foods that you eat (ASK ALL)
- The amount of salt you take in (ASK ALL)
- How fit or unfit you are (ASK ALL)
- Your weight (IF FEEL UNDER/OVERWEIGHT AT G2)
- Smoking (IF CURRENT SMOKER AT H 2)
- The amount of alcohol you drink (IF EVER DRINK ALCOHOL AT I 2)
- Using drugs (IF USE ANY AT J 2)
- And thinking about <CHILD>, how worried are you about the effect of <CHILD>'s weight on <his/her> health (IF FEEL CHILD IS UNDER/OVERWEIGHT AT G2a - CAPI ALWAYS ASK LAST)

Not at all worried 1 … 7 Very worried

ALL THOSE WITH NEGATIVE BEHAVIOUR. IF ELIGIBLE FOR 2 OR MORE THEN PRIORITISE LEAST PREVALENT BEHAVIOUR (I.E. THE BEHAVIOUR FURTHEST DOWN THE LIST). IF ELIGIBLE FOR ALCOHOL AND OTHER(S) (EXCLUDING DRUGS), ASK ALCOHOL AND NEXT LEAST PREVALENT OTHERS GO TO L2.

L1a You told us earlier [about the things you eat/the physical activity you do/you smoke/you drink alcohol/you use drugs]. What things prevent you from [BEHAVIOUR]?

- eating more fruit and veg (IF E4 LESS THAN 5)
- doing more physical activity (IF F3 LESS THAN 150)
- stopping smoking (IF H2 CODES 1 OR 2 OR H2 AUDIO CODE 1)
- reducing your alcohol intake (IF I3 CODES 1-3 OR I3 AUDIO CODE 1)
- stopping drug use? (IF J2 ANY DRUG EXCEPT NONE OF THESE OR J2 AUDIO YES TO ANY)

Please type in your answer: you can say as many things as you want

Now changing the subject..

L 2 Have you had any of these in the past 2 years? The check could be done by your doctor or a pharmacist

PLEASE SELECT ALL THAT APPLY

IF MALE	IF FEMALE
Test for diabetes	Test for diabetes
Memory test (55+s only)	Memory test (55+s only)
Eye test	Eye test
Skin check (e.g. moles/skin cancer)	Skin check (e.g. moles/skin cancer)
Bowel cancer screening	Bowel cancer screening
Test for high blood pressure	Test for high blood pressure
Test for high cholesterol	Test for high cholesterol
Testicular cancer check	Cervical smear test
Prostate check	Breast cancer check e.g. mammogram
Chlamydia test	Chlamydia test
HIV test	HIV test
Full health check	Full health check
None of these	None of these

L2a Which, if any, of these things do you do regularly?

Check your testes/balls for lumps or changes [MALES ONLY]
Check your breasts for lumps or changes [FEMALES ONLY]
Check for moles on the skin
None of these

Now a few more questions about how you feel (ONS wellbeing questions)

L 3 Overall, how satisfied are you with your life nowadays?
Not at all 0 … 10 Completely

L 4 Overall, to what extent do you feel the things you do in your life are worthwhile?
Not at all 0 … 10 Completely

L 5 Overall, how happy did you feel yesterday?
Not at all 0 … 10 Completely

L 6 Overall, how anxious did you feel yesterday?
Not at all 0 … 10 Completely

IF PARENT OF 2-16
And a few questions about <child>.

L 7 How much do you agree or disagree… it's very important to me to set <child>a good example through the things that I do
Disagree strongly
Disagree
Disagree slightly
Neither disagree nor agree
Agree slightly
Agree
Agree strongly

IF PARENT OF CHILD AGED 9-16

L 8 How easy or difficult would you find it to talk to <CHILD> about…?

- Sex and relationships
- Smoking tobacco
- Drinking alcohol
- Illegal drugs/legal highs

Very easy
Fairly easy
Neither easy nor difficult
Fairly difficult
Very difficult

L 9 Which of these subjects, if any, have you talked to <child> about?

PLEASE SELECT ALL THAT APPLY

Sex and relationships
Smoking tobacco
Drinking alcohol
Illegal drugs/legal highs
None of these

FOR EACH DISCUSSED

L 10 Thinking about the first conversation about <subject from L9 > you had with <child>, how did it come up?

CHOOSE ALL THAT APPLY

ANSWER LIST VARIES BASED ON CONVERSATION (SEE BELOW)

Sex and relationships
Because I found out <he/she> was doing something sexual
Because <he/she> was dating/seeing someone
I found condoms in <his/her> room/in another person's room
Following a school lesson
Something else at school
Something happened at home
Something happened out of home
Saw something on the television/in a newspaper/magazine/ on the radio
I raised it
They asked about it
Something else (specify)

Smoking

Because I found out <he/she> had been smoking
I found cigarettes in <his/her> room/in another person's room
Following a school lesson
Something else at school
Something happened at home
Something happened out of home
Saw something on the television/in a newspaper/magazine/ on the radio
I raised it
They asked about it
Something else (specify)

Drinking alcohol

Because I found out <he/she> had been drinking alcohol
Because I found out <he/she> got drunk
I found alcohol in <his/her> room/in another person's room
Following a school lesson
Something else at school
Something happened at home
Something happened out of home
Saw something on the television/in a newspaper/magazine/ on the radio
I raised it
They asked about it
Something else (specify)

Illegal drugs

Because I found out <he/she> had been taking illegal drugs/ legal highs
Following a school lesson
Something else at school
Something happened at home
Something happened out of home
Saw something on the television/in a newspaper/magazine/ on the radio
I raised it
They asked about it
Something else (specify)

ASK ALL WHO LIVE WITH 1 OR MORE OTHER PEOPLE IN HOUSEHOLD

L 11 Do other people who live in your household do any of the following nowadays? You don't need to say who.

PLEASE SELECT ALL THAT APPLY

Smoke cigarettes
Is a heavy drinker
Take illegal drugs or legal highs
None of these

L11a Do you have any of the health problems listed below?
PLEASE SELECT ALL THAT APPLY

Cancer
Stomach, liver, kidney or digestive problems
Heart disease/stroke
High blood pressure
Type I diabetes
Type II diabetes
Diabetes – not sure which type
Asthma/other breathing difficulty
HIV/AIDS
Any sexually transmitted infection
Stress or depression that you are receiving treatment for
Other conditions (Please specify)
None of these
Don't know
Prefer not to answer

L11b Have any of the things below happened to you in the past few years?

CHOOSE ALL THAT APPLY

Got married/moved in with a partner
Got pregnant or your partner got pregnant
Had a baby
Had serious difficulties with any of your children because of their health or behaviour or for some other reason
Your last child left home
Moved house
Got a new job
You or the main earner in this household lost a job or thought you would lose a job
Become divorced/separated/split up from a long term partner

Had major financial difficulties (e.g. debts, difficulty paying bills)
Been assaulted or robbed
Had serious problems with officials or with the law
Been bullied or harassed at work
You or the main earner in this household retired
Developed or found out you have a serious illness or disability or an existing condition that got worse
Had to take on caring responsibilities for someone who requires long term care
Death of a partner
Death of other close family member or friend

None of these

Thank you for answering these questions. Please give the laptop back to the interviewer

L 12 Do you have any long standing illness, disability or infirmity that limits your normal day to day activities? By 'long-standing' I mean anything that has troubled you over a period of time or that is likely to affect you over a period of time. Normal day to day activities include everyday things like eating, washing, walking and going shopping

SHOWSCREEN

Yes I have any long-standing illness, disability or infirmity
It limits my activities all of the time
It limits my activities some of the time
It doesn't limit my activities
I don't have any long-standing illness, disability or infirmity

ASK ALL AGED 55+, OTHERS GO TO SECTION **ERROR! REFERENCE SOURCE NOT FOUND.**

L 13 How often, if at all, do you see or speak to a relative or other adult who doesn't live in your household? You could speak to them on the phone. (Disabled for Life & ELSA)

SHOW SCREEN

Every day
5 or 6 days a week
3 or 4 days a week
Once or twice a week
At least once a month
Less often
Never

L 14 Have you had a conversation with a friend or family member about any of these subjects in the past 3 months? You can just read out the numbers that apply if you prefer

CODE ALL THAT APPLY
SHOW CARD 1

A specific health problem I have
A sign or symptom which had just become apparent
A sign or symptom which had changed or got worse
A general conversation about my health/how I was feeling
Something else (specify)
None of these

IF SPECIFIC HEALTH CONCERN (CODES 1 – 4) AT L 14

L 15 Thinking about the last conversation you had with friends or family who raised the conversation? Was it…raised the conversation?

Them
You
Someone else
It came up in conversation
Don't know/ can't remember

M Deleted

N Delete

O Demographics

The next few questions are about you and your household situation.

O1a Have you ever worked as a health professional in a clinical role?
IF YES – is that currently or in the past?

Yes - currently work as a health professional
Yes - in the past
No

O 1 DELETED

O 2 Can I just check, is anyone in your household currently receiving any of these benefits?
CODE ALL MENTIONED

None of these
Job Seekers Allowance
Income Support/Employment and Support Allowance
Working Tax Credit
Child Tax Credit
Housing Benefit
Council Tax Benefit
Disability Living Allowance/ Other Disability Benefit
Healthy Start Vouchers
Carer's allowance
Incapacity benefit
Child benefit
Other state benefits (specify)

O 3 Thinking of the income of the household as a whole, which of the groups on this card represents the total income of the whole household, before deductions for income tax, National Insurance etc. You can just read out the letter
NOTE – THIS RELATES TO THE INCOME OF **EVERYONE** IN THE HOUSEHOLD

Bands will show weekly/monthly/annual income

O 4 To which of these groups do you consider you belong?

A White	British Irish Polish Other Central/Eastern European Any other White background
B Mixed	White and Black Caribbean White and Black African White and Asian Any other Mixed background
C Asian or Asian British	Indian Pakistani Bangladeshi Any other Asian background
D Black or Black British	Caribbean African Any other Black background
E Chinese or other ethnic group	Chinese Any other (specify).

O 5 How old were you when you finished continuous full-time education?

RECORD AGE IN YEARS, AN ESTIMATE IS ACCEPTABLE. RANGE FROM 10-74

Enter age

Still studying

O 6 May I ask what is the job or profession of the Chief Income Earner in your household? IF NECESSARY: that is the person with the highest income, whether from employment, pensions, state benefits, investments or any other source

IF RETIRED, PROMPT FOR PREVIOUS JOB/PROFESSION

- JOB TITLE
- JOB DESCRIPTION
- INDUSTRY
- QUALIFICATIONS
- SIZE OF COMPANY

INTERVIEWER: RECORD SOCIAL GRADE

A
B
C1
C2
D
E

P Other

P 1 GfK NOP may want to contact some people on behalf of the Department of Health to ask them some more questions about their experiences. Would you be willing to be contacted again to answer some more questions on this subject?

Yes – willing
No – not willing

COLLECT/CHECK FULL NAME, ADDRESS AND TELEPHONE NUMBER, EMAIL ADDRESS

FOR THOSE WHO ARE WILLING AT P 1

P 2 The Department of Health is also interested in looking at people's responses based on the area in which they live. Would you be willing for us to pass on your postcode linked to your survey data to the Department of Health? We assure you that this would only be for data analysis and not for any other purpose

Yes – willing
No – not willing

INTERVIEWER: DO NOT ASK THE FOLLOWING QUESTIONS

P 3 Was the respondent interviewed...?

Wholly in English
Partly in English, partly in another language
Wholly in another language

IF ANOTHER LANGUAGE AT P 3

P 4 Which other language was used for the interview?

Write in

P 5 Who provided the translation?

CODE ALL THAT APPLY

Interviewer
Other household member
Friend/neighbour
Interpreter provided by research company
Other person (write in who)

ALL ANSWER

P 6 Was anyone else present in the room, or passing through, or nearby, during any part of the interview and (possibly) able to overhear?

Yes
No

P 7 Did anyone else in the household look at or discuss any part of the self-completion questionnaire during completion?

Yes – looked at/read/completed together
Yes – discussed only
No
Self-completion questions not completed

Lifecourse Tracker YOUTH Questionnaire Wave 2 FINAL

Contents Page

A Who are you? (intro and demographics)

YP 1 To start, what is your name? I only need your first name or what you prefer to be known as

IF NECESSARY: This is just so I can make sure that we ask questions in the most appropriate way for you

ENTER NAME

A 1 And can I ask you how old you are?

Enter actual age
If refused: use bands below
11-12
13-14
15-17

A 2 CODE RESPONDENT GENDER

Male
Female
Other

ASK IF AGED 15+

A 3 Which of these categories best describes what you mainly do at the moment?

SHOWSCREEN

CODE MAIN ACTIVITY ONLY

Full time pupil/student at school or college
Part time student at college
In paid work
On a training course or scheme
Doing an apprenticeship
Waiting for a course or job to start
Unemployed and looking for work
Doing unpaid work
Looking after the family or home
Not working because temporarily sick or injured
Not working because long-term sick or disabled
Other (please specify)
None of these

IF AGED 11

A 4 Are you in…

SHOW SCREEN

Year 6 at Primary school
Year 6 at Middle school
Year 7 at Middle school
Year 7 at Senior/Secondary school

B How content or in control are you?

The first section of questions is about the way you think and feel about things. As with the rest of this interview, there are no right or wrong answers - we are interested in your views and opinions.

YP 2 In general, how happy do you feel about your life today?
SHOWSCREEN

I feel very happy
I feel quite happy
I don't feel very happy
I'm not happy at all

B 1 How much do you agree or disagree with these things?
IF NECESSARY: If you don't want to say your answer out loud, you can just read from the screen and tell me the number which goes with the answer you want to give.
SHOWSCREEN
PROBE: Do you agree/disagree strongly or slightly, or just agree/disagree

Disagree strongly
Disagree
Disagree slightly
Neither agree nor disagree
Agree slightly
Agree
Agree strongly

ROTATE

- I feel good about myself (SELF ESTEEM - Healthy Foundations)
- I like to take risks (RISK TAKING – Healthy Foundations)
- I can remain calm when facing difficulties (Amended from HBSC)

YP 3 Which of these things do you worry about? You can choose all you think from this card. Just read out the numbers

SHOWCARD 1

1. Problems at home
2. Being cool / acceptance / fitting in
3. Having good friends
4. Bullying
5. Peer pressure
6. Lack of things to do and places to hang out

7. Crime
8. Drinking alcohol
9. Illegal drugs
10. Smoking

11. Negative image of young people
12. Amount of schoolwork / pressure at school
13. Passing exams
14. Tuition fees/ costs of higher education
15. Young people not being able to get jobs

16. Having boyfriends/girlfriends
17. Sexual relationships
18. Teen pregnancy
19. Money

Any other problem (specify)

C How do you view your health

C 1 How is your health in general? Would you say it was ...

SHOW SCREEN

1 …very good
2 good
3 fair
4 bad, or
5 very bad?

REST OF SECTION C NOT USED FOR YOUNG PEOPLE

D NOW PART OF SECTION C

E Healthy Eating

Next I would like to ask you some questions about food and what you eat. There are no right or wrong answers here, so please be as honest as possible.

E 1 NOT USED FOR YOUNG PEOPLE

E 2 How often do you eat each of these things in a normal week?

- Fruit, vegetables or salad. These could be fresh, frozen, tinned, dried or juiced, but don't include potatoes
- Foods that are high in sugar, such as cakes, puddings, pastries or biscuits, sweets or chocolate
- Foods that are high in fat or fried foods such as fried fish, chips, cooked breakfast, samosa, crisps or fatty meats not including oven chips
- Fizzy drinks or soft drinks like squash – not including diet or sugar free drinks, or sparkling water

SHOWSCREEN

Several times a day
Once a day
5 or 6 days a week
3 or 4 days a week
Once or twice a week
Less often
Never

YP 4 In a usual week, how often do you eat breakfast? By that I mean more than a glass of milk or fruit juice.

Every day
5 or 6 days a week
3 or 4 days a week
Once or twice a week
Less often
Never

YP 5 In a usual week how often do you eat an evening meal with your mum or dad or another carer? By that, I mean where you sit and talk, rather than only watching TV while you eat.

SHOWSCREEN

Every day
5 or 6 days a week
3 or 4 days a week
Once or twice a week
Less often
Never

REST OF SECTION E NOT USED FOR YOUNG PEOPLE

F Activities

F 1 DELETED FOR YOUNG PEOPLE SURVEY

READ OUT
The next question is about MODERATE PHYSICAL ACTIVITY that is activity that at least makes you breathe slightly faster than usual. For example:

- sports
- cycling
- swimming
- walking to school, college or work
- school or college activities
- Playing with friends
-

F 2 Thinking about the last 7 days, on how many days have you done any moderate physical activity? This is any physical activity that makes you breathe slightly faster than usual

Write in (0-7)

YP 6 Have you done any of these things in the last FOUR WEEKS?

Please don't include activities done as part of a school or college lesson or homework or coursework.

SHOWCARD 2

Taken part in any kind of **sport** (e.g. football / netball) **or other physical activity** (e.g. gymnastics / dance / karate)
Taken part in **other activities** such as drama / arts / crafts / photography / playing a musical instrument, etc.
Gone to see a **football match** or other **sports event**
Gone to a **party, dance, nightclub or disco**
Gone to a **cinema, theatre, concert, museum or art gallery**
Gone to a **political meeting, march, rally or demonstration**
Done **community work** (such as helping elderly, disabled or other dependent people; cleaning up the environment; helping volunteer organisations or charities)
Gone to a **youth club** or something like it (including scouts or girl guides)
Attended a **religious group** (include attending religious services or church)
Just hung around / messed about **near your home**
Just hung around / messed about **away from home**
None of the above

REST OF SECTION F NOT USED FOR YOUNG PEOPLE

G Self-completion section

READ OUT: I'd now like you to answer some questions on the laptop. The reason I am asking you to complete this section yourself is that some of the questions are personal to you and doing it this way means nobody will know what you have answered.

Your answers will be completely confidential, and please be assured you will not get into any trouble for anything you say.

Please remember, you do not have to answer any questions you do not want to, but this is a serious survey which will help the government to plan health services.

G 1 Would you prefer to answer the questions by reading them on the laptop screen, or by listening to them through the headphones?

IF NECESSARY: If you read the answers on the screen, the questions are a little quicker to answer

Read on screen and enter answers by themselves (continue)
Listen through headphones (start audio interview)
Prefer interviewer to read questions from screen (INTERVIEWER: some of the questions are quite personal, so it may be worthwhile to move to another room or ask others to leave the room while you are completing the questions)
Other (discuss requirements with respondent and type in how the questions will be answered)

INTERVIEWER: HAND RESPONDENT THE CAPI MACHINE AND DEMONSTRATE USE BY HELPING RESPONDENT TO COMPLETE THE EXAMPLE QUESTIONS.

INTERVIEWER: MAKE SURE YOU DEMONSTRATE ALL THREE EXAMPLES SO THE RESPONDENT IS USED TO DIFFERENT QUESTION TYPES

EXAMPLE 1: SINGLE RESPONSE: How much do you agree or disagree that … I like football

Disagree strongly
Disagree
Disagree slightly
Neither agree nor disagree
Agree slightly
Agree
Agree strongly

EXAMPLE 2: MULTIPLE RESPONSE: Which of the following types of pets do you have, if any?

Cats
Dogs
Hamsters
Gerbils
Rabbits
Fish
Other type of pet (type in your answer)
None of these

EXAMPLE 3: TYPED IN RESPONSE: Please type in the name of your first pet. If you have never had a pet, type in the name you would give a pet if you had one.

Type in

READ OUT: please answer the next questions in your own time. If you have any problems please ask me and I will be happy to help you.

Remember, if you don't know or don't want to answer a question, there is a place for you to click

YP 7b At present are you on a diet or doing something else to lose weight?

No, my weight is fine
No, but I should lose some weight
No, because I need to put some weight on
Yes

YP 7 How do you feel about your body? Is it ….?

Much too thin
A bit too thin
About the right size
A bit too fat
Much too fat

YP7a How many nights a week do you get at least 8 hours sleep?

Every/most nights
4-5 nights a week
2-3 nights a week
About once a week
Less often than this or never

H Tobacco

ASK ALL
The next few questions are about smoking. Please remember, try to answer honestly. No one you know will be able to see your answers and we won't tell anyone what you have said.

H 1 How much do you agree or disagree that smoking is very bad for your health?

Disagree strongly
Disagree
Disagree slightly
Neither disagree nor agree
Agree slightly
Agree
Agree strongly

YP 8 How many … smoke nowadays….?

- of your close friends
- other people of your age at your <school / college / that you know >
- adults

All of them
Most of them but not all
About half
Some of them but less than half
Only a few
None of them

YP 9 Please pick a number from 1-10 to show how you would describe someone of your age who smokes

For example, an answer of 1 would mean that you think that person is very popular, and 10 means you think they are very boring

How would you describe someone of your age who smokes?

SHOW IN GRID, ROTATE ORDER

Choose one answer only	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Don't know**	
Very popular	1	2	3	4	5	6	7	8	9	0	X	Very unpopular
Very clever	1	2	3	4	5	6	7	8	9	0	X	Very stupid

H 2 NOT USED FOR YOUNG PEOPLE

YP 10 Have you ever smoked a cigarette?

PLEASE READ ALL OF THE FOLLOWING SENTENCES CAREFULLY AND CHOOSE THE ONE WHICH YOU THINK YOU ARE THE MOST LIKE.

I have never smoked
I only ever tried smoking once
I used to smoke sometimes, but I never smoke now
I sometimes smoke now, but not as often as once a week
I smoke at least once a week, but I don't smoke every day
I smoke every day
Don't know
Prefer not to answer

IF SMOKED (CODES 2 - 6) AT YP 10, OTHERS GO YP 13

YP 11 How old were you when you first tried smoking a cigarette, even if it was only a puff or two?

PLEASE CHOOSE ONE ONLY

FILTER BY RESPONDENT AGE:
Before age 11
11-12
13-14
15-17

IF REGULAR SMOKER (CODES 4 - 6) AT YP 10, OTHERS GO TO YP 13

H 3 At what age did you start to smoke regularly?

PLEASE CHOOSE ONE ONLY

FILTER BY RESPONDENT AGE

Before age 11
11-12
13-14
15-17

IF REGULAR SMOKER (CODES 4 - 6) AT YP 10

YP 12 Do(es) your parent(s) or carer(s) know you smoke?

PLEASE REMEMBER WE ARE NOT GOING TO TELL YOUR PARENT(S) OR CARER(S)

Yes
No

ASK ALL

YP 13 DELETED

REST OF SECTION H NOT USED FOR YOUNG PEOPLE

I Alcohol

ASK ALL
The next few questions are about drinking alcohol.

I 1 How much do you agree or disagree with these things about drinking alcohol?

Disagree strongly
Disagree
Disagree slightly
Neither disagree nor agree
Agree slightly
Agree
Agree strongly

- REGULARLY drinking alcohol can slowly damage your body in ways you cannot see and may not realise
- It's okay for people of my age to drink alcohol, so long as they are not getting drunk
- Young people aged under 18 should not drink any alcohol at all

YP 14 How many … drink alcohol REGULARLY nowadays….?

- of your close friends
- other people of your age at your <school / college/ that you know >

All of them
Most of them but not all
About half
Some of them but less than half
Only a few
None of them

YP 15 How would you describe someone of your age who drinks alcohol REGULARLY?

SHOW IN GRID, ROTATE ORDER

Choose one answer only	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Don't know**	
Very popular	1	2	3	4	5	6	7	8	9	0	X	Very unpopular
Very clever	1	2	3	4	5	6	7	8	9	0	X	Very stupid

YP 16 Have you ever had a proper alcoholic drink- a whole drink, not just a sip?

Yes
No

IF YES AT YP 16 OTHERS GO TO YP 24

YP 17 How old were you when you had your first proper alcoholic drink? That means a whole drink, not just a sip.

FILTER BY RESPONDENT AGE
Before age 11
11-12
13-14
15-17

YP 18 How often do you usually have an alcoholic drink?

PLEASE CHOOSE ONE ONLY

Every day
5 or 6 days a week
3 or 4 days a week
Once or twice a week
Once or twice a month
Once every couple of months
Once or twice a year
Less than this or never

YP 19 When you drink alcohol, where are you usually? Are you…
PLEASE SELECT ALL THAT APPLIES

At home with parent(s)/carer(s) or another responsible adult
At home with friends or someone else
At someone else's home
Out on the street, in a park or other public area
At a party with parent(s)/carer(s) or another responsible adult
At a party with friends
In a pub or bar
In a restaurant
In a club or disco
Sports / social club
Somewhere else (please type in)

ASK ALL WHO HAVE EVER DRUNK ALCOHOL OTHERS GO TO YP 24

YP 20 Which, if any, of these things do you do nowadays?
PLEASE SELECT ALL THAT APPLY
RANDOMIZE

Before I start drinking I plan how much I am going to drink or spend on alcohol
Pace myself with water/soft drinks
Deliberately get drunk at home before a night out
Deliberately don’t eat before I go out so that I can get drunk more easily
Get so drunk that I can’t remember what happened at the end of the night
Feel sick or ill because of the amount I have drunk
Make sure I don’t drink until I am sick / ill
None of these

YP 21 How often do you get drunk?

Almost every time I drink alcohol
Most of the times that I drink alcohol
Now and again when I drink alcohol
Only once
I have never been drunk

IF EVER BEEN DRUNK AT YP 21

YP21a How old were you when you first got drunk?

FILTER BY RESPONDENT AGE

Before age 11
11-12
13-14
15-17
Can't remember

YP 22 Can I just check do(es) your parent(s) or carer(s) know you <drink/have drunk> alcohol?

PLEASE REMEMBER WE ARE NOT GOING TO TELL YOUR PARENT(S) OR CARER(S)

Yes
No

IF EVER BEEN DRUNK AT YP 21 AND YES AT YP 22

YP 23 Have your parent(s) or carer(s) ever seen you drunk?

Yes
No

ASK ALL

YP 24 DELETED

REST OF SECTION I NOT USED FOR YOUNG PEOPLE

I 2

J Drugs

ASK ALL
The next questions are about drugs. This includes illegal drugs or 'legal highs', not drugs given to you by the doctor.

Please answer honestly – remember that your answers are completely confidential, and we will not tell anyone what you have said.

YP 25 How much do you agree or disagree with these things about drugs?

Remember to only think about illegal drugs or legal highs, not drugs given to you by the doctor

Disagree strongly
Disagree
Disagree slightly
Neither disagree nor agree
Agree slightly
Agree
Agree strongly

- It's okay to use drugs, so long as you're not doing it all the time
- Using Cannabis is very bad for your health
- People should never use drugs

YP 26 How many …do you think use drugs nowadays….?

- of your close friends
- other people of your age at your <school/college/ that you know >

All of them
Most of them but not all
About half
Some of them but less than half
Only a few
None of them

YP 27 How would you describe someone of your age who uses drugs?

SHOW IN GRID, ROTATE ORDER

Choose one answer only	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Don't know**	
Very popular	1	2	3	4	5	6	7	8	9	0	X	Very unpopular
Very clever	1	2	3	4	5	6	7	8	9	0	X	Very stupid

J 1 NOT USED FOR YOUNG PEOPLE

J 2 Have you used any of these drugs in the past 12 months?
PLEASE SELECT ALL YOU HAVE USED

Cannabis (marijuana, grass, hash, ganja, blow, skunk, draw, weed, spliff)
Ecstasy (E, MDMA)
Cocaine
Amphetamines (speed, whiz, uppers, billy)
Mephedrone (M-cat or Miaow)
Ketamine (special K)
Legal Highs (e.g. Ivory Wave, Bubble)
Nitrous oxide (laughing gas)
Glues, solvents, gas or aerosols (to sniff)
None of these

FOR EACH OF CANNABIS, ECSTASY, COCAINE USED IN THE PAST 12 MONTHS, OTHERS GO TO SECTION K

J 3 How often have you used <INSERT DRUG NAME J2> in the past 12 months?
CHOOSE ONE ONLY

Every day
5 or 6 days a week
3 or 4 days a week
Once or twice a week
Once or twice a month
Once every couple of months
Once or twice in the past 12 months

YP 28 At what age did you start using < INSERT DRUG NAME J2>?

PLEASE CHOOSE ONE ONLY

FILTER ON RESPONDENT AGE

Before age 11
11-12
13-14
15-17

YP 29 Do(es) your parent(s) or carer(s) know you use <INSERT DRUG NAME(S) J2>?

J 4 PLEASE REMEMBER WE ARE NOT GOING TO TELL YOUR PARENT(S) OR CARER(S)

Yes
No

YP 30 Removed

J 5 NOT USED FOR YOUNG PEOPLE

K SEXUAL HEALTH

ALL CHILDREN AT PRIMARY/MIDDLE SCHOOL (I.E. CODES 1,2 AND 3 AT A4), SKIP SECTION K

Moving on to a different subject. We would like to get a picture of people's health, including sex and relationships, and therefore want to ask you some questions about this.

Some of these questions are quite personal, but please remember that your answers will not be revealed to anyone you know and you do not have to answer any questions you don't want to. Please be honest.

IF AGED 11 (AND IN SECONDARY SCHOOL) OR 12. AGES 13-17 GO STRAIGHT TO YP31

YP30a Firstly, can we just check, how much have you thought about sex and relationships before today?
This means have you had any classes at school/college, read any information about it, tried it or talked about it with friends or family?

Thought about it a lot
Thought about it a little
Not thought about it at all
Don't know
Prefer not to answer

IF NOT THOUGHT ABOUT IT AT ALL/DON'T KNOW/PREFER NOT TO ANSWER AT YP30A, SKIP REST OF SECTION K. OTHERS CONTINUE

ASK ALL AGED 13-17 OR (11 IN SECONDARY SCHOOL OR 12 WHO HAVE THOUGHT ABOUT SEX AND RELATIONSHIPS BEFORE)

YP 31 How much do you agree or disagree with these things about sex and relationships?

RANDOMISE

- It's OK for people my age to have sex
- Talking to friends or family about sex is important

Disagree strongly
Disagree
Disagree slightly
Neither disagree nor agree
Agree slightly
Agree
Agree strongly

YP 32 How many …do you think have had sex?

- of your close friends
- other people of your age at your <school / college/ that you know >

All of them
Most of them but not all
About half
Some of them but less than half
Only a few
None of them

YP 33 How would you describe someone of your age who has had sex?

SHOW IN GRID, ROTATE ORDER

Choose one answer only	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Don't know**	
Very popular	1	2	3	4	5	6	7	8	9	0	X	Very unpopular
Very clever	1	2	3	4	5	6	7	8	9	0	X	Very stupid

YP32a If you wanted more information about contraception or sex and relationships, would you know where to go?

Yes
No
Don't know
Don't want any (more) information about sex and relationships

YP 34 Some statements about sex and contraceptives are shown below. Please choose one answer for each to say whether you think it is true or false

RANDOMISE, SHOW IN GRID

True
False
Not sure
Prefer not to say

- Contraceptives or condoms are available to everyone, free of charge
- A girl under 16 can be prescribed contraceptives without her parents knowing
- A girl can get pregnant the first time she has sex
- A girl can get pregnant during her period
- You can tell who has a sexually transmitted infection (STI) by looking at them

YP 35 How easy or difficult would you find it to…. (similar to adult K7)

RANDOMISE

- Say no to something sexual you don't want to do
- Talk about using condoms with someone you might have sex with
- Talk about sexually transmitted infections (STIs) with someone you might have sex with
- Make sure you use a condom when having sex

Very easy
Fairly easy
Neither easy nor difficult
Fairly difficult
Very difficult

The next few questions are about the things that you have done. Some of them are very personal, but do please remember that this is completely private. If you don't want to answer any of the questions, just touch the refused button on the screen.

YP 36 Are you mainly attracted to…?

Boys
Girls
Both

YP 37 Have you ever kissed using tongues?

Yes
No

YP 38 Have you ever had any experience of other sexual activity with another person? That means more than just kissing

Yes
No

IF YES AT YP 38, IF NO GO TO YP 46

YP 39 Which of these things have you ever done with another person?

PLEASE CHOOSE ALL THAT YOU HAVE EVER DONE

Touched each other's private parts/genitals
Oral sex (mouths touching private parts/genitals)
Had sexual intercourse (sometimes called 'making love', 'having sex' or 'going all the way')
None of these

ONLY ASK IF HAD SEXUAL INTERCOURSE AT YP 39.
OTHERS GO TO YP 46

The next few questions are about the first time you had sexual intercourse, made love or went all the way

YP 40 How old were you when you first had sexual intercourse?

TYPE IN

YP 41 Which of these best describes you the first time you had sexual intercourse?

PLEASE CHOOSE THE ONE THAT BEST APPLIES

Looking back, I think I was too young
I believed I was old enough and I had found the right person
I believed I was old enough, but looking back I should have waited until I found the right person
I didn't really consider my age or the person – I just wanted to try sex

YP 42 And which of these best describes your situation when you first had sexual intercourse?

PLEASE CHOOSE ALL THAT APPLY

I put pressure on the other person to have sex
The other person put pressure on me to have sex
I felt pressurised by my mates to have sex
There was no pressure - it was a mutual decision
There was no real pressure – but I felt it was expected of me
There was no pressure – it's just the norm to have sex

YP 43 Did you discuss contraception or protection with your partner **before** you had sexual intercourse for the first time?

Yes
No

YP 44 Did you use any of these types of contraception or protection the first time you had sexual intercourse?

CHOOSE ALL THAT YOU USED

Condom
The Pill
Emergency Contraception (e.g. morning after pill, emergency IUD/coil)
Some other form of contraception
We didn't use contraception/protection

YP 45 Which, if any, of these things have you done in the past 12 months? (similar to adults K6)

PLEASE CHOOSE ALL THAT APPLY

Had sex with someone new when drunk
Had sex with someone new under the influence of drugs
Had sex with more than one person in the same week
Had unprotected sex with someone new (i.e. sexual intercourse without a condom)
None of these

IF HAVE NOT HAD SEX AT YP 39

YP 46 How much pressure do your friends put on you to lose your virginity or have sex for the first time?

A lot of pressure
A little pressure
No pressure at all
We haven't discussed it

YP 47 DELETED

L Other views

Now changing the subject, some questions about you and how you feel.

YP 48 In the last 6 months how often have you had the following?

- Headache
- Stomach ache
- Felt dizzy
- Difficulties in getting to sleep

About every day
More than once a week
About every week
About every month
Rarely or never

YP 49 How often do you :

- Feel left out of things
- Feel confident in yourself
- Feel low

Always
Often
Sometimes
Never

YP49b When you are stressed or unhappy have you ever deliberately tried to hurt yourself in some way (such as cut or scratched yourself or punched a wall)?

Yes – in the past 12 months
Yes – longer ago but not in the past 12 months
No – but I have seriously thought about doing it
No – not at all
Prefer not to answer

YP49aHow much do you agree or disagree with these things?

Disagree strongly
Disagree
Disagree slightly
Neither disagree nor agree
Agree slightly
Agree
Agree strongly

- I always obey the rules in this family
- I really enjoy spending time with my family

YP 50 Who would you feel comfortable talking to about things that really bother you?

CHOOSE ALL THAT YOU WOULD FEEL COMFORTABLE TALKING TO

Father / stepfather / my mother's partner
Mother/ stepmother/ my father's partner
Grandmother or grandfather
Aunt or uncle
Older brother or sister
Teacher
Adult at a youth or sports club or other club
Religious or faith leader (e.g. Priest, vicar, imam, rabbi, elder)
Another adult (type in who they are)
I don't have an adult I could talk to

YP 51 Which of these things, if any, have you and your parent(s) or carer(s) talked about?

CHOOSE ALL YOU HAVE TALKED ABOUT

Sex and relationships
Smoking tobacco/cigarettes
Drinking alcohol
Illegal drugs/legal highs
None of these

FOR EACH MENTIONED AT YP 51 (WHERE RELEVANT – SEE BELOW)

YP 52 Thinking about the first conversation about <subject from YP 51> you had with your parent(s) or carer(s), how did it come up?

CHOOSE ALL THAT APPLY

ANSWER LIST VARIES BASED ON CONVERSATION (SEE BELOW)

Sex and relationships

Because they found out I was doing something sexual (ONLY ASK IF YES AT YP 38)
Because I was dating/seeing someone
They found condoms in my room/in another person's room
Following a school lesson
Something else at school
Something happened at home
Something happened out of home
Saw something on the television/in a newspaper/magazine/ on the radio
I was worried about a friend
My parents talked to me about it
I asked them about it
Something else (specify)

Smoking

Because they found out I had been smoking (ONLY ASK IF YES AT YP 10)
They found cigarettes in my room/in another person's room
Following a school lesson
Something else at school
Something happened at home
Something happened out of home
Saw something on the television/in a newspaper/magazine/ on the radio
I was worried about a friend
My parents talked to me about it
I asked them about it
Something else (specify)

Drinking alcohol

Because they found out I had been drinking alcohol (ONLY ASK IF YES AT YP 16)
Because they found out I got drunk (ONLY ASK IF HAVE EVER BEEN DRUNK AT YP 21)
They found alcohol in my room/in another person's room
Following a school lesson
Something else at school
Something happened at home
Something happened out of home
Saw something on the television/in a newspaper/magazine/ on the radio
I was worried about a friend
My parents talked to me about it
I asked them about it
Something else (specify)

Illegal drugs

Because they found out I had been taking illegal drugs/ legal highs (ONLY ASK IF ANY AT J 2)
Following a school lesson
Something happened at home
Something happened out of home
Something happened while we were out
Saw something on the television/in a newspaper/magazine/ on the radio
I was worried about a friend
My parents talked to me about it
I asked them about it
Something else (specify)

FOR EACH MENTIONED AT YP 51

YP52BHow old were you when you first discussed <subject from YP51> with your parent(s) or carer(s)?

FILTER BY RESPONDENT AGE
Before age 11
11-12
13-14
15-17
Can't remember

ASK ALL
If you needed to talk to someone about these things, how easy or difficult would you find it to talk to your parent(s) or carer(s)?

YP 53 How easy or difficult would you find it to talk to your parent(s) or carer(s) about …?

- Sex and relationships
- Smoking tobacco/cigarettes
- Drinking alcohol
- Illegal drugs/legal highs

Very easy
Fairly easy
Neither easy nor difficult
Fairly difficult
Very difficult

YP 54 Can you tell me whether anyone who you live with does any of the following nowadays? You don't need to say who. (ADULTS L11)

CHOOSE ALL THAT APPLY

Smoke cigarettes
Gets drunk
Use illegal drugs or legal highs
None of these

FOR EACH MENTIONED AT YP 54

YP 55 And have you seen someone who you live with <smoking / get drunk / use illegal drugs?>

Yes
No

Thank you for answering these questions. Please give the laptop back to the interviewer

ASK ALL THOSE WHO ATTEND SCHOOL OR COLLEGE
OTHERS GO TO YP 57

READ OUT: I am going to ask you some questions about school or college

YP 56 How much do you agree or disagree with these things?
SHOWSCREEN

- Our teachers/tutors/lecturers treat us fairly
- I feel safe in my school/college

Disagree strongly
Disagree
Disagree slightly
Neither agree nor disagree
Agree slightly
Agree
Agree strongly

ASK ALL

YP 57 Please think back to the topics that might have been covered in lessons at your school. Which of the topics listed here were covered in lessons at your school?
SHOWSCREEN

Smoking
Drinking alcohol
Drug use
Sex and relationships
None of these

YP 58 Removed

M Barriers to making healthy changes

NOT USED FOR YOUNG PEOPLE

N Interactions with health services

NOT USED FOR YOUNG PEOPLE

O Demographics

These are the final questions which will help us look at your answers with those of the other people like you

O 1 NOT USED FOR YOUNG PEOPLE
O 2 NOT USED FOR YOUNG PEOPLE
O 3 NOT USED FOR YOUNG PEOPLE
O 4 NOT USED FOR YOUNG PEOPLE

O 5 To which of these groups do you consider you belong?
SHOWCARD 3

A **White**	British Irish Polish Other Central/Eastern European Any other White background
B **Mixed**	White and Black Caribbean White and Black African White and Asian Any other Mixed background
C **Asian or Asian British**	Indian Pakistani Bangladeshi Any other Asian background
D **Black or Black British**	Caribbean African Any other Black background
E **Chinese or other ethnic group**	Chinese Any other (specify).

IF AT SCHOOL, OTHERS GO TO YP 60.

SHOWSCREEN

YP 59 What do you hope to do when you leave school?

Get a job at 16
Study and then get a job at 18
Study to go to university
Something else

IF LEFT SCHOOL, OTHERS GO TO ADULT QUESTIONS (YP 61)

YP 60 Can I just check do you intend to study to get a degree?

Yes
No

Thank you very much for your time. I now need to ask a responsible adult in the household a few more questions to finish the interview. It would be useful if you could stay as I may have a couple more questions for you at the very end of the survey.

ASK ADULT IN THE HOUSEHOLD

I need to ask you some questions about <CHILD'S NAME> and your household which will enable to understand the answers given.

YP 61 Please can you tell me <CHILD NAME>'s relationship to you? <He/she> is my …

SHOWSCREEN

Son/daughter (incl. adopted)
Step-son/daughter
Foster child
Son-in-law/daughter-in-law
Brother/sister (incl. adopted)
Step-brother/sister
Foster brother/sister
Brother/sister-in-law
Grand-child
Other relative
Other non-relative

O 6 TO O 8 ARE SIMILAR TO ADULT QUESTIONNAIRE A4-A7

O 6 Who do you live with in this household? Please make sure you include <CHILD> when you answer.

SHOWSCREEN

CODE ALL MENTIONED

Spouse/civil partner/partner
Parent (including in-law or step parent)
Grandparent (including in-law or step)
Son/daughter (including in-law, adopted, step or foster)
Brother/sister (including in-law, adopted, step or foster)
Other relative
Friend
Personal assistant/paid carer
Other person (specify)

O 7 How many children or young people aged under 17 live in this household? This would include <CHILD> as well as your own children or other people's children who usually live in this household.

Enter Number
None

IF O 7>1, OTHERS GO TO O 9

O 8 COLLECT AGES OF ALL CHILDREN/YOUNG PEOPLE AGED UNDER 25 OTHER THAN <CHILD> WHO LIVE IN THE HOUSEHOLD

Enter ages

ASK ALL

O 9 Is anyone in your household currently receiving any of these benefits? (ADULT O2)

SHOWCARD 4

None of these
Job Seekers Allowance
Income Support/Employment and Support Allowance
Working Tax Credit
Child Tax Credit
Housing Benefit
Council Tax Benefit
Disability Living Allowance/ Other Disability Benefit
Healthy Start Vouchers
Carer's allowance
Incapacity benefit
Child benefit
Other state benefits (specify)

O 10 Thinking of the income of the household as a whole, which of the groups on this card represents the total income of the whole household, before deductions for income tax, National Insurance etc. Just read out the number on the show card (ADULT O3)

NOTE – THIS RELATES TO THE INCOME OF **EVERYONE** IN THE HOUSEHOLD

SHOWCARD 5

Bands will show weekly/monthly/annual income

O 11 Does <CHILD> have any long standing illness, disability or infirmity that limits <his/her> normal day to day activities? (ADULT L12)

By 'long-standing' I mean anything that has troubled <him/her> over a period of time or that is likely to affect <him/her> over a period of time.
Normal day to day activities include everyday things like eating, washing, walking and going shopping

SHOWCARD 6

Yes he/she has any long-standing illness, disability or infirmity
It limits his/her activities all of the time
It limits his/her activities some of the time
It doesn't limit his/her activities
He/she doesn't have any long-standing illness, disability or infirmity

O 12 May I ask what is the job or profession of the Chief Income Earner in your household? IF NECESSARY: that is the person with the highest income, whether from employment, pensions, state benefits, investments or any other source

IF RETIRED, PROMPT FOR PREVIOUS JOB/PROFESSION

- JOB TITLE
- JOB DESCRIPTION
- INDUSTRY
- QUALIFICATIONS
- SIZE OF COMPANY

INTERVIEWER: RECORD SOCIAL GRADE.

A
B
C1
C2
D
E

P Other

P 1 GfK NOP may want to contact some young people on behalf of the Department of Health to ask them some more questions about their experiences. Would you be willing for us to contact <NAME OF CHILD> again to answer some more questions on this subject?

Yes – willing for child to be contacted
No – not willing for child to be contacted
Don't know

P 2 The Department of Health is also interested in looking at young people's responses based on the area in which they live. Would you be willing for us to pass on your postcode linked to <NAME OF CHILD>'s survey data to the Department of Health? We assure you that your child will not be identified individually and it would only be for data analysis and not for any other purpose

Yes – willing postcode to be passed on
No – not willing postcode to be passed on
Don't know

ASK YOUNG PERSON

IF PARENT WILLING AT P1:
To finish the survey I need to ask <child's name> another question.

IF PARENT WILLING AT P1 AND P2:
To finish the survey I need to ask <child's name> a couple of questions

P 3 GfK NOP may want to contact you again to ask you some more questions on behalf of the Department of Health. Your parent/carer has said they are happy for us to talk to you again. Would you be willing for us to contact you again to answer some more questions on this subject?

Yes – willing to be contacted again
No – not willing to be contacted again
Don't know

COLLECT/CHECK FULL NAME AND TELEPHONE NUMBER. IF TEL NUMBER REFUSED PLEASE ENTER EMAIL ADDRESS

PARENT WILLING AT P2 AND IF YES AT P3 AND

P 4 The Department of Health is also interested in looking at young people's responses based on the area in which they live. Would you be willing for us to pass on your postcode linked to what you told me today to the Department of Health? They will not be able to identify you personally and it would only be used for data analysis and not for any other purpose.

Yes – willing for postcode to be passed on
No – not willing for post code to be passed on
Don't know

THANK YOU / HAND OUT LEAFLET

INTERVIEWER: PLEASE TURN AWAY THE SCREEN AND DO NOT ASK THE FOLLOWING QUESTIONS

P 5 Was the respondent interviewed..

Wholly in English
Partly in English, partly in another language
Wholly in another language

IF ANOTHER LANGUAGE AT P 5

P 6 Which other language was used for the interview?

Write in

P 7 Who provided the translation?

CODE ALL THAT APPLY

Interviewer
Other household member
Friend/neighbour
Interpreter provided by research company
Other person (write in who)

ALL ANSWER

P 8 Was anyone else present in the room, or passing through, or nearby, during any part of the interview and (possibly) able to overhear?

Yes
No

P 9 Did anyone else in the household look at or discuss any part of the self-completion questionnaire during completion?

Yes – looked at/read/completed together
Yes – discussed only
No
Self-completion questions not completed

27214500224 Lifecourse Tracker Questionnaire PWM02 Wave 2 FINAL

Contents

A Who are you? (intro and demographics)

First a few questions about you and the people you live with

A 1 How old are you?

Under 18 - CLOSE
18-24
25-29
30-34
35-39
40-44
45-49
50-54
55+

P1 Which of these applies to you?
CODE ALL THAT APPLY

I am currently pregnant
I am the mother of a child/children aged 24 months or under who live(s) with me
None of these - CLOSE

IF BOTH CURRENTLY PREGNANT AND A MOTHER OF A CHILD AGED UNDER 24 MONTHS – **PRIORITISE CURRENTLY PREGNANT**

P2 How many children do you have, including any who don't live here with you <but excluding the child you are currently pregnant with >?

Enter number

IF CURRENTLY PREGNANT AND P2>0 OR IF MOTHER OF CHILD AGED UNDER 24 MONTHS AND P2>1, ASK P3.
OTHERWISE CHECK ROUTING ABOVE P5

P3 Please select the age ranges of all of your children, including any who don't live here with you <but excluding the child you are currently pregnant with >.
CODE ALL THAT APPLY

0-24 months
25 months – 4 yrs old
5-7
8-11
12-15
16-18
19+

IF NOT PREGNANT AND NO CHILDREN UNDER 2, CLOSE SURVEY HERE
IF MOTHER OF CHILD AGED UNDER 24 MONTHS, AND HAS MORE THAN ONE CHILD IN THAT AGE GROUP (I.E. P2>1 AND ONLY UNDER 2 SELECTED AT P3)
IF PRIORITISED AS PREGNANT WOMAN, GO STRAIGHT TO P8

P4 Please type the name of your <CAPI randomise - OLDEST/YOUNGEST> child aged 24 months or under in the box below. This is so we can refer to him/her in later questions.
IF YOU HAVE TWINS: PLEASE TYPE IN THE NAME OF THE CHILD WHO WAS BORN <FIRST/LAST>

Enter name

IF ONE CHILD AGED UNDER 24 MONTHS

P5 Please type his or her name in the box below. This is so we can refer to them in later questions.

Enter name

ASK ALL MOTHERS OF CHILDREN AGED UNDER 24 MONTHS,

P6 Is <child> …

Male
Female

P7 How old is <child> now?

Enter number of weeks or months (0-104 weeks, 0-24 months)

IF CURRENTLY PREGNANT

P8 How many weeks into your pregnancy are you?
PLEASE TYPE IN THE NUMBER OF WEEKS. IF YOU'RE NOT SURE, PLEASE TYPE IN YOUR BEST ESTIMATE

Enter number

ASK ALL

P9 Was <your current pregnancy/your pregnancy with <child>> planned?
CODE ONE ONLY

Yes – we were actively trying for a baby
To some extent
No – not planned at all

P9a And can we just check, <do any of these apply to your current pregnancy/did any of these apply to your pregnancy with <child>?
CHOOSE ALL THAT APPLY

PREGNANT WOMEN
The pregnancy is classified as high risk
There have been complications with the pregnancy
I have been seriously ill/unwell during the pregnancy
I was ordered to take bed rest
None of these

MOTHERS OF 0-2S
The pregnancy was classified as high risk
There were complications with the pregnancy
I was seriously ill/unwell during the pregnancy
I was ordered to take bed rest
There were complications with the birth
<child> was premature
None of these

ASK ALL

A1a Who do you live with in your household? <Don't forget to include <CHILD> <and any other children you have already told us about> in your answer.>
CHOOSE ALL THAT APPLY

Spouse/civil partner/partner
Parents (including in-law or step parent)
Grandparents (including in-law or step)
Sons/daughters (including in-law, adopted, step or foster)
Brothers/sisters (including in-law, adopted, step or foster)
Other relatives
Friends
Personal assistants/paid carers/nannys/au pairs
Other persons (specify)

A1b Please select the age ranges of all of the children **who live in your household** <including any children you have already told us about>. This could include other people's children who usually live in this household, as well as your own children.
CODE ALL THAT APPLY

Under 2
2-4
5-7
8-11
12-15
16-18

A 2 REMOVED

A 3 Which of these categories best describes what *you* personally do at the moment?
IF YOU DO MORE THAN ONE, PLEASE CHOOSE THE MAIN THING YOU DO
CODE ONE ONLY

Working as an employee or on a self-employed basis
On maternity leave from a job (employee or self-employed)
Unemployed and actively seeking work
On a special government training or employment scheme
A full time student or pupil
Looking after the family or home
Not working because temporarily sick or injured
Not working because long-term sick or disabled
Retired from paid work
None of these

B How content or in control are you?

The first section of questions is about the way you think and feel about things

B 1 How much do you agree or disagree with these things?

Disagree strongly
Disagree
Disagree slightly
Neither agree nor disagree
Agree slightly
Agree
Agree strongly

- I feel good about myself (SELF ESTEEM)
- I believe you need to take risks to lead a full life (RISK TAKING)

REST OF SECTION B NOT USED FOR PWM02

C How do you view your health

The next few questions ask you about your feelings about health in general. As with the rest of this interview, please remember that there are no right or wrong answers, as we are interested in your views and opinions.

C 1 How is your health in general? Would you say it was ...

1 …very good
2 good
3 fair
4 bad, or
5 very bad?

C 2 How much do you agree or disagree with these things about health in general?

ROTATE ORDER OF PRESENTATION

Disagree strongly
Disagree
Disagree slightly
Neither agree nor disagree
Agree slightly
Agree
Agree strongly

HEALTH LOCUS OF CONTROL

- The main thing which affects my health is what I personally do

HEALTH FATALISM

- If a person is meant to get ill, they will get ill anyway, regardless of whether they lead a healthy lifestyle

P9b How much of a priority would you say leading a healthy lifestyle is/was to you at each of these times?

- Before you got pregnant
- During your pregnancy <with <child>>
- (ONLY MOTHERS OF 0-2s) After the birth of <child>
- (ONLY MOTHERS OF 0-2S) Nowadays

Very high
Quite high
Not very high
Not a priority at all

C 3 NOT USED FOR PWMO2

C 4 Thinking generally how would you personally describe a 'healthy lifestyle' for you? Please type in your answer in the box below

Open ended

C 5 For you, how easy or difficult would it be to lead a healthy lifestyle over the next 3 months? (RESPONSE EFFICACY)

Extremely difficult 1 … 7 Extremely easy

C 6 How much control do you believe you have over whether or not you lead a healthy lifestyle over the next 3 months? (SELF EFFICACY)

No control 1 … 7 Complete control

C 7 Next I would like you to think about your friends and family. How many of them do you think lead a healthy lifestyle nowadays?

All of them
Most of them but not all
About half
Some of them but less than half
Only a few
None of them

C 8 During the past four weeks, how often did you get enough sleep to feel rested upon waking in the morning? Did this happen...

All of the time,
Most of the time,
A fair amount of the time,
Some of the time,
A little of the time,
None of the time?

D NOW PART OF SECTION C

E Healthy Eating

Next are some questions about food and what you eat nowadays. Please remember that there are no right or wrong answers here, so please be as honest as possible.

E 1 To what extent would you agree or disagree with these things about healthy eating?

Disagree strongly
Disagree
Disagree slightly
Neither disagree nor agree
Agree slightly
Agree
Agree strongly

- Healthy eating means giving up too many of the foods I enjoy
- Most people I know eat healthily nowadays
- Healthy eating is only for those that can afford it

E1a How high a priority for you is healthy eating nowadays?

Very high
Quite high
Not very high
Not a priority at all

E 2 How often do you eat each of these things in a normal week?

Several times a day
Once a day
5 or 6 days a week
3 or 4 days a week
Once or twice a week
Less often
Never

- Fruit, vegetables or salad. These could be fresh, frozen, tinned, dried or juiced, but don't include potatoes
- Foods that are high in sugar, such as cakes, puddings, pastries or biscuits, sweets or chocolate
- Foods that are high in fat or fried foods such as fried fish, chips, cooked breakfast, samosa, crisps or fatty meats but not including oven chips
- Fizzy drinks or soft drinks like squash – not including diet or sugar free drinks, or sparkling water

E4a And which of these things apply to the way you personally eat nowadays, as part of a normal day?

You limit the number of unhealthy snacks you eat between meals
You limit the amount of food and drink you consume that is high in calories
You limit the amount of salt or lo-salt you take in
None of these

E 3 REMOVED

E3a At the table do you…. PLEASE SELECT ONE ONLY

PLEASE TREAT LO-SALT AS SALT

Generally add salt to your food without tasting it first
Taste the food, but then generally add salt
Taste the food, but only occasionally add salt
Rarely, or never, add salt at the table

E 4 Thinking just about YESTERDAY how many portions of fruit, vegetables or salad did you eat- fresh, frozen, tinned, dried or juiced?

NOTE: A portion is a medium sized piece of fruit such as an apple, a glass of 100% fruit juice or 3 heaped tablespoons of cooked vegetables. It does not include potatoes.

ENTER NUMBER
None

E 5 To what extent do you intend to start eating a healthier diet over the next 3 months?

Definitely don't intend to 1 … 7 Definitely intend to
I don't intend to eat a healthier diet – I already eat healthily

For mothers: Now some questions about diet during pregnancy

P10a What do you think are the guidelines for food and nutrition for women who are pregnant? It doesn't matter if you are not sure, we are just interested in your impressions.
PLEASE WRITE IN YOUR ANSWER BELOW

Open ended

P10 (IF CURRENTLY PREGNANT) Which of these supplements have you taken or are planning to take during your pregnancy? These could be on their own or as part of a multivitamin or other supplement

(IF MOTHER OF 0-2) Which of these supplements did you take at any time when you were pregnant with <child>? This could be on their own or as part of a multivitamin or other supplement
CHOOSE ALL THAT APPLY

Vitamin D
Folic Acid
None of these

P11 (IF CURRENTLY PREGNANT) Which of these describes what you are doing in your current pregnancy?

(IF MOTHER OF 0-2) Which of these describes what you did when you were pregnant with <child>?

(IF HAD COMPLICATIONS WITH PREGNANCY AT P9A) Where possible, please answer in relation to the 'normal' part of your pregnancy: not at any time when there were complications.

CHOOSE ONE ANSWER PER ROW (SHOW AS GRID)

	I <eat/ate> the same amount as before I was pregnant	I <eat/ate> a little more than I did before	I <eat/ate> a lot more than I did before
When 1-13 weeks pregnant (ask all)			
When 14-26 months pregnant (if at least 20 weeks pregnant or mother of 0-2)			
From 27 weeks pregnant onwards (if at least 31 weeks pregnant or mother of 0-2)			

P12 MOVED TO P10A

Now thinking about breastfeeding.

P13 How much do you agree or disagree with these things about breastfeeding?

Disagree strongly
Disagree
Disagree slightly
Neither disagree nor agree
Agree slightly
Agree
Agree strongly

- Most of the mothers I know breastfeed/have breastfed
- I would feel uncomfortable breastfeeding when I'm out and about
- While your baby is still young, it is worth sticking with breastfeeding for as long as you can
- Formula milk is as good for your baby as breast milk

ASK ALL PREGNANT WOMEN

P14 To what extent do you intend to try breastfeeding your baby?

Definitely don't intend to 1 … 7 Definitely intend to
I know I will not be able to breastfeed my baby for health/medical reasons

ASK ALL MOTHERS OF 0-2S, PREGNANT WOMEN GO TO P23

P15 Have you ever breastfed/given breast milk to <child> even if this was only once?
CODE ONE ONLY

Yes – am currently exclusively breastfeeding (i.e. not feeding <child> formula/other milk)
Yes – am currently mixed/partial breastfeeding (i.e. feed some breast milk and some formula/other milk)
Yes –have breastfed in the past but not now
No – not at all

IF YES IN THE PAST AT P15

P16 How old was <child> when <he/she> was LAST exclusively given breast milk?

(filter codes on age of child)
1 week or less
1-6 weeks
More than 6 weeks, up to 12 weeks
More than 12 weeks, up to 4 months
More than 4 months, up to 5 months
More than 5 months, up to 6 months
More than 6 months
Never exclusively breastfed

IF EXCLUSIVELY BREASTFEEDING NOW AT P15 AND CHILD AGED UNDER 6 MONTHS

P17 At what age do you intend to stop exclusively breastfeeding <child>?

(filter codes on age of child)
1 week or less
1-6 weeks
More than 6 weeks, up to 12 weeks
More than 12 weeks, up to 4 months
More than 4 months, up to 5 months
More than 5 months, up to 6 months
More than 6 months

ASK ALL MOTHERS OF 0-2S, UNLESS EXCLUSIVELY BREASTFEEDING NOW AT P15

P18 How old was <child> when they were first given ANY KIND OF MILK OTHER THAN BREAST MILK, such as formula milk?

(filter codes on age of child)
Not been given other milk
1 week or less
2-6 weeks
More than 6 weeks, up to 12 weeks
More than 12 weeks, up to 4 months
More than 4 months, up to 5 months
More than 5 months, up to 6 months
More than 6 months

ASK MOTHERS OF CHILDREN AGED UNDER 12 MONTHS, MOTHERS OF CHILDREN AGED 13-24 MONTHS GO TO P20

P19 Has <child> ever had any solid foods such as cereal, baby rice, fruit, vegetables or any other kind of solid foods?

Yes
No

IF YES AT P19 OR CHILD AGED 13-24 MONTHS

P20 How old was <child> when <he/she> first had any solid foods?

(filter codes on age of child)
1 week or less
2-6 weeks
More than 6 weeks, up to 12 weeks
More than 12 weeks, up to 4 months
More than 4 months, up to 5 months
More than 5 months, up to 6 months
More than 6 months
<child> has not yet had any solid foods

IF NO AT P19 OR CHILD HAS NOT YET HAD ANY SOLID FOODS AT P20

P21 At what age do you think you will give <child> any solid foods?

(filter codes on age of child)
6 weeks or less
More than 6 weeks, up to 12 weeks
More than 12 weeks, up to 4 months
More than 4 months, up to 5 months
More than 5 months, up to 6 months
More than 6 months

IF YES AT P19 OR CHILD AGED 13-24 MONTHS

P22 How often do you do each of these things for <child>?

Always
Mostly
Sometimes
Occasionally
Rarely
Never

- Check that I don't give <him/her> food with added salt
- Check that I don't give <him/her> food with added sugar
- Make sure <he/she> eats vegetables every day
- Make sure <he/she> has foods with a variety of tastes and textures

ASK ALL

P23 How much do you agree or disagree…?

ROTATE STATEMENTS

Disagree strongly
Disagree
Disagree slightly
Neither disagree nor agree
Agree slightly
Agree
Agree strongly

(ALL)

- Setting healthy eating habits when they are young will impact on <<child>'s/my baby's> health later on
- There is enough support available to help new mothers breastfeed (moved from E1)

(ONLY MOTHERS OF 0-2S)

- As long as a child is a healthy weight, parents needn't worry about what the child eats

(ONLY IF BABY HAS STARTED HAVING SOLID FOOD AT P19)

- There is enough support available to help mothers with weaning/introducing solid foods into their baby's diet

ASK ALL MOTHERS

P23a And now thinking about the weight of <child> at the moment, which of the following best describes them?

Very overweight
A little overweight
Healthy weight
A little underweight
Very underweight

IF FEEL CHILD IS UNDER/OVERWEIGHT AT G2a

P23b How worried are you about the effect of <CHILD>'s weight on <CHILD>s health?

Not at all worried 1 … 7 Very worried

F Physical activity

ASK ALL
Next some questions about exercise and physical activity.

F 1 How much do you agree or disagree with these things?

Disagree strongly
Disagree
Disagree slightly
Neither disagree nor agree
Agree slightly
Agree
Agree strongly

- Most people I know are physically active nowadays
- There are plenty of ways that I could be active without having to go to the gym or take part in organised sports

The next few questions are about MODERATE PHYSICAL ACTIVITY that is activity that at least makes you breathe slightly faster than usual. For example:

- brisk walking
- going to the gym
- swimming
- aerobics
- sports
- cycling
- heavy gardening
- physical activity as part of or getting to work/job

ASK ALL MOTHERS OF 0-2S, PREGNANT WOMEN GO TO F 4

F 2 Thinking about the last 7 days, on how many days have you done *any* moderate physical activity? This is any physical activity that makes you breathe slightly faster than usual

Write in (0-7)

UNLESS NONE AT F 2, OTHERS GO TO F 4

F 3 Across the last 7 days, how many minutes in total have you spent doing moderate physical activity? This is any physical activity that makes you breathe slightly faster than usual

Enter minutes

ASK ALL

F 4 Which of these activities have you done in the last 7 days to the point where you were breathing faster than usual due to physical exertion?

CODE ALL THAT APPLY

Walking to work, shopping, etc
Leisure time walking e.g. hillwalking, golf, rambling
Cycling
Heavy gardening
Physical exercise such as fitness-training, going to the gym, doing exercise classes/aerobics, playing football, playing another sport, swimming, jogging etc
Dancing
Something else (specify)
None of these

IF CURRENTLY PREGNANT

P24 How does the amount of physical activity you do nowadays compare with what you did before you were pregnant?
(IF HAD COMPLICATIONS WITH PREGNANCY AT P9A)
Please answer in relation to the 'normal' part of your pregnancy: not at any time when there were complications.
CODE ONE ONLY

I do a lot less than before I was pregnant
I do a little less than before I was pregnant
I do about the same amount
I do a little more than before I was pregnant
I do a lot more than before I was pregnant

MOTHERS OF 0-2S

P24a How did the amount of physical activity you did during your pregnancy compare with what you did before you were pregnant?
(IF HAD COMPLICATIONS WITH PREGNANCY AT P9A)
Please answer in relation to the 'normal' part of your pregnancy: not at any time when there were complications.
CODE ONE ONLY

I did a lot less when I was pregnant than I did before I got pregnant
I did a little less when I was pregnant than before
About the same amount
I did a little more than before I was pregnant
I did a lot more when I was pregnant than I did before I got pregnant

P25 Thinking about your weight <at the moment/before you became pregnant> which of the following best <describes/ described> you?
I think I <am/was>….

Very overweight
A little overweight
Healthy weight
A little underweight
Very underweight

ASK ALL MOTHERS OF 0-2S ONLY, PREGNANT WOMEN GO TO SECTION H

F 5 Do you intend to increase the amount of physical activity you do over the next 3 months?

Definitely don't intend to 1…7 Definitely intend to
Unable to because of a medical condition
I don't intend to increase the amount of physical activity – I already do enough

F6-F8 NOT ASKED

P26 Which of these best describes the stage of development of <child>?
CODE ONE ONLY

Able to run around
Able to walk without holding on to anything
Able to stand while holding on to something (e.g. furniture)
Able to crawl or sit up without falling over
Able to hold head up unsupported
Not yet able to hold head up without support

ASK MOTHERS OF CHILDREN AGED 4-24 MONTHS

P27 Which of these things, if any, do you do nowadays for <child>, as part of a normal day?
CODE ALL THAT APPLY

(if child not yet walking) Encourage <child> to be physically active playing on the floor (e.g. on a play mat)

(if child is walking) Ensure that <child> is physically active for at least 3 hours every day

Make sure that <child> is not sitting still for more than one hour at a time during the day, except when sleeping (e.g. in a high chair, rocker, buggy or car seat)

None of these

H Tobacco

ASK ALL
The next few questions are about smoking. Please try to answer as honestly as possible

H 1 To what extent would you agree or disagree with these things about smoking and tobacco?

Disagree strongly
Disagree
Disagree slightly
Neither disagree nor agree
Agree slightly
Agree
Agree strongly

- More people are stopping smoking nowadays
- The health risk from smoking is greatly exaggerated
- Fewer pregnant women smoke these days compared with 5 years ago

H 2 NOT ASKED OF PWM02

H 3 NOT ASKED OF PWM02

P28 Which of these best describes you <and your current pregnancy/when you were pregnant with <child>>? Please think about both ready-made and hand-rolled cigarettes

CODE ONE ONLY

I have never smoked*
I have smoked in the past, but had given up before I found out I was pregnant
I was a smoker but I gave up as soon as I found out I was pregnant
I <have> smoked for some of my pregnancy**
I <have> smoked for all of my pregnancy

IF ** SMOKED FOR SOME OF PREGNANCY AND FOUR WEEKS PREGNANT OR MORE

P29 During your pregnancy in which weeks <have you/did you smoke>? Please select all that apply, even if you didn't know you were pregnant at the time. If you only smoked for part of any one period, e.g. only a few days during weeks 5-8, please still select that period. (SHOW AS GRID)

1. At 0-4 weeks (ALL WOMEN WHO ARE 4 WEEKS PREGNANT OR MORE)
2. At 5-8 weeks (ALL WOMEN WHO ARE 5 WEEKS PREGNANT OR MORE)
3. At 9-12 weeks (ALL WOMEN WHO ARE 9 WEEKS PREGNANT OR MORE)
4. At 13-16 weeks (ALL WOMEN WHO ARE 13 WEEKS PREGNANT OR MORE)
5. At 17-20 weeks (ALL WOMEN WHO ARE 17 WEEKS PREGNANT OR MORE)
6. At 21-24 weeks (ALL WOMEN WHO ARE 21 WEEKS PREGNANT OR MORE)
7. At 25-28 weeks (ALL WOMEN WHO ARE 25 WEEKS PREGNANT OR MORE)
8. At 29-32 weeks (ALL WOMEN WHO ARE 29 WEEKS PREGNANT OR MORE)
9. At 33-36 weeks (ALL WOMEN WHO ARE 33 WEEKS PREGNANT OR MORE)
10. From 37 weeks onwards (ALL WOMEN WHO ARE 37 WEEKS PREGNANT OR MORE)

ASK MUMS OF 0-2S AND PREGNANT WOMEN UNLESS NEVER SMOKED AT P28 (*)

P30 Which of the following best applies to you today?
PLEASE CHOOSE ONE ONLY

I smoke cigarettes (including hand-rolled) every day
I smoke cigarettes (including hand-rolled), but not every day
I do not smoke
None

ASK ALL CURRENT SMOKERS, OTHERS GO TO H 7

H 4 On average, how many cigarettes or hand rolled cigarettes do you usually smoke a day?
IF THE NUMBER VARIES BETWEEN WEEKDAYS AND WEEKENDS, PLEASE ENTER AN AVERAGE FOR EACH DAY. ENTER 0 IF SMOKE LESS THAN 1 CIGARETTE PER DAY.
PLEASE ENTER NUMBER

Enter number

H 5 NOT ASKED OF PWM02, P31 ASKED INSTEAD

IF SMOKED DURING PREGNANCY (P28)

P31 <Did you make/have you made> a serious attempt to give up smoking < when you were pregnant/during your pregnancy>? By serious attempt I mean you decided that you would try to make sure you never smoked again.
<Please include any attempt that you are currently making >

Yes
No

IF YES AT P31, IF NO GO TO H 6

P32 Which, if any, of these did you try to help you stop smoking at that time?
CHOOSE ALL THAT APPLY

Attended a **special group or one to one service for pregnant women** who want to stop smoking
Attended **another** stop smoking group or one to one service
Phoned the NHS **Pregnancy** Smoking Helpline
Phoned the **general** NHS Smoking Helpline
Phoned a non- NHS Smoking Helpline
Visited www.nhs.uk/smokefree website/other website
Used nicotine replacement product (eg. patches/gum/inhaler) without a prescription
Used nicotine replacement product on prescription or given to you by a health professional
Other (specify)
None of these

P33 Which, if any, of these things prompted you to try to give up smoking at that time?
CHOOSE ALL THAT APPLY

Advice from a GP
Advice from a Midwife
Advice from another Health Professional
Something said by friends or family
Concern about the health of my baby
Concern about my own health
Advertising or something seen in the media
Smoking is too expensive/cost of smoking
Other (specify)
Don't know

ASK ALL CURRENT SMOKERS

H 6 Which of these best describes you today?
CODE ONE ONLY

I REALLY want to stop smoking and intend to in the next month
I REALLY want to stop smoking and intend to in the next 3 months
I REALLY want to stop smoking but I don't know when I will
I want to stop smoking and hope to soon
I want to stop smoking but haven't thought about when
I think I should stop smoking but don't really want to
I don't want to stop smoking

ASK ALL

H 7 Is smoking allowed in the house?

PLEASE CHOOSE ONE ONLY

Yes
Only when children are NOT in the house
No – not at all

H 8 Is smoking allowed in the family car?

PLEASE CHOOSE ONE ONLY

Yes
Only when children are NOT in the car
No – not at all
Not applicable – do not have a family car

I Alcohol

ASK ALL
The next few questions are about drinking alcohol.

I 1 Which of these best describes your thoughts about drinking alcohol when pregnant?
PLEASE CHOOSE ONE ONLY

It's okay to drink alcohol…

as long as you don't get drunk
as long as it's no more than 1 or 2 drinks a day
as long as it's no more than 1 or 2 drinks a week
as long as you only have a sip or two occasionally

It's not okay to drink any alcohol at all when pregnant
It's OK to drink any amount of alcohol when you are pregnant

I 2 Approximately how often do you drink alcohol **nowadays**? This could be drunk in your own home, in someone else's home or out of the home in pubs, bars or restaurants
CODE ONE ONLY

Every day
5 or 6 days a week
3 or 4 days a week
Once or twice a week
Once or twice a month
Once every couple of months
Once or twice a year
Less than this or never*

UNLESS NEVER AT I 2, IF NEVER AT I 2 GO TO P34

I 3 When did you last have an alcoholic drink?
CODE ONE ONLY

Today
Yesterday
Some other time during the last 7 days
More than 1 week but less than 2 weeks ago
More than 2 weeks but less than 4 weeks ago
More than 1 month but less than 6 months ago
More than 6 months ago

IF HAVE HAD AN ALCOHOLIC DRINK IN PAST 7 DAYS AT I 3 ANSWER I4, OTHERS CHECK ROUTING BEFORE I 5

UNLESS LESS OFTEN/NEVER (*) AT I 2,

I 4 Thinking about the amount of alcohol that you usually drink nowadays how would you describe yourself?

A very light drinker
A light drinker
A moderate drinker
A heavy drinker
A very heavy drinker

I 5 NOT ASKED OF PWM02 (SEE P34)

IF MOTHER OF 0-2 OR PREGNANT WOMAN WHO EVER DRINKS AT I 2, ANSWER I 6. IF NEVER DRINK GO TO P34

I 6 To what extent do you intend to cut down the amount of alcohol you drink over the next 3 months?

Definitely don't intend to 1…7 Definitely intend to
Don't intend to – I don't drink that much

ASK ALL

P34 Which of these changes to the amount you <drank did you make when you found out/ drink have you made since you found out> you were pregnant <with <child>>?
CHOOSE ONE ONLY

I cut down on the amount I drank for all of the pregnancy
I cut down on the amount I drank for some of the pregnancy
I gave up altogether [INCLUDE SOFT CHECK IF RESPONDENT IS PREGNANT AND SAYS THEY DRINK NOWADAYS FOR THE REMAINDER OF YOUR PREGNANCY]
I did not drink alcohol at all at the time I found out I was pregnant <with <child>>
None of these

J Drugs

SECTION J NOT ASKED OF PWM02

K Sexual health

SECTION K NOT ASKED OF PWM02

L Other views

L 1 NOT ASKED FOR PWMO2

L 2 NOT ASKED FOR PWMO2

Now a few more questions about how you feel

L 3 Overall, how satisfied are you with your life nowadays?

Not at all 0 … 10 Completely

L 4 Overall, to what extent do you feel the things you do in your life are worthwhile?

Not at all 0 … 10 Completely

L 5 Overall, how happy did you feel yesterday?

Not at all 0 … 10 Completely

L 6 Overall, how anxious did you feel yesterday?

Not at all 0 … 10 Completely

ASK ALL MOTHERS

L6a Now thinking about being a parent. How much do you agree or disagree with the following

ROTATE

- I find being a parent rewarding
- As a parent I find it difficult to cope

Disagree strongly
Disagree
Disagree slightly
Neither disagree nor agree
Agree slightly
Agree
Agree strongly

L 7 How much do you agree or disagree that it is important for you to set <<child>/your child> a good example through the things that you do?

Disagree strongly
Disagree
Disagree slightly
Neither disagree nor agree
Agree slightly
Agree
Agree strongly

L 8 NOT ASKED OF PWMO2

L 9 NOT ASKED OF PWMO2

L 10 NOT ASKED OF PWMO2

ASK ALL WHO LIVE WITH 1 OR MORE OTHER PERSON IN HOUSEHOLD

L 11 Do other people in your household do any of the following nowadays? You don't need to say who.

CODE ALL THAT APPLY

Smoke cigarettes
Is a heavy drinker
Take illegal drugs or legal highs
None of these

L11b And have any other people in your household made any of the following changes to their lifestyle because of your pregnancy/since you had your baby?
CODE ALL THAT APPLY

- **Smoking**
  - Cut down on smoking
  - Stopped smoking
  - Neither – smokers in the household have not changed their smoking habits
  - Not applicable as no one in household smoked when I got pregnant / when I had the baby

- **Alcohol**
  - Cut down the amount of alcohol they drink
  - Completely stopped drinking alcohol
  - Neither – drinkers in the household have not changed their drinking habits
    Not applicable as no one in household drank when I got pregnant / when I had the baby

- **Drugs**
  - Cut down drug use
  - Completely stopped using drugs
  - Neither – drug users in the household have not changed their drug use
  - Not applicable as no one used drugs when I got pregnant / when I had the baby

L11a Do you have any of the health problems listed below?

None of these
Cancer
Stomach, liver, kidney or digestive problems
Heart disease/stroke
High blood pressure
Type I diabetes
Type II diabetes
Diabetes – not sure which type
Asthma/other breathing difficulty
HIV/AIDS
Any sexually transmitted infection
Stress or depression that you are receiving treatment for
Other conditions (Please specify)
Don't know
Prefer not to answer

ASK ALL MOTHERS

L11c Do you have or do you think you might have post natal depression (even if it has not been diagnosed by a medical professional)?

Yes- and it has been diagnosed
Yes – but it has not been diagnosed
No

ASK ALL

L 12 Do you have any long standing illness, disability or infirmity that limits your normal day to day activities?

By 'long-standing' we mean anything that has troubled you over a period of time or that is likely to affect you over a period of time.
Normal day to day activities include everyday things like eating, washing, walking and going shopping
CODE ONE ONLY

I have any long-standing illness, disability or infirmity
It limits my activities all of the time
It limits my activities some of the time
It doesn't limit my activities

I don't have any long-standing illness, disability or infirmity

REST OF SECTION L NOT ASKED OF PWM02

N Interactions with health services

P35 Have you done any of these things in the past FOUR WEEKS?
CHOOSE ALL THAT APPLY

Used a **Surestart Centre** or **Children's Centre**
Gone to a **playgroup** (ONLY IF HAVE CHILDREN)
Gone to a **soft play centre** (ONLY IF HAVE CHILDREN)
Gone to other classes/groups with <child> e.g.Tumbletots, baby yoga, baby massage, baby signing, swimming, music classes (ONLY IF HAVE CHILDREN)
Taken part in any activities such as drama / arts / crafts / photography/playing a musical instrument, etc.
Gone to a **cinema, theatre, concert, museum** or **art gallery**
Gone to see a **football match or other sports event**
Taken part in any kind of **sport** (e.g. football / netball) **or other physical activity** (e.g. gymnastics / dance / karate)
Took part in any **courses or classes** intended to lead to a qualification
Took part in any **courses or classes** or other learning, not intended to lead to a qualification
Gone to a **political meeting, march, rally or demonstration**
Helped out in the community on a formal basis (e.g. working in a charity shop, helping volunteer organisations or charities, fundraising, being on a committee)
Helped out in the community on an informal basis (e.g. helping elderly, disabled or other dependent people, helping with a sports team, etc.)
Attended a **religious group** (include attending religious services or church)
None of these

P36 And which of these things <did you do/have you done> in preparation for the birth <of <child>>?
CHOOSE ALL THAT APPLY

Mothers of 0-2s

	Attended this	Available to me but did not attend	Not available to me
Attended antenatal classes / workshop / one to one session run by the local NHS (e.g. at local doctor's surgery or local hospital)			
Attended antenatal classes run by the NCT (formerly the National Childbirth Trust), Active Birth Centre (ABC) or somebody similar			
Attended other antenatal classes			
Took a tour of hospital facilities			

Pregnant women

	Attended this	Planning to attend	Available to me but not planning to attend	Not available to me
Attend antenatal classes/workshop / one to one session run by the local NHS (e.g. at local doctor's surgery or local hospital)				
Attend antenatal classes run by the NCT (formerly the National Childbirth Trust), , Active Birth Centre (ABC) or somebody similar				
Attend other antenatal classes				
Take a tour of hospital facilities				

N 1 And thinking about all the services that you <have used so far in your pregnancy/used during your pregnancy and after the birth of <child>>, how satisfied were you with these things ?

Very satisfied
Satisfied
Fairly satisfied
Neither satisfied nor dissatisfied
Fairly dissatisfied
Dissatisfied
Very dissatisfied
<Did not use/have not used yet>

The service received from

- Midwives
- Health visitors

The amount of information provided by local health services

- To prepare you for the birth
- On bringing up your baby

ASK MUMS 0-2s. PREGNANT WOMEN GO TO NEXT SECTION

N 2 If you need advice or support about parenting, for example if you had a specific problem breast feeding, weaning or potty training, which of the following would you turn to?

SELECT ALL THAT APPLY

Husband/partner
Parent
Grandparent
Other relation
Friends/ other mother
A baby group (such as anti-natal group, NCT group or playgroup)
Colleagues at work
Paid caregiver (nanny, nursery etc.)
GP / Doctor / Family doctor
Practice nurse
Health Visitor
Paediatrician
Midwife
Pharmacist\ chemist
NHS walk in centres
SureStart Centre
Children's centres
Parenting books/magazines
Website/Internet (SPECIFY)
Other (SPECIFY)
None of these
Don't know

N 3 From where would you like to receive **more** advice or support?

Same list as at N2

N 4 How much do you agree or disagree with the following?

- I see my friends and family as often I would like
- I have the opportunity to share my problems and experiences of being a parent with others
- I live close enough to my family to see them as often as I would like
- I live close enough to my friends to see them as often as I would like

Disagree strongly
Disagree
Disagree slightly
Neither disagree nor agree
Agree slightly
Agree
Agree strongly

N 5 If you had an emergency and needed someone to look after <child> for a few hours, is there someone you trust who you could get to do that?

Yes
No
Don't know

N 6 Now thinking generally about all sources of support, to what extent do you feel supported in your role as a parent?

Don't feel supported at all 1…7 feel fully supported

O Demographics

The next few questions are about your household situation.

O 1 NOT ASKED FOR PWM02 (SEE P35)

O1a Have you ever worked as a health professional in a clinical role?
IF YES – is that currently or in the past?

Yes - currently work as a health professional
Yes - in the past
No

O 2 Is anyone in your household currently receiving any of these benefits?
CHOOSE ALL THAT APPLY

None of these
Healthy Start Vouchers
Child benefit
Job Seekers Allowance
Income Support/Employment and Support Allowance
Working Tax Credit
Child Tax Credit
Housing Benefit
Council Tax Benefit
Disability Living Allowance/ Other Disability Benefit
Carer's allowance
Incapacity benefit
Other state benefits (specify)

O 3 Thinking of the income of the household as a whole, which of these groups represents the total income of the whole household, before deductions for income tax, National Insurance etc.

Bands will show weekly/monthly/annual income

O 4 To which of these groups do you consider you belong?
CHOOSE ONE ONLY

A **White**	British Irish Polish Other Central/Eastern European Any other White background
B **Mixed**	White and Black Caribbean White and Black African White and Asian Any other Mixed background
C **Asian or Asian British**	Indian Pakistani Bangladeshi Any other Asian background
D **Black or Black British**	Caribbean African Any other Black background
E **Chinese or other ethnic group**	Chinese Any other (specify).

O 5 How old were you when you finished continuous full-time education?

RECORD AGE IN YEARS, AN ESTIMATE IS ACCEPTABLE. RANGE FROM 10-74

Enter age
Still studying

PLUS QUESTIONS TO ESTABLISH HOUSEHOLD SOCIAL GRADE

O 6 GfK NOP may want to contact some people on behalf of the Department of Health to ask them some more questions about their experiences. Would you be willing to be contacted again to answer some more questions on this subject?

Yes – willing
No – not willing

COLLECT/CHECK FULL NAME, ADDRESS AND TELEPHONE NUMBER, EMAIL ADDRESS

FOR THOSE WHO ARE WILLING AT O 6

O 7 The Department of Health is also interested in looking at people's responses based on the area in which they live. Would you be willing for us to pass on your postcode linked to your survey data to the Department of Health? We assure you that this would only be for data analysis and not for any other purpose

Yes – willing
No – not willing

COLLECT FULL NAME AND TELEPHONE NUMBER

O 8 Would you like to be entered into the prize draw?

Yes
No

P37 Was anyone else present in the room, or passing through, or nearby when you were completing this interview?

Yes
No

P38 Did anyone else in the household look at or discuss any part of the questionnaire with you?

Yes – looked at/read/completed together
Yes – discussed only
No

The following is a list of sources of information and advice:
ALSO PROVIDE OPTION TO SAVE THIS AS A PDF FILE

For new and expectant mothers
http://www.nhs.uk/Planners/pregnancycareplanner/Pages/PregnancyHome.aspx NHS pregnancy planner which contains all you need to know to have a healthy and happy pregnancy, and to make sure you get the care that's right for you. It has over 125 pages of NHS-accredited information, including videos and interactive planning tools. You'll also find all the facts you need to choose the best maternity services in your area.
http://www.nhs.uk/planners/birthtofive/pages/birthtofivehome.aspx NHS guide to parenting from 0 to 5 years containing a range of information from how to soothe a crying baby to how to prepare your child for school. Find out how to spot the signs of serious illness, what to do if an accident happens, and how to help potty training go smoothly. Information for the parent or carer is also provided and covers your health after having a baby, as well as your rights, benefits and NHS services.
http://www.direct.gov.uk/en/Parents/index.htm Public services website which contains a wide range of information for parents from childcare to family leisure and recreation.
http://www.nct.org.uk NCT Helpline 0300 330 0700 A charity for parents which provides practical and emotional support in all areas of pregnancy, birth and early parenthood including help with feeding.
http://www.bbc.co.uk/health/physical_health/pregnancy/pregnancy_index.shtml Covering pregnancy advice, pregnancy symptoms, what is happening to your body and your growing baby.
General Health
www.nhs.uk This site helps you make choices about your health, from lifestyle decisions about things like smoking, drinking and exercise, through to the practical aspects of finding and using NHS services.
http://www.webmd.boots.com/default.htm The site provides information about a range of health topics for adults and children.
www.direct.gov.uk Direct.gov.uk is a government website providing information on all public services. The website provides information on areas such as education, employment, money and benefits, health and rights.
www.bbc.co.uk/health/ This site provides information about a range of health related topics, covering both physical and emotional health, as well as outlining places where further support is available
Support

http://www.samaritans.co.uk / e-mail: jo@samaritans.org / Tel: 08457 90 90 90 Samaritans provides confidential non-judgemental emotional support, 24 hours a day for people who are experiencing feelings of distress or despair. Whatever you're going through, whether it's big or small, don't bottle it up. If you're worried about something, feel upset or confused, or just want to talk to someone, then get in touch with the Samaritans using the contact details above.
Nutrition & Diet, Physical Activity
www.nhs.uk/livewell/healthy-eating This NHS site gives advice about eating a healthy diet as well as giving information on nutrition essentials.
http://www.nhs.uk/LiveWell/Fitness This part of the NHS site gives advice and information on being physically active.
http://www.nhs.uk/change4life Change4Life gives practical and fun exercise and healthy eating tips and guidance for adults and families
http://www.bbc.co.uk/health/healthy_living Provides information about being physically active and keeping fit, diet and nutrition
Smoking, drinking and substance use
http://smokefree.nhs.uk/ Tel: 0800 169 0169 The smokefree website contains information about the free NHS support services as well as videos of people who have quit talking about what worked best for them. You can also find the contact details of local NHS Stop Smoking Services. The NHS Smoking Helpline offers free, confidential advice about smoking.
www.quit.org.uk **/** Tel: **0800 00 22 00** QUIT is the UK charity that helps smokers to stop smoking and young people to never start
http://www.nhs.uk/livewell/alcohol This NHS site gives information about alcohol consumption in Britain, it lets you identify whether you are at risk from alcohol related illnesses and gives tips for cutting down.
http://www.al-anonuk.org.uk/ Tel**:** 020 7403 0888 Al-Anon Family Groups provide support, understanding and strength to anyone whose life is, or has been, affected by someone else's drinking.
http://www.drinkaware.co.uk/ Contains information on sensible drinking and will help you work out how much alcohol is contained in particular branded drinks.
www.talktofrank.com / Tel: 0800 77 66 00 FRANK offers free confidential drugs information and advice.

20 GfK NOP credentials

GfK NOP is a Market Research Society (**MRS**) Company Partner

GfK NOP follows **ICC/ESOMAR The World Association of Research Professionals:**

ISO 20252:2012 Market, Opinion and Social Research Standard

ISO 9001:2008 Quality Assurance Standard

GfK NOP is a member of Interviewer Quality control Scheme (**IQS**)

This means:

- Client engagement at all stages
- Competency of staff through training and appraisal
- Controlled project management
- Robust interviewer training and full briefing on the project requirements
- Validation levels of 5% minimum of all telephone work and 10% of face-to-face
- 10% minimum validation of data entry, up to 100% if requested
- 5% minimum validation of coding
- Data analysis verification for completeness and accuracy
- Security and confidentiality of the data
- Control and due diligence of sub-contractors
- And much more….

GfK NOP is a Launch Partner of the **MRS Fair Data Marque**, endorsed by the Information Commissioner and backed by Jack Straw, MP. The Fair Data Marque was launched in January 2013 at the House of Lords