

MY WORLD SURVEY

NATIONAL STUDY OF YOUTH MENTAL HEALTH IN IRELAND



UCD School of Psychology



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NATIONAL STUDY OF YOUTH MENTAL HEALTH IN IRELAND

Barbara Dooley^{1,2} and Amanda Fitzgerald¹

¹ UCD School of Psychology, Belfield, Dublin 4

² Headstrong - The National Centre for Youth Mental Health, Dublin 2

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Foreword



The lived experience of many of our young people is painfully at odds with what we would all wish for them. We hear on a daily basis of yet another young person's suicide, young people engaging in high-risk behaviour, and unemployed young people at the margins of our society who are frustrated because their futures and their dreams have been taken from them.

How are we to support our young people so that they feel empowered to live a life that means something to them? We can begin by listening to them. The My World Survey (MWS) was designed as a structured way of listening to young people. The aim was to deepen what we know about young people's mental health so that we can be more sensitive to their real needs.

This project was a collaboration between Headstrong and University College Dublin (UCD). It has taken five years and has been funded by The One Foundation, to whom we are deeply grateful.

To date, in Ireland, we have had very limited knowledge of young people and their mental health. We know, for example, that one in five of them, at any given point in time, is distressed to a significant degree. However, we know very little about what contributes to their distress and what helps them to face and overcome their difficulties.

The My World Survey broadens our understanding of what it is like to be young in Ireland today. It also maps the mental health experience of over 14,000 adolescents and young adults aged between 12 and 25.

It is evident from the findings that mental health difficulties emerge in early adolescence and peak in the late teens and early 20s, making this period in young people's lives a highly vulnerable one. This peak in mental health difficulties, in general, is coupled with a decrease in protective factors such as self-esteem, optimism and positive coping strategies.

The richness of the MWS data allows us to identify critical 'protective' factors that enable young people to resolve the challenges they face, and also the 'risk' factors that compound their distress.

One of the strongest predictors of good mental health in the lives of young people surveyed is the availability of at least 'One Good Adult' in their lives; someone who knows them personally and is available to them, especially in times of need. The presence of such a person in their lives is related to the development of their self-esteem, their sense of belonging, and how they cope or do not cope with their difficulties. The absence of One Good Adult is significantly related to their level of depression, suicide and self-harm.

We are all potential 'Good Adults' in the lives of young people we know in our families, our communities, schools and youth services. Many of us may not appreciate the power we have in influencing a young person's self-belief and how they learn from us the fundamental skills they need to live. The MWS findings highlight how all young people, especially those who are not coping with their lives, need our support, now more than ever.

A handwritten signature in black ink that reads "Tony Bates". The signature is written in a cursive, flowing style.

Dr Tony Bates

Founding Director

Headstrong – The National Centre for Youth Mental Health

Young Person's Response to Findings



We have known for some time that being young in Ireland is a much more complex experience than media reports would suggest. The My World Survey (MWS) knits the isolated facts into something like a narrative, offering us a much more nuanced picture of youth in Ireland than has been available until now. It uncovers the facts that don't show up in a simple, clinical diagnosis. It lifts the lid on the experience of the 'typical young person' and reveals the subtleties that come under this description.

It seems like we grow up pretty early in this country. Problem drinking, financial stress and an acute awareness of just what it is that's happening to us: these are very grown-up concerns.

Unfortunately, the people we're talking about are financially and politically disenfranchised, in need of an appropriate environment in which to receive help, and dependent on those on the other side of the generation gap to get where they want to be.

The MWS is an attempt to reach across this gap in understanding. Ask us what we need, ask us what it's like to be alive right now, and you'll get a clear response. The experiences of a 16-year-old differ greatly from those of someone aged 20 or 21. The MWS reflects these differences – which seems to make a clear argument for the tailoring of support services, even within the 'youth and adolescence' bracket.

If the MWS itself is one form of adults reaching out to young people, then its contents also argue in favour of a close relationship between young people and an adult they can trust – a family member, a teacher, or someone encountered outside the usual structures. Put simply, they are 'One Good Adult'. The presence of this figure in a young person's life is a moderating, insulating force, one that helps us to develop the resilience and self-esteem we need to live this stage in our lives to the full. This justifies the work that Jigsaw does in bringing young people into contact with formal and informal supports of this kind. Ask us what we need, and we'll tell you. Reach out, and you'll see us flourish.

The MWS helps us see the truths behind the facts. It is the beginning of a frank and honest conversation about what it is to be young in this country. Its narrative may be a clear one, but its main value lies in revealing the means by which to make the trajectory from adolescence to adulthood smoother, less turbulent, and more positive for Ireland and its young people.



Tim Smyth

Headstrong's Youth Ambassador

Acknowledgements

The My World Survey would not have been possible without the help and commitment of many people, groups and organisations. We would like to thank all of them on behalf of both Headstrong and the UCD School of Psychology research team.

First, we acknowledge the funding from The One Foundation without which it would not have been possible for this research to be conducted.

Next, we thank the following research assistants, all whom contributed to the success of the project:

- | | |
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We also thank our volunteers who gave so generously of their time to work on the My World Survey with us:

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Finally, above all, we wish to thank the almost 15,000 young people who participated in the My World Survey. This research would not have been possible without the time they so willingly provided to us.

Executive Summary



Introduction

The number one health issue for young people is their mental health. Mental health has been defined as a state of well-being in which the individual recognises their own abilities and is able to cope with normal daily stresses in life (World Health Organisation, 2005).

Good mental health in adolescence is a requirement for optimal psychological development, the development and maintenance of productive social relationships, effective learning, an ability to care for oneself, good physical health, and effective economic participation as adults.

About 70% of health problems and most mortality among the young arise as a result of mental health difficulties and substance-use disorders (McGorry, 2005). Almost 75% of all serious mental health difficulties first emerge between the ages of 15 and 25 (Hickie, 2004; Kessler et al, 2005; Kim-Cohen et al, 2003).

Why conduct the My World Survey (MWS)?

Large-scale studies that capture the mental health profile of young people help us to understand their experiences and inform service provision. To date, there is a limited body of research on the prevalence of mental health difficulties among young people aged 12-25, particularly in the Irish context. Most published Irish studies provide data up to age 18, with a primary focus on negative factors. The MWS had two broad aims: to extend the age distribution up to 25 years, and to consider protective factors in conjunction with risk factors. Thus, this is the first national study of youth mental health in Ireland from age 12-25 years.

What is the MWS?

The MWS was developed by Headstrong and UCD School of Psychology following a review of positive and negative functioning in youth mental health. No previously published study has comprehensively profiled youth mental health functioning in the community, exploring assets and deficits. Internationally, the positive (protective) and negative (risk) domains in the MWS have previously been individually used for this population (12-25 years), but there is no research that considers both these domains collectively and explores how they interact and affect the mental health of a young person.

Positive (protective) factors include: resilience, optimism, coping, social support, life satisfaction, self-esteem and help-seeking behaviour. Negative (risk) factors include: stress, depression, anxiety, alcohol and drug use, bullying, suicidal behaviour, and gambling behaviour.

The MWS was developed for use (1) within the second-level school system and (2) for young adults after their second-level schooling. Thus two versions of the MWS were developed: MWS-Second Level (MWS-SL) and MWS-Post Second Level (MWS-PSL). The factors in each version were predominantly equivalent.

Who participated in the MWS?

A total of 72 second-level schools randomly selected from the Department of Education and Skills database participated in the MWS-SL.

- › 6,085 adolescents completed the MWS-SL
- › Age range: 12-19 years (M = 14.93)
- › 51% were females
- › All school years were represented in the study

Participants in the MWS-PSL were drawn from the following samples: (1) young adults in third-level education, (2) those enrolled on national training courses/schemes, (3) those who were unemployed, and (4) those who were employed.

- › 8,221 young adults participated in the MWS-PSL
- › Age range: 17-25 years (M = 20.35)
- › 65% were females

Data were collected from young people in second-level education in each of the 26 counties, and from every university, in the Republic of Ireland, giving a sample size for this report of nearly 15,000 young people. Only 14,306 are included in this report. Approximately 600 respondents were excluded from this report as they were not permanent residents in Ireland.

Key findings

The majority of young people were found to be functioning well across a variety of mental health indicators. Interesting findings emerged when we looked at our data across the age span of 12-25. It was evident that mental health difficulties emerged in early adolescence and peaked in the late teens and early 20s. This peak in mental health difficulties, in general, was coupled with a decrease in protective factors such as self-esteem, optimism and positive coping strategies. This stage in a young person's life, therefore, is a particularly vulnerable period.

Gender was seen to be both a risk and a protective factor. For example, males consistently reported higher levels of self-esteem and satisfaction with life compared to females. But they also engaged in more risk-taking behaviour, including problem drinking, substance misuse, and violence towards others. Females reported higher levels of perceived social support and help-seeking behaviours but also engaged in more avoidant coping strategies compared to males.

To broaden our understanding of being a young person in Ireland today, the data were analysed not just descriptively but also across a number of key themes. The following themes were found to be significantly related to key mental health indicators, as measured by the MWS:

- › 'One Good Adult' is important in the mental well-being of young people.
- › Excessive drinking has very negative consequences for the mental health and adjustment of young people.
- › Young adults' experiences of financial stress are strongly related to their mental health and well-being.
- › Rates of suicidal thoughts, self-harm and suicide attempts were found to be higher in young adults who did not seek help or talk about their problems.
- › Talking about problems is associated with lower mental health distress and higher positive adjustment.

Based on the data from the emergent themes, the MWS indicates that, by asking a young person a number of key screening questions, we may be able to determine their mental health status. These questions have been collated into the *MWS At-Risk Index*.

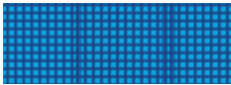
This research is a key pillar of Headstrong's objective to change how Ireland thinks about young people and their mental health needs. These findings are testimony to both the resilience and the vulnerability of our young people. The MWS brings into focus and highlights the needs of a significant number of young people who are not coping with their lives, and strongly reaffirms the importance of early intervention.

LEGEND

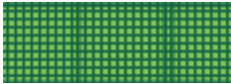
MWS versions are defined by a combination of colour and unique pattern.
Positive and negative domains are identified by a specific pattern:



MWS-SL
Grid lines / Shades of Red



MWS-PSL
Grid lines / Shades of Blue



MWS 12-25 Years
Cross hatch
Grid lines / Shades of Green



Positive Domains
Plus sign
(colour determined by the
respective age group)



Negative Domains
Minus sign
(colour determined by the
respective age group)

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1 / Introduction and Background

1.1. Introduction

Ireland to date has lacked a comprehensive national database on youth mental health. Apart from the consistent finding that one in five young people experience some degree of emotional distress at any one time (Lynch, Mills, Daly & Fitzpatrick, 2005; Martin, Carr, Burke, Carroll & Byrne, 2006; Sullivan, Arensman, Keeley, Corcoran & Perry, 2004), little is known about the mental health risk and protective factors of young people from age 12-25 years.

The My World Survey (MWS) is the first national study on youth mental health in Ireland. It addresses the gaps in our understanding by providing data at a national level to benchmark the mental health of our young people.

This report presents descriptive findings from the MWS. These findings are divided into three sections:

- 1) Young people in second-level education (12-19 years)
- 2) Young adults (17-25 years)
- 3) Developmental data on risk and protective factors of mental health and risk-taking behaviours for the entire MWS sample (12-25 years)

This report is mainly descriptive, although some analyses were carried out assessing the role of key risk and protective factors on mental health outcomes. A series of reports on key aspects of mental health (e.g. depression) and risk-taking behaviours (e.g. gambling) emanating from the MWS national data will follow this report.

1.2. Pilot Testing of the MWS

Before the national study, a pilot My World cross-sectional survey was conducted with a sample of 1,051 adolescents aged 12-18 in second-level education (Tobin, 2009). This study demonstrated that the MWS was a sensitive and reliable measure, was easy to administer, had good psychometric properties (that is, used good tests and measures) and was cost-efficient. Following recommendations from the pilot MWS research, some of the measures and protocols in the MWS were revised and amended before data were collected from the national sample of young people.

1.3. Background and Objectives of the MWS

1.3.1. Introduction

The study was a collaboration between Headstrong and University College Dublin. Headstrong is committed to changing how Ireland thinks about young people's mental health through the Jigsaw programme of service development, Research and Advocacy. Headstrong is an evidence-led organisation. The study was carried out by Dr Barbara Dooley (Headstrong and UCD School of Psychology) and Dr Amanda Fitzgerald (UCD School of Psychology).

1.3.2. Aims and objectives

The main aim of the My World Survey (MWS) national study is to provide a baseline of youth mental health on risk and protective factors in Ireland. The specific objectives of the MWS are to:

1. Profile youth mental health at a national level across the age spectrum 12-25 years, thus allowing communities and service providers to use resources appropriately. This profile is presented as follows:
 - a. Adolescent Sample – MWS-Second Level (MWS-SL)
 - b. Young Adult Sample – MWS-Post Second Level (MWS-PSL)
 - c. Full Sample – Developmental Data for 12-25 year-olds
2. Identify whether various groups of young people (i.e. those in third level, trainees, those who are unemployed, those who are employed) differ in the risk and protective factors associated with their mental health
3. Profile the mental health needs of young people who are not considered to be 'typically developing', so as to help plan adequate supports and services tailored to their needs
4. Use the national data collected to inform the development of a model of resilience which could be used in prevention programmes to enhance youth mental health
5. Enable international comparisons between youth mental health data in Ireland and published international norms
6. Provide an accessible national archive of youth mental health data

This report specifically addresses the first objective of the research. Further reports will address objectives two to six.

1.3.3. Relevance of the MWS in an Irish context

It is particularly appropriate that the MWS national study took place at this time. The Ireland that young people are growing up in today bears little resemblance to that of their parents. Over the past decade, there have been enormous and rapid changes in Ireland's economy, sociodemography, culture, society and value systems (Whelan & Layte, 2006). These rapid changes have significant consequences for young people:

Changes in the economy: Similar to the international economy, Ireland has experienced major economic changes in the last few years and undergone a major reversal in the prosperous economic climate that had prevailed since the mid-1990s. The census figures for unemployment show an increase from 4% in 2006 to 14.2% in 2012 (Central Statistics Office [CSO], 2012). Many young people have experienced a drop in their standard of living, which may affect their mental health and well-being.

Changes in family structure: Significant changes in family structure have taken place since the early 1990s in Ireland. There has been a substantial increase in non-marital births; around 33% of births in Ireland today are to non-married women (CSO, 2008). Census figures show an increase in the number of lone parents (with a youngest child aged under 18) from 68,500 in 1995 to 112,900 in 2006 (2.7% of the population) (CSO, 2006). Many of the support systems that previous generations relied on and took for granted are

less available to young people today. For many young people, quality family time has diminished or disappeared. Dual-income houses have become more prevalent, with an increase in the female labour market. In some parts of the country, parents are spending long periods commuting to and from work, and are at home less often, while they may lack the emotional resources to be fully available after a day's work. In general, there are more pressures for parents in terms of work-life balance and making time available for family and children. In an increasingly busy and disconnected society, many young people may be left feeling isolated in their attempts to cope with difficulties they may be facing.

Changes in the meaning of adolescence: A child's journey into adolescence is starting earlier and finishing later than in previous generations. Young people are experiencing at a much younger age many of the personal and social pressures that adolescence brings, and are taking longer to assume the responsibility of 'adulthood' (Arnett, 2004). They are entering marriage and parenthood later; education lasts longer, and many young people in their late adolescence and 20s explore a variety of activities and experiment with different careers in a way that was not possible for their parents (Bates, Illback, Scanlan & Carroll, 2009). The implications of all these changes are still poorly understood.

The changes outlined in this Chapter have affected both Irish society in general and the status of young people in particular. There has been little understanding of the impact of these changes on young people. The MWS, however, will provide new and comprehensive information on the current position of young people in Ireland and their mental health.

2.1 Definition of Adolescence

Adolescence refers to the period of life during which an individual makes the transition from childhood to adulthood. In keeping with World Health Organisation (WHO, 2005) policy, and also that of countries such as Australia and New Zealand, which have been the pioneers in youth mental health, the age range denoted by the adolescent period in this report covers the age span from 12-25 years. The terms 'young people' and 'youth' are also commonly used to describe those aged 12-25.

Over the past few decades, society's definition of adolescence has changed dramatically. Prior to the 20th century, children moved fairly rapidly into an adult lifestyle, taking on adult roles of wage-earning in their early to mid-adolescence or even earlier in some cases. In many countries, it is still common today for many adolescents to be responsible for child-rearing, wage-earning or being part of the community survival effort (Aggleton, Hurry & Warwick, 2000). However, in this report, we are referring to young people living in a society where they typically enjoy a transitional period of development between the dependency of childhood and the relative independence of adulthood.

At a developmental level, young people are emerging adults, sexually mature, in their final stages of their education or in the early stages of their career, about to undertake many socially accepted adult pursuits including finding and keeping a job, and establishing relationships with romantic partners (Patel, Flisher, Hetrick & McGorry, 2007).

Adolescence may also be characterised by an increase in risk-taking and problematic behaviours. Young people may engage in behaviours that risk their health and well-being, including smoking, drug and alcohol use, careless driving, unprotected sexual behaviour, delinquency and suicidal behaviours (Keren & Hasida, 2007; UNICEF, 2007).

2.2. Definition of Adolescent Mental Health

The WHO (2005, p.7) defines adolescent mental health as:

"... the capacity to achieve and maintain optimal psychological functioning and well-being. It is directly related to the level reached and competence achieved in psychological and social functioning."

Mental health has been defined as a state of well-being in which the individual recognises their own abilities and is able to cope with normal daily stresses in life (WHO, 2005). Good mental health facilitates young people in achieving

developmental milestones that occur during adolescence (Kapphahn, Morreale, Rickert & Walker, 2006). The young person can work productively and fruitfully and is able to make a contribution to their community and society. Therefore, mental health is more than the absence of a mental disorder, and can be viewed as a continuum. This continuum can range from a state of positive emotional health and well-being, where the person experiences a sense of balance and contentment, to a state of poor health, where an individual's thoughts, feelings and behaviours cause them to feel unstable and unwell. As a result, the young person, their relationships and their place and role within the community are also greatly affected.

Adolescent mental health includes a sense of identity and self-worth, sound family and peer relationships, an ability to be productive and to learn, and a capacity to use developmental challenges and cultural resources to maximise development (Dawes et al, 1997). Good mental health in adolescence is a requirement for optimal psychological development, the development and maintenance of productive social relationships, effective learning, an ability to care for oneself, good physical health and effective economic participation as adults.

2.3. Mental Health of Young People

The number one health issue for young people is their mental health. About 70% of health problems and most mortality among the young arise as a result of mental health and substance-use disorders (McGorry, 2005). Mental disorders account for a large proportion of the disease burden in young people in all societies. Almost 75% of all mental disorders first emerge between the ages of 15 and 25 (Hickie, 2004; Kessler et al, 2005; Kim-Cohen et al, 2003).

Lifetime prevalence of deliberate self-harm in Irish adolescents aged 15-17 years is between 8% and 12%, while research has shown that it is three times more prevalent among females than males (McMahon et al, 2010). The national Deliberate Self-Harm (DSH) registry in the Republic of Ireland reported that the highest rate of hospital-treated DSH was for females aged 15-19, whereas the highest rate was in the 20-24 age group for males (Perry et al, 2012). A recent study conducted among 30,477 adolescents aged 14-17 in seven European countries, including Ireland, examined reasons for self-harm. Findings revealed that the most commonly reported reasons were: 'to get relief from a terrible state of mind' followed by 'I wanted to die'.

Irish young people are over-represented among those who die by suicide (Scoliers et al, 2009). In Ireland, the mortality rate from suicide in the 15-24 age group is the fourth highest in the EU (National Office of Suicide Prevention [NOSP], 2010), and the third highest among young men aged 15-19 (Eurostat, 2009).

Suicidal behaviours have been shown to coincide with many psychological problems, including depressive episodes (Hollis, 1996), anxiety (D'Attilio & Campbell, 1990), alcoholism (Buri, von Bonin, Strik & Moggi, 2009) and psychotic manifestations (Nishida et al, 2010). There is also evidence that suicide behaviours are related to a range of risk behaviours including risky sexual behaviour (Kim et al, 2011), substance misuse (Schneider et al, 2011; Zahran et al, 2007) and delinquency (Bjorkenstam et al, 2011). There is a strong relationship between poor mental health and many other health and development concerns for young people, including educational achievements, substance use and abuse, violence, and reproductive and sexual health.

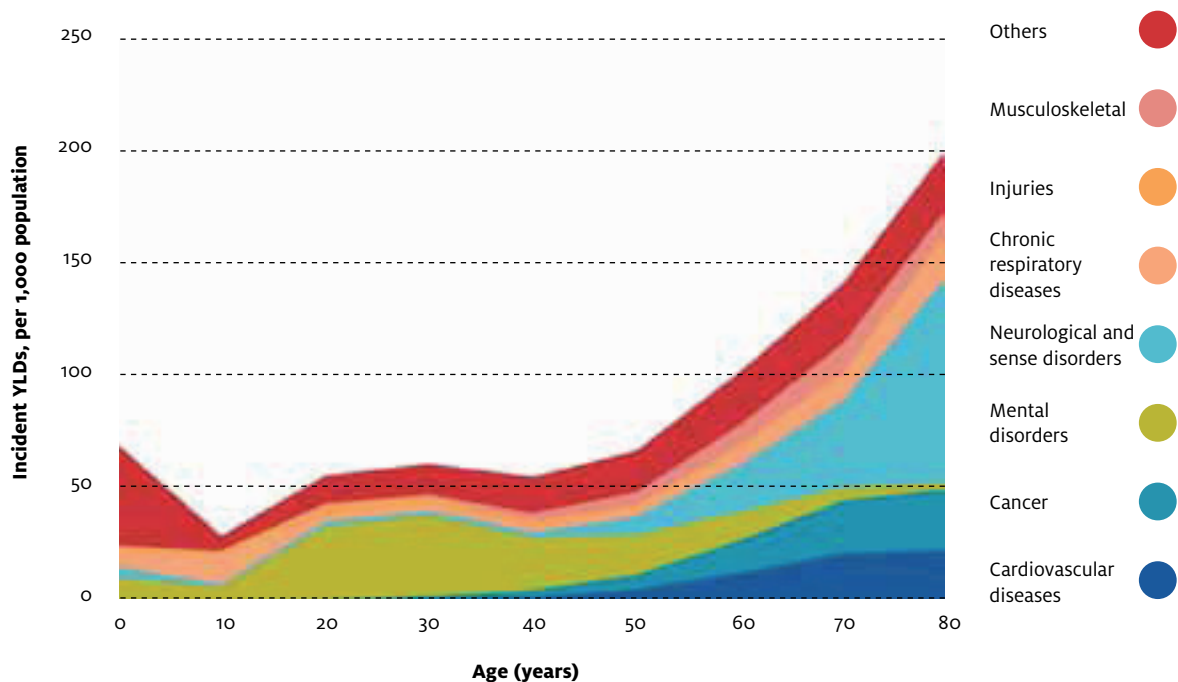
2.4. Burden of Mental Disorders in Young People

According to the WHO's 2004 Global Burden of Disease study, mental health disorders account for nearly half (45%) of the disease burden in the world's adolescents and young adults (Gore et al, 2011). Overall, mental health disorders were the most prevalent source of disability for young people aged 10-24 worldwide, accounting for 45% of total morbidity.

Disorders included major depression, substance abuse, schizophrenia and bipolar disorder. For males, the top three causes of disability were road traffic accidents (8%), unipolar depressive disorders (7%) and violence (6%). For females, the top three causes were unipolar depressive disorders (10%), schizophrenia (4%) and bipolar disorders (4%) (Gore et al, 2011).

The Victorian Burden of Disease Study (2001) conducted in Australia clearly displays the peak onset of mental health problems during the adolescent period. Figure 2.1 below displays the overall burden of disease for the Victorian population. Cancer, cardiovascular disease and mental disorders were the top three contributors to the burden of disease. While cancer and cardiovascular disease produced most of the mortality in older people, mental disorders produced most of the non-fatal disability, starting in younger people. It is evident from Figure 2.1 that mental disorders emerge during adolescence and are the most prevalent single group of disorders through adolescence into early adulthood.

Figure 2.1: Incidence of years lost due to a disability (YLD) rates per 1,000 by age and broad disease grouping, Victoria 2001



Source: Reproduced with permission from the Health Surveillance and Evaluation Unit, Rural and Regional Health and Aged Care Service Division, Department of Human Services Victoria, Australia.

Mental disorders appear to have increased markedly in prevalence among young people living in developed countries over the past fifty years, although the evidence remains disputed (Collishaw, 2009; Eckersley, 2008a; 2009b). Two meta-analyses reported an increase in symptoms of psychopathology among American college students between 1938 and 2007, and among high-school students between 1951 and 2002 (Twenge et al, 2010). Five times as many young people in 2002 scored above common cut-offs for psychopathology as they did in previous generations. In the UK, Collishaw et al (2010) examined trends in adolescent emotional problems between 1986 and 2007. The findings revealed that twice as many young people reported frequent feelings of depression or anxiety in 2006 as in 1986. Some symptoms, such as worry, irritability and fatigue showed marked change in prevalence over time, whereas other symptoms (e.g. loss of enjoyment, worthlessness) showed no change.

2.5. Previous Irish Studies

Large-scale studies that capture the health profile of adolescents help us to understand the experiences of young people and inform service provision. To date, there is a limited body of research on the prevalence of mental health difficulties among young people aged 12-25.

- › Lynch, Mills, Daly and Fitzpatrick (2005), who screened 723 young people aged 12-15 in Dublin, found that one in five were 'at risk' of developing a mental health disorder, while 16% met the criteria for a current diagnosis; of these, few had come to the attention of the appropriate Child and Adolescent Mental Health Services (CAMHS).
- › The Clonmel Project (Martin, Carr, Burke, Carroll & Byrne, 2006) examined the prevalence of psychological disorders among 3,374 children and adolescents aged 18 years and under in the south-east of Ireland. The study reported that about 19% met the criteria for at least one psychological disorder (21% for those aged 12-18). Of these, 43% were identified as having an anxiety disorder, 25% had oppositional defiant disorder, and 10% had either a mood disorder or an intellectual disability, or were abusing alcohol. One-fifth of individuals had symptoms or problems associated with clinical risk (e.g. thoughts of being suspended or expelled from school, or of death or dying). Typically, individuals identified with clinical risk were from more socially disadvantaged backgrounds and had more behavioural, physical health, family, life stress and coping problems than those not thus identified. Most of those identified as either being at risk or meeting the criteria for a psychiatric disorder were receiving no professional help, and fewer still had contact with the child and adolescent mental health services.
- › The Lifestyle and Coping Survey (Sullivan, Arensman, Keeley, Corcoran & Perry, 2004) is one of the largest studies conducted on youth mental health in Ireland to date. Almost 4,000 students aged 15-17 were screened for mental health problems in the Cork and Kerry region. Serious personal, emotional, behavioural or mental health problems were experienced by 27% of adolescents who were surveyed. Of these, less than one-fifth (18%) sought help from a professional. A higher proportion of females displayed signs of depression (8%) and had an emotional disorder (13%) than males (5% and 6% respectively). A lifetime history of deliberate self-harm was reported by 12%; of those who had harmed themselves, 46% had done so more than once. Females were three times more likely to harm themselves than males (14% vs. 4%), similar to findings by McMahon and colleagues (2010). When asked whom they would talk to about their problems, most reported a preference for talking to friends, followed by family. Very few reported that they would talk to a teacher, and fewer that they would talk to a healthcare professional.

Taken together, these studies indicate that about one in five young people in Ireland are experiencing serious emotional distress at any one time. Of these, only a small minority is in contact with any form of helping agency. The discrepancy between the relatively high number of young people with mental health difficulties and the low number who seek help if they have a problem points to a hidden population of young people who are not coming to the attention of the health services.

If only a minority of those experiencing tough times or difficult problems are seeking professional help, many young people are navigating the challenges of adolescence without help or access to constructive support systems. There is overwhelming evidence that, when appropriate support is given early to young people with mental health difficulties, many recover or at least develop coping strategies to more effectively manage stresses in their lives (Evans et al, 2005).

2.6. Building on Earlier Studies

The research outlined above is valuable in providing an insight into the prevalence of mental health problems and disorders among Irish young people. However, these studies captured mental health data on young people aged 12-17 years, presenting no data on those aged 18 upwards. Secondly, they were conducted in specific counties in Ireland, and thus the findings cannot be extrapolated to the broader population. Thirdly, they focus on mental health problems and disorders, with no focus on positive aspects of mental health.

The MWS collects mental health data on a broad age range of young people, spanning from 12 to 25 years. Secondly, it collects data on close to 14,500 young people in order to provide the first national baseline of youth mental health in Ireland.

2.7. Risk and Protective Factors of Youth Mental Health

Central to our understanding of the development of mental health difficulties is the identification of risk and protective factors. Definitions of these factors vary. Essentially, however, *risk factors* refer to circumstances, characteristics or hazards that may increase the possibility of a person developing a mental health difficulty or disorder (see Table 2.1). When these factors are unrelenting, they can have a particularly negative impact on an individual. 'At risk' populations of young people are groups where there is a greater than expected number of risk factors affecting their lives at any given time.

Protective factors refer to a broad range of assets that may improve the likelihood that a person will respond successfully to hazards. These include characteristics such as talents, strengths and constructive interests as well as characteristics in their social environment such as family support, parental involvement, supportive relationships with adults in their lives, opportunities to express themselves through creative activities, and opportunities to participate in making decisions that affect their lives (Bates, Illback, Scanlan & Carroll, 2009).

Researchers also distinguish between internal and external risk and protective factors. Internal risk and protective factors are seen as internal psychological states, which are subjectively experienced by the young person. These can be influenced by the individual characteristics of the person, such as their age and gender. An internal protective factor, such as resilience or optimism, is defined as any factor that reduces the impact of internal risk factors such as

depression and is likely to prevent the person from engaging in potentially harmful behaviours (Spooner, Hall & Lynskey, 2001). Examples of internal risk factors include age, gender, depression, anxiety and anger, while examples of internal protective factors include resilience, optimism, subjective well-being, satisfaction with life, self-esteem and coping.

A multitude of external factors can affect young people's mental health. External protective factors act as opportunities for the young person to develop positively, learn skills, and develop and maintain relationships. External risk factors act as threats to the young person and cause distress. Examples include family status and living arrangements, school demands and performance, experiences of bullying, and ongoing stressful problems in the young person's life. Examples of external protective factors include access to social supports, connectedness with family and friends, and use of mental health services when in need.

The internal and external risk and protective variables identified above have been shown to contribute to the mental health of young people and are explored in the MWS.

2.8. Risk-taking and Problematic Behaviours in Adolescence

Adolescence is often characterised by an increase in risk-taking behaviours, such as substance misuse, using illegal drugs, careless driving, eating disorders, unprotected sexual behaviour, delinquency and suicidal behaviours (Keren & Hasida, 2007). These behaviours are described as risky, as they are usually dangerous and a threat to the person's physical and psychological health, and their outcomes are uncertain (Furby & Beyth-Marom, 1992; Igra & Irwin, 1996).

Social/environmental theories emphasise the influence of parents, peers, teachers, community and culture on risk-taking during adolescence (Igra & Irwin, 1996). Other research suggests that adolescent risk-taking is partly based on the impulse to eliminate negative feelings (e.g. depression) by gaining the social rewards of participating with others in risky behaviours (Bonomo & Bowes, 2001; Caffray & Schneider, 2000; Coogan et al, 1998).

Aggressive behaviour and violence among adolescents have been shown to co-occur with risk-taking behaviours (Haynie et al, 2001). Problem behaviours are defined as externalising behaviours that are socially disruptive and distressing to others, such as being in a fight, failing to use birth control, alcohol use, marijuana use, skipping school, and having multiple sex partners (Bartlett, Holditch-Davis & Belyea, 2005). Problem behaviours occur as a result of complex interactions between internal and external risk and protective factors (Dekovic, 1999).

In the literature, both risk-taking and problem behaviours have been linked to a number of negative outcomes:

- › Alcohol misuse has been linked to aggressive and impulsive behaviours, dysphoric moods and suicide risk (Boles & Miotto, 2003; Bukstein et al, 1993; Milgram & Palti, 1993).
- › Alcohol misuse is also related to interpersonal adversities, violence, problems with the law and self-destructive behaviour (Perkins, 2002; Pirkola et al, 1999).
- › Drug misuse has been associated with mental health problems, and is one of the most frequently diagnosed mental health disorders (Pirkola et al, 1999; Weaver & Schnoll, 2003), indicating the long-term and detrimental effects of substance misuse.
- › Alcohol, drug misuse and suicidal behaviour have been found to be interrelated, with an estimated 7% lifetime risk of suicide associated with alcohol use (Brady, 2006; Inskip, Harris & Barraclough, 1998).

Antisocial behaviour describes a multitude of behaviours, including the destruction of property, violence towards people and animals, theft, deceitfulness and serious rule violations (Bengt-Åke & Henning Andreassen, 2009). There is evidence of a link between antisocial behaviour and psychological problems such as depression and distress in adolescents (Vermeiren et al, 2002). Although many adolescents engage in some form of antisocial behaviour, only 5-10% of those who do so will continue to display the behaviour as adults (Moffitt, 1993; 2005).

Thus, from a review of the literature, it is evident that engaging in risk-taking and problematic behaviours can negatively influence the young person and their mental health. The MWS thus investigates risk-taking and problematic behaviours among Irish young people.

2.9. Conceptual Framework for MWS

The MWS study adopted an ecological risk/protective framework to identify selected risk and protective factors for adolescent mental health across all domains important to a young person's development. In recent years, the ecological risk/protective factor model has become increasingly popular as a framework through which to investigate risk and protective factors related to adolescent mental health (e.g. Costello, Swendsen, Rose & Dierker, 2008).

An important aspect of the ecological risk/protective model is that it places the young person within the context of family, cultural and societal influences that may affect their mental health. Thus, risk and protective factors have been identified in terms of the individual characteristics of the young person, family, peer group, school/college, work, neighbourhood, community and the larger society.

Table 2.1 provides examples of variables used in the MWS that are pertinent to the ecological risk/protective factor model.

Table 2.1: Selected risk and protective factors of adolescent mental health in MWS

Domain	Risk factors	Protective factors
<i>Biological</i>	Age/Gender Substance abuse	Age/Gender
<i>Psychological</i>	Stress Anxiety Depression Angry a lot High level of avoidant coping Learning disorders/difficulties Financial stress	Self-esteem Optimism Resilience Copes well with problems High level of support-focused coping High level of problem-solving
<i>Social</i>		
<i>a) Family</i>	Low socioeconomic status Family status/structure Parental criticism Death of a family member	Enjoys family life Family support Parental approval
<i>b) Friends</i>	Friend	Friend support Peer connectedness Satisfaction with friends/romantic partner
<i>c) School</i>	Bullying Academic failure	Teacher connectedness School connectedness
<i>d) Community</i>	Trouble with the gardaí Discrimination/Racism	Neighbourhood safety Support from significant others

3 / Methodology for Adolescent Sample

3.1. Overview

This chapter describes the methodology used to carry out the My World Survey of young people at second level, known as the MWS-Second Level (MWS-SL) study. It details the characteristics of those who took part and explains the survey instrument used for data collection (for more detailed information on the methodology, see Appendix 1).

3.2. Ethical Approval

The design of the MWS national study, the surveys and the procedures for collecting the data were reviewed and approved by the UCD Human Research Ethics Committee in December 2010.

3.3. Recruitment of Schools

School principals in each of the 171 post-primary schools were contacted by post about the possibility of participating in the MWS-SL. They received a research pack that contained an information sheet describing the study, letters for students and guardians describing the study, consent forms, a paper copy of the MWS-SL, and a Headstrong support card.

3.4. Characteristics of the Post-Primary Students

A total of 72 post-primary schools and 6,085 students completed the MWS-SL. The final sample consisted of 3,101 females (51%) and 2,952 males (49%) (gender was not reported for 32 participants). The students ranged in age from 12-19, with a mean age of 14.94 (SD=1.63). The breakdown by school year can be seen in Table 3.1. Note: Sample size may vary depending on the number of respondents who replied to that question.

Table 3.1: Breakdown of second-level sample by school year

School year	n (%)
1st year	1215 (20%)
2nd year	1446 (24%)
3rd year	904 (15%)
4th year	786 (13%)
5th year	1073 (18%)
6th year	610 (10%)

3.5. Description of MWS-SL

3.5.1. Demographic and personal well-being questions

Participants were asked a range of demographic and personal well-being questions about:

- 1) their academic position
- 2) whether they enjoy their family life
- 3) whether they cope well with problems
- 4) whether they have ever been in trouble with the gardaí
- 5) the three most significant stressors/problems in their life
- 6) the three ways that help them cope when things are tough
- 7) whether their mother or father ever had a mental health problem (e.g. depression, alcohol or drug addiction)
- 8) whether they themselves had ever seen a mental health professional (e.g. a therapist, psychologist, psychiatrist); if so, how recently, and whether they found this helpful

3.5.2. Positive and negative domains of psychological functioning

The MWS-SL contained a number of scales previously shown to have reliability and validity, organised into positive and negative aspects of psychological functioning.

Listed below in Table 3.2 are those scales, the number of items in each scale, and the alpha (essentially, a measure of the internal consistency or reliability of scores) based on data from the MWS-SL study (see Appendix 1 for further information on the scales).

Table 3.2: Reliabilities of scales in the MWS-SL

Scales in MWS-SL	Number of Items in Scale	Cronbach's Alpha
POSITIVE DOMAINS +++++		
Rosenberg Self-Esteem Scale (RSE)	10	.89
Coping Strategy Indicator (CSI-15)	15	.74
Life Orientation Test – Revised (LOT-R)	6	.74
Formal Help-Seeking Scale	2	.74
Informal Help-Seeking Scale	8	.73
Resilience Scale for Adolescents (READ)	28	.91
Brief Multidimensional Students' Life Satisfaction Scale (BMSLSS)	6	.86
Multidimensional Scale of Perceived Social Support (MSPSS)	12	.94
NEGATIVE DOMAINS -----		
DASS-21	21	.93
Alcohol Use Disorders Identification Test (AUDIT)	10	.82
CRAFFT Substance Misuse	6	.74
Behavioural Adjustment Scale (BAS)	13	.86

POSITIVE DOMAINS +++++

1) Rosenberg's Self-Esteem Scale (RSE)

Self-esteem is assessed with the Rosenberg Self-Esteem scale (RSE; Rosenberg, 1965). The 10 items of the RSE assess a person's overall evaluation of his/her worthiness as a human being. This scale uses 'strongly agree' to 'strongly disagree' as response alternatives to statements such as: 'On the whole I am satisfied with myself' and 'I wish I could have more respect for myself'.

2) Coping Strategy Indicator (CSI)

The CSI (Amirkhan, 1990) assesses three dimensions of coping strategies: Problem-Solving, Seeking Social Support, and Avoidance. This scale asks the adolescent to indicate when they have difficulties or problems and how they respond (from 'never' to 'always'). The items are focused on being proactive ('I plan how to solve the problems before I do anything else'), approaching a friend ('I go to a friend for advice') or avoidance ('I avoid the problem by spending more time alone').

3) Life Orientation Test Revised (LOT-R)

The LOT-R is a measure of dispositional optimism. This scale asks the adolescent to indicate on a five-point scale the degree to which 'I agree a lot' or 'I disagree a lot' with items such as: 'In uncertain times, I usually expect the best' and 'I hardly ever expect things to go my way'.

4) Formal and Informal Help-Seeking Behaviour

Formal help-seeking is assessed using a measure that was slightly adapted (see Saunders, Resnick, Hoberman & Blum 1994) and had been previously used on a sample of Irish adolescents (Daly, 2006). Participants were asked: 'Have you had any serious problems in the past year?' – e.g. personal, emotional, behavioural problems that caused you considerable stress and you felt you would have benefited from professional help (e.g. counsellor, psychologist, psychiatrist, GP). The response alternatives were: 'I have few or no problems', 'I have had some problems but I did not feel I needed professional help', 'I have had some problems but I did not seek professional help although I thought I needed it', and 'I have had some problems and I did seek professional help'.

Informal help-seeking was assessed with eight items adapted from Saunders et al (1994). Participants were asked two general questions: 'When you have problems, do you talk about them with anyone?' 'If yes, who would you talk to ... family, friend, no one?' They were then asked: 'Who would you talk to first if you had problems with: 1) your family, 2) a friend, 3) a romantic relationship, 4) school, 5) depression, 6) alcohol and drug use.'

5) Resilience Scale for Adolescents (READ)

The READ (Hjemdal, Friborg, Stiles, Martinussen & Rosenvinge, 2006) is a 28-item measure of adolescent resilience. Higher scores reflect a higher degree of resilience. This scale focuses on how the adolescent relates to family and friends, and the degree to which they are goal-oriented.

6) Multidimensional Scale of Perceived Social Support (MSPSS)

The MSPSS (Zimet et al, 1988) measures perceived social support from family, friends and a significant other. This 12-item scale asks the adolescent to indicate on a seven-point scale the degree to which they 'very strongly agree' to 'very strongly disagree' with statements such as: 'There is a special adult who is around when I am in need', 'My friends really try to help me'.

7) Support About Your Mental Health

Two questions assessed 1) what sources young people are likely to use and 2) what sources they have actually used to get information and support about their mental health. The list of sources included: parents, relatives, friends, internet, phone help-line, teacher/ guidance counsellor, doctor/GP, psychologist/ counsellor/therapist, or other. These items were included in the MWS based on a request from Inspire Ireland Foundation, a charitable organisation that helps young people lead happier lives (www.inspireireland.ie).

8) Brief Multidimensional Students' Life Satisfaction Scale (BMSLSS)

The BMSLSS (Huebner, Suldo, Valois, Drane & Zullig, 2004) is a six-item measure which asks the adolescent to indicate the degree to which they are 'very dissatisfied' to 'very satisfied' with family life, friends, school experience, myself, where I live and with my overall life.

9) Hemingway Measure of Adolescent Connectedness (MAC)

Three subscales from the Hemingway Measure of Adolescent Connectedness (Karcher, 1999) were used to assess adolescents' connectedness with their peers, teachers and school. Each subscale consisted of six items designed to measure their degree of caring for and involvement in relationships with 1) peers, 2) teachers and 3) involvement in school.

NEGATIVE DOMAINS -----

1) Depression, Anxiety and Stress Scale (DASS-21)

The DASS-21 is a self-report measure in which participants rate the frequency and severity of experiencing negative emotions over the previous week. The scale contains items on depression ('I felt that I had nothing to look forward to'), anxiety ('I felt close to panic') and stress ('I found it difficult to relax'). Using recommended cut-off scores (Lovibond & Lovibond, 1995), adolescents are classified as displaying normal, mild, moderate, severe or extremely severe symptoms of depression, anxiety or stress.

2) Alcohol Use Disorders Identification Test (AUDIT)

The AUDIT was developed by the World Health Organisation (Saunders, Aasland, Babor, de la Fuente & Grant, 1993) as a screening tool for hazardous alcohol consumption. The AUDIT consists of 10 items designed to measure three content domains: 1) alcohol consumption, 2) signs of alcohol dependence and 3) alcohol-related harm. According to the WHO recommended cut-offs (Babor, Higgins-Biddle, Saunders & Monteiro, 2001), participants can be classified as within the: 1) normal drinking range, 2) problem drinking range, 3) harmful and hazardous drinking range and 4) having a possible alcohol dependence.

3) CRAFFT Substance Use Screening Scale

The CRAFFT is a valid measure to detect substance problem use, abuse and dependence among adolescent populations (Knight et al, 2002). This six-item scale asks the adolescent if they have ever been in a car driven by someone who had been using alcohol or drugs, and experienced other types of problems because of alcohol or drugs.

4) Cannabis Use

Adolescents are asked about whether they have ever used cannabis and, if yes, at what age they started using it.

5) Behavioural Adjustment Scale (BAS)

A shortened version of the BAS (Brown, Clasen & Eicher, 1986) is used to assess the frequency over the past month of substance misuse and school misconduct. The adolescent is asked how many times over the past month

they have done various things that are harmful with regard to substances (cigarettes, alcohol, cannabis, other drugs), done things they shouldn't do at school (talked back to my teachers, cheated in an exam), and been punished for things they did in school (been kicked out of class by a teacher).

6) Pupils' Experience of Bullying Scale (PEBS)

Experiences of bullying were assessed with items that have been used in previous research (Griffin, 2006). The adolescent is asked if they have seen anyone bullied, if they have been bullied and, if so, how recently (from daily to within the last 4-5 years) and how they were bullied (e.g. physical, verbally, emotionally, via the internet, by text) and where they were most frequently bullied (e.g. in school, at home, internet, by text).

The next chapter summarises the findings of the adolescent survey.

4 / Findings on Adolescents

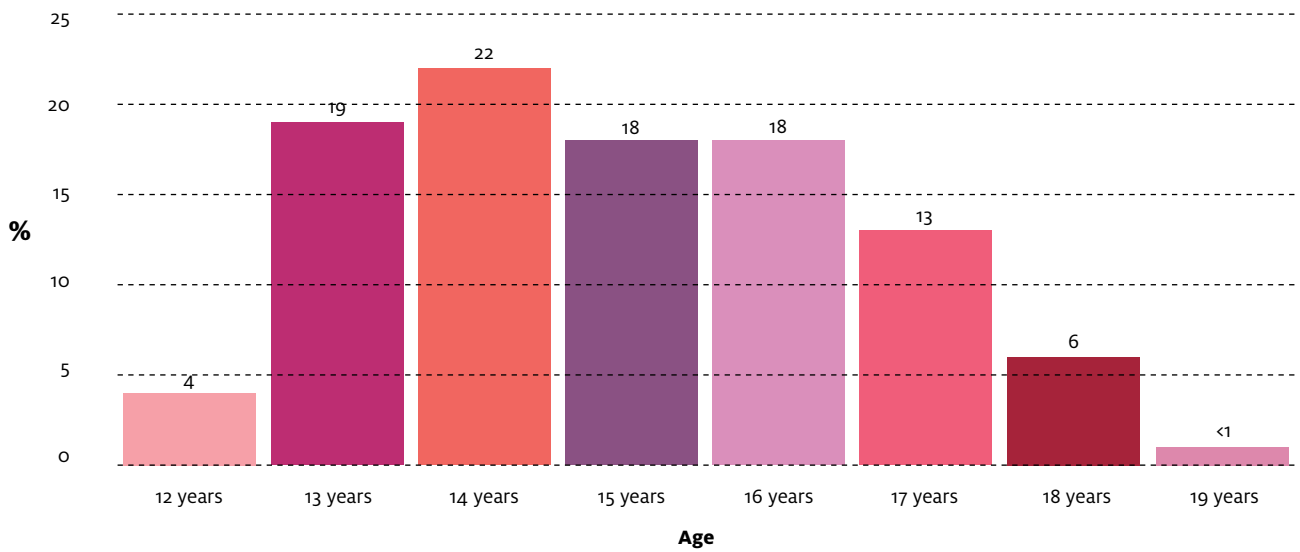
4.1. Overview

This chapter describes the demographics and characteristics of the adolescent sample who took part in the My World Survey Second Level (MWS-SL). It presents data on the risk and protective factors of adolescent mental health, and the risk-taking and problematic behaviours of adolescents. The data are analysed for the overall sample and by gender and school year. Statistical findings are reported at the $p < .01$ level. All data reported are statistically significant. Percentages reported in the Figures are rounded to the nearest whole number.

4.2. Demographics

The sample consisted of 6,085 adolescents ranging in age from 12 to 19 years ($M=14.93$, $SD=1.62$); 51% of the sample were female. Figure 4.1 summarises the age breakdown. Of the overall sample, 95% identified themselves as 'white'. Only 1% of the sample reported themselves as adopted, and of these half identified themselves as Irish adoptees.

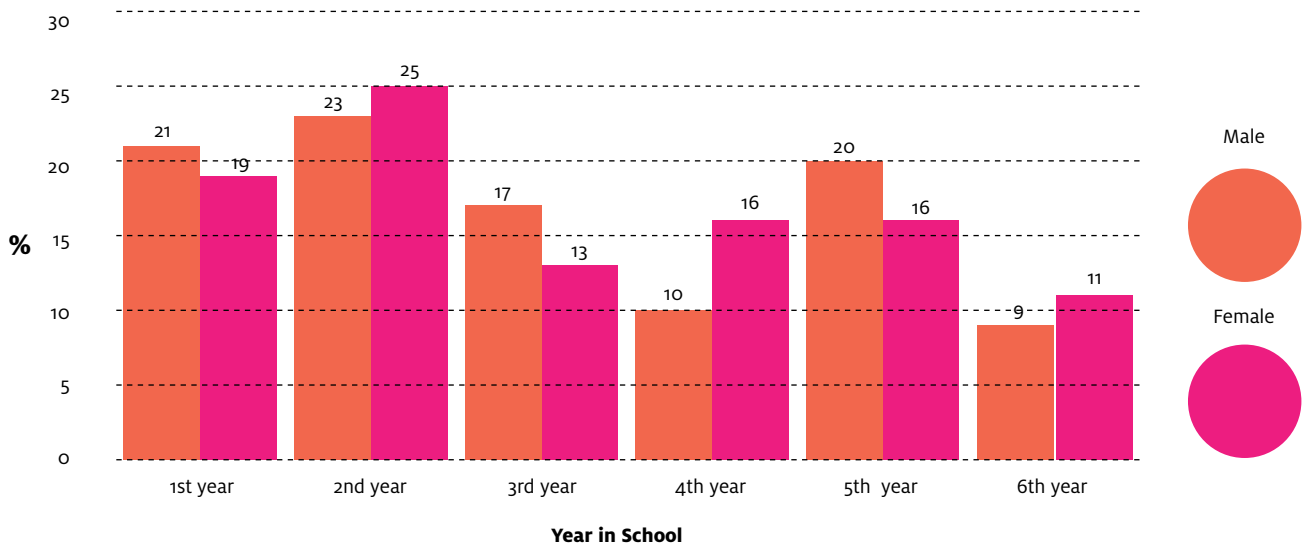
Figure 4.1: Age breakdown of adolescent sample



School year

Figure 4.2 below shows the school-year breakdown of the sample by gender, with 20% of adolescents in 1st year, 24% in 2nd year, 15% in 3rd year, 13% in 4th year, 18% in 5th year and 10% in 6th year.

Figure 4.2: School-year breakdown of adolescent sample



Family type

The majority (81%) of adolescents lived in two-parent families, 10% in single-parent families, and 7% with their parent and 'other' e.g. grandparent. A small percentage lived with their grandparents, other relatives, or foster parents.

Marital status of parents

The majority of adolescents indicated that their parents were married (78%), while 10% reported that they were separated, 4% divorced and 2% single. About 3% reported that their parents were 'living together but not married' and less than 1% 'remarried', while just under 1% reported that a parent was 'deceased'.

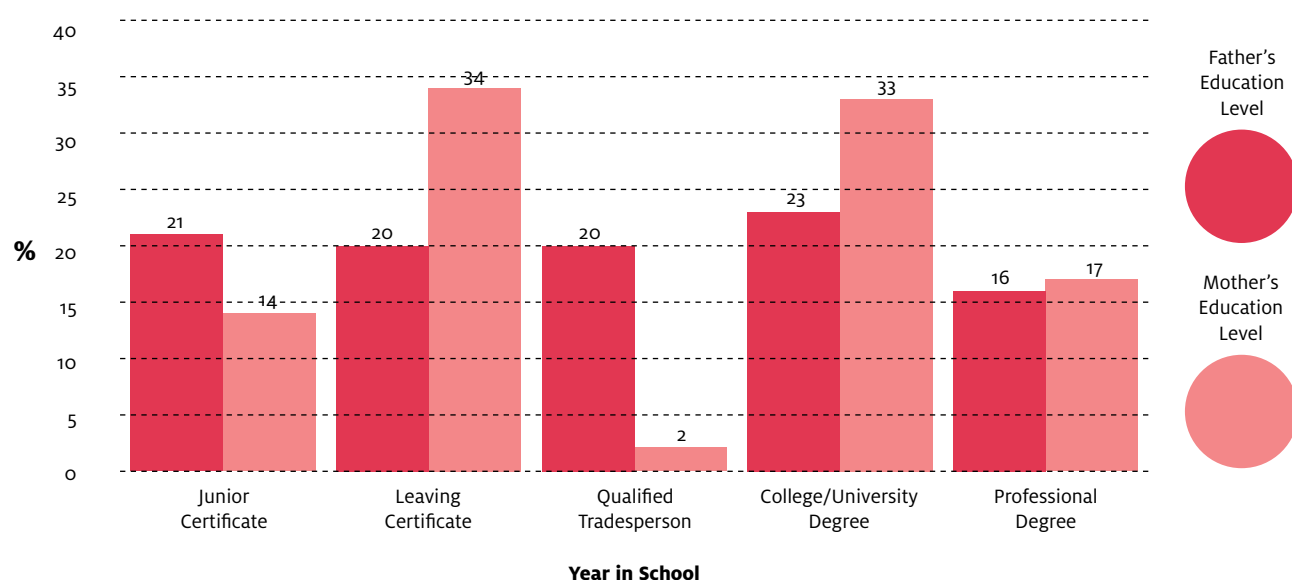
Table 4.1: Marital status of parents of adolescents in MWS-SL

Marital status	%
Married	78
Separated	11
Divorced	4
Living together but not married	3
Single	1
Remarried	<1
Deceased	<1

Parental education status

Figure 4.3 shows the highest educational qualification achieved by mothers and fathers of adolescents in the sample. Nearly 26% of adolescents reported not knowing their mother's education status, and 28% not knowing their father's. Adolescents in the Junior Cycle (JC) were more likely to report not knowing their parents' educational status.

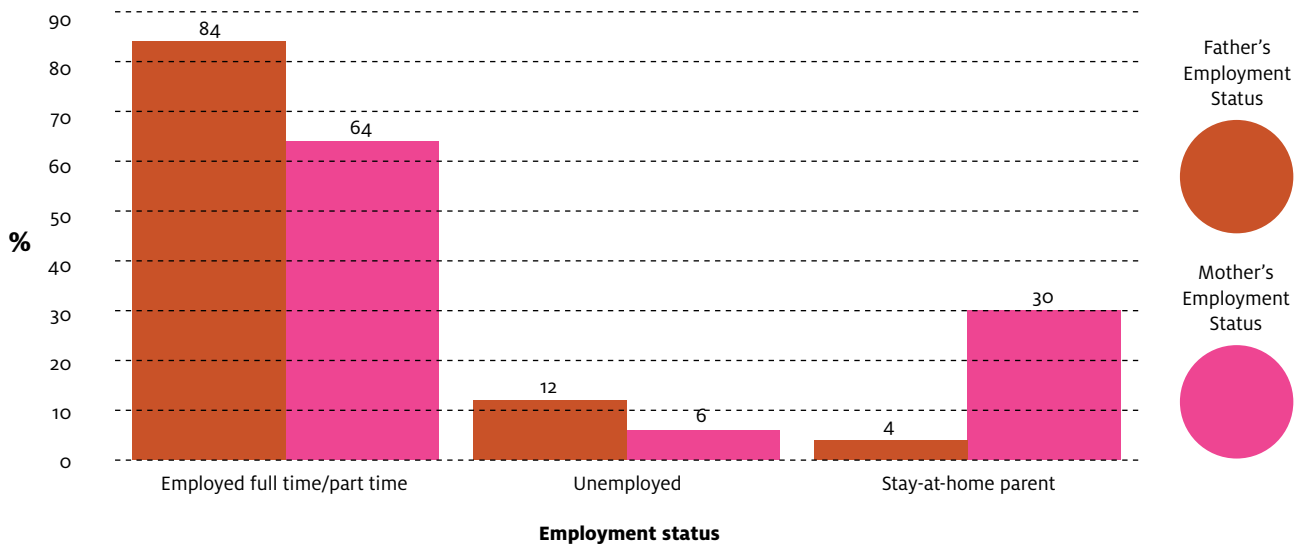
Figure 4.3: Parent's education level



Parental employment status

The employment status of parents is provided in Figure 4.4. Approximately 64% of adolescents reported that their mother was employed full or part-time, compared to 84% for fathers. Nearly 6% reported that their mother was unemployed compared to 12% for fathers. While 30% of adolescents identified their mother as a 'stay-at home parent', only 4% did so for their father.

Figure 4.4: Employment status of parents



Number of children living in the family

Nearly two-thirds of adolescents reported living in a family with 1-3 children, 27% in a family with 4-5 children, and 7% in a family with 6 or more children.

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4.3. Personal Well-Being

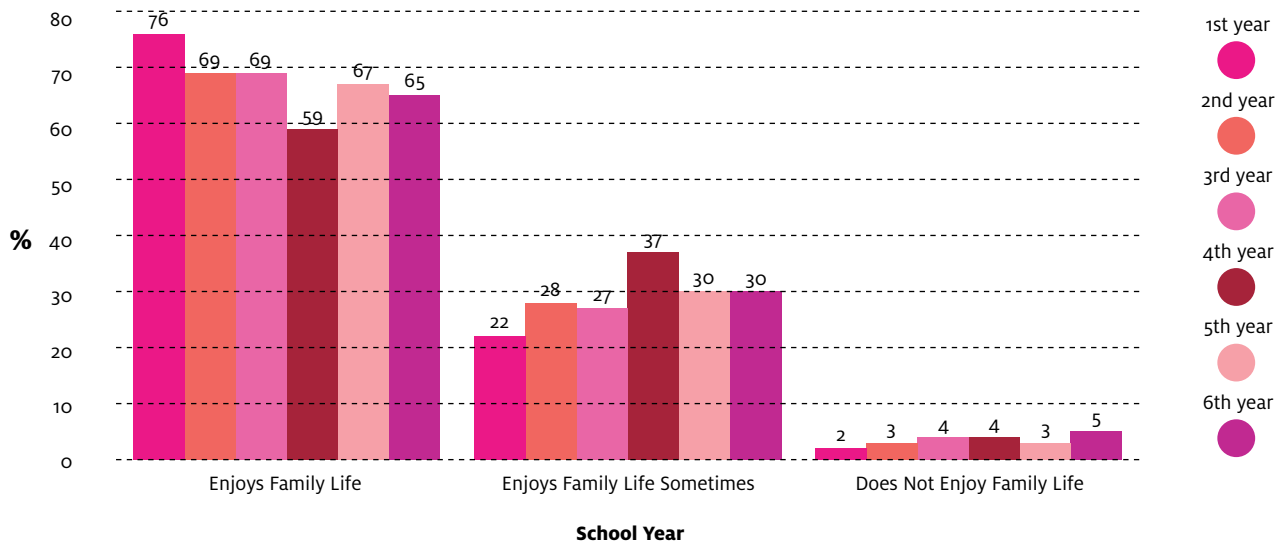
A number of key self-reported variables assessed adolescents' perceptions of their personal well-being, including 1) enjoyment of family life, 2) academic position in school, 3) receiving additional teaching support at school, 4) ability to cope well with problems, 5) having been in trouble with the gardaí, 6) feeling angry a lot, and 7) having seen a mental health professional.

Nearly two-thirds of adolescents reported living in a family with 1-3 children.

4.3.1. Enjoying family life

Approximately 68% of adolescents reported that they enjoyed family life, while 28% reported that they sometimes did so and 3% that they did not. These percentages were similar for females and males. Looking to school year, as illustrated by Figure 4.5, first-years were more likely to report enjoying their family life, while sixth-years were more likely to report that they did not.

Figure 4.5: Enjoys family life by school year



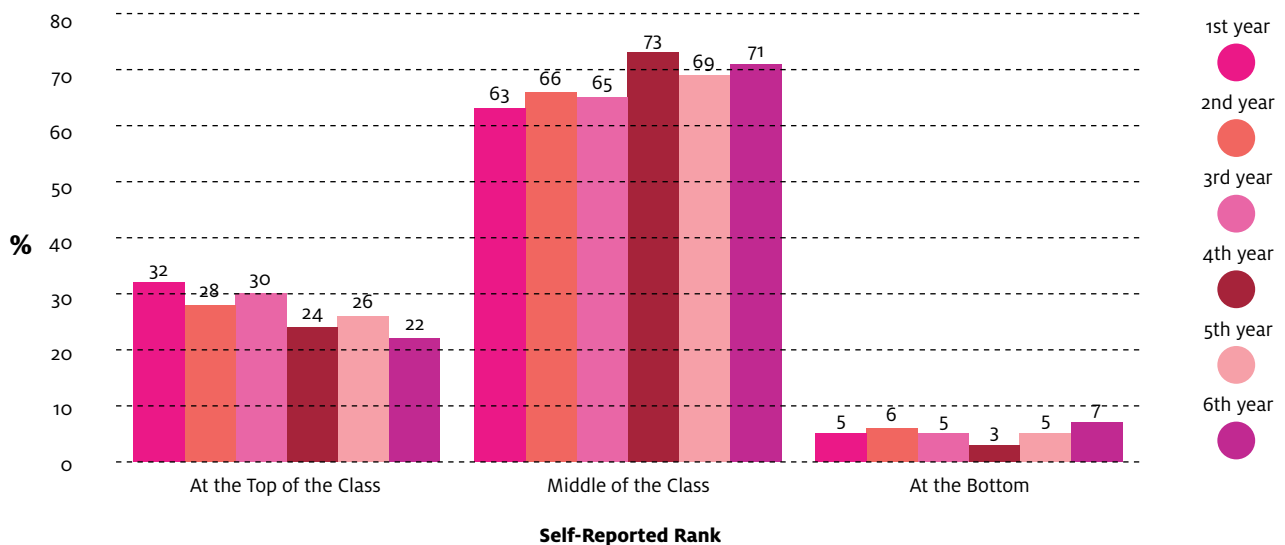
Approximately 68% of adolescents reported that they enjoyed family life.

4.3.2. School work

In terms of their school work, 27% of adolescents ranked themselves as being at the top of the class, 66% as being in the middle and 5% as being at the bottom. Males were more likely to say they were at the top of the class.

First-years were the most likely to rank themselves as top of the class, while sixth-years were the most likely to rank themselves at the bottom (see Figure 4.6).

Figure 4.6: Self-reported rank in school work by school year



4.3.3. Coping with problems

Participants were asked if they generally coped well with problems. Almost half (48%) reported that they coped well, 46% that they sometimes coped well, and 5% that they did not cope well.

While 58% of males reported coping well, just 40% of females did so. This ability to cope well with problems was not associated with school year.

4.3.4. Trouble with the gardai

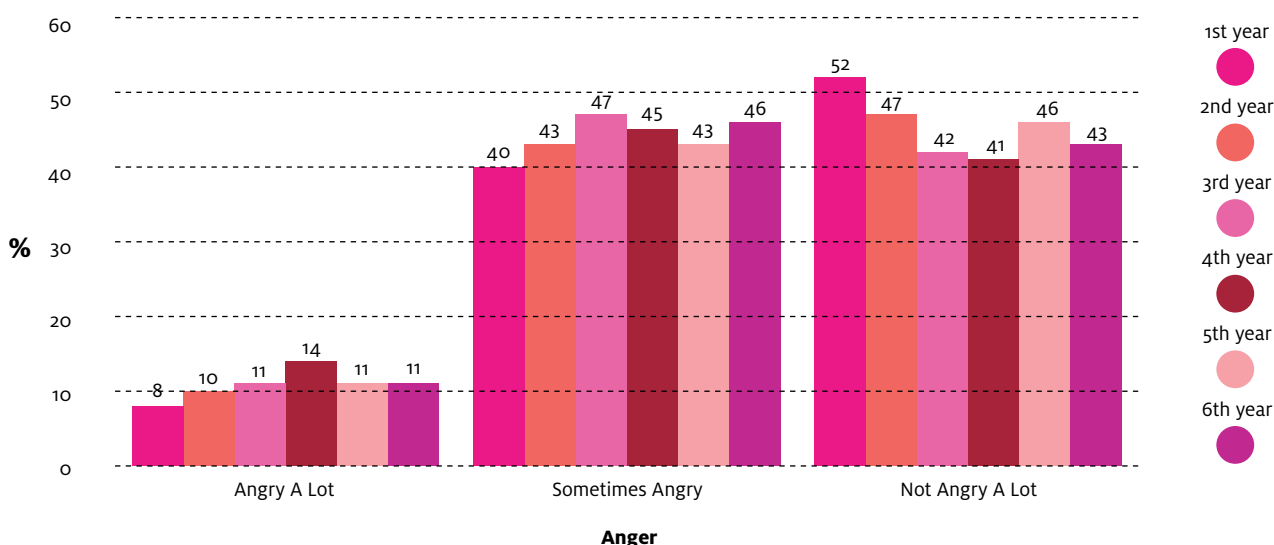
Of the sample, 13% reported that they had been in trouble with the gardai in the past. One in five males reported this compared to just 7% of females. Across school year, first-years (9%) were less likely to report having been in trouble with gardai than sixth-years (17%).

4.3.5. Anger

A total of 10% of adolescents reported that they felt angry a lot, 43% that they sometimes felt angry and 45% that they did not feel angry a lot. These percentages were similar for females and males. First-years were less likely to report feeling angry a lot (see Figure 4.7).

**Almost half (48%)
reported that they
coped well**

Figure 4.7: Anger by school year



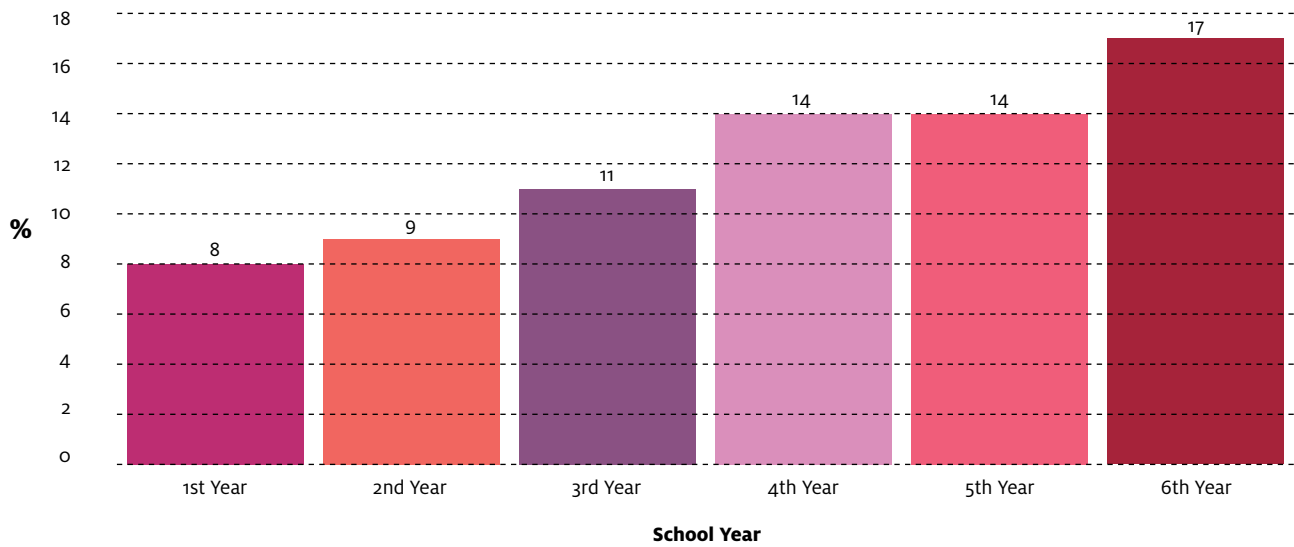
4.3.6. Parents' mental health

Approximately 12% of adolescents reported having at least one parent who has had a mental health problem (MHP). Females (14%) were more likely to report this than males (10%). First-years (6%) were significantly less likely to report it than sixth-years (18%).

4.3.7. Seen a mental health professional

Approximately 11% of participants reported that they had seen a mental health professional (MHP) (with no gender effect). There was a linear trend across the school years of increasing likelihood of having seen a MHP (Figure 4.8). First-years were the least likely to have seen one (8%) and sixth-years the most likely (17%). This is an expected finding in that mental health issues emerge in early adolescence and do not peak until early adulthood.

Figure 4.8: Adolescents who have seen a mental health professional by school year



Of those who reported that they had seen a MHP, only 60% reported that they found it helpful.

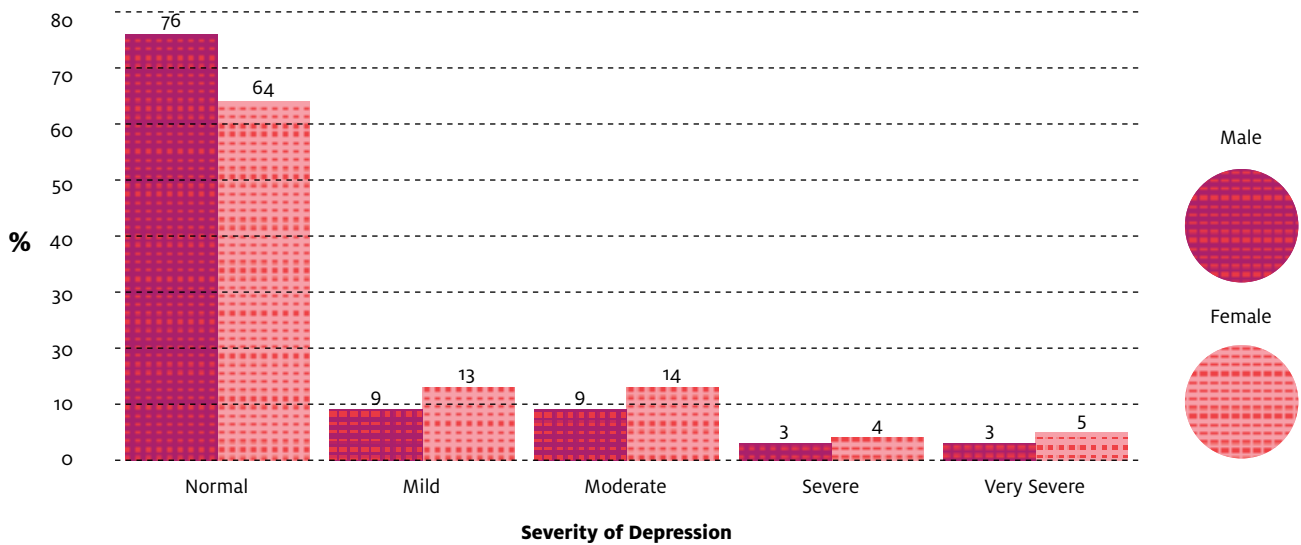
4.4. Risk Factors

4.4.1. Depression, anxiety and stress

Depression categories

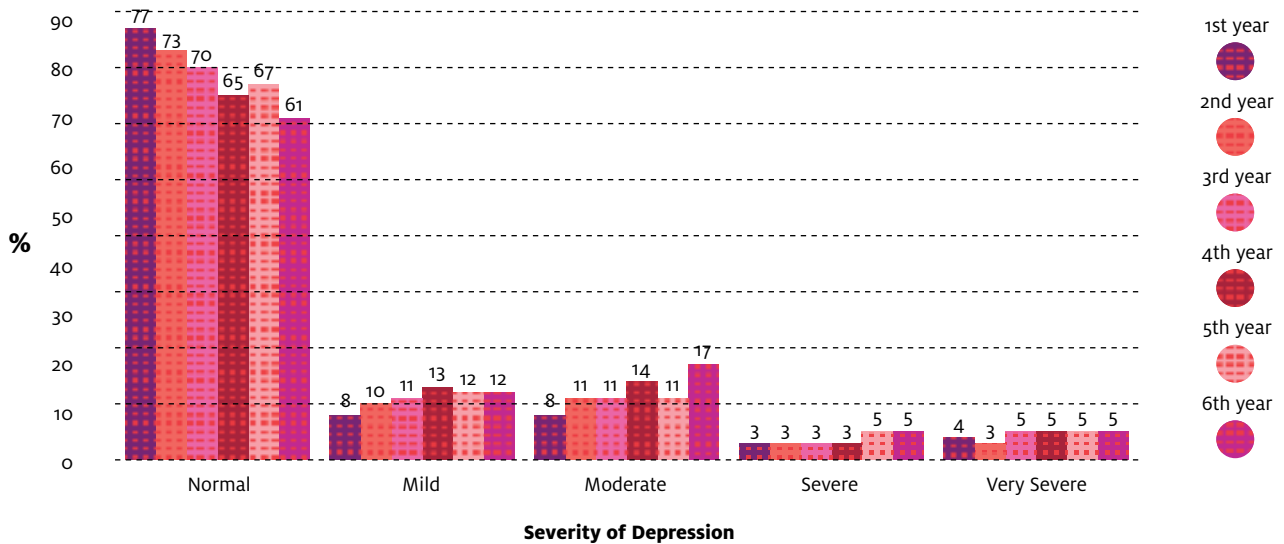
In the sample 70% of adolescents were classified as having normal levels of depression. Approximately 11% were in the mild range, 11% in the moderate, and 8% in the severe (4%) or very severe (4%). Males were more likely to be classified in the normal range.

Figure 4.9: DASS depression categories by gender



As seen in Figure 4.10, depression increased across school year with 39% of sixth-years outside the normal range compared to 23% of first years.

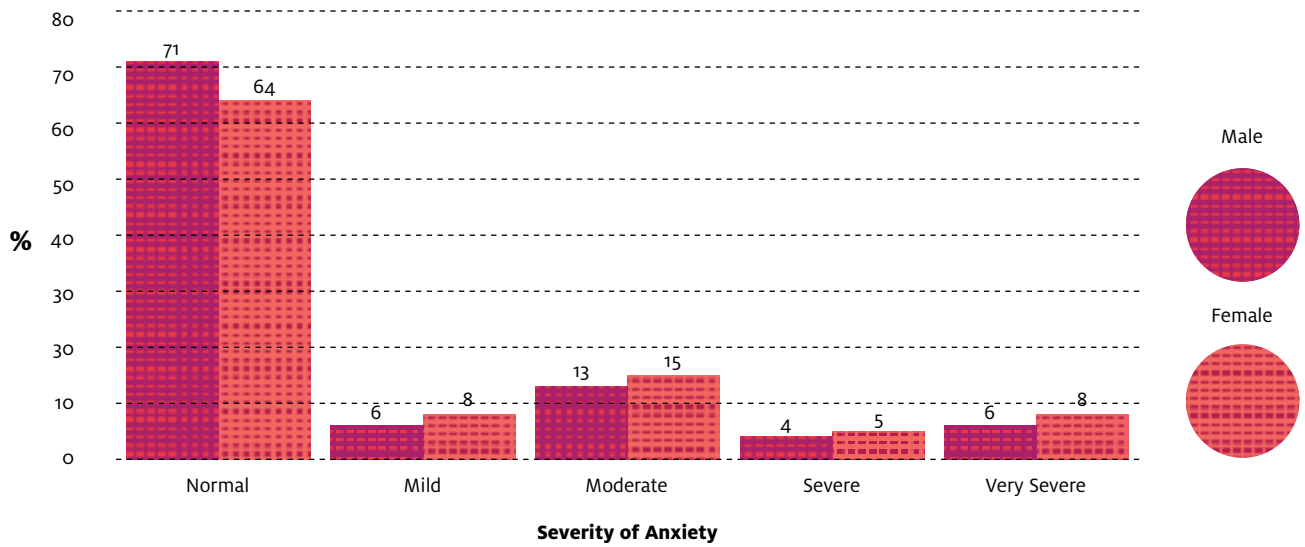
Figure 4.10: DASS depression categories by school year



Anxiety categories

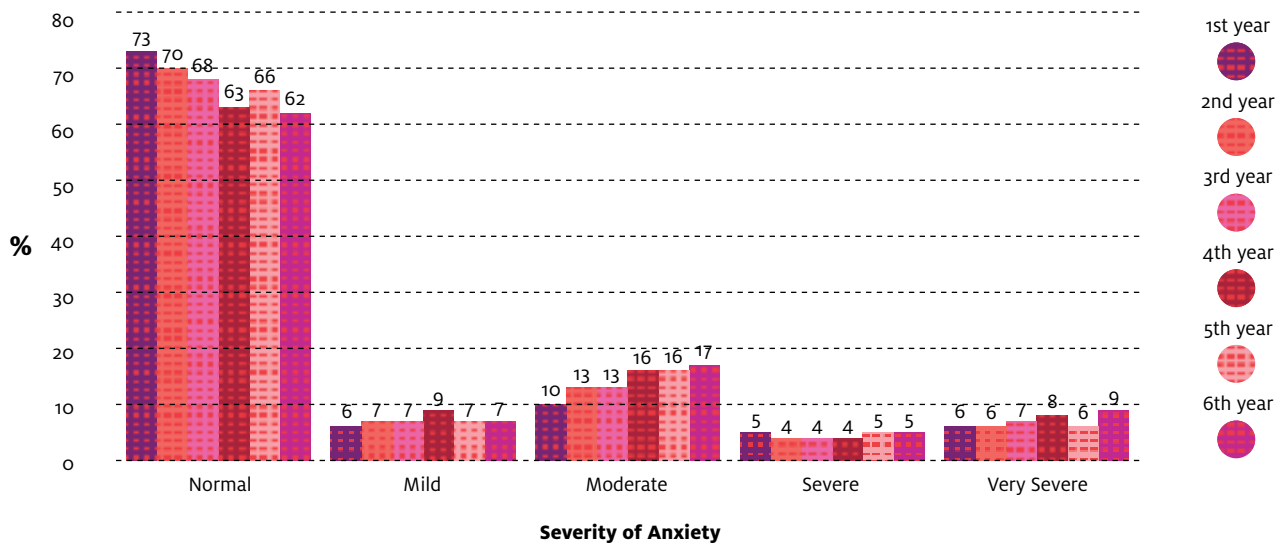
Similarly to the breakdown for depressive symptoms, 68% of adolescents were found to be within the normal range for anxiety. About one-fifth were classified as being in the mild (7%) and moderate range (14%) and 11% in the severe (4%) or very severe (7%) range. As seen in Figure 4.11, males were more likely to fall within the normal range for symptoms of anxiety (71%) than females (64%).

Figure 4.11: DASS anxiety categories by gender



Similar to depression, anxiety increased gradually across the school years, from 1st year to 6th year (Figure 4.12).

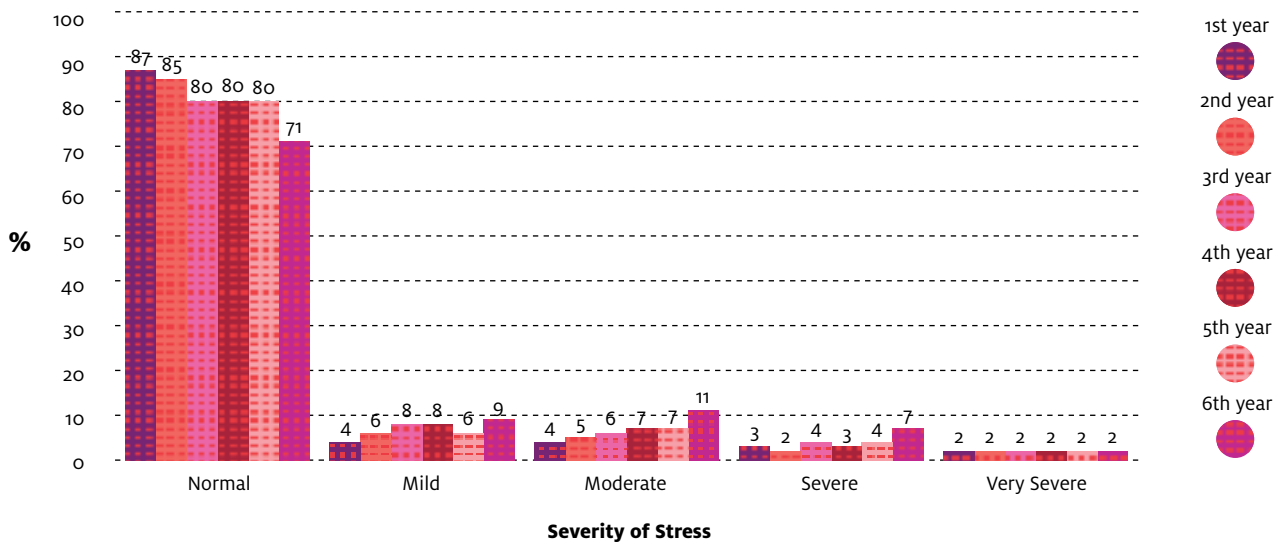
Figure 4.12: DASS anxiety categories by school year



Stress categories

Over 80% of adolescents were categorised within the normal range for stress; 14% fell within the mild (7%) and moderate (7%) range and 5% within the severe (3%) to very severe (2%) range. Across school years, the pattern was similar to that for depression and anxiety.

Figure 4.13: DASS stress categories by school year



4.4.2. Top three stressors

Participants were asked an open-ended question – what are ‘the three most significant stressors in your life?’. Figure 4.14 below displays in the graphic form of a word cloud the most common stressors reported. The larger the type size, the more frequently this stressor was identified by the adolescents. School, family and friends were the three biggest stressors.

Figure 4.14: Top stressors in adolescents' lives



52%

Only 52% of sixth-years fell into the normal drinking category.

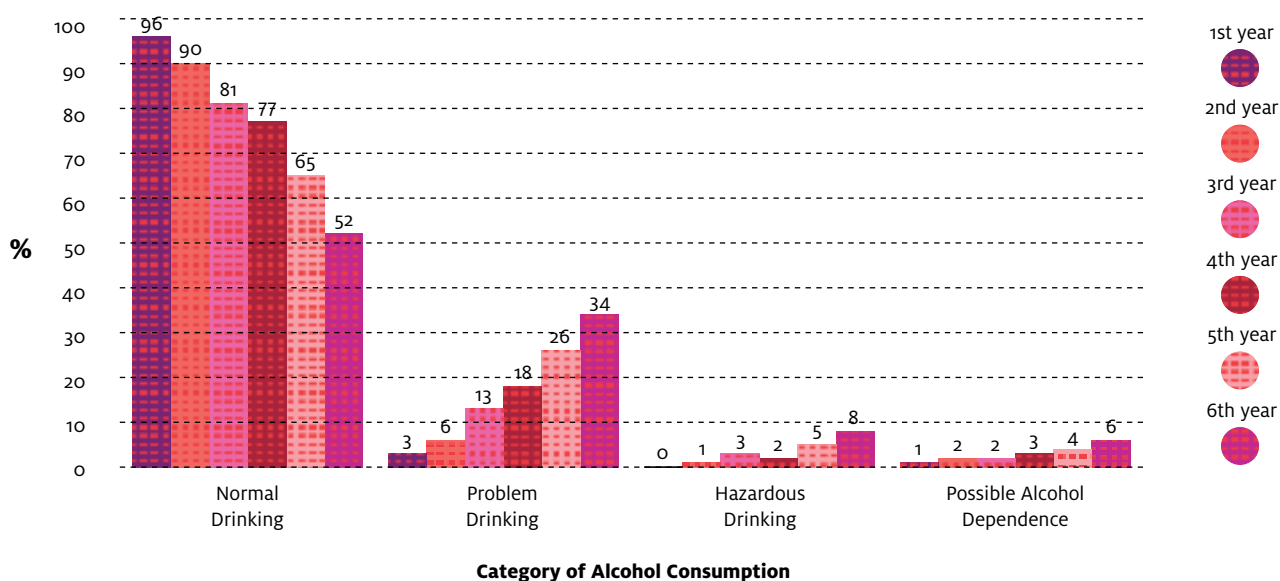
4.4.3. Alcohol behaviour

Adolescents' alcohol behaviour was assessed using the Alcohol Use Disorders Identification Test (Babor, Higgins-Biddle, Saunders & Monteiro, 2001). In the sample, scores ranged between 0 and 49 ($M=3.91$, $SD=5.82$), where scores below 8 were considered indicative of normal drinking behaviour. Using the WHO recommended cut-offs, scores were classified into:

- › 'normal drinking'
- › 'problem drinking' (score of 8 or more)
- › 'hazardous and harmful drinking' (score of 16 or more)
- › 'possible alcohol dependence' (score of 20 or more)

Of the sample, 79% of adolescents fell into the normal drinking range, 15% were classified as problem drinkers, 3% as harmful and hazardous drinkers, and nearly 3% as potentially alcohol-dependent. Figure 4.15 shows a clear linear relationship between abnormal drinking behaviour and school year. Most first-years (96%) fell into the normal drinking category, but this figure decreased with each school year, and only 52% of sixth-years fell into the normal drinking category.

Figure 4.15: Abnormal drinking by school year

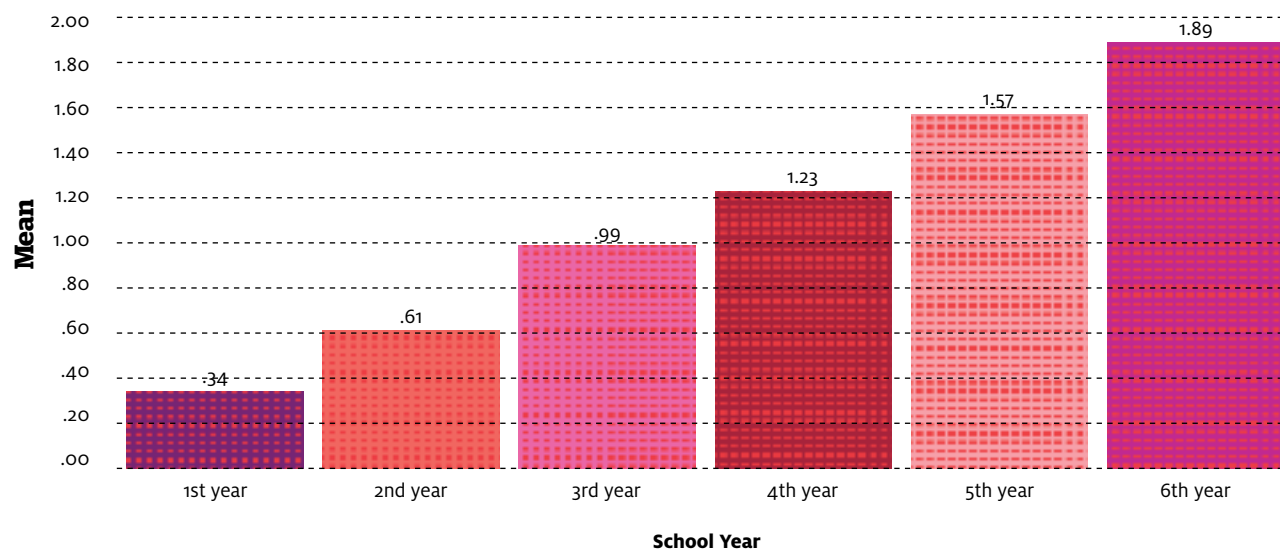


4.4.4. Substance use

A six-item, yes/no response scale called the CRAFFT (Knight, Shrier, Bravender, Farrell, Vander & Shaffer, 1999) was used to assess substance problem use, abuse and dependence. Scores ranged from 0 to 6 ($M=0.99$, $SD=1.44$), with higher scores indicating higher levels of drug and alcohol misuse.

Over 25% of adolescents scored 2 or higher, which indicates high levels of substance misuse. There were no gender effects but school-year effects were observed (see Figure 4.16). A significant difference was found between all school years and a clear trend can be seen; first-years reported the lowest levels of alcohol and drug use ($M=0.34$), and sixth-years the highest ($M=1.89$).

Figure 4.16: Substance use by school year

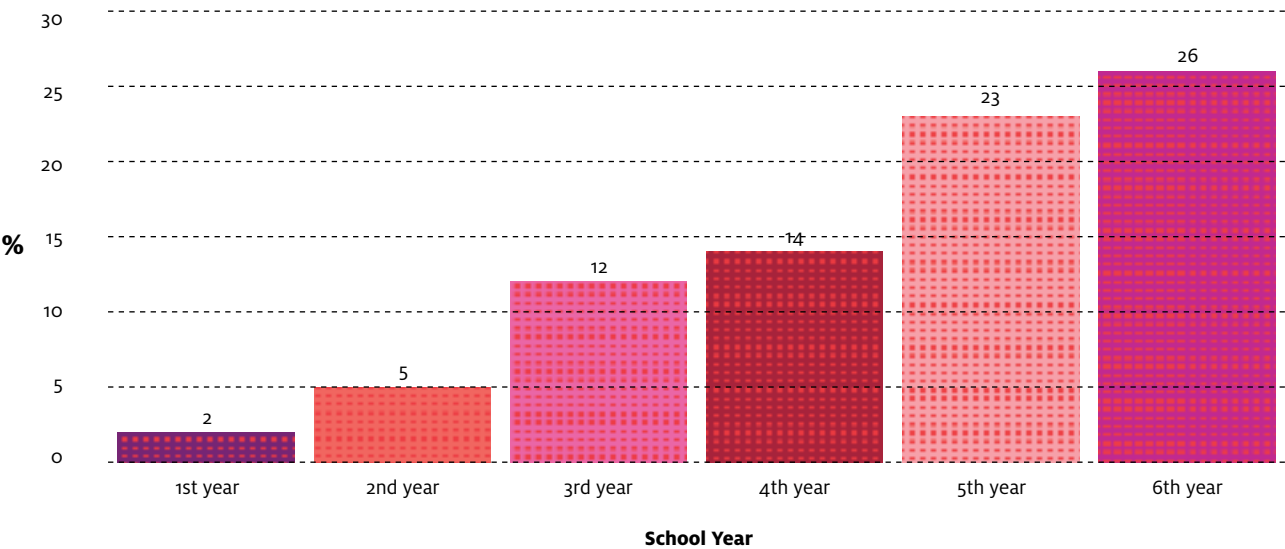


Reported cannabis use was 26% in 6th year.

4.4.5. Cannabis use

Approximately 12% of adolescents reported that they had smoked cannabis; 16% of males reported this compared to 9% of females. A clear trend of increasing likelihood of having smoked cannabis was evident across school year. Reported use in 1st year was 2% and 26% in 6th year (see Figure 4.17).

Figure 4.17: Cannabis use by school year



40%
reported that they had been bullied at some point.

4.4.6. Pupil's experience of bullying

Adolescents were asked questions about their experiences of bullying. Over 40% reported that they had been bullied at some point. Of these, 30% of bullying had occurred in the last year, 14% in the past month, and 7% on a weekly (4%) or daily basis (3%).

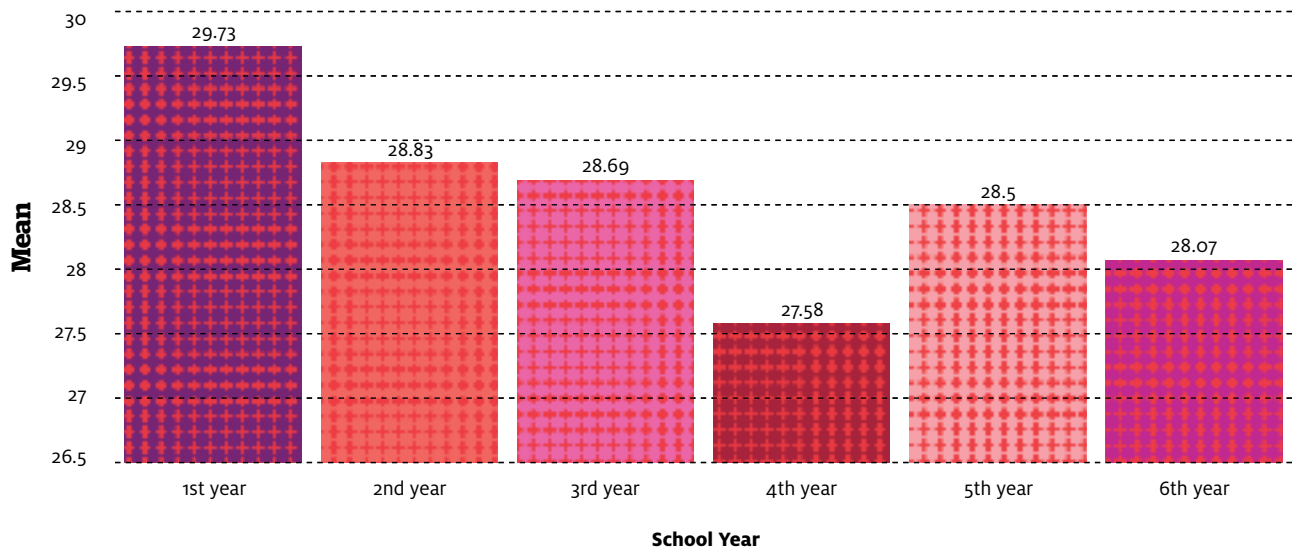
With regard to where adolescents were most frequently bullied, over three-quarters (77%) indicated school, 5% over the internet (2%) or by text (3%), 5% at home, and 13% 'elsewhere'. Nearly half (49%) of females reported that they had been bullied compared to 40% of males.

4.5. Protective Factors

4.5.1. Self-esteem

Adolescents were asked to complete a 10-item measure of global self-esteem called the Rosenberg Self-Esteem Scale (RSE; Rosenberg, 1965). Scores ranged between 10 and 40 (M=28.67, SD=5.7) where higher scores indicated greater self-esteem. Males (M=30.31) displayed significantly higher levels than females (M=27.13), as did first-years compared to all other year groups (see Figure 4.18).

Figure 4.18: Self-esteem by school year



4.5.2. Coping strategies

Adolescents' coping strategies were assessed using the Coping Strategy Indicator (Amirkhan, 1990). Three fundamental coping strategies were assessed: problem-solving, seeking social support, and avoidance. High scores on problem-solving and seeking social support and low scores on avoidance coping indicate more adjusted coping strategies.

Problem-solving

Males ($M=16.57$) were significantly more likely to use problem-solving as a coping strategy than females. No school-year differences were observed.

Seeking social support

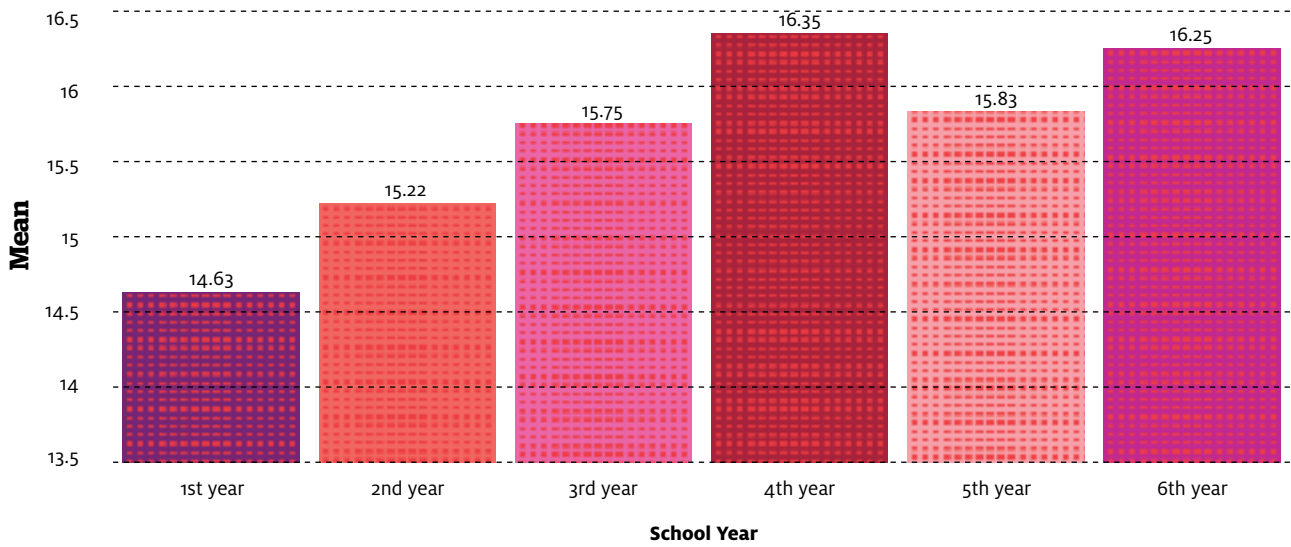
Females ($M=16.13$) showed a significantly greater tendency to use social support than males.

Avoidant coping

While females were more likely to use social support to deal with problems than males, they were also significantly more likely ($M=16.28$) to avoid problems than males ($M=14.78$). Levels of avoidant coping increased across the Junior Cycle (see Figure 4.19).

Females were significantly more likely to avoid problems than males.

Figure 4.19: Use of avoidance as a coping strategy by school year



4.5.3. Top three coping strategies

An open-ended question asked adolescents to 'list the top three ways that help you cope when things are tough'. Figure 4.20 below shows the range of coping strategies in the form of a word cloud. The larger the type size, the more frequently this coping strategy was identified by adolescents. The top three coping strategies are friends, talking and music.

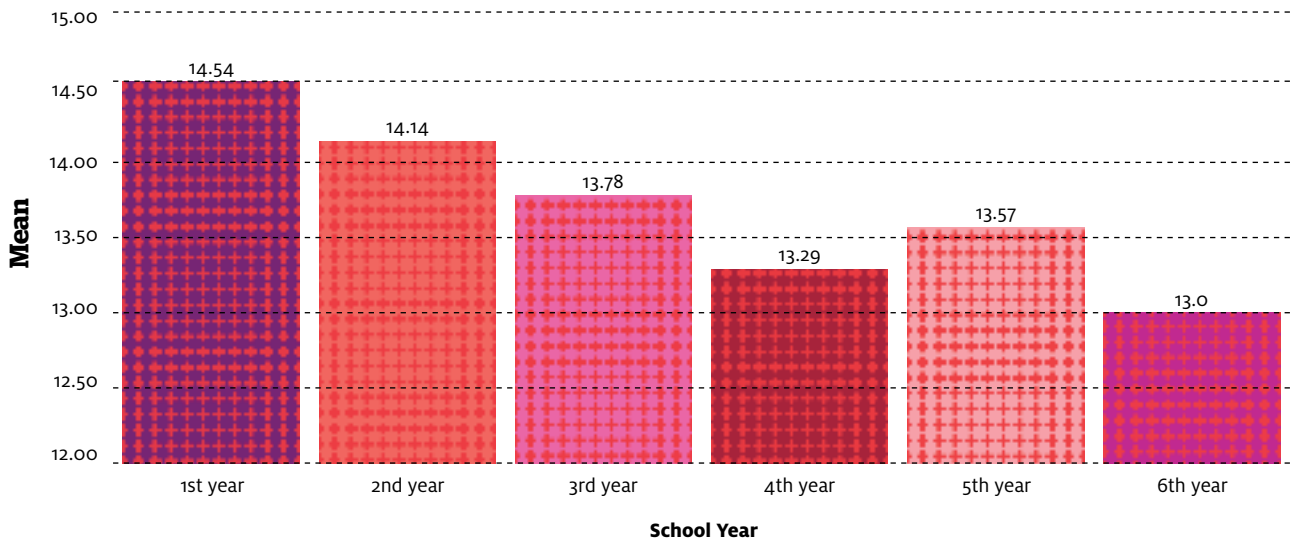
Figure 4.20: Top coping strategies in adolescents' lives



4.5.4. Optimism

Males reported greater optimism ($M=14.62$) than females ($M=13.09$). First-years displayed significantly higher levels ($M=14.54$) than those in later years, while fourth-years ($M=13.29$) and sixth-years ($M=13$) displayed the lowest levels (see Figure 4.21).

Figure 4.21: Optimism by school year



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reported that they would be likely to use their friends as a source of support.

4.5.5. Help-seeking behaviour

Adolescents' help-seeking behaviour was assessed in a number of ways throughout the MWS-SL.

Sources of support

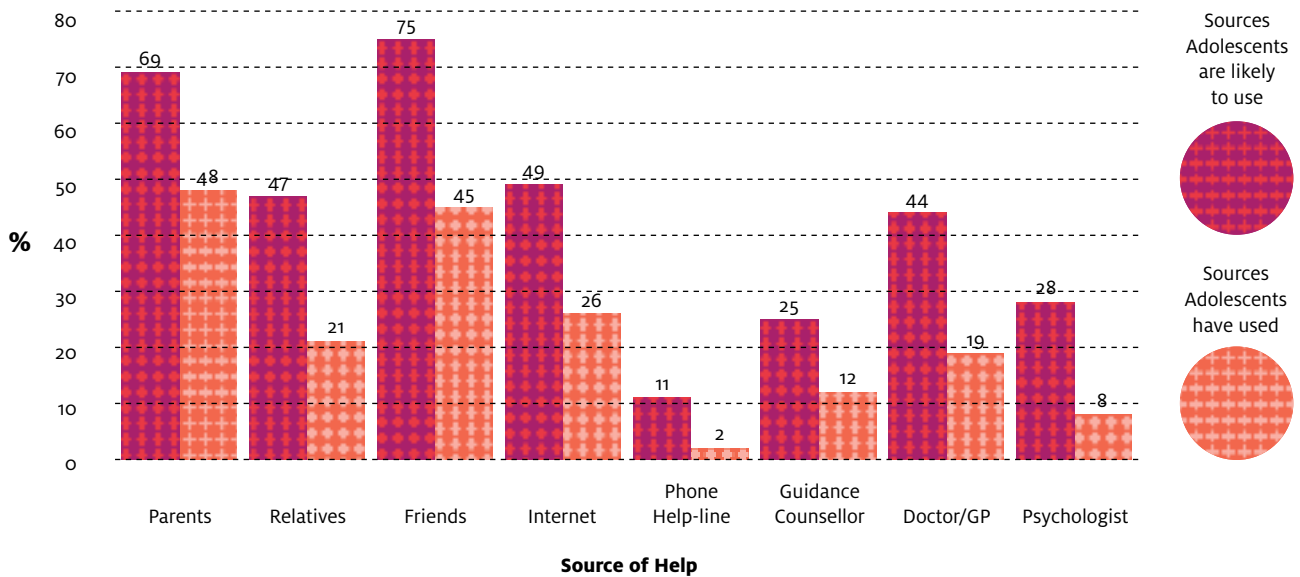
Adolescents were asked how likely they would be to use a variety of sources to obtain information or support about their mental health and well-being. Three-quarters reported that they would be likely to use their friends as a source of support. Parents came next (69%), followed by the internet (49%) and relatives (47%).

Doctors/GPs were the most likely source of formal support with 44% reporting this, followed by a psychologist, counsellor or therapist (28%), and a teacher or guidance counsellor (25%). Only 11% reported that they would be likely to use a phone help-line.

Adolescents were also asked what sources they had actually used to obtain information or support about their mental health and well-being. Parents were the most common source, with 48% of adolescents reporting this, followed by friends (45%), the internet (26%) and relatives (21%).

Doctors/GPs were the most common source of formal support accessed (19%), followed by a teacher or guidance counsellor (12%), and a psychologist, counsellor or therapist (8%). Only 2% had used a phone helpline (see Figure 4.22).

Figure 4.22: Help-seeking



Formal help-seeking

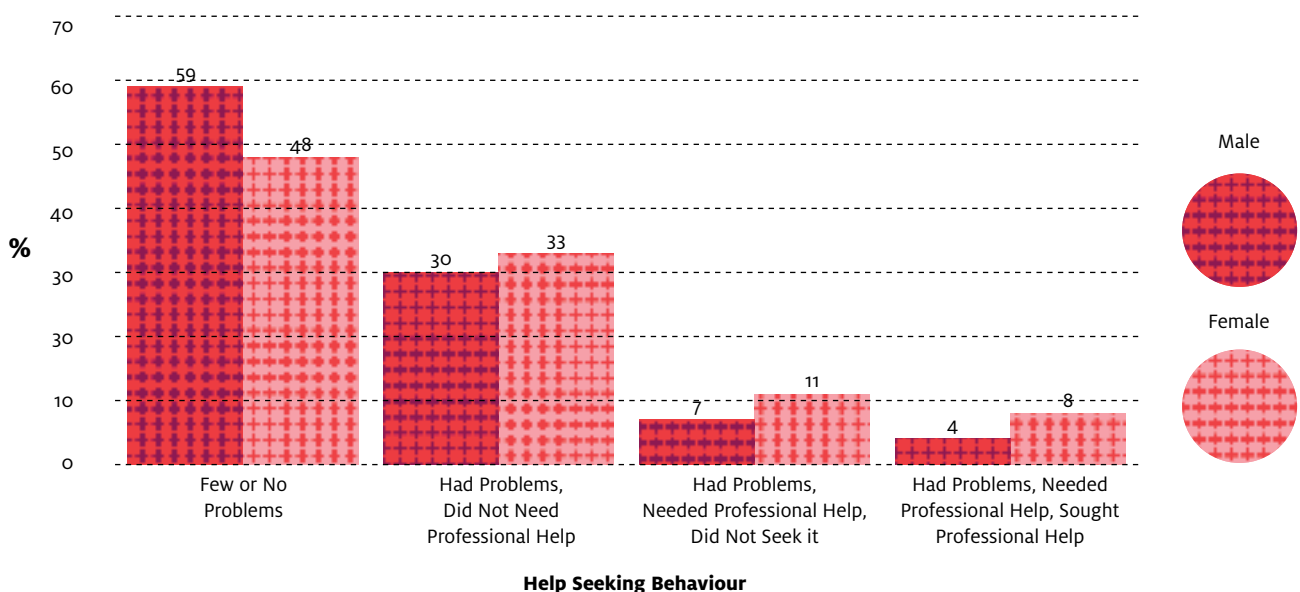
Adolescents were asked if they had any serious problems in the past year, whether they felt they needed help for these problems, and whether or not they had sought professional help. Over half reported few or no problems in the past year, 31% reported problems but had not felt they needed professional help, and 9% reported problems but did not seek professional help even though they felt they had needed it. Finally, 6% reported that they had problems and had sought professional help.

Males were more likely to report few or no problems (59%). Females were more likely to report needing professional help but that they had not sought it (11%) or that they had needed it and had sought it (8%).

9%

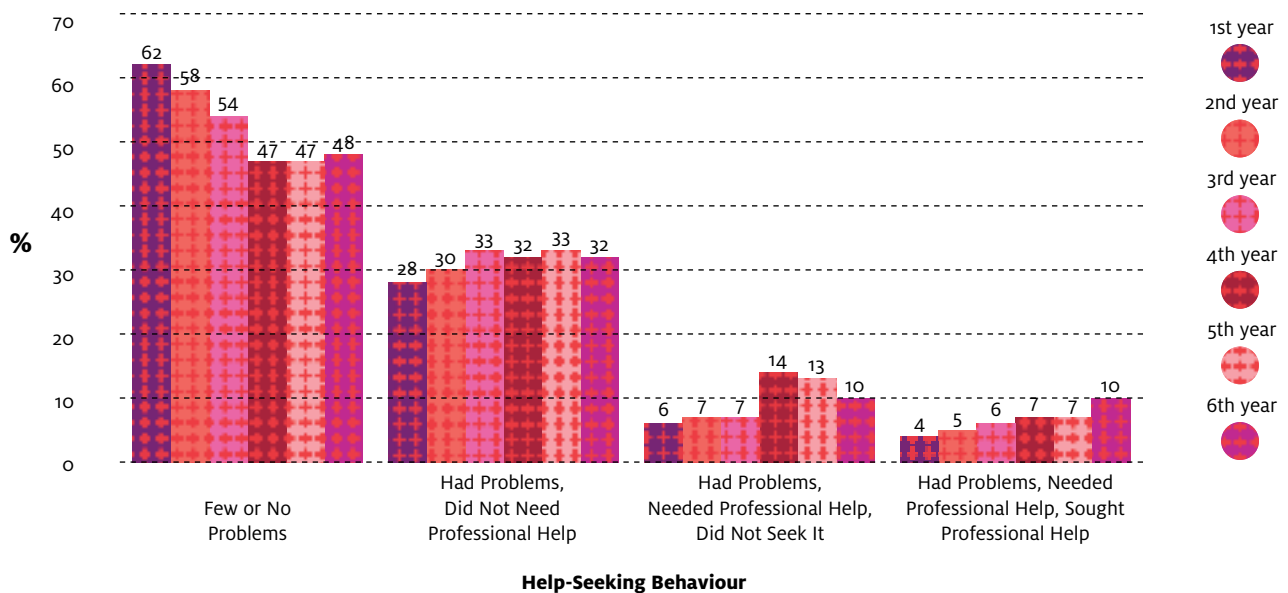
reported problems but did not seek professional help even though they felt they had needed it.

Figure 4.23: Formal help-seeking behaviour by gender



Across the school years (Figure 4.24), first-years (62%) and second-years (58%) were more likely to report having few or no problems. The later-years, such as fourth-years (14%) and fifth-years (13%), were more likely to report that they had needed professional help but not sought it. Finally, sixth-years were more likely to report that they had needed professional help and had sought it (10%).

Figure 4.24: Formal help-seeking behaviour by school year



65%

of adolescents reported that, when they had problems, they usually talked about them with someone.

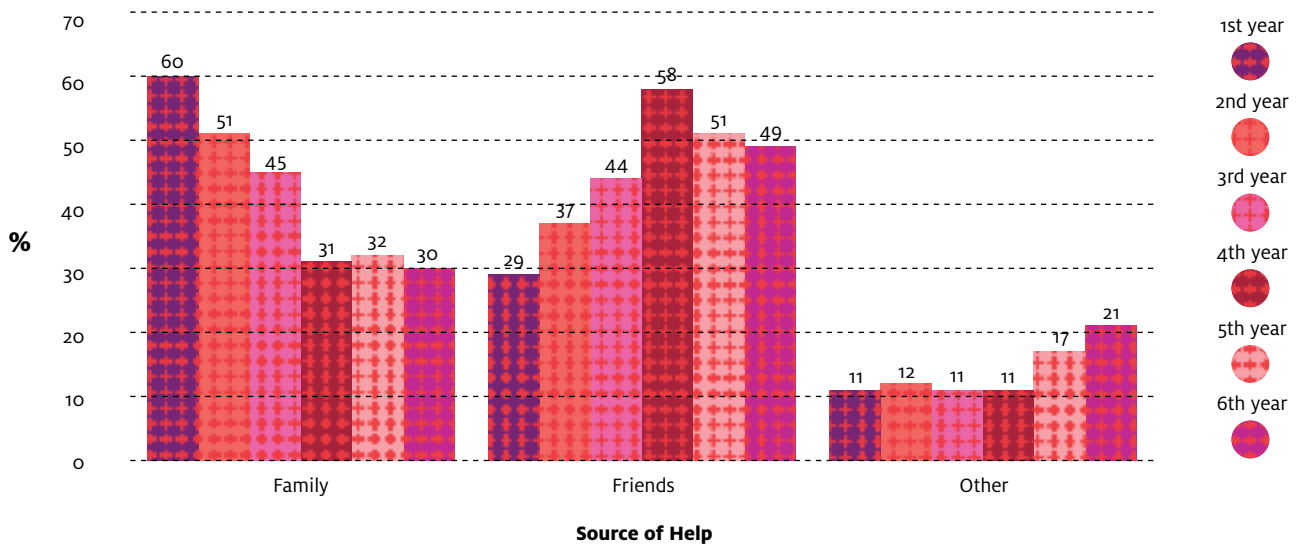
Informal help-seeking

Approximately 65% of adolescents reported that, when they had problems, they usually talked about them with someone. Females (72%) were more likely to do so than males (60%).

First-years (72%) were also more likely to talk about their problems; the percentage dropped to 69% in 2nd year and again to 63% in 3rd year, rose to 67% in 4th year and then dropped to 63% in 5th and 6th year.

Younger adolescents were more likely to report that they would talk to a family member about their problems. By 6th year, it appears that adolescents were becoming more autonomous and were more likely to report that they would talk to someone other than family or a friend (15%).

Figure 4.25: Most likely source of help for problems by school year

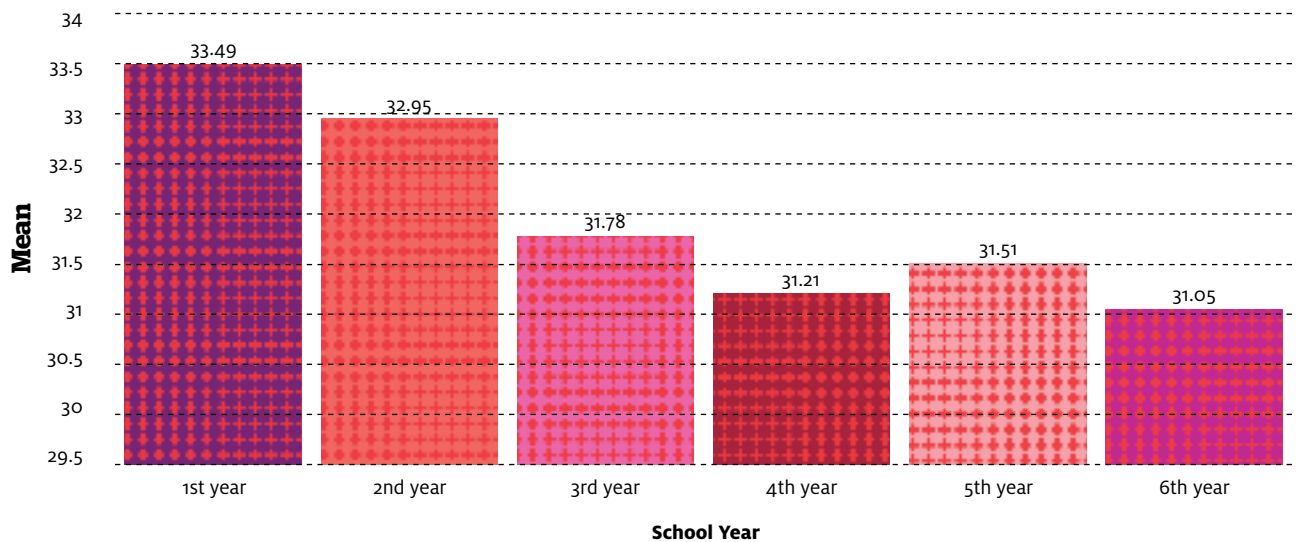


4.5.6. Satisfaction with life

Males ($M=32.84$) reported being more satisfied overall with their lives than females ($M=31.58$). First-years ($M=33.49$) and second-years ($M=32.95$) displayed greater life satisfaction than older year groups (see Figure 4.26).

Males reported being more satisfied overall with their lives than females.

Figure 4.26: Satisfaction with life by school year



Females reported significantly higher levels of perceived social support than males.



4.5.7. Social support

Females reported significantly higher levels of perceived social support (M=64.2) than males (M=60.3). There were no gender differences in perceived support from family.

First-years reported the highest level of social support (see Figure 4.27). A clear linear trend emerged for school year, where first-years reported the most perceived support from their families (M=21.55) and sixth-years the lowest (M=19.85).

Females perceived greater support from friends (M=22.36) than males (M=20.39). They also perceived greater support from a significant adult (M=21.46) than males (M=20.01).

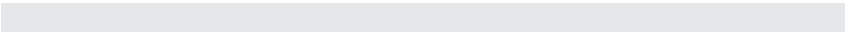
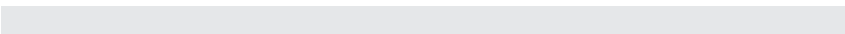
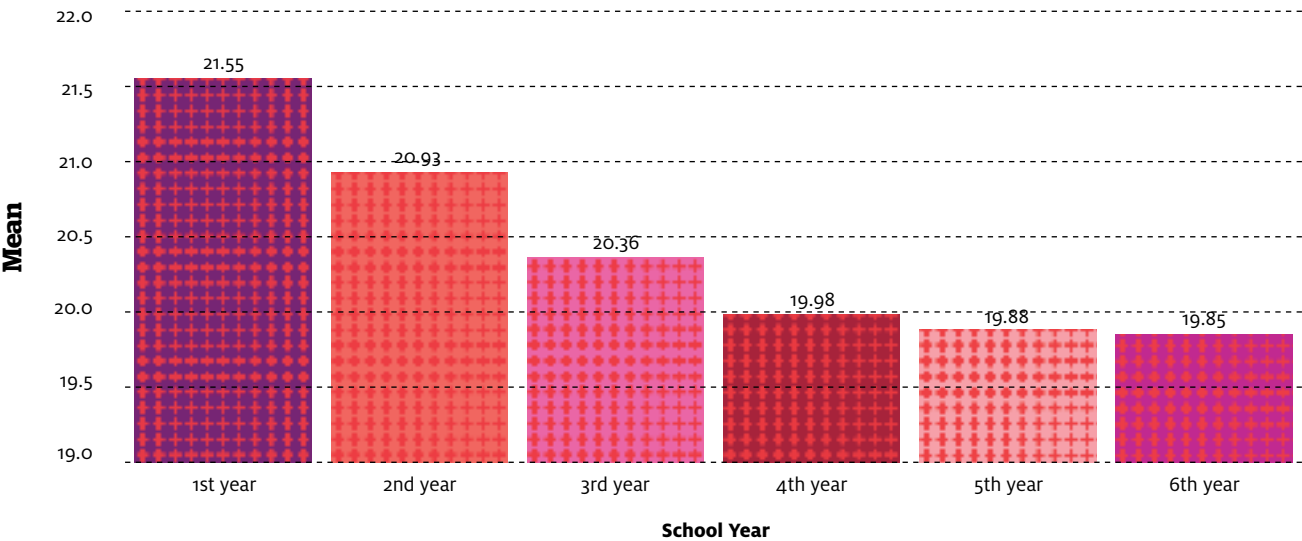


Figure 4.27: Support from family by school year



4.6. Key Indicators of Mental Health Status

To obtain a comprehensive picture of adolescent mental health, analyses were carried out comparing depression, anxiety and stress levels across a number of key self-reported variables in adolescents’ lives, including:

- 1) alcohol behaviour
- 2) bullying
- 3) perceived availability of a special adult when in need
- 4) academic position
- 5) receiving additional school teaching support
- 6) formal and informal help-seeking.

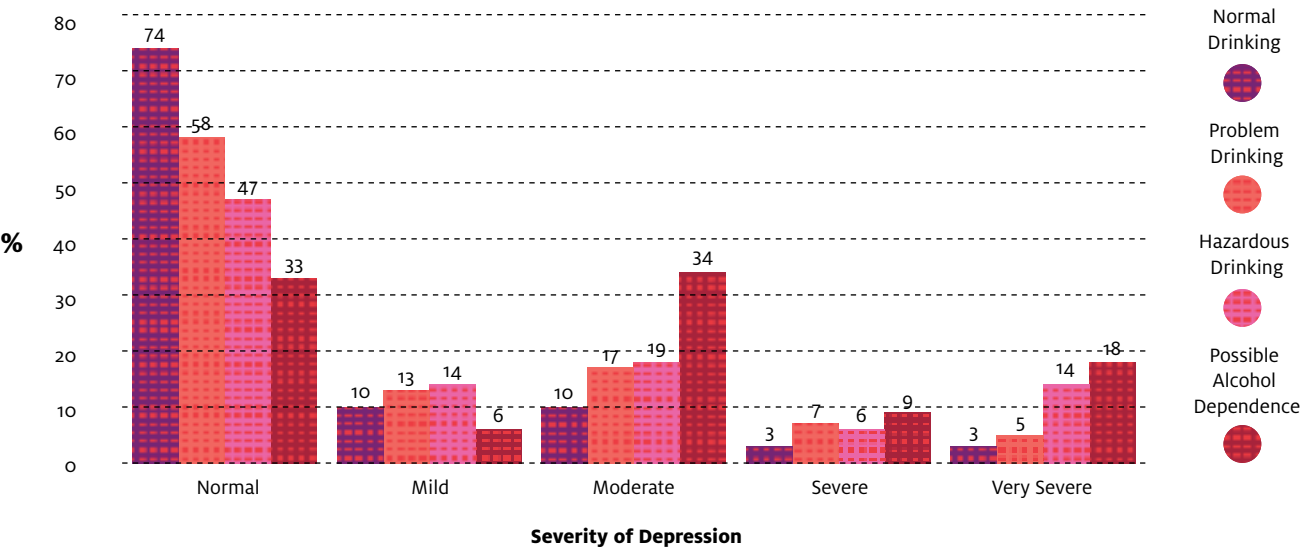
4.6.1. Alcohol behaviour and depression, anxiety, stress

The AUDIT (Babor, Higgins-Biddle, Saunders & Monteiro, 2001) cut-offs revealed (as previously mentioned) that 79% of adolescents fell into the normal drinking range, 15% were classified as problem drinkers, 3% as hazardous drinkers and nearly 3% as potentially alcohol-dependent.

Analyses revealed a clear link between hazardous levels of alcohol behaviour and psychological distress. Adolescents classified as normal drinkers were likely to fall within the normal range for depression. In contrast, those classified as hazardous drinkers were more likely to fall within the moderate to very severe range for depressive symptoms.

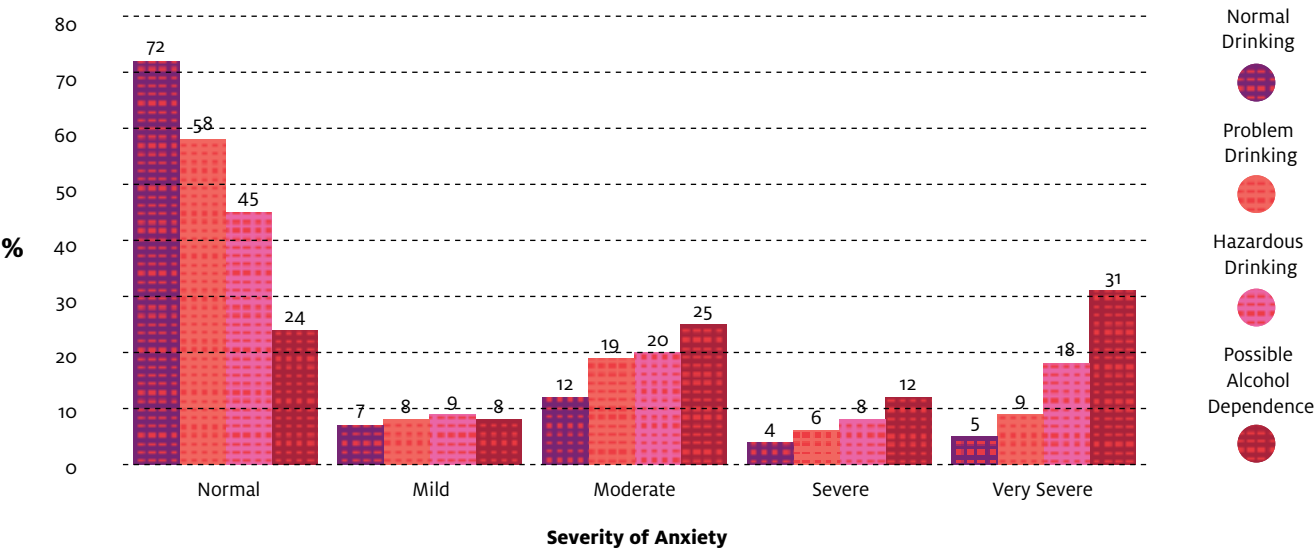
Only 3% of normal drinkers were classified as having very severe levels of depression (Figure 4.28), whereas 18% of those with possible alcohol dependence fell within this category.

Figure 4.28: Depressive symptoms by alcohol behaviour



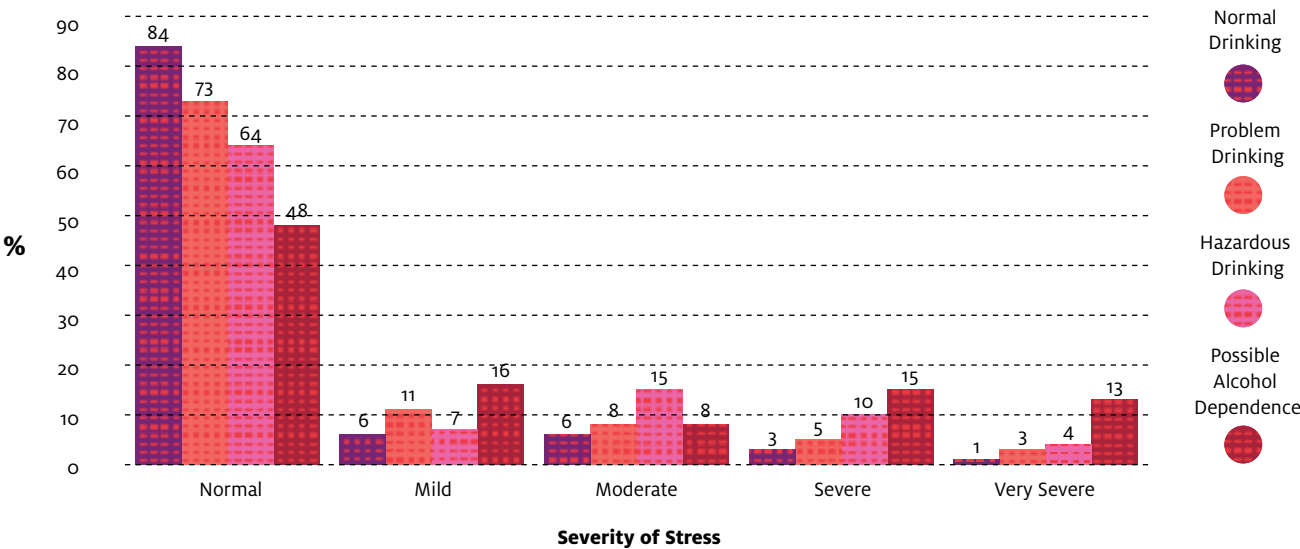
A stronger pattern emerged for symptoms of anxiety. As evident from Figure 4.29, 72% of those identified as normal drinkers fell within the normal category for anxiety, compared to only 24% of those with possible alcohol dependence. The reverse pattern was observed for the 'very severe anxiety' category; 5% of those identified as normal drinkers reported severe anxiety symptoms compared to 31% of those with possible alcohol dependence.

Figure 4.29: Symptoms of anxiety by alcohol behaviour



Again, a comparable pattern emerged for symptoms of stress, and especially for severe and very severe levels of stress (Figure 4.30). Adolescents identified as hazardous drinkers and as potentially alcohol-dependent were more likely to report moderate to very severe symptoms of stress. For example, only 1% of those classified as normal drinkers fall within the very severe range for stress compared to 13% of those classified as having possible alcohol dependence.

Figure 4.30: Symptoms of stress by alcohol behaviour



4.6.2. Bullying and depression, anxiety, stress

Nearly 42% of adolescents reported that they had been bullied at some point, and those who did so were more likely to report symptoms of distress outside of the normal range.

As is evident from Figure 4.31, adolescents who reported being bullied were more likely to report moderate to severe depressive symptoms, while those who reported not being bullied were more likely to fall within the normal range for depression. Similar patterns were observed for anxiety (see Figure 4.32), and stress (see Figure 4.33).

Figure 4.31: Depressive symptoms by experience of bullying

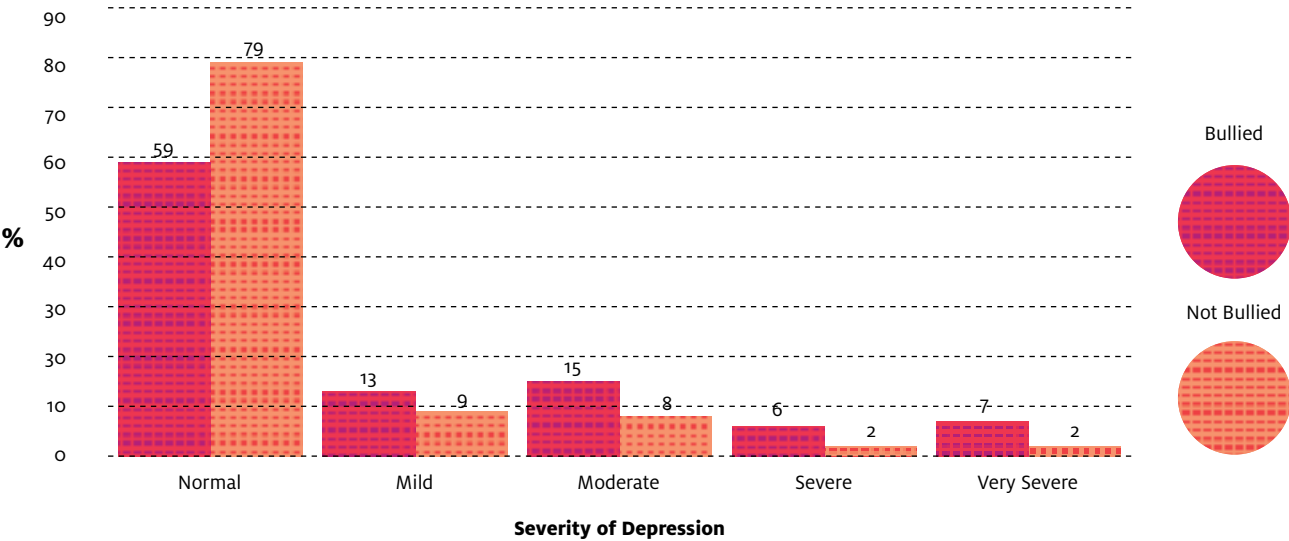


Figure 4.32: Symptoms of anxiety by experience of bullying

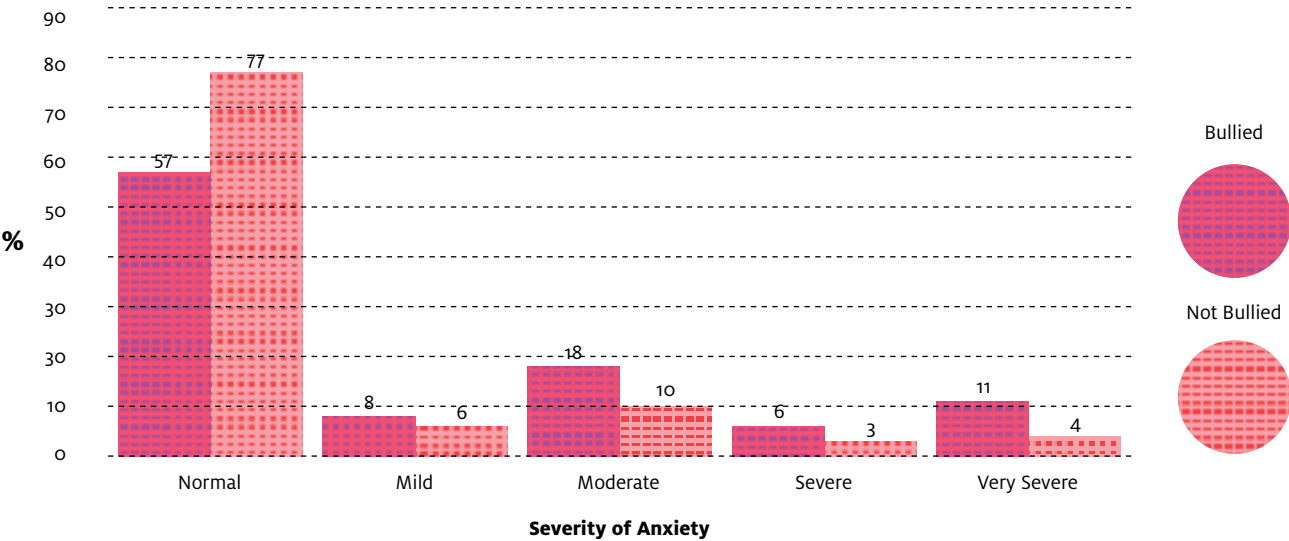
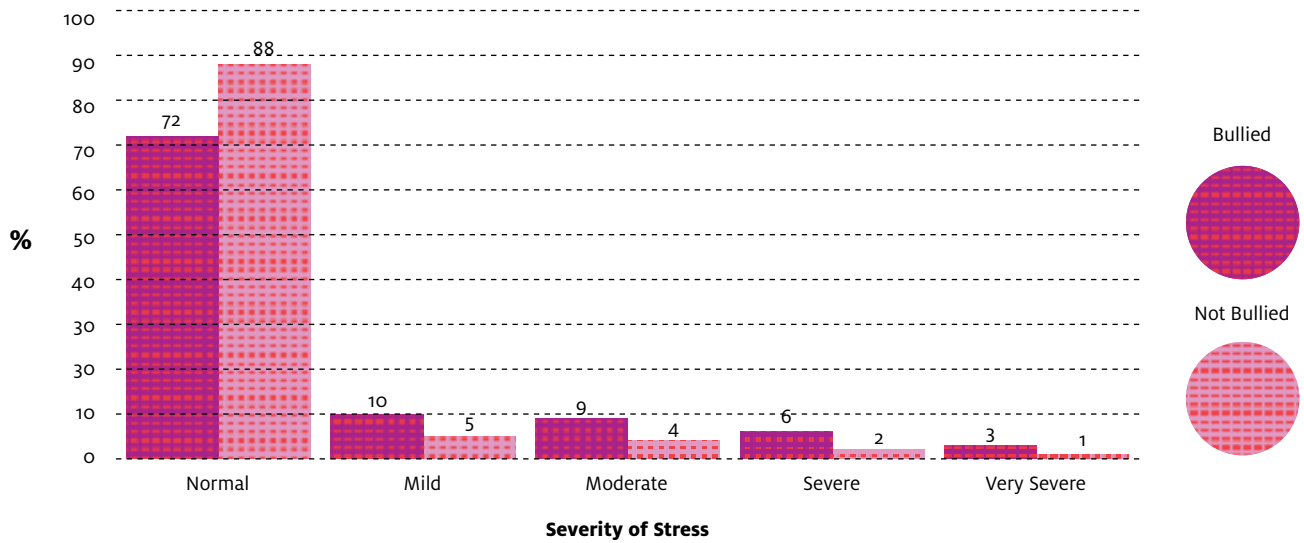


Figure 4.33: Symptoms of stress by experience of bullying



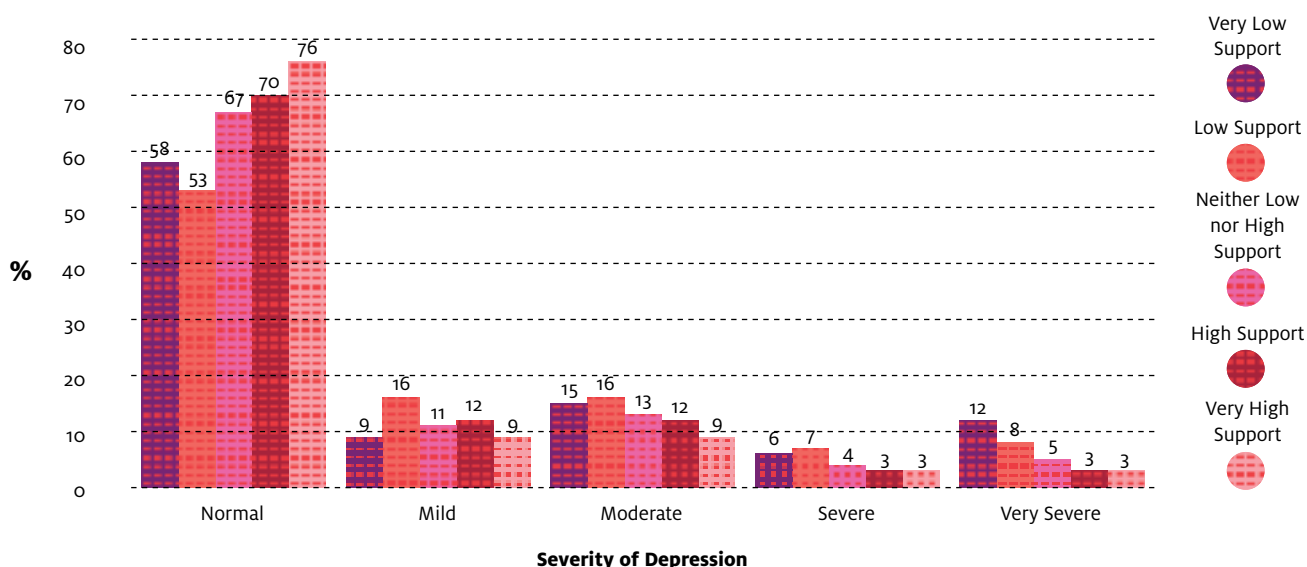
4.6.3. Perceived support from a special adult when in need

Adolescents were asked about a special adult being available when they were in need. Based on their responses, they were categorised into five groups, according to those who perceived:

- › very high support from a special adult (42%)
- › high support (29%)
- › neither high nor low support (13%)
- › low support (8%)
- › very low support (8%)

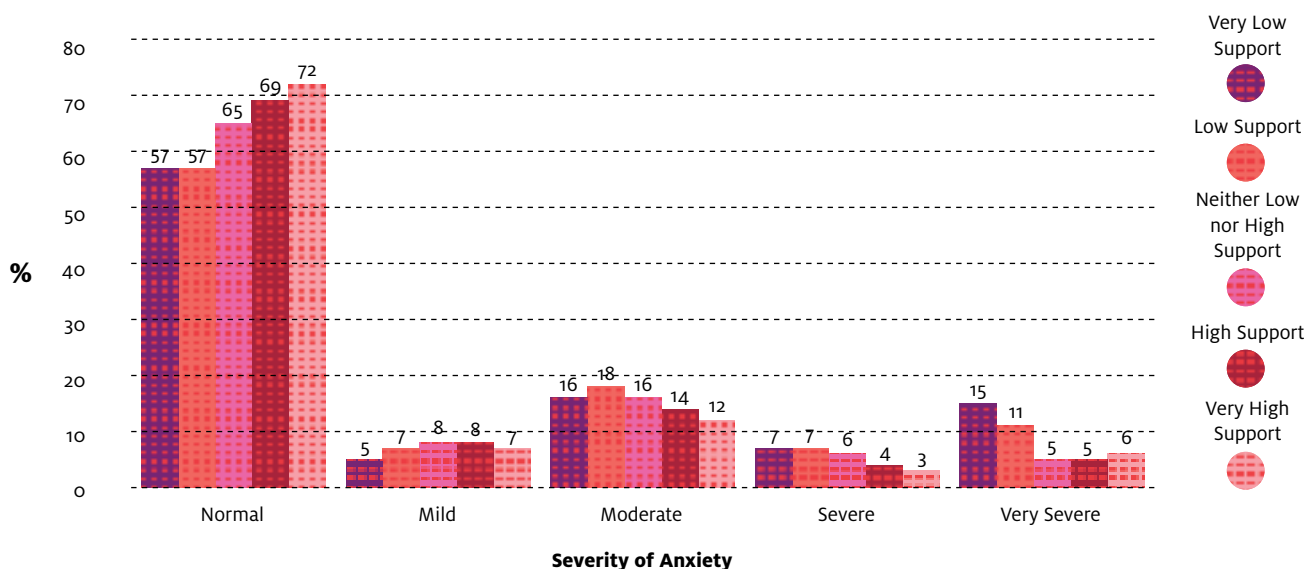
Perceived support from a special adult was significantly related to symptoms of psychological distress. This effect was strongest for depression (see Figure 4.34). Adolescents who perceived very low support from a special adult when in need were likely to report levels of depression that were, at least, moderate.

Figure 4.34: Depressive symptoms and support from a special adult



A broadly similar result emerged for anxiety (see Figure 4.35).

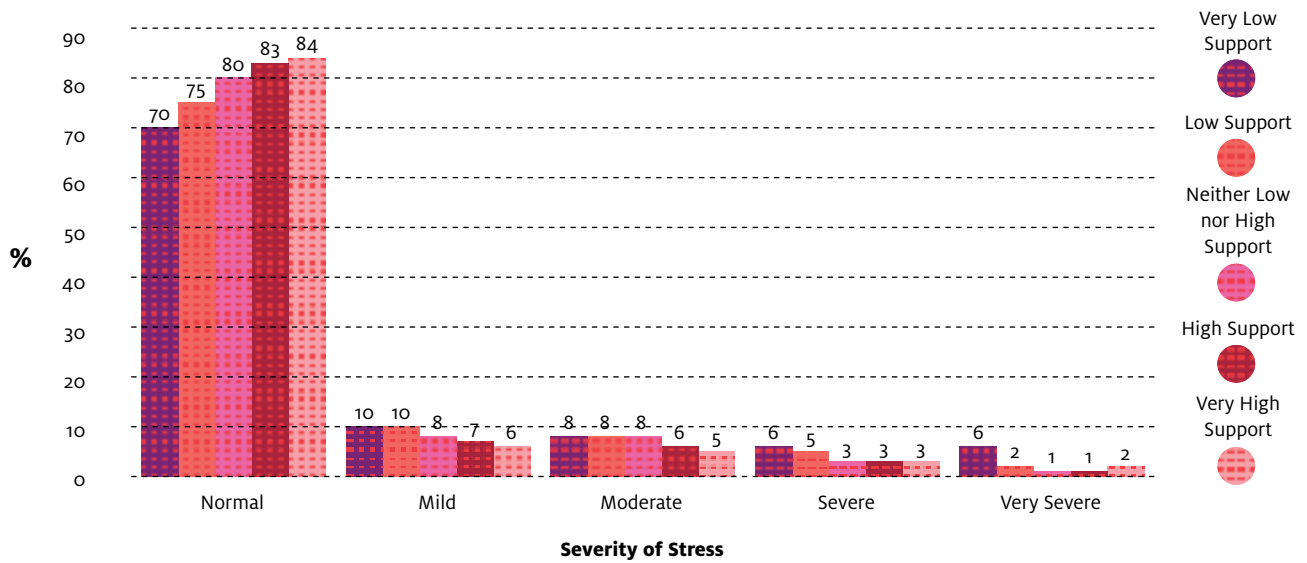
Figure 4.35: Symptoms of anxiety and support from a special adult



Turning to stress, those who reported very low support from a special adult were more likely to fall within the severe or very severe range of stress (see Figure 4.36).

In sum, the presence of a special adult when in need was related to low levels of symptoms of depression and anxiety, whereas the absence of such an adult when in need was more strongly related to symptoms of stress. Thus, high availability of a special adult when in need is a protective factor.

Figure 4.36: Symptoms of stress and support from a special adult

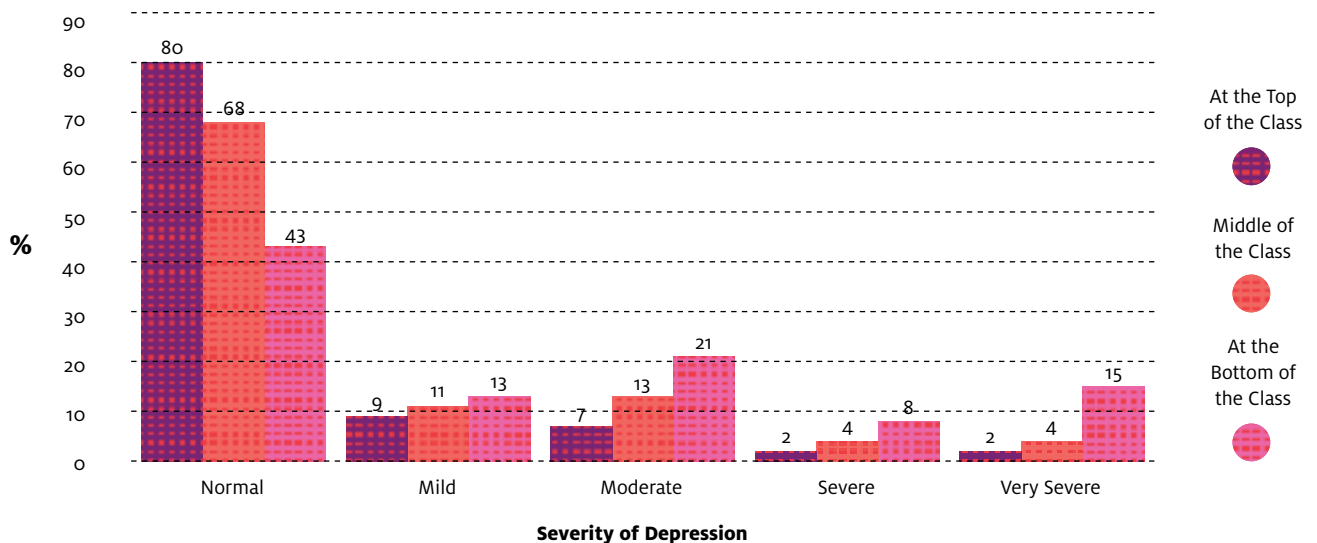


4.6.4. Academic position

Adolescents were asked where they would rank themselves in terms of their schoolwork. Overall, 27% ranked themselves as being at the top of the class, 66% in the middle and 5% at the bottom.

Those who ranked themselves as being at the bottom of the class were likely to experience more severe symptoms of psychological distress – especially depressive symptoms (see Figure 4.37). Those who said ‘at the bottom of the class’ reported moderate to very severe symptoms of depression, whereas those who said ‘at the top’ were more likely to fall within the normal range.

Figure 4.37: Depressive symptoms by self-reported rank in school class



Similar findings arose for symptoms of anxiety (Figure 4.38), and stress (Figure 4.39). Looking at Figure 4.38 for anxiety, 75% of those ‘at the top of the class’ were in the normal range for anxiety compared to 41% of those ‘at the bottom of the class’.

Figure 4.38: Symptoms of anxiety by self-reported rank in school class

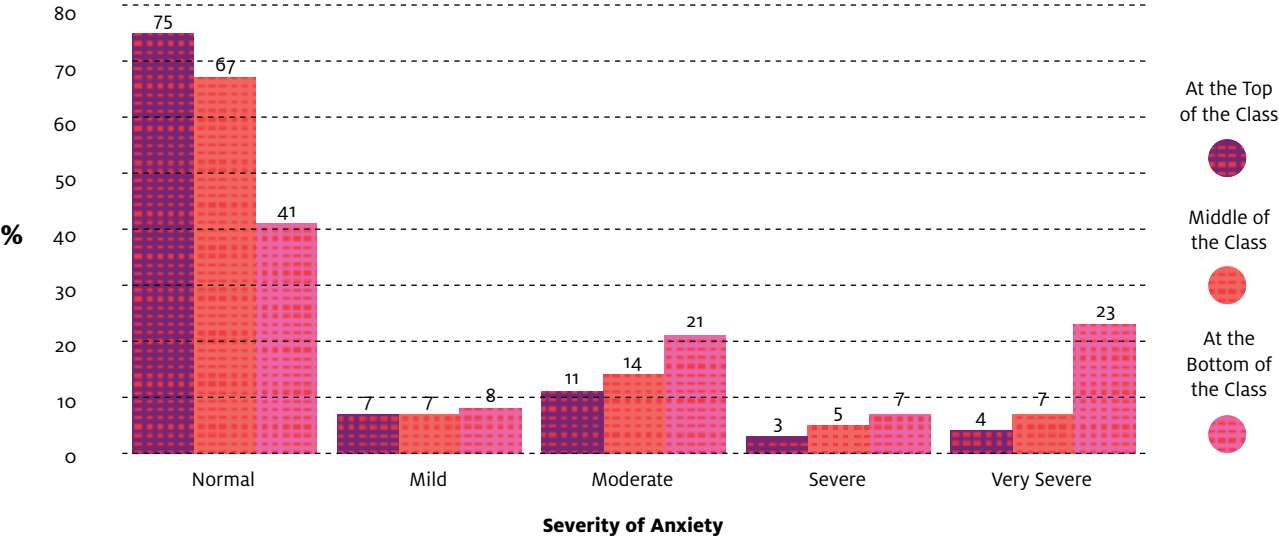
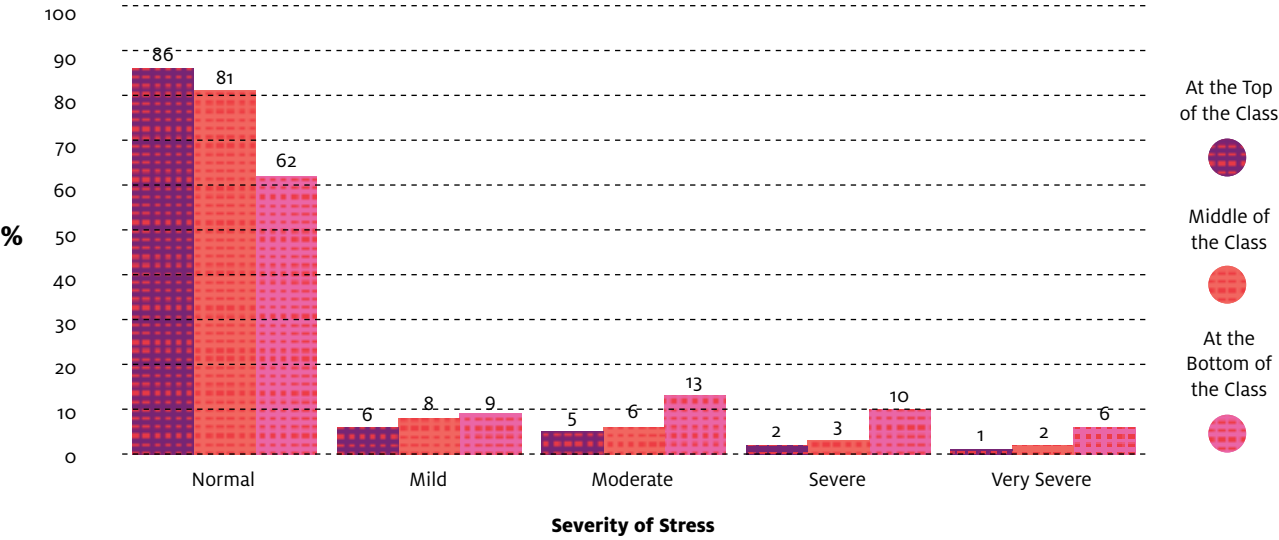


Figure 4.39: Symptoms of stress by self-reported rank in school class

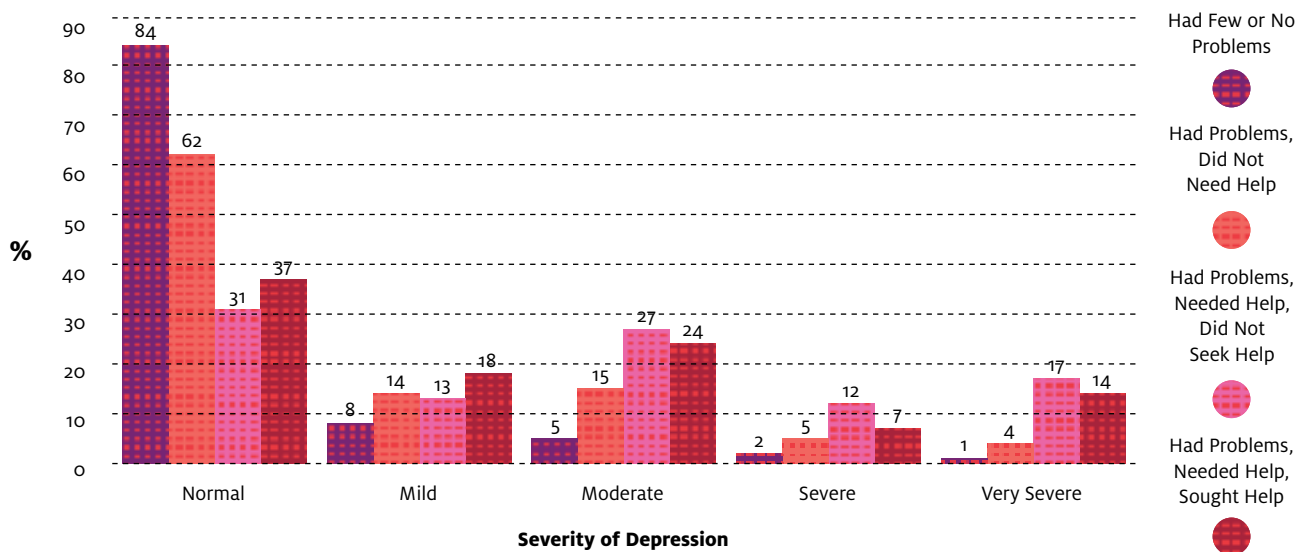


4.6.5. Formal help-seeking and depression, anxiety, stress

Over 50% of adolescents reported few or no problems in the past year, 30% reported 'some' but did not feel that they had needed professional help, 9% reported 'some' but did not seek professional help even though they felt they had needed it, and 6% reported that they had problems and sought professional help for them.

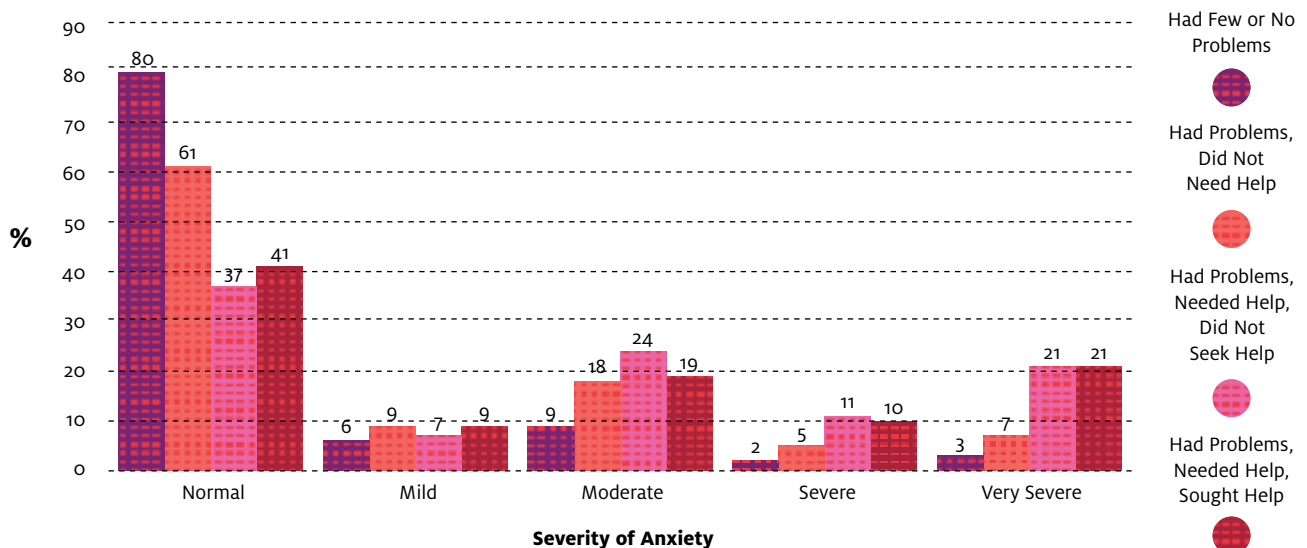
Those who identified themselves as needing professional help but not seeking it were more likely to fall into the moderate, severe, or very severe range for depressive symptoms, as were those who reported needing professional help and seeking it (Figure 4.40).

Figure 4.40: Depressive symptoms by formal help-seeking behaviour



As illustrated in Figure 4.41, similar formal help-seeking patterns emerged for anxiety.

Figure 4.41: Symptoms of anxiety by formal help-seeking behaviour



The same pattern emerged for symptoms of stress. As shown in Figure 4.42, over 90% of those who reported having few or no problems were in the normal range for stress, compared to 53% for those who reported needing professional help but not seeking it and 54% for those needing professional help who had sought it.

Figure 4.42: Symptoms of stress by formal help-seeking behaviour

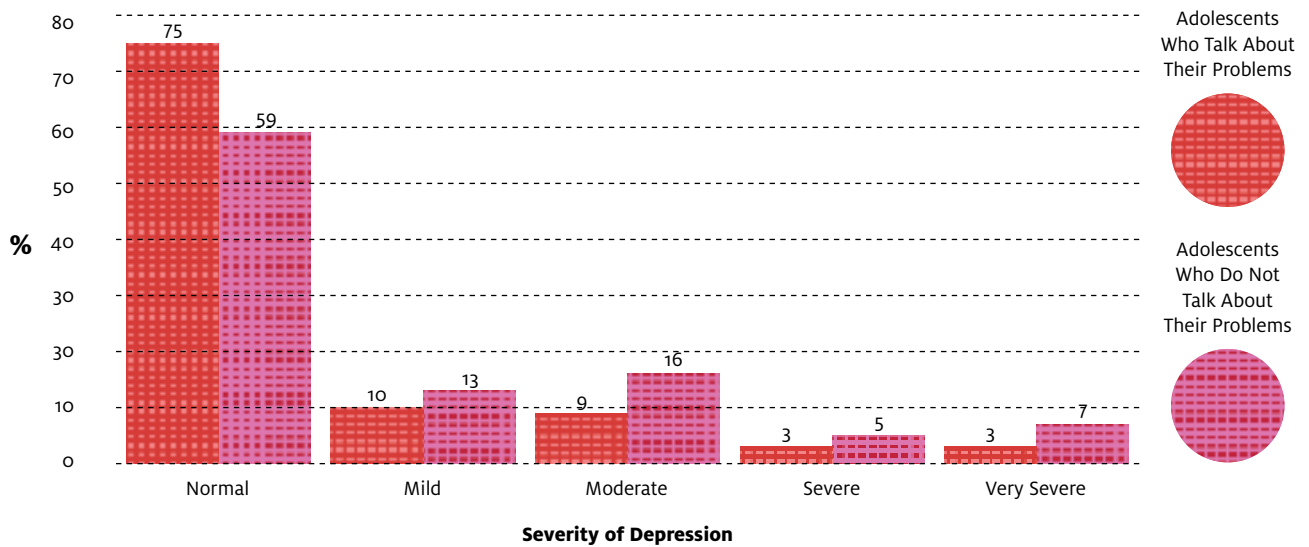


The findings indicate that, when young people are asked about their problems, they display an awareness of their difficulties, as evidenced by the links between perceived severity of problems and psychological distress levels. In general, the more severe the problems reported, the more severe the level of distress. Adolescents displayed a clear ability to identify when their symptoms of distress were severe enough to require professional help.

4.6.6. Informal help-seeking and depression, anxiety, stress

Approximately 65% of adolescents reported that they usually talked about their problems with someone. Those who reported not doing so displayed higher levels of distress, which indicates a relationship between help-seeking behaviour and mental health in adolescence. This effect was strongest for depressive symptoms. Those who reported not talking about their problems reported moderate to very severe depressive symptoms (see Figure 4.43).

Figure 4.43: Depressive symptoms by informal help-seeking behaviour



An almost identical pattern emerged for both symptoms of anxiety (Figure 4.44) and stress (Figure 4.45), whereby those who talked about their problems were more likely to fall within the normal range for anxiety and stress.

Figure 4.44: Symptoms of anxiety by informal help-seeking behaviour

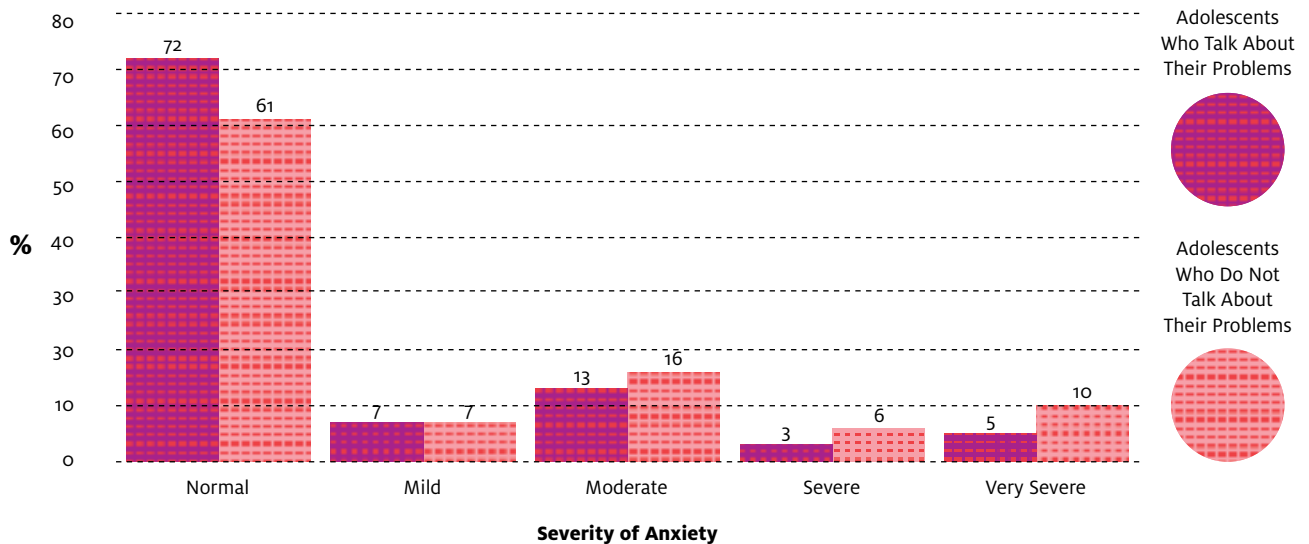
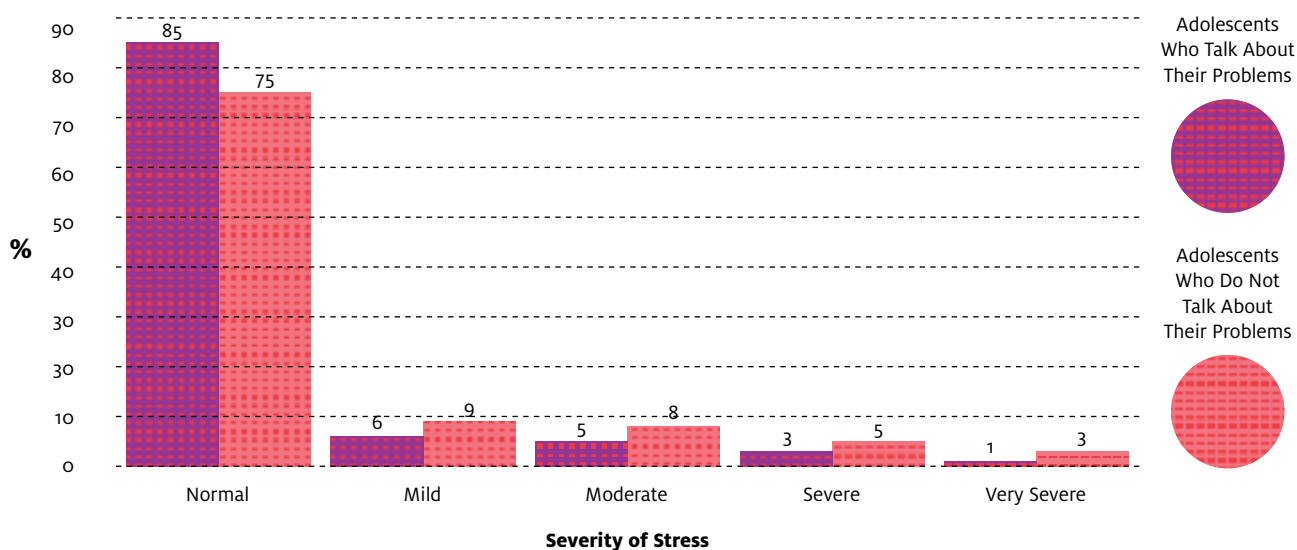


Figure 4.45: Symptoms of stress by informal help-seeking behaviour



4.6.7. Summary

The findings on key self-reported indicators of mental health status indicate that:

- › Adolescents classified as outside the normal range for alcohol consumption were more likely to experience higher levels of depression, anxiety and stress, with the strongest pattern emerging for anxiety.
- › Those who had experienced bullying were more likely to report symptoms of distress outside the normal range.
- › Perceived high availability of a special adult when in need is a protective factor for symptoms of depression and anxiety, while perceived low availability of a special adult is a risk factor for symptoms of stress.
- › Adolescents who ranked themselves at the bottom of the class were more likely to experience more severe symptoms of depression and anxiety, but not stress.
- › Those who perceived that they needed professional help were more likely to fall outside the normal range for depression, stress and anxiety.
- › Adolescents who reported not talking about their problems reported more severe symptoms of distress.

5 / **Methodology For Young Adult Sample**

5.1. Overview

This chapter describes the methodology for the young adult sample (17-25 years) who took part in the MWS-Post Second Level (MWS-PSL) study. It provides an overview of the characteristics of the sample, and outlines the measures included in the survey (for more detailed information on the recruitment procedures and methodology for sample, see Appendix 2).

5.2. Characteristics of the Young Adult Sample

The young adult sample consisted of 8,221 young people ranging in age from 17 to 25 years ($M=20.35$; $SD=1.91$), 35% of whom were male. A total of 17% were aged 17-18, 43% 19-20, 17% 21 and 24% 22-25.

Most (93%) were Irish, 3% were foreign-national residents in Ireland for five years or more, and around 1% were foreign-national residents in Ireland for less than five years. Less than 1% were first-generation Irish. One percent of the sample reported having been adopted.

5.3. Description of MWS-PSL

In general, the MWS-PSL took the same format as the second-level version of the MWS. While most of the scales are identical for both surveys, some are unique to each. Scales described above, common to both surveys, are not reported here. Additional scales included in the MWS-PSL are described below.

5.3.1. Positive and negative domains of psychological functioning

POSITIVE DOMAINS +++++

1) Satisfaction with Life Scale – SWLS

The Satisfaction with Life Scale (SWLS; Diener, Emmons, Larson & Griffin, 1985) is a five-item self-report scale designed to measure life satisfaction. Higher scores on the SWLS indicate greater satisfaction with one's life overall.

NEGATIVE DOMAINS -----

1) Suicidal behaviour

Four questions on suicidal ideation, self-harm and suicide attempt were used to tap into suicidal behaviour. The questions were:

- › 'Have you ever deliberately hurt yourself without wanting to take your life?'
- › 'Have you ever thought that life was not worth living?'
- › 'Have you ever thought about taking your life, even though you would not do it?'
- › 'Have you ever made an attempt to take your life?'

Each question measured lifetime rate and frequency in the past year (i.e. within the last year, within the last six months, within the last month).

The participant was also asked about whether they had accessed help or support after a suicide attempt, how easy it was to get the support they needed, who they approached for support, and whether they felt that accessing support had helped them.

(For a more detailed description of the MWS-PSL methodology, see Appendix 2).

6/ Findings on Young Adults

6.1. Overview

This chapter describes the demographics and characteristics of the young adult sample who took part in the My World Survey Post Second Level (MWS-PSL). It presents data on personal well-being variables as well as risk and protective factors of mental health. Data are also presented on the risk-taking behaviours of young adults. The data are analysed for the overall sample and by gender. Statistical findings are reported at the $p < .01$ level. All data reported are statistically significant. Percentages reported in the Figures presented are rounded to the nearest whole number.

6.2. Demographics

6.2.1. Marital status of young adults

Most of the sample (81%) identified themselves as single, while 13% identified themselves as being in a relationship, and 6% were living with a partner. Less than 1% were married.

6.2.2. Marital status of parents

Most young adults indicated that their parents were married (80%), 13% said 'separated' or 'divorced', 2% 'single' and less than 1% 'remarried', while 1% reported that a parent was deceased.

6.2.3. Number of children in the family

Over two-thirds of the sample (67%) reported that they grew up in a family of 1-3 children, 27% in a family with 4-5 children and 6% in a family with six or more.

6.3. Personal Well-Being

Key personal well-being variables related to young adults' lives were assessed:

- 1) enjoyment of family life
- 2) ability to cope with problems
- 3) having been in trouble with the gardaí
- 4) being stressed by their financial situation
- 5) feeling angry towards themselves and others
- 6) having seen a mental health professional

6.3.1. Enjoying family life

The young adults were asked whether they enjoyed their family life. Two-thirds (66%) reported that they did, 31% that they sometimes did and 3% that they did not. Percentages were similar for males and females.

6.3.2. Coping with problems

Participants were asked if they generally coped well with problems. Just over half (53%) indicated that they did, 40% that they sometimes did, and 7% that they did not. Males (59%) were more likely to state that they coped well than females (49%).

6.3.3. Trouble with the gardaí

The majority of the sample (90%) reported that they had not been in trouble with the gardaí. Of those who had, only 5% reported that the incidence had occurred in the past 12 months. Males were much more likely to have been in trouble with the gardaí than females.

6.3.4. Stressed by financial situation

Overall, 45% of young adults indicated that they were often stressed by their financial situation, and another 14% that they were highly stressed by it.

6.3.5. Anger

Males (16%) were more likely than females (12%) to report having been violent to others.

6.3.6. Seen a mental health professional

Approximately 30% of young adults reported that they had seen a mental health professional (MHP). Females (33%) were more likely to report this than males (24%). Of those who reported it, 56% indicated that they had found it helpful; females (58%) were more likely to report this than males (52%).

6.4. Risk Factors

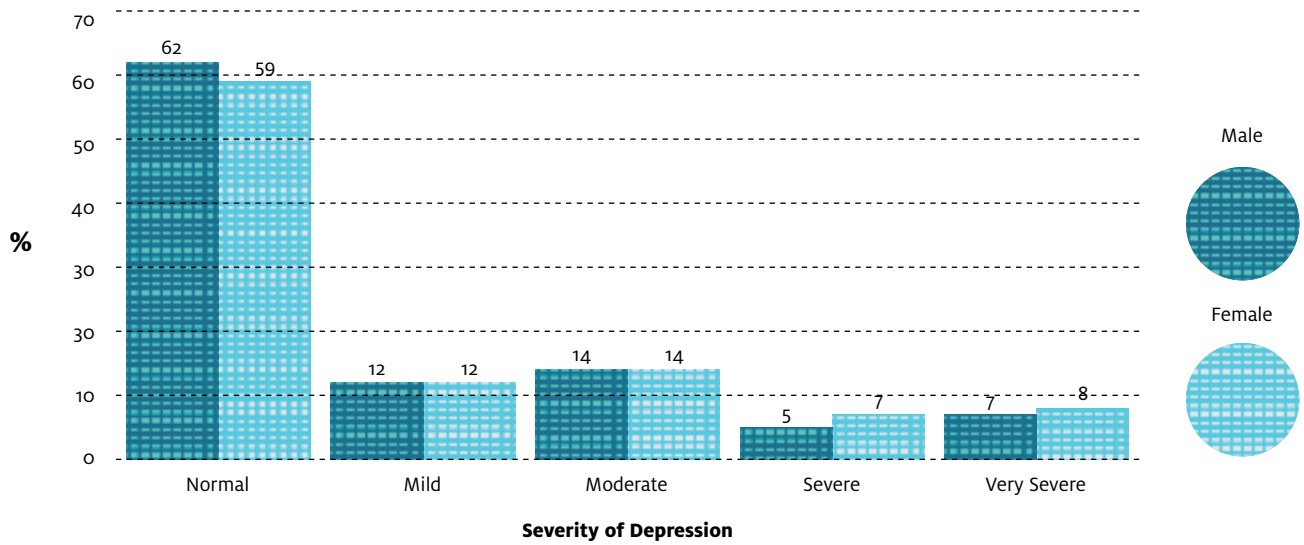
6.4.1. Depression, anxiety and stress

As previously reported, the Depression Anxiety and Stress Scale (DASS-21) was used to measure psychological distress.

Depression categories

Using the DASS cut-offs, 60% of young adults were classified as in the normal range for depression, 12% in the mild range, 14% in the moderate range, and 14% in the severe (6%) to very severe (8%) range. The depression categories by gender are displayed in Figure 6.1.

Figure 6.1: DASS depression categories by gender

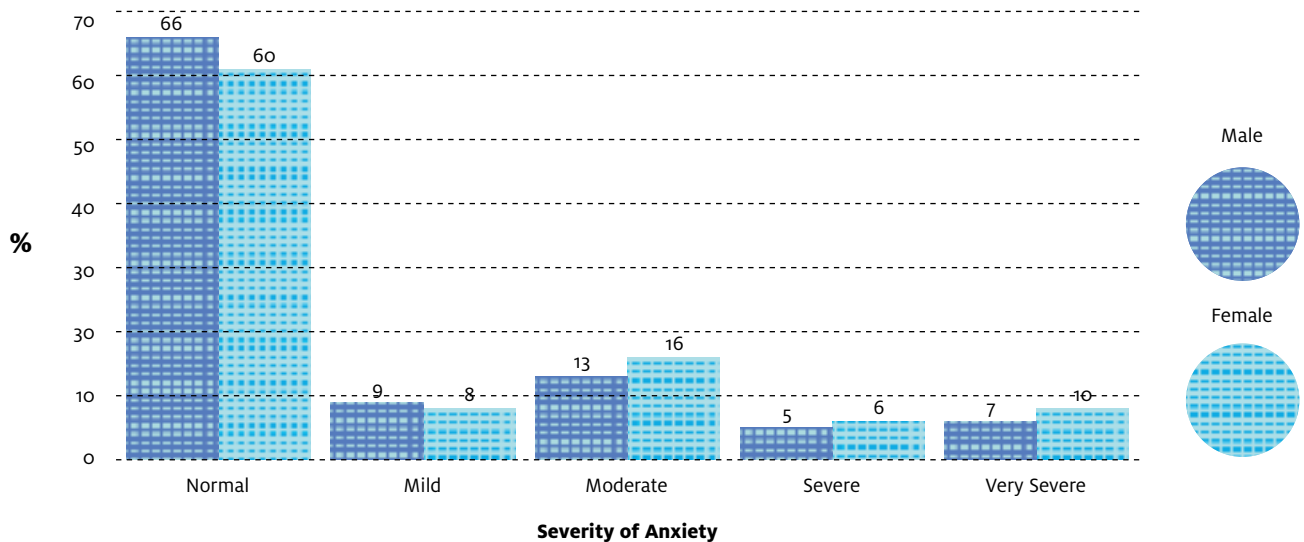


63% of young adults were classified as within the normal range for anxiety.

Anxiety categories

Similar to the breakdown for depressive symptoms, 63% of young adults were classified as within the normal range for anxiety, 8% in the mild range, 15% in the moderate range, 5% in the severe and a further 9% in the very severe range. The gender breakdown is presented in Figure 6.2.

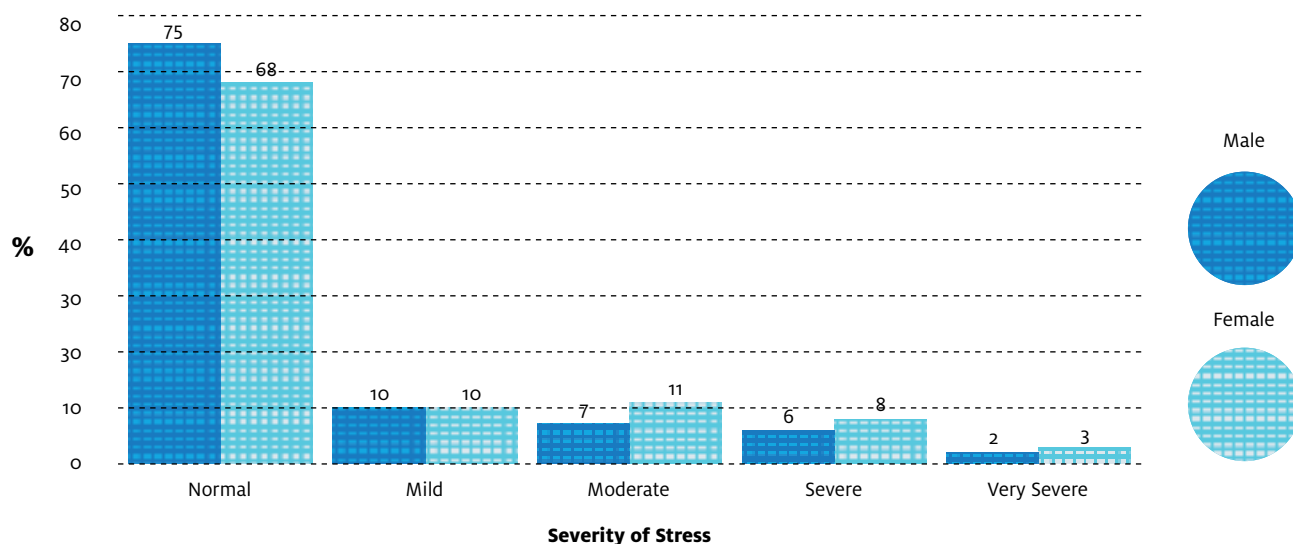
Figure 6.2: DASS anxiety categories by gender



Stress categories

Overall, 70% of the sample were categorised within the normal range for stress, 10% in the mild range, 10% in the moderate range and 10% in the severe (7%) to very severe (3%) range. As shown in Figure 6.3, males (75%) were more likely to fall within the normal range than females (68%).

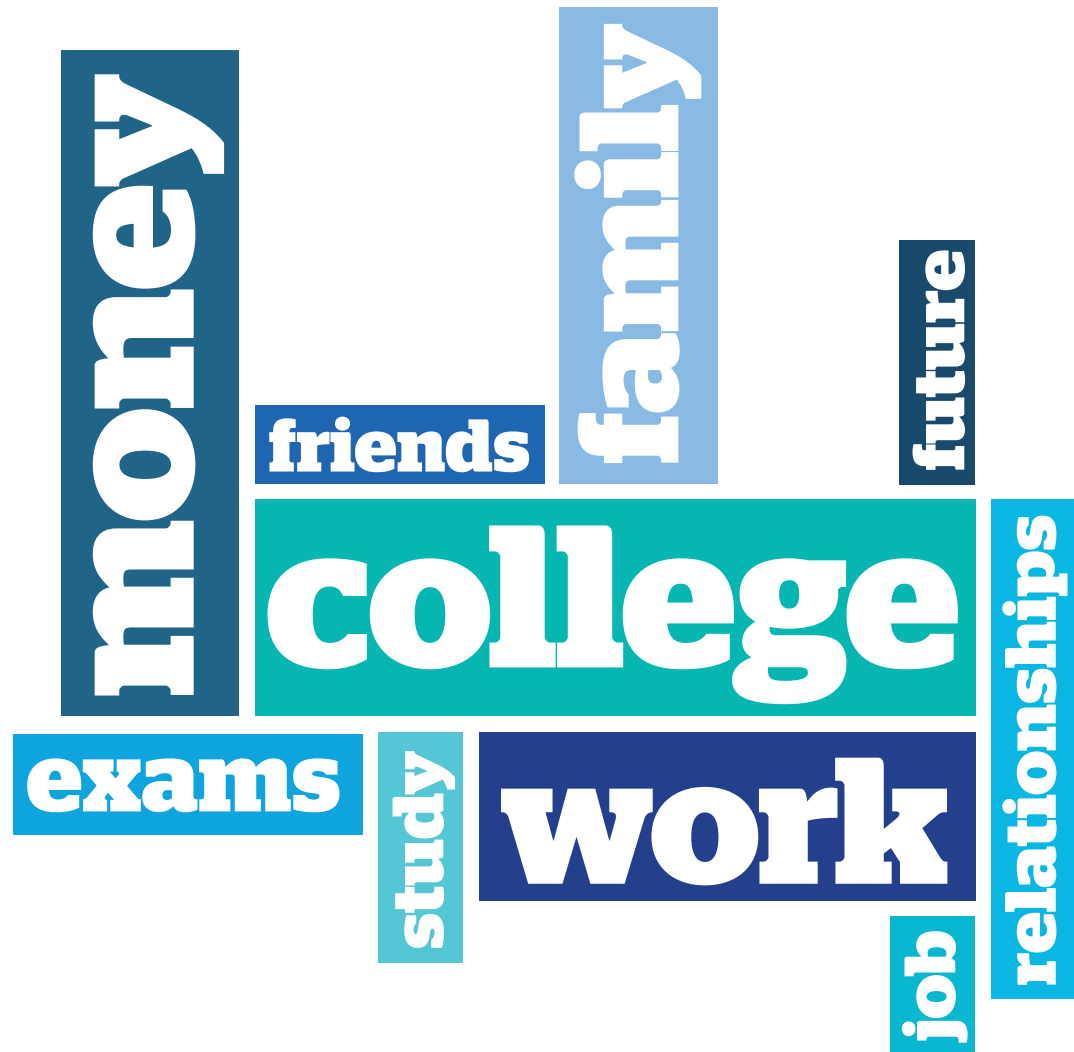
Figure 6.3: DASS stress categories by gender



6.4.2. Top three stressors

The young adults were asked the open-ended question: 'What are the three most significant stressors/problems in your life?' The most frequently reported stressors were: 1) college (the majority of the sample were third-level students) followed by 2) money, 3) work and 4) family (shown in the form of a word cloud in Figure 6.4).

Figure 6.4: Top stressors for young adults



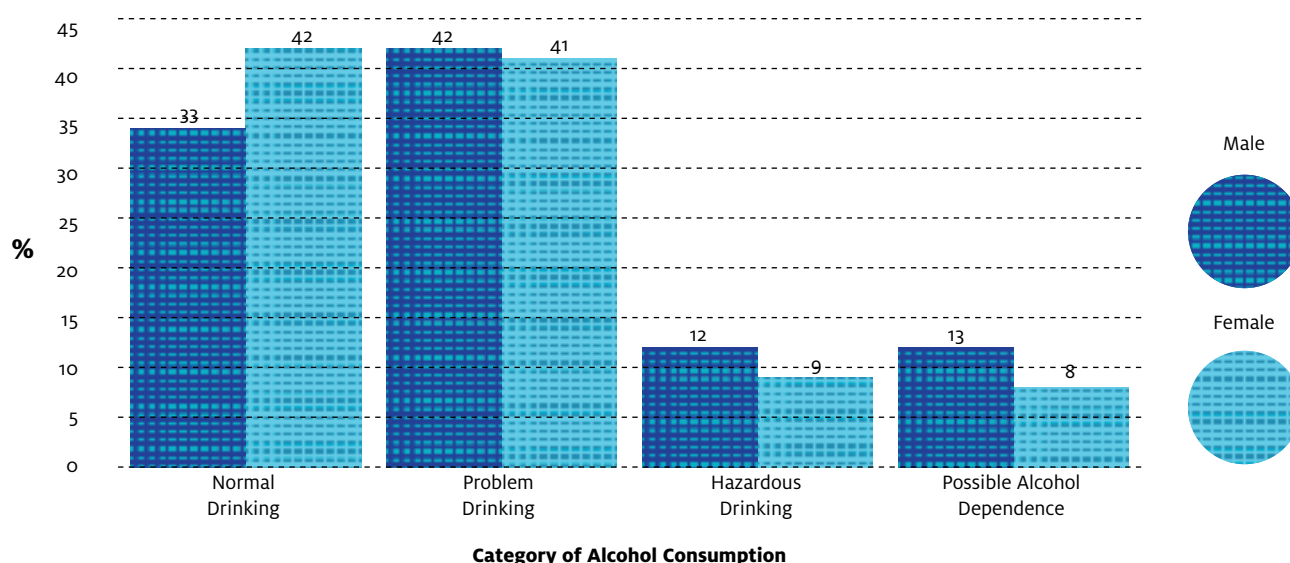
61%

of young adults were outside the normal range for drinking behaviour.

6.4.3. Alcohol behaviour

Young adults' alcohol behaviour was assessed using the Alcohol Use Disorders Identification Test (AUDIT) screening tool for hazardous alcohol consumption (Saunders, Aasland, Babor, de la Fuente & Grant, 1993). According to the AUDIT WHO cut-offs (Babor, Higgins-Biddle, Saunders & Monteiro, 2001), 39% of participants fell into the range for normal drinking behaviour, 41% into the problem drinking range and 10% into the harmful and hazardous drinking range, while 10% were classified as having a potential alcohol dependence. Males (33%) were less likely to be in the normal category for drinking behaviour than females (42%).

Figure 6.5: Alcohol behaviour based on AUDIT cut-offs by gender



6.4.4. Substance misuse

The CRAFFT (Knight, Shrier, Bravender, Farrell, Vander & Shaffer, 1999) was used to detect substance problem use, abuse and dependence. Young adults' mean score on substance misuse ($M=2.31$; $SD=1.66$) fell above Knight et al's cut-off score of 2, indicating high levels of substance misuse. Males reported significantly higher levels of substance use ($M=2.59$; $SD=1.77$) than females ($M=2.12$; $SD=1.57$).

6.4.5. Cannabis use

A total of 45% of young adults reported that they had used cannabis. Males (52%) were significantly more likely to do so than females (42%). Of those who reported taking cannabis, 77% had begun at age 15-19 years.

6.4.6. Suicidal behaviours

Four questions on suicidal ideation, self-harm and suicide attempt were used to tap into suicidal behaviour. Each question measured lifetime rate and frequency in the past year.

Life not worth living

Approximately 43% reported that they had thought that their life was not worth living at some point. A third of participants (33%) reported that they had thought this within the past year, 14% within the past six months, and 18% within the past month. Males (40%) were less likely than females (44%) to report having thought that life was not worth living.

Suicidal ideation

Just over half the sample (51%) had thought about taking their life though they 'would not do it'. Of these, 35% indicated that they had thought about it within the past year and 14% within the past six months or past month. A further 38% reported thinking about it at some other time. No gender effects were found.

Self-harm

More than a fifth of the sample (21%) reported that they had deliberately hurt themselves without wanting to take their life. A quarter of these (26%) reported that it had happened within the past year, 15% within the past six months and 14% within the past month. A further 45% reported that they had

43%

reported that they had thought that their life was not worth living at some point.

21%

reported that they had deliberately hurt themselves without wanting to take their life.



hurt themselves at some other time. Females (24%) were much more likely to report self-harm than males (16%).

Suicide attempt

The majority of young adults (93%) reported that they had never attempted to take their life. Of the 7% who indicated that they had, 24% said it had been within the past year, 12% within the past six months and about 3% within the past month. Males (6%) were less likely to indicate that they had attempted suicide than females (8%).

Support after suicide attempt

More than half of those who attempted to take their life (53%) reported that they did not access help or support. More females (49%) reported having accessed help or support following a suicide attempt than males (42%).

A total of 36% of those who did access help or support found it difficult or very difficult to get the support they needed and 26% found it neither difficult nor easy. Overall, 65% of those who had accessed support reported that it was helpful. More males (76%) than females (63%) indicated that accessing support had been helpful.

6.4.7. Sexuality

In terms of sexual orientation, 89% of participants described themselves as heterosexual, 4% as gay or lesbian and 4% as bisexual, while 3% were 'not sure'. Although 51% of those who described themselves as gay, lesbian or bisexual were 'very comfortable' with their sexuality, 39% were 'less than very comfortable' and another 10% 'not comfortable at all'.

6.5. Protective Factors

6.5.1. Self-esteem

Males reported significantly greater self-esteem overall ($M=29.01$; $SD=5.81$) than females ($M=27.60$; $SD=5.66$).

6.5.2. Coping strategies

Males indicated higher levels of problem-solving/planned coping ($M=17.41$; $SD=5.21$) than females ($M=16.87$; $SD=5.17$), while females reported higher levels of support-focused coping ($M=14.50$; $SD=4.74$ vs. $M=12.39$; $SD=4.51$), and avoidant coping ($M=17.74$; $SD=6.16$ vs. $M=16.41$; $SD=5.92$).

6.5.3. Top three coping strategies

The young adults were asked an open-ended question about 'the top three ways that help you cope when things are tough'. The most frequently reported ways of coping were 1) friends, 2) talking, 3) music, 4) family and 5) exercise (see Figure 6.6).

Figure 6.6: Top coping strategies for young adults



6.5.4. Optimism

The young adults' mean score on optimism was slightly above the mid-point ($M=13.48$; $SD=5.44$), suggesting that overall they were not overly optimistic about their life. Males reported significantly higher levels of optimism ($M=14.05$; $SD=5.25$) than females ($M=13.32$; $SD=5.49$).

6.5.5. Help-seeking behaviour

Sources of help young adults are likely to use

The young adults were asked how likely they would be to use various sources to obtain information or support about their mental health and well-being. Over three-quarters (77%) reported they would be likely to use the internet, 71% friends, and 56% their parents.

Doctors/GPs were the most likely source of formal support, at 46%, followed by psychologist, counsellor or therapist (37%), student counselling services (34%) and a relative (30%). Only 13% indicated that they would use a phone help-line, and just 6% stated they would turn to their lecturer.

Sources of help young adults have used

The young adults were also asked what sources they had actually used to obtain information or support about their mental health and well-being. The internet was the most common source (55%), followed by friends (52%) and parents (45%).

Males reported significantly higher levels of optimism than females.

77%

Over three-quarters (77%) reported they would be likely to use the internet as a source of help.

Doctors/GPs were the most common source of formal support, at 22%, while nearly one-fifth (18%) had seen a psychologist, counsellor or therapist, 17% had turned to a relative and 15% had used student counselling services. Only 3% had consulted a lecturer, and just 2% had used a phone help-line.

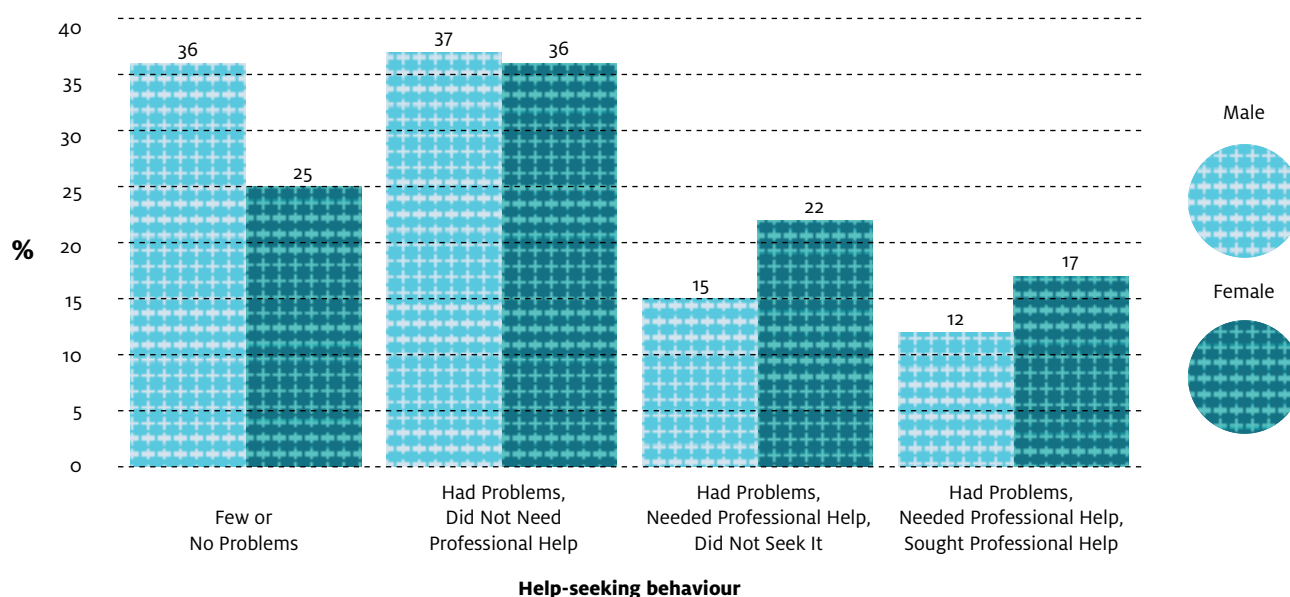
Formal help-seeking

The young adults were asked if they had any serious problems in the past year, whether they had felt they needed professional help for these problems and whether or not they had sought professional help. Approximately 29% reported that they had few or no problems in the past year and 36% that they had some problems but not felt that they needed professional help. A fifth (20%) indicated that they had problems but did not seek professional help despite feeling that they needed it. Finally, 15% of participants indicated that they had problems and had sought professional help.

It is clear from Figure 6.7 that there is an association between gender and help-seeking behaviour:

- › Males (36%) were much more likely to report that they had few or no problems than females (25%).
- › Females (22%) were more likely to report that they had problems and did not seek help even though they needed it, compared to males (15%).
- › However, females (17%) were also more likely to report that they had problems and had sought professional help than males (12%).

Figure 6.7: Formal help-seeking by gender



A fifth (20%) indicated that they had problems but did not seek professional help despite feeling that they needed it.

Informal help-seeking

Over a third (37%) reported that they did not talk about their problems. Males were less likely to talk about their problems than females.

6.5.6. Satisfaction with life

The young adults' mean score on satisfaction with life was marginally above the mid-point ($M=21.46$; $SD=6.33$; range 5-35), which may suggest that they were not very satisfied with their life. No gender differences were reported.

6.5.7. Social support

Females reported significantly higher levels of perceived social support overall ($M=62.75$; $SD=16.08$) than males ($M=59.14$; $SD=14.45$).

Females ($M=21.03$; $SD=5.84$) reported significantly higher levels of perceived support from their friends ($M=20.02$; $SD=5.30$). Again, females ($M=21.73$; $SD=6.46$) reported significantly higher levels of perceived support from a significant adult in their lives than males (19.62 ; $SD=6.46$).

6.6. Key Indicators of Mental Health Status

To obtain a comprehensive picture of young adults' mental health, analyses were carried out comparing depression, anxiety and stress levels across a number of key self-reported variables: 1) alcohol behaviour, 2) self-harm, 3) sexuality, 4) perceived support from a special adult, and 5) formal help-seeking.

6.6.1. Alcohol behaviour and depression, anxiety, stress

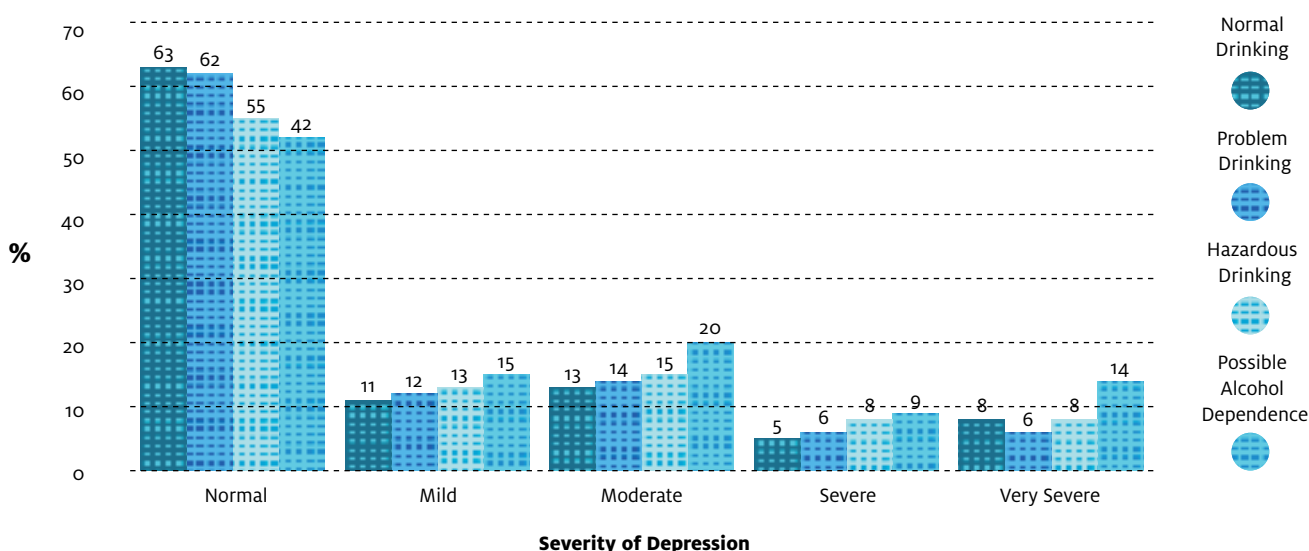
Using the AUDIT WHO (Babor, Higgins-Biddle, Saunders & Monteiro, 2001) recommended cut-offs, 40% of young adults were in the normal range for alcohol use, 41% in the problem drinking range and 10% in the hazardous drinking range, while 10% were classified as 'possibly alcohol-dependent'.

Analyses revealed a clear link between hazardous levels of alcohol behaviour and psychological distress. Alcohol behaviour was found to be strongly associated with depression. Young adults in the normal drinking range were more likely to fall within the normal range for depression (63%), while those classified as possibly alcohol-dependent were much more likely to report elevated levels of depression (Figure 6.8).

Young adults in the normal drinking range were more likely to fall within the normal range for depression (63%)

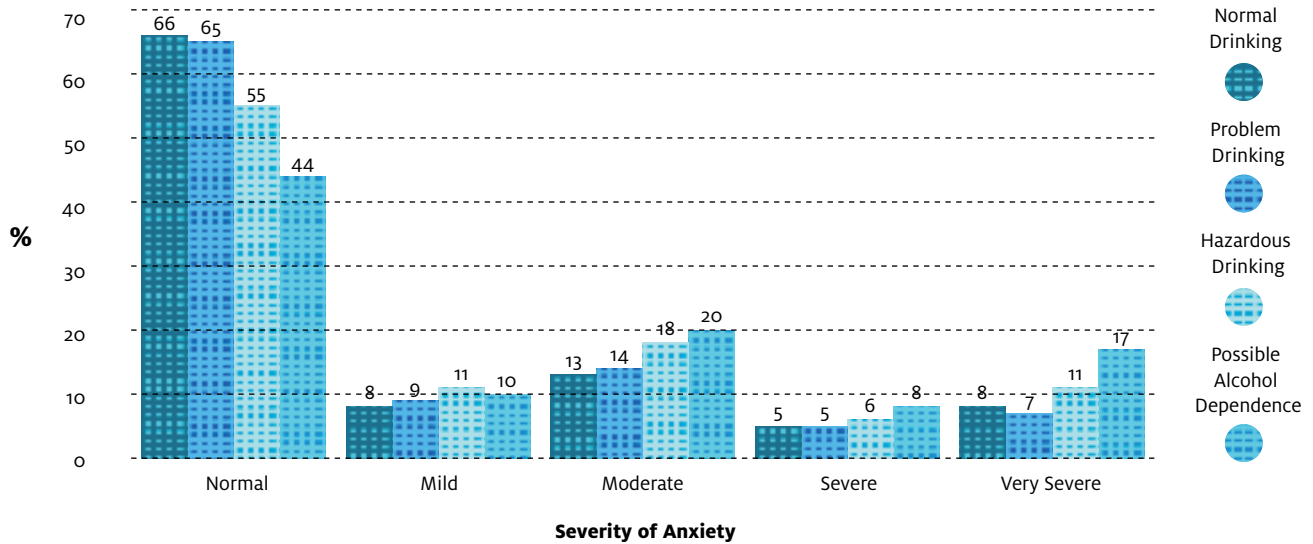
63%

Figure 6.8: Depressive symptoms by alcohol behaviour



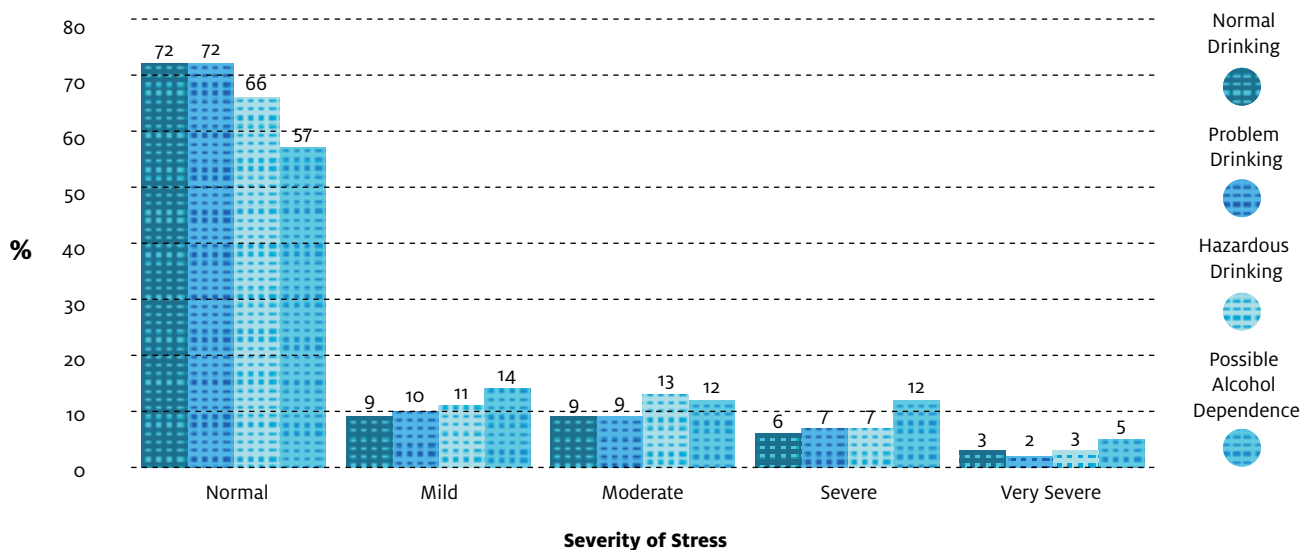
The strongest association was found between alcohol behaviour and symptoms of anxiety. Young adults classified as possibly alcohol-dependent were much less likely to report scores in the normal range for anxiety – 44% compared to 66% of those within the normal drinking category.

Figure 6.9: Symptoms of anxiety by alcohol behaviour



A similar pattern emerged for stress. About 12% of those classified as possibly alcohol-dependent were found to report stress levels in the severe range, compared to only 6% of those classified as having normal drinking behaviour (Figure 6.10).

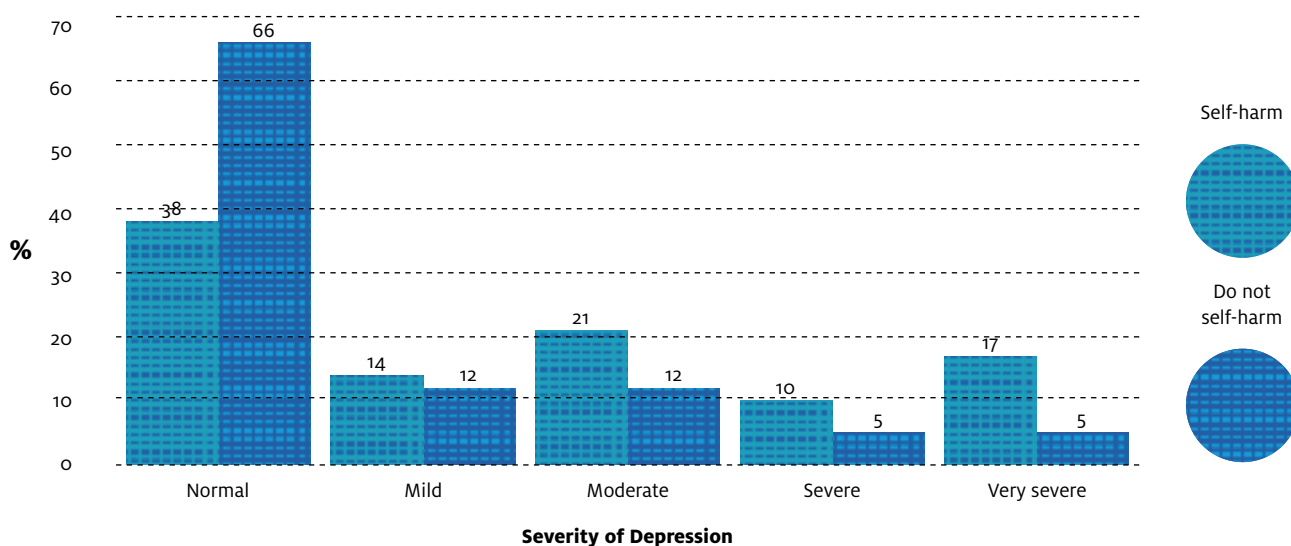
Figure 6.10: Stress symptoms by alcohol behaviour



6.6.2. Self-harm and depression, anxiety, stress

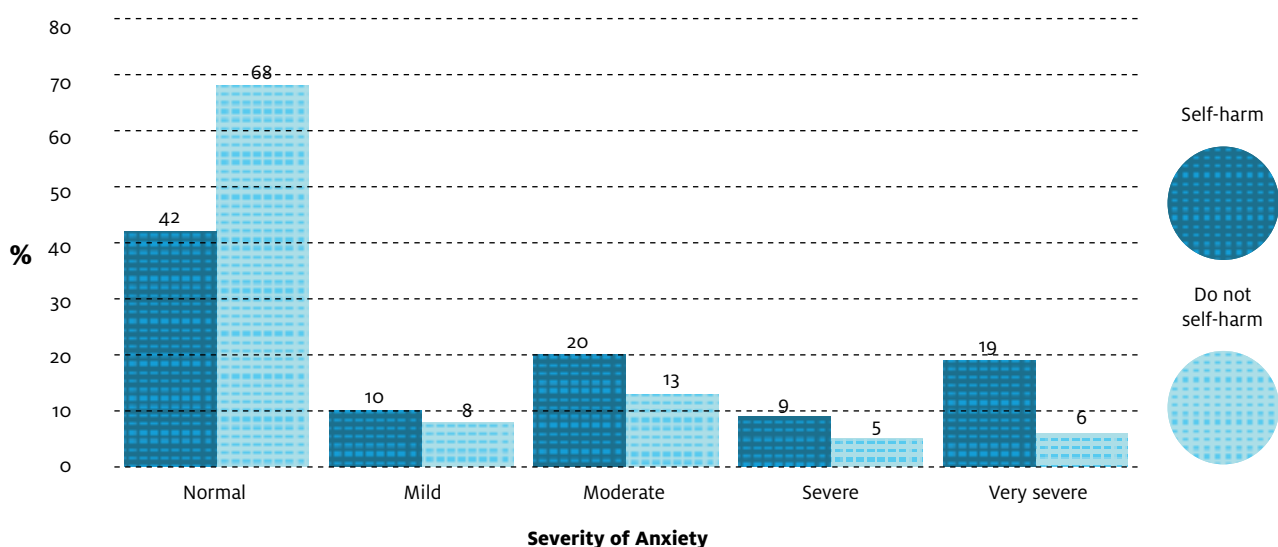
Just over a fifth (21%) of young adults indicated that they had engaged in self-harm. There was a clear link between self-harm and psychological distress. A very strong relationship was observed between self-harm and depression. Young adults who reported self-harm were much more likely to indicate moderate (21%), severe (10%), or very severe levels of depression (17%) (Figure 6.11).

Figure 6.11: Depressive symptoms by self-harm



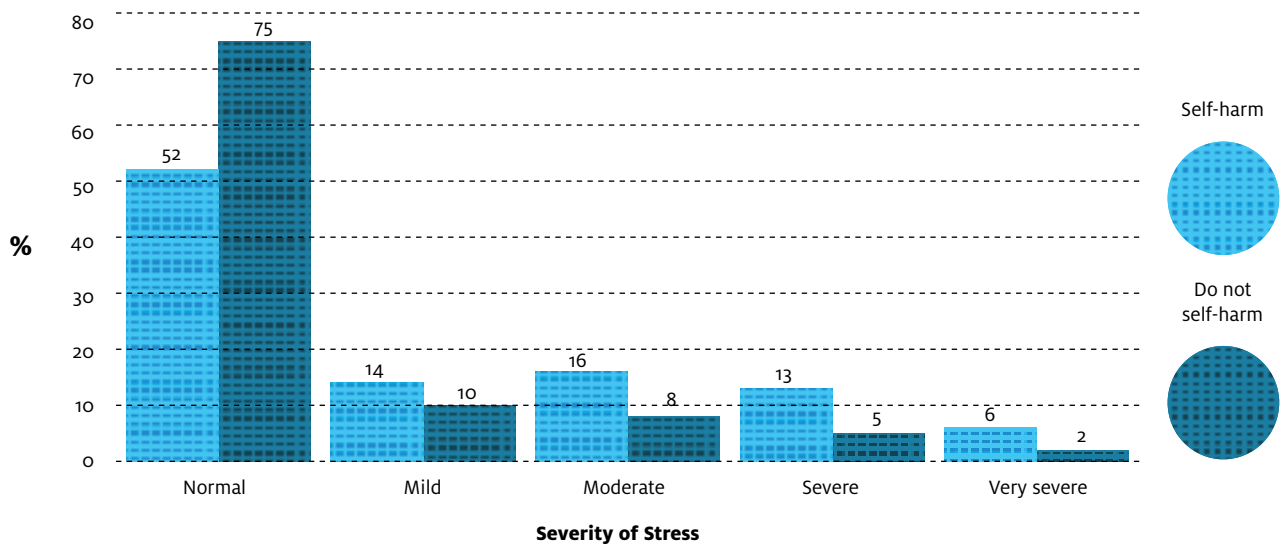
As shown in Figure 6.12, there was also a strong relationship between self-harm and reported levels of anxiety.

Figure 6.12: Symptoms of anxiety by self-harm



Again, as can be seen in Figure 6.13, there was a clear link between self-harm and reported stress levels.

Figure 6.13: Stress symptoms by self-harm



6.6.3. Sexuality and depression, anxiety, stress

Overall, 89% of participants described themselves as heterosexual, 4% as gay or lesbian and 4% as bisexual, while 3% were 'not sure'. A clear link emerged between sexual orientation and psychological distress.

A significant relationship was found between sexual orientation and depression, anxiety and stress (see Figures 6.14-6.16). Young adults who described themselves as heterosexual were more likely to report normal levels of distress, while those who described themselves as gay or lesbian, bisexual or were not sure of their sexuality were less likely to do so.

Figure 6.14: Depressive symptoms by sexuality

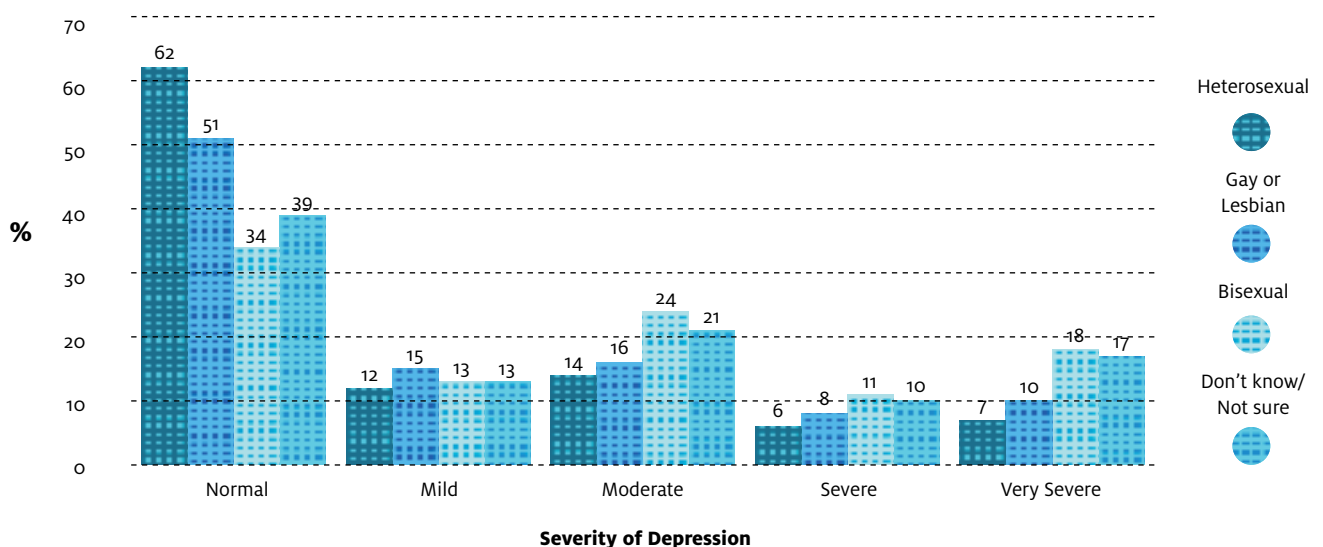


Figure 6.15: Symptoms of anxiety by sexuality

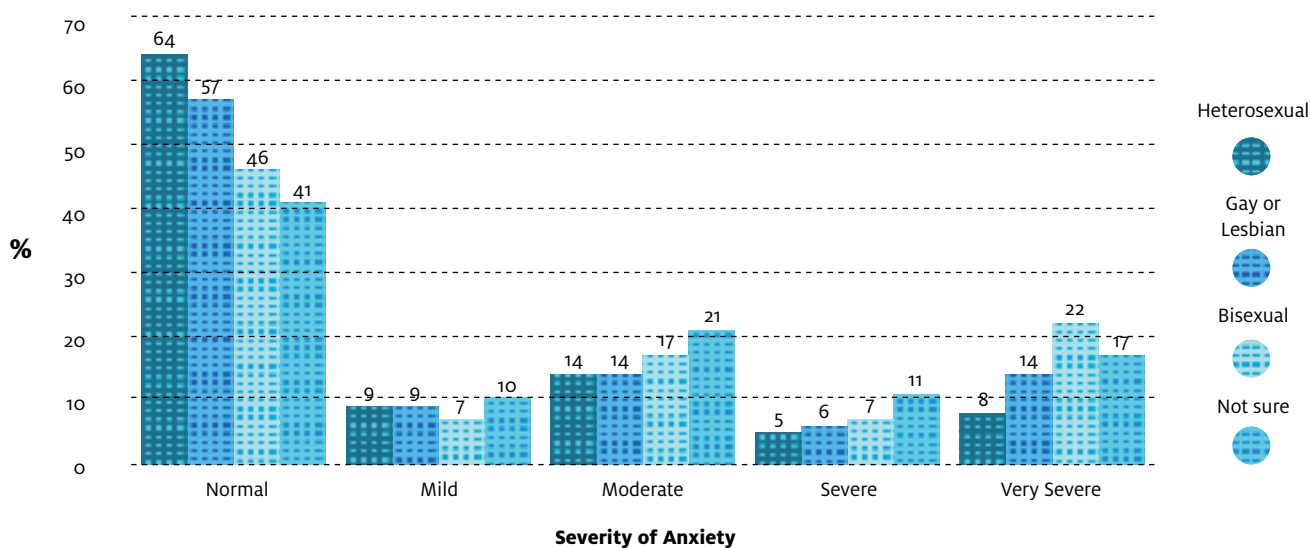
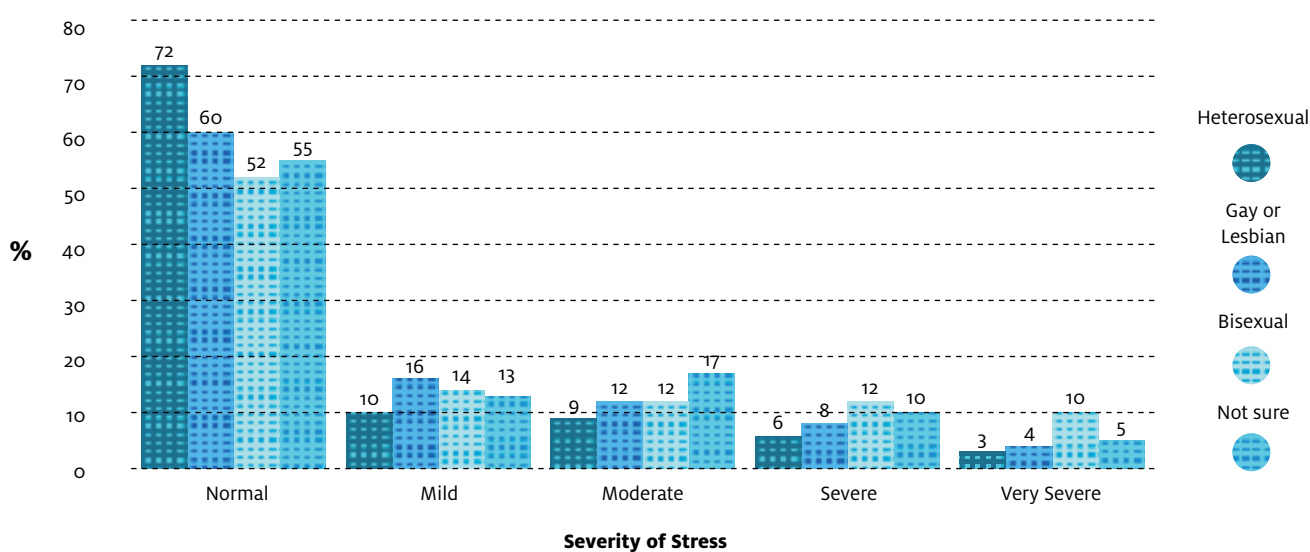


Figure 6.16: Stress symptoms by sexuality



The strongest association was observed between sexual orientation and anxiety (see Figure 6.15).

It is evident from the data that those who reported that they were bisexual were particularly vulnerable, being much more likely to indicate severe or very severe mental distress. In addition, those who were not sure of their sexuality were less likely to be in the normal range for depression, anxiety and stress.

6.6.4. Perceived support from a special adult when in need

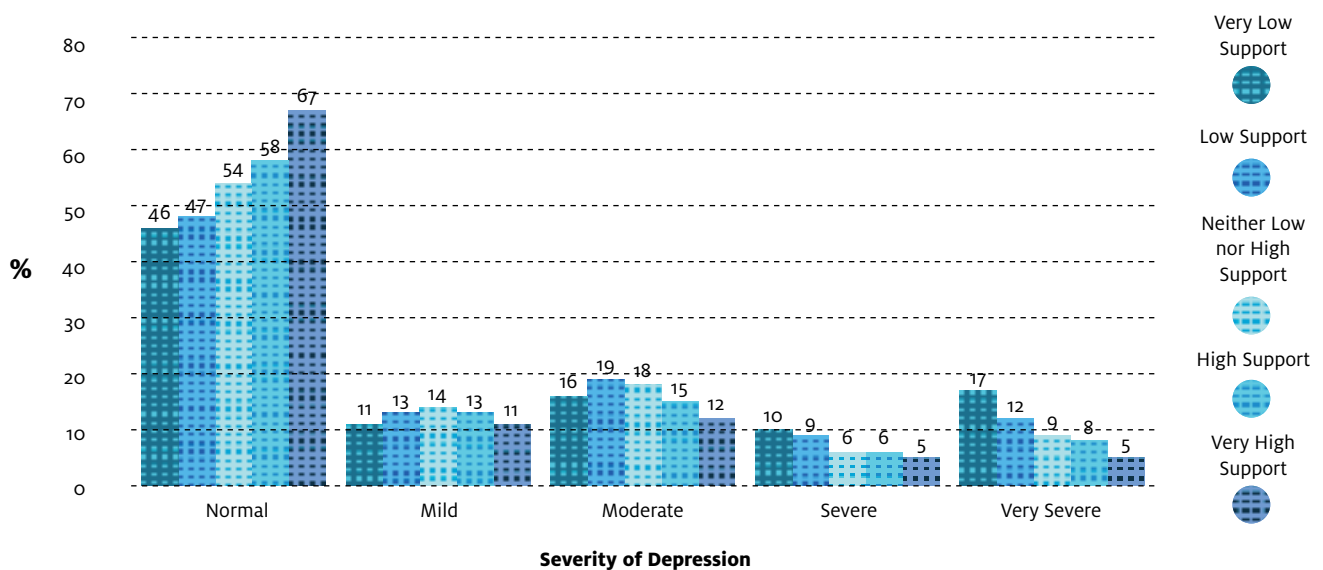
The young adults were asked to rate if there was a special adult around when they were in need. Based on their responses, they were categorised into five groups:

- › those who perceived very high support from a special adult (47%)
- › those who perceived high support (25%)
- › those who perceived neither high nor low support (10%)
- › those who perceived low support (8%)
- › those who perceived very low support (10%)

These perceived levels of support were significantly related to symptoms of psychological distress. The effect was strongest for depression. Young adults who reported high support from a special adult when in need were much more likely to report normal levels of depression, while those who reported low or very low support were much more likely to indicate moderate, severe or very severe levels of depression (Figure 6.17).

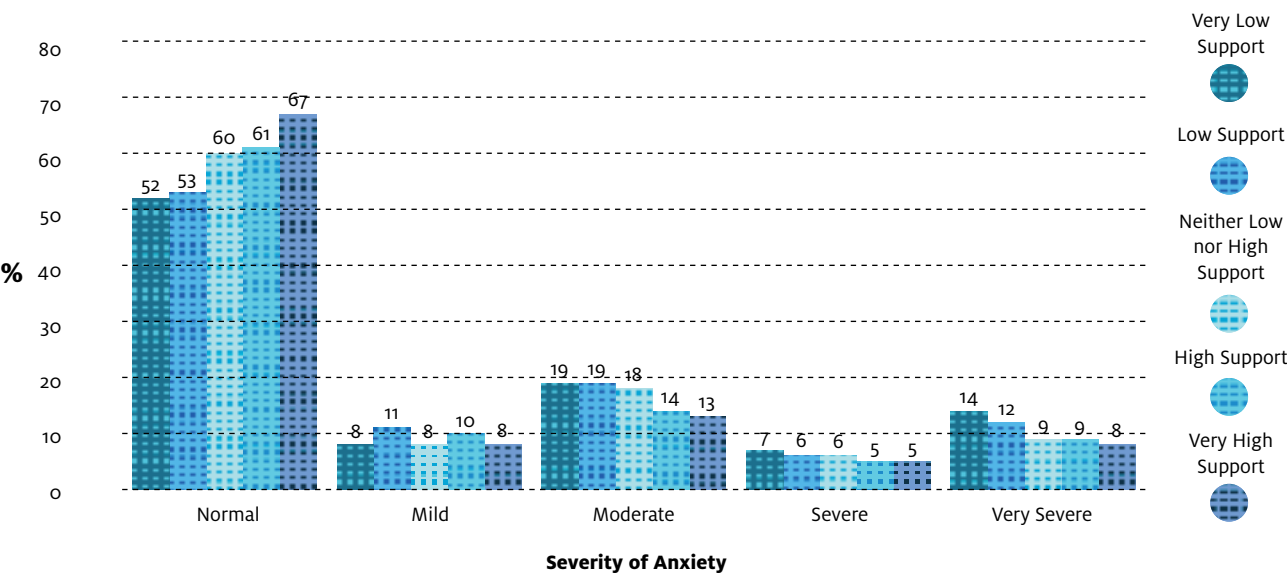
While only 5% of those who reported very high support scored in the very severe range for depression, 17% of those with very low support scored in this range (Figure 6.17).

Figure 6.17: Depressive symptoms and support from a special adult



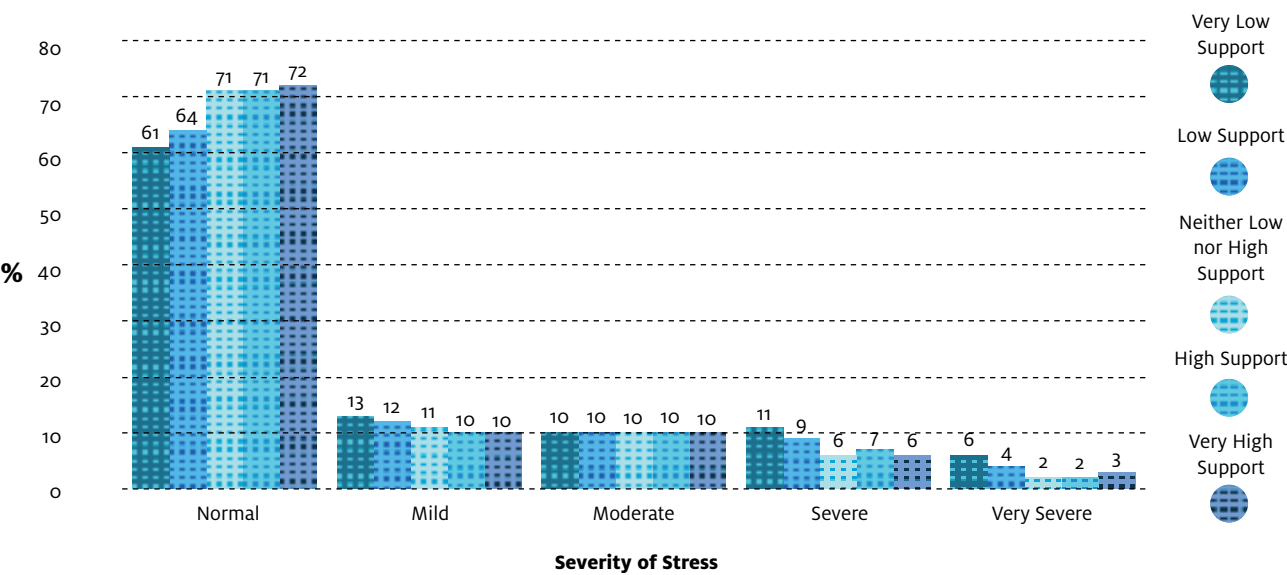
As can be seen in Figure 6.18, there was also a significant relationship between the support of a special adult and anxiety.

Figure 6.18: Symptoms of anxiety and support from a special adult



Again, this relationship was observed for stress. Those who reported receiving very low support from a special adult were less likely to report normal levels of stress (Figure 6.19).

Figure 6.19: Stress symptoms and support from a special adult



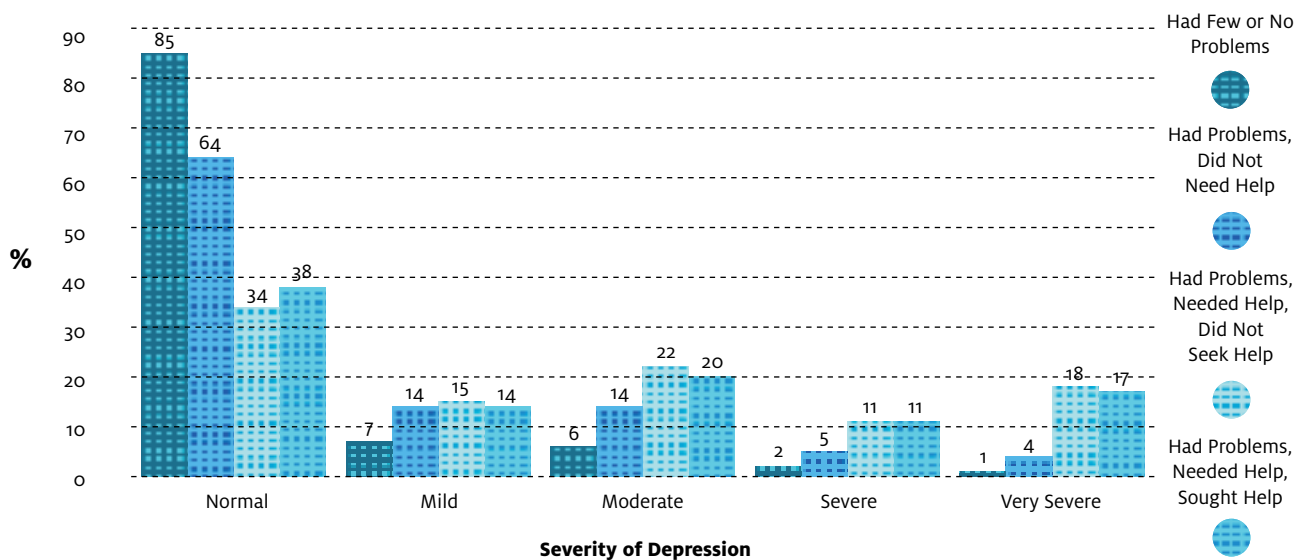
The absence of support from a special adult when in need is most strongly linked to depression; those who reported very little support were found to be much more likely to indicate very severe levels of depression, anxiety and stress.

Thus, support from a special adult when in need is a protective factor for young adults' mental health.

6.6.5. Formal help-seeking and depression, anxiety, stress

As can be seen in Figure 6.20, a very strong relationship between help-seeking and depression was evident. Young adults who reported that they had few or no problems were much more likely to score in the normal range for depression, while those who reported not seeking help although they needed it, and those who had sought professional help were much more likely to indicate severe and, in particular, very severe levels of depression.

Figure 6.20: Depressive symptoms by formal help-seeking behaviour



Help-seeking was also associated with lower levels of anxiety and stress (see Figures 6.21 and 6.22).

Figure 6.21: Symptoms of anxiety by formal help-seeking behaviour

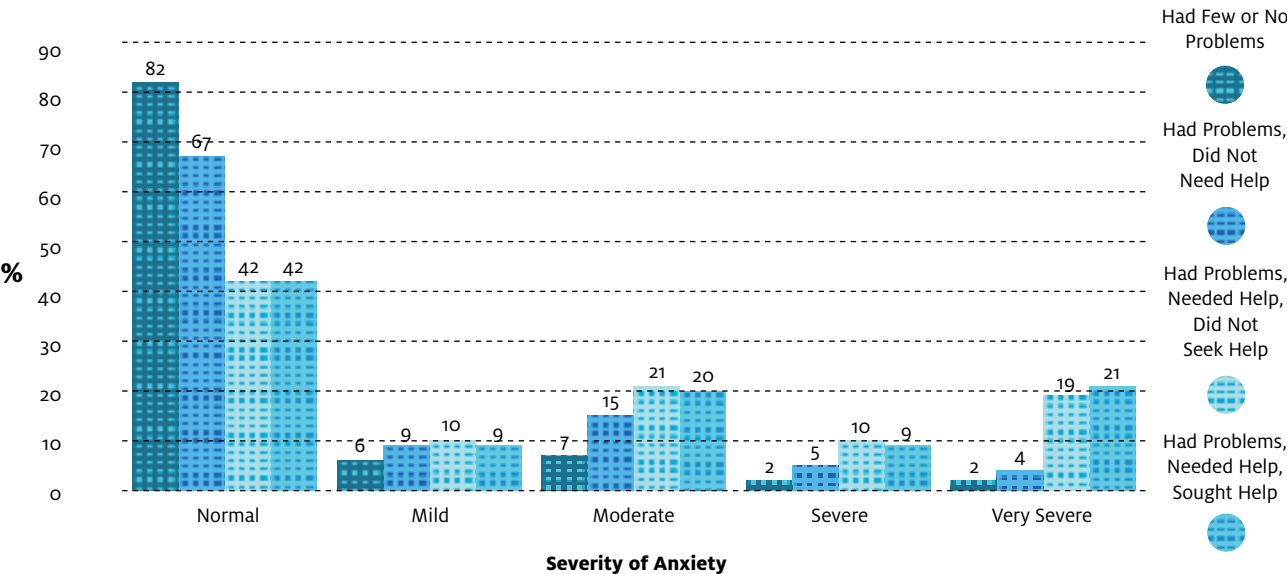
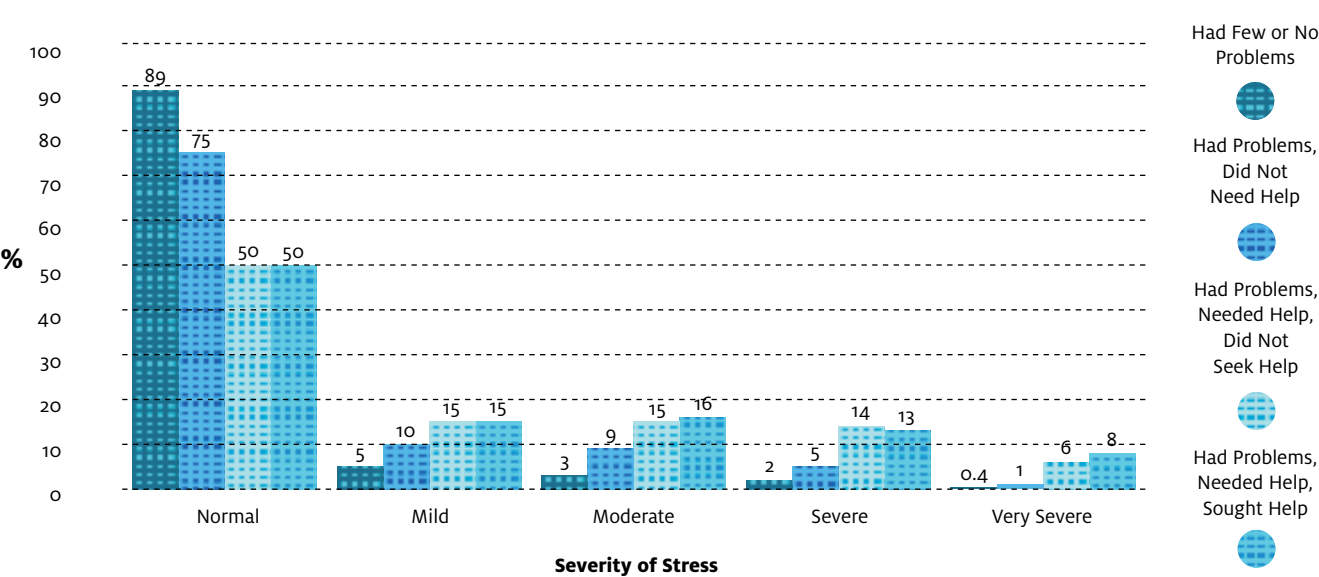


Figure 6.22: Stress symptoms by formal help-seeking behaviour



It is evident from the data that young adults who had some problems and sought help and those who reported not seeking help although they needed it displayed a similar level of psychological distress.

The strongest association was observed between help-seeking behaviour and depression. Just under a fifth of young adults who did not seek help reported very severe levels of depression. Those who had not sought help were also much more likely to indicate very severe levels of anxiety and stress.

Overall, the data suggest that when young people are asked about their problems, they display good awareness of their difficulties, as is apparent from the links between perceived severity of problems and psychological distress levels.

6.6.6. Summary

The findings on key self-reported indicators of mental health status for young adults indicate that:

- › Young adults classified as possibly alcohol-dependent were much less likely to report scores in the normal range for anxiety.
- › There was a clear link between self-harm and psychological distress.
- › A significant relationship was found between sexual orientation and depression, anxiety and stress.
- › Young adults who reported high support from a special adult when in need were much more likely to report normal levels of depression.
- › Just under a fifth of young adults who did not seek help reported very severe levels of depression.

7 / Key Trends for Young People Overall

- Age 12 to 25

7.1. Overview

This chapter looks at the trends that emerge across the entire 12 to 25 year-old My World Survey (MWS) sample. The results presented thus include:

- › the 12 to 19 year-old cohort who completed the My World Survey Second Level (MWS-SL)
- › the 12 to 19 year-old cohort who completed the My World Survey First Level (MWS-FL)
- › the 17 to 25 year-old cohort who completed the My World Survey Post-Second Level (MWS-PSL)

The data are separated into a number of common risk and protective factors that could affect young people's mental health and well-being.

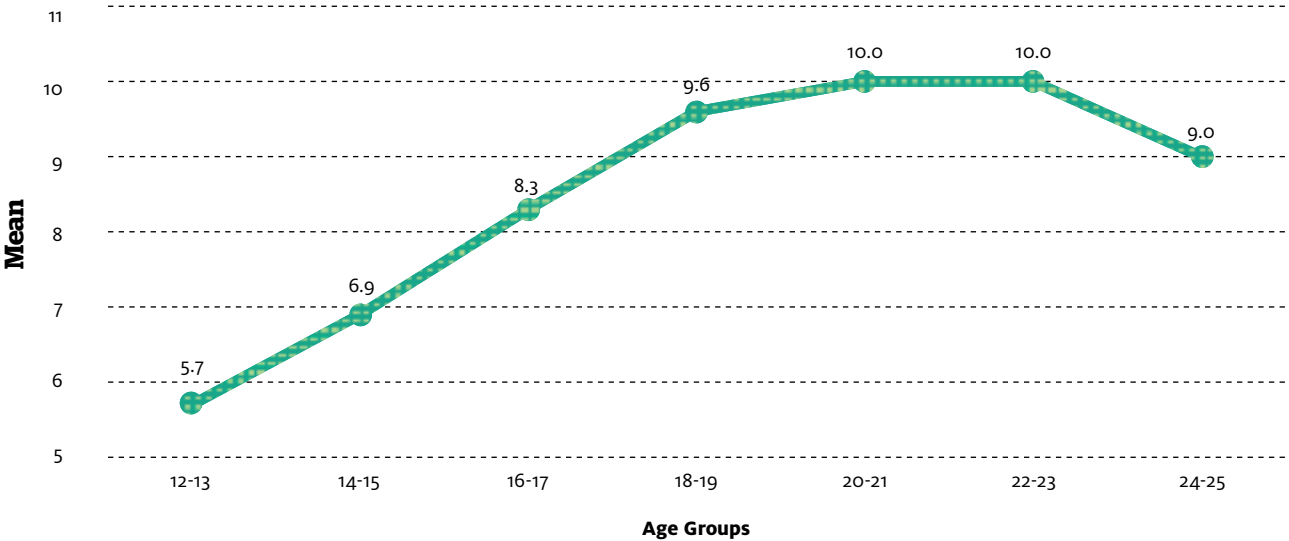
7.2. Common Risk Factors

7.2.1. Depression, Anxiety & Stress Scales (DASS)

Depression

There were significant differences between the levels of self-reported depression across age groups. Scores ranged from 0 to 42 ($M=8.8$, $SD=9.3$), with scores of 0 to 8 regarded as within the normal range for depression. Figure 7.1 indicates that depression was lowest for those aged 12-13 years ($M=5.7$, $SD=8.1$) and gradually increased up to the ages of 20-21 ($M=10$, $SD=9.7$) and 22-23 years ($M=10$, $SD=9.5$), where levels of depression moved marginally outside the normal range.

Figure 7.1: DASS depression scores across age groups



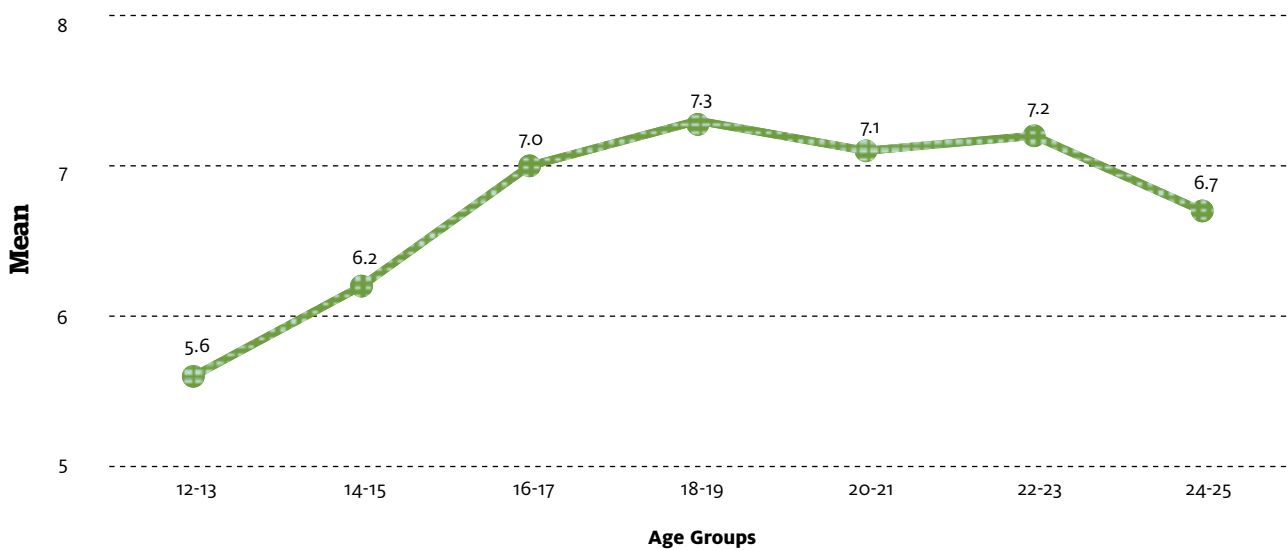
The levels of depression for these 20-23 year-olds were significantly higher than for those aged 12-17. While depression levels decrease at 24-25 years, they remain significantly higher than for those aged 12-15.

Anxiety

There were significant age differences found in self-reported levels of anxiety. Scores ranged from 0 to 42 ($M=6.8$, $SD=7.5$), with scores above 7 regarded as outside the normal range.

Figure 7.2 shows that, similar to depression, anxiety is lowest at 12-13 years ($M=5.6$, $SD=7.1$). However, unlike stress and depression, anxiety levels begin to peak at the earlier age of 16-17 ($M=7.0$, $SD=7.6$), where scores level off and remain relatively stable from 16 through to 23 years. A similar pattern to depression is again evident, where anxiety levels fall slightly at 24-25 years.

Figure 7.2: DASS anxiety scores across age groups



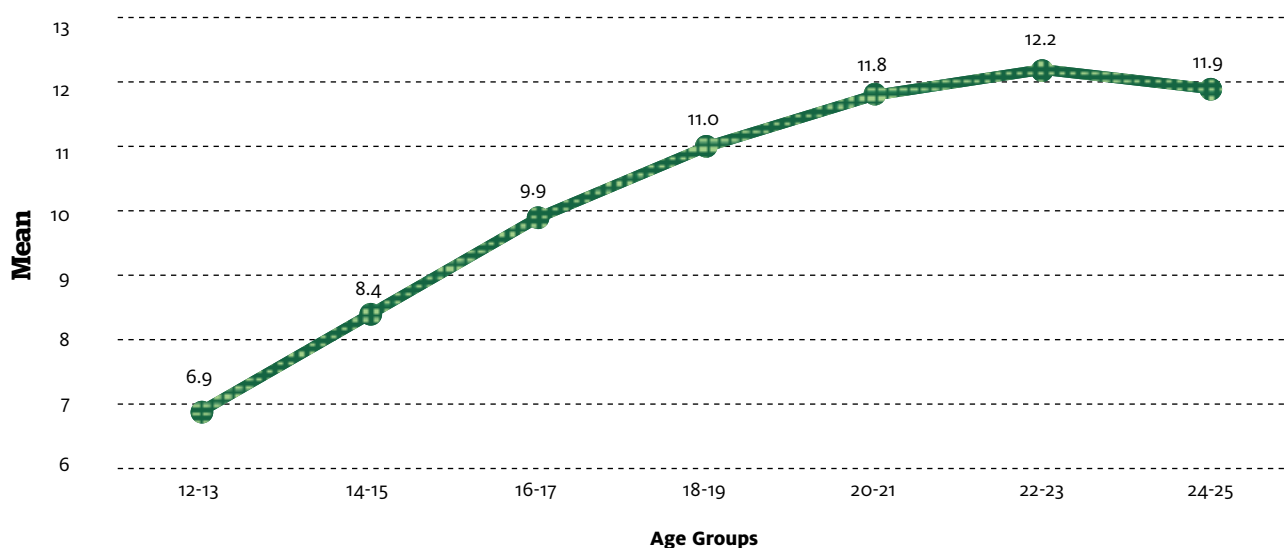
Throughout the 16-23 age group, anxiety is higher than for those aged 12-15, indicating that as young people move beyond 15 their anxiety increases. In addition, between 18 and 23, young people were marginally outside the normal range of anxiety as a group, with levels only falling back into the normal range at 24-25 years ($M=6.7$, $SD=7.6$).

Stress

Significant age differences were found in stress levels. Scores for stress ranged from 0 to 42 ($M=10.4$, $SD=8.9$), with scores of 0 to 13 within the normal level of stress.

As can be seen in Figure 7.3, stress levels were lowest at 12-13 years ($M=6.9$, $SD=7.8$), with year-on-year increases evident up to 22-23 ($M=12.2$, $SD=9.1$) where stress levels were highest. At this peak, stress levels were significantly higher than for those aged 12-19. Although stress decreased at 24-25 years ($M=11.9$, $SD=9.2$), this level of stress also remained significantly higher than for those aged 12-17.

Figure 7.3: DASS stress scores across age groups



These results suggest that, as young people move through their teens and into their early 20s, their stress levels increase. However, the increases in stress levels do not lead to any age group moving out of the normal range.

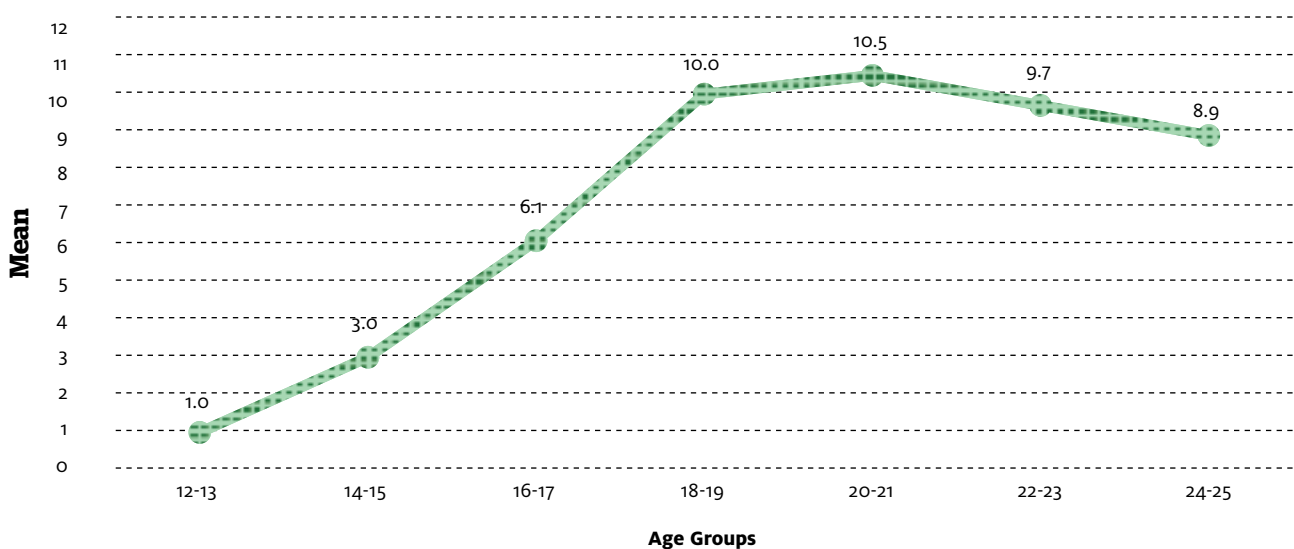
7.2.2. Alcohol Consumption

Alcohol behaviour

Significant age differences were found in self-reported levels of alcohol consumption. Scores ranged from 0 to 40 ($M=7.6$, $SD=7.1$), with scores of 7 or below considered to be normal drinking behaviour.

It can be seen in Figure 7.4 that alcohol consumption is at its lowest at 12-13 years ($M=1$, $SD=3.4$), but consumption increases up to the ages of 18 to 21, where levels move out of the normal range. At both 18-19 ($M=10$, $SD=6.8$) and 20-21 years ($M=10.5$, $SD=6.9$), alcohol consumption is at its peak and reported levels are significantly higher than for those aged 12-17.

Figure 7.4: AUDIT alcohol consumption scores across age groups



While consumption levels show a slight decrease from 22 to 25 years, they do not move back into the normal range. In fact, at both 22-23 ($M=9.7$, $SD=6.6$) and 24-25 years ($M=8.9$, $SD=6.1$), consumption levels are also significantly higher than for those aged 12-17.

These results indicate that, in general, from 18-19 years of age, young people in Ireland move outside the normal range of alcohol consumption and remain above it until at least age 25.

This developmental trend toward higher alcohol consumption is further evident when we look at the association between age and alcohol consumption.

Those aged 12-17 are significantly more likely to be within the normal range while all age groups above this – that is, those aged between 18 and 25 – are less likely to be within the normal range. In fact, 18-21 year-olds are more likely to be in the problem drinking, hazardous drinking and possible alcohol dependence categories. Further, 22-23 year-olds are more likely to fall within the problem drinking or possible alcohol dependence category, while 24-25 year-olds are more likely to fall within the problem drinking category.

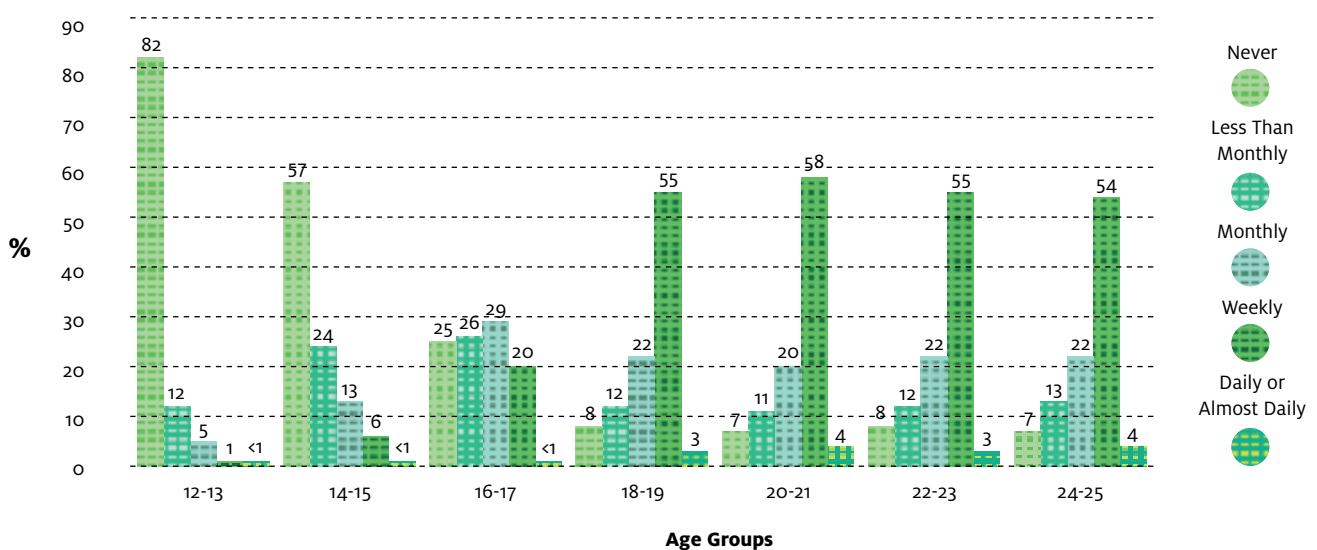
Frequency of alcohol use

Young people were asked how often they drank alcohol (never, less than monthly, monthly, weekly, or daily/almost daily). Looking at age and alcohol use across the entire sample in Figure 7.5, a significant association was observed:

- › At earlier ages, reported levels of alcohol use are low; 12-13 year-olds are more likely to have 'never' drunk alcohol (82%), while 13-14 year-olds are more likely to report either 'never' drinking (57%) or drinking 'less than monthly' (24%).
- › While 16-17 years-olds also reported being more likely to drink 'less than monthly', for the first time we see an age group reporting that they are more likely to drink 'monthly' (29%).
- › With 18-19 year-olds, we see a further increase in alcohol use – they not only report being more likely to drink 'weekly' (55%) but also 'daily or almost daily' (3%).

Alcohol use continues to remain high from 20 to 25, where, at each age group, young people report being more likely to drink on a 'weekly' or 'daily or almost daily' basis.

Figure 7.5: Alcohol use across age groups



Looking at Figure 7.5 (above), we can see that:

- › 55% of 18-19 year-olds, 58% of 20-21 year-olds, 55% of 22-23 year-olds and 54% of 24-25 year-olds report drinking 'weekly'.
- › 3% of 18-19 year-olds, 4% of 20-21 year-olds, 3% of 22-23 year-olds and 4% of 24-25 year-olds report drinking 'daily or almost daily'.

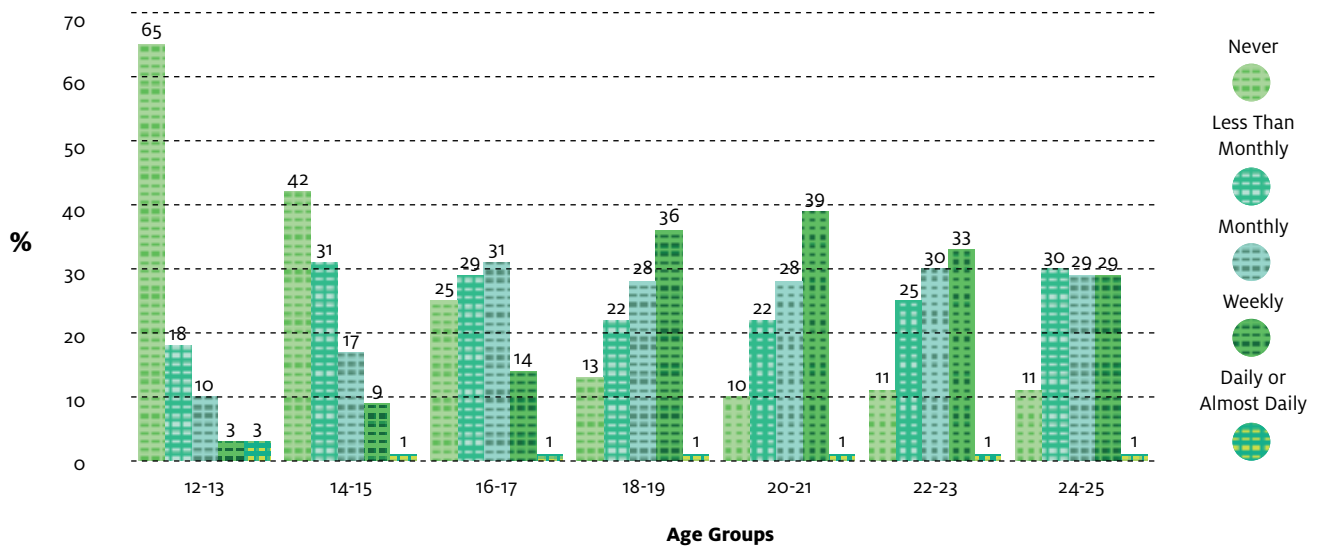
These results clearly indicate that, as young people move from their early teens, where they are more likely to report never drinking, to their mid-teens and mid-20s, they are more likely to increase their alcohol intake.

Six or more drinks in one sitting or session

Young people who drank alcohol were asked how often they had six or more drinks in one sitting or session – which is regarded as binge drinking.

Those aged 12-13 years were likely to ‘never’ drink this amount (64%). At 14-15 (45%) and 16-17 years (25%), they were also more likely to report ‘never’ drinking this amount. However, we begin to see a slight move toward increased alcohol intake: 31% of 14-15 year-olds are likely to engage in binge drinking ‘less than monthly’, while 16-17 year-olds are likely to binge-drink ‘less than monthly’ (29%) but also ‘monthly’ (31%) (see Figure 7.6).

Figure 7.6: Percentage of young people reporting six or more drinks in one sitting or session

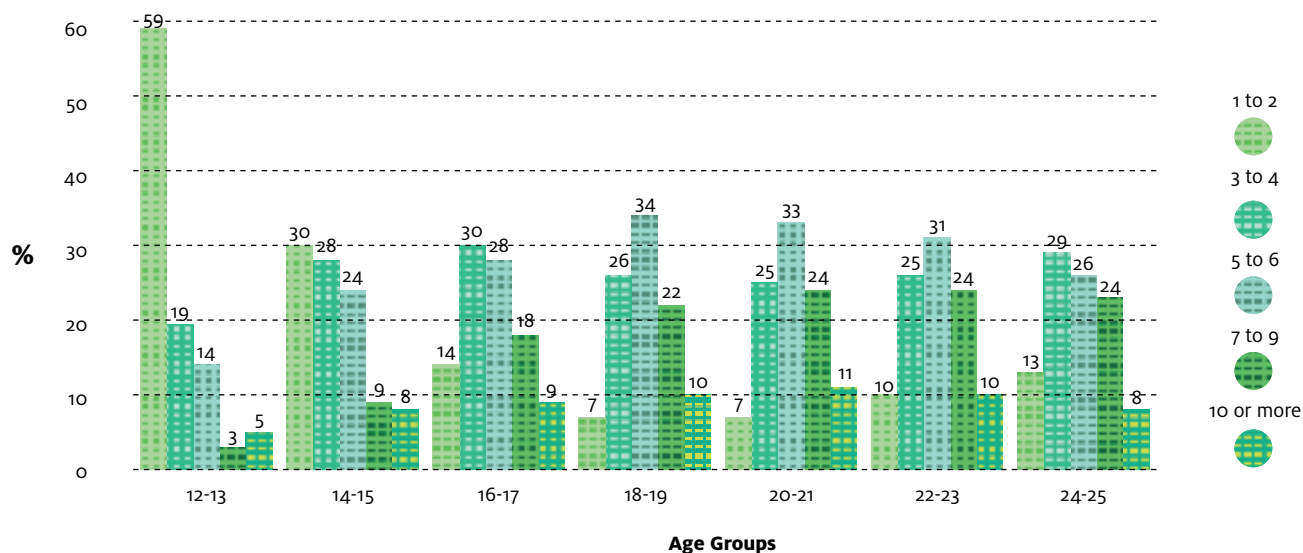


Increases in binge-drinking were found for those aged 18-19; for the first time young people reported being more likely to binge-drink on a weekly basis (36%). These higher levels of drinking persisted into the early 20s; at 20-21 (39%) and 22-23 years (33%), young people continue to be more likely to report binge-drinking on a weekly basis.

Number of alcoholic drinks when drinking

Young people were asked how many drinks they would typically have when drinking. At 12-13 (59%) and 14-15 (30%), they are more likely to drink only '1 to 2' drinks. We see the first signs of an increasing trend in quantity of drinking with 16-17 year-olds, who are more likely to drink '3 to 4' alcoholic drinks in one sitting (30%), while 18-19 year-olds reported being more likely to drink '5 to 6' (34%). See Figure 7.7.

Figure 7.7: Number of alcoholic drinks when drinking across age groups



This increasing trend continues at 20-21, where young people were more likely to report drinking '7 to 9' (24%) and '10 or more' (11%) drinks in a single sitting. The number of drinks taken during a single sitting appears to drop slightly at 22-23 years, as this group report being more likely to drink '7 to 9' drinks (24%).

7.2.3. CRAFFT and age of use of cannabis

Substance misuse (CRAFFT)

Age group was significantly related to substance misuse – that is, drug and alcohol misuse. Scores ranged from 0 to 6 ($M=1.8$, $SD=1.7$), with higher scores indicating greater risk-taking. Knight et al (1999, 2002) set the optimal cut-off score at 2 on the CRAFFT for identifying substance use, abuse and dependence.

Figure 7.8: CRAFFT substance misuse across age groups

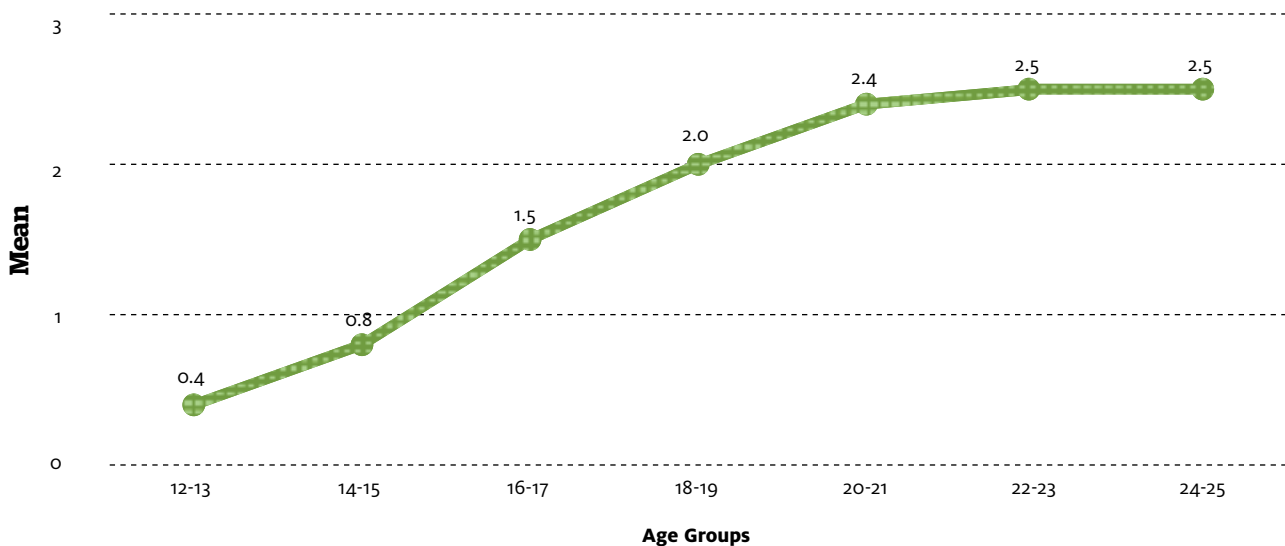
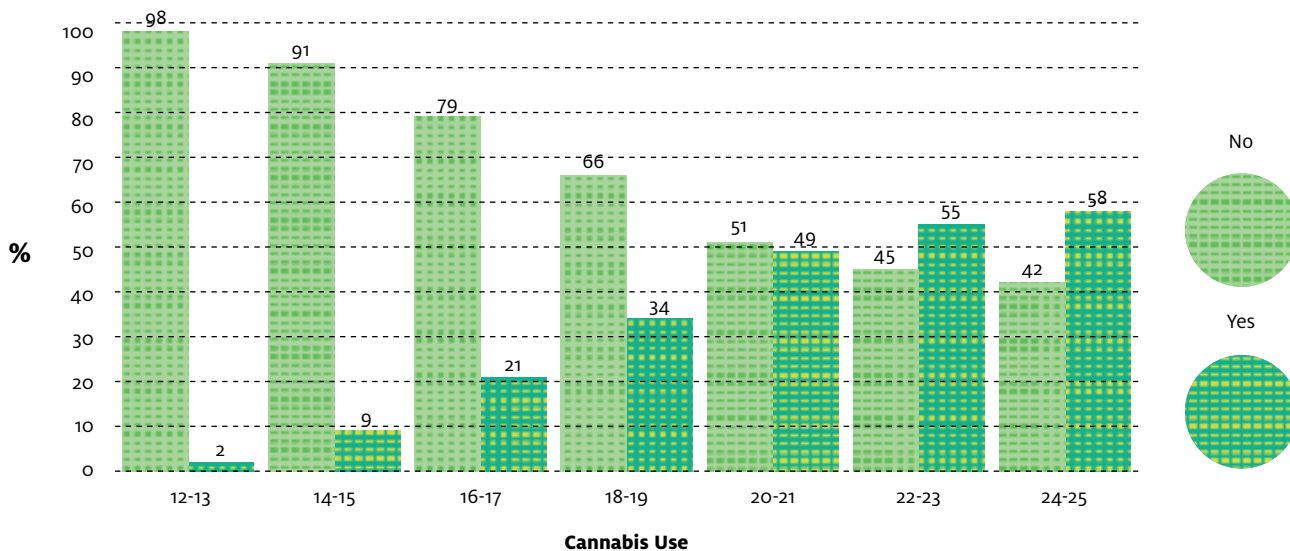


Figure 7.8 shows the increase of self-reported substance use from the lowest levels at 12-13 years ($M=0.4$, $SD=1$) through to 20-21 ($M=2.4$, $SD=1.7$). Levels remain relatively stable through to 24-25 years. These results clearly suggest that, as young people age, they are more likely to engage in substance misuse. In the present study, those aged 18 to 25 are at least marginally above the cut-off for substance abuse and dependence.

Cannabis use

A significant association was found between age and cannabis use. Those aged 12-17 are significantly less likely to report smoking cannabis – 98% for 12-13 year-olds, 91% for 14-15 year-olds and 79% for 16-17 year-olds.

Figure 7.9: Self-reported use of cannabis across age groups



A shift occurs around the ages of 18-19, where for the first time young people are more likely to have smoked cannabis (34%). It can be seen in Figure 7.9 that 49% of 20-21 year-olds, 55% of 22-23 year-olds and 58% of 24-25 year-olds state that they have smoked cannabis.

58%
of 24-25 year-olds
state that they have
smoked cannabis.

7.3. Common Protective Factors

7.3.1 Self-esteem

Significant differences were found between age groups and reported levels of self-esteem. Scores ranged from 10 to 40 ($M=28.4$, $SD=5.7$), with higher scores indicating higher self-esteem.

Figure 7.10: Self-esteem scores across age groups

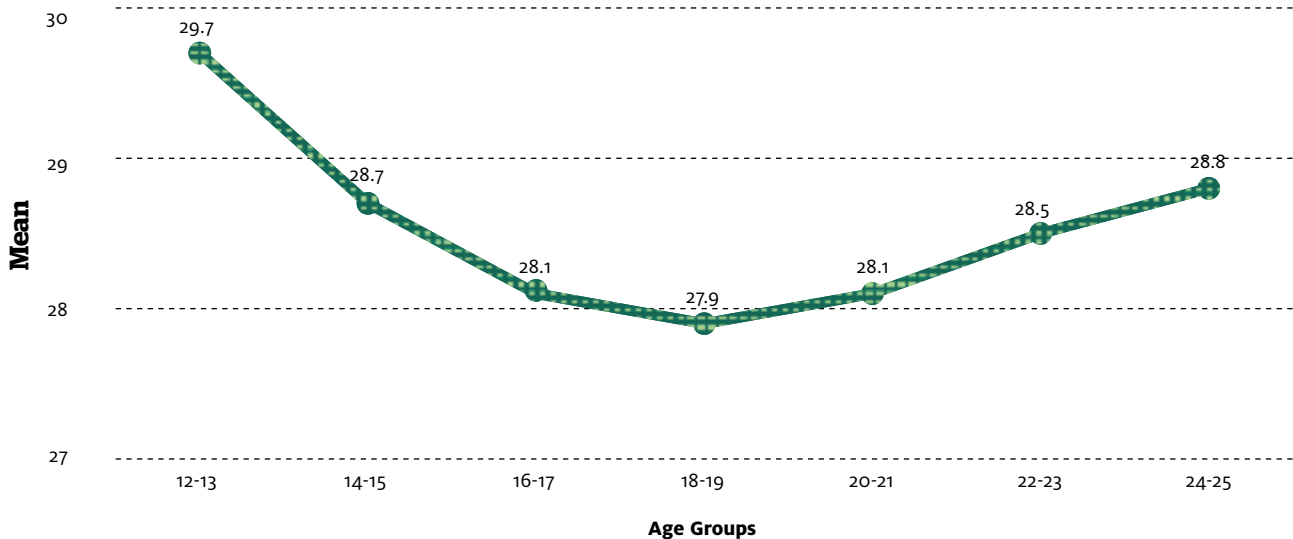


Figure 7.10 shows that, while self-esteem is highest at 12-13 years ($M=29.7$, $SD=5.5$), levels change as young people age. For example, young people aged 18-19 report the lowest self-esteem ($M=27.9$, $SD=5.7$); the levels are significantly lower than for those aged 12-13, 14-15 ($M=28.7$, $SD=5.7$) and 24-25 ($M=28.8$, $SD=5.7$).

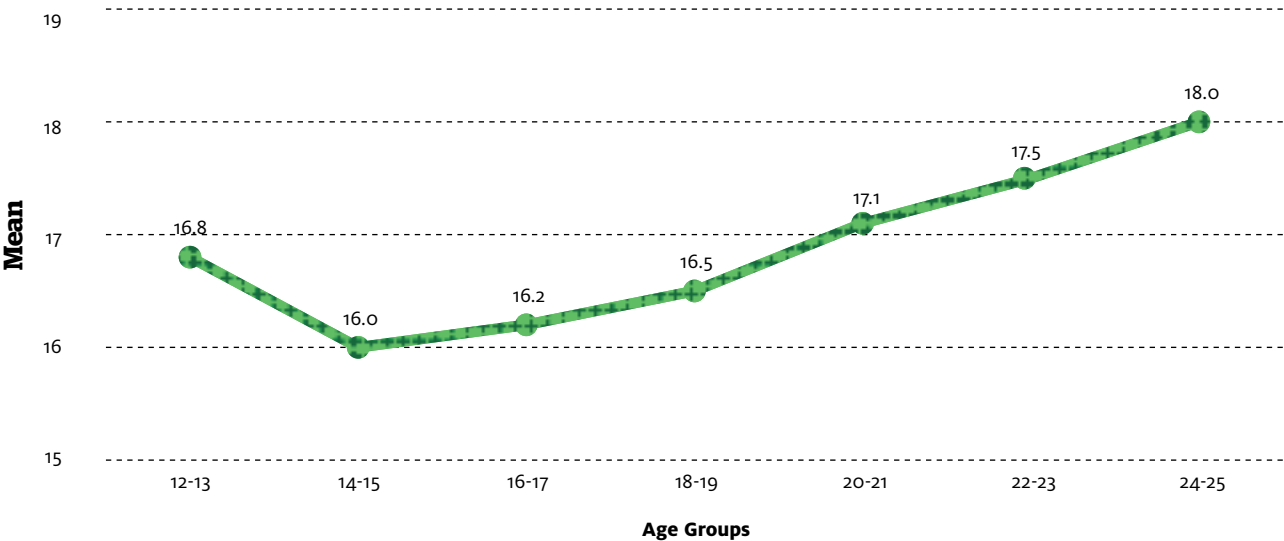
From 18-19 years of age, levels of self-esteem increase up to the ages of 24-25, but the levels reported by 12-13 year-olds are still significantly higher than for any other age group, including 24-25 year-olds.

7.3.2. Coping

Planned coping (problem-solving)

There was a significant association between age group and use of problem-solving as a coping strategy. Scores ranged from 5 to 30 ($M=16.7$, $SD=5.4$), with higher scores indicating higher use of problem-solving strategies (see Figure 7.11).

Figure 7.11: CSI planned coping scores across age groups



There is an initial significant drop in problem-solving from 12-13 ($M=16.8$, $SD=6.1$) to 14-15 years ($M=16$, $SD=5.6$), where levels are at their lowest. However, from 14-15 years onwards, levels of problem-solving increase year on year up to 24-25 years ($M=18$, $SD=5.1$).

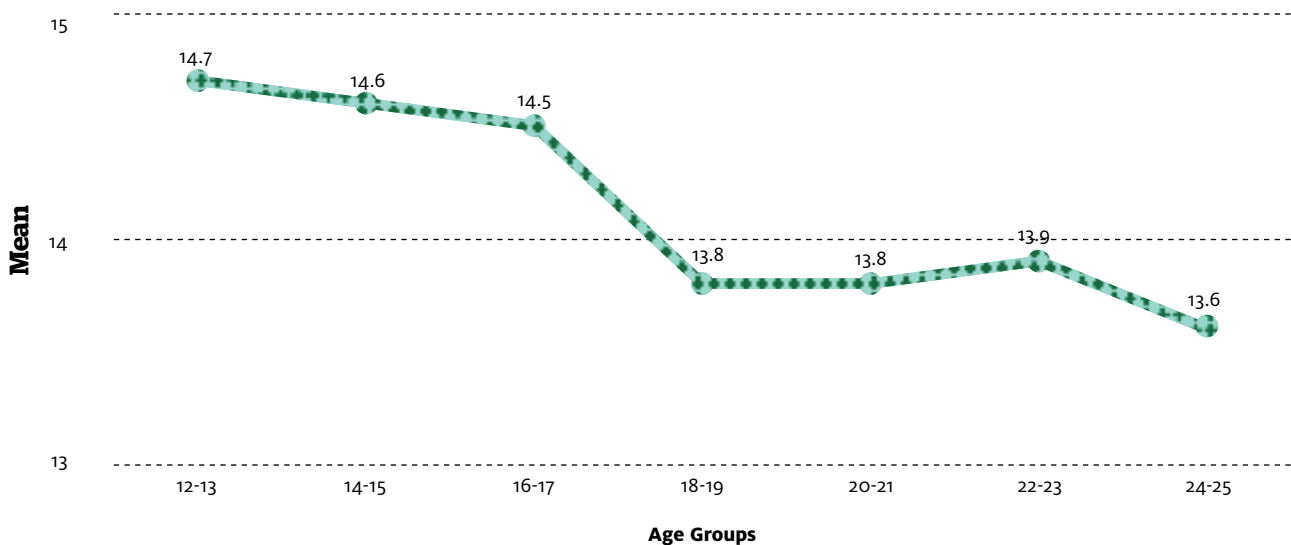
For those aged 24-25, levels are significantly higher than for those aged 12 to 21, indicating that a potential development shift occurs around the ages of 22 to 25 as young people more often use problem-solving skills as a coping strategy.

Support coping (seeking social support)

Significant age differences were found in self-reported levels of seeking social support as a coping strategy. Scores ranged from 4 to 24 ($M=14.1$, $SD=5.1$), with higher scores indicating more frequent attempts to seek social support to deal with problems.

Figure 7.12 suggests a possible developmental trend in young people's use of social support. The highest levels of support sought are at 12-13 years ($M=14.7$, $SD=5.6$) and the lowest at 24-25 years ($M=13.6$, $SD=4.6$).

Figure 7.12: CSI scores of seeking social support as a coping strategy across age groups

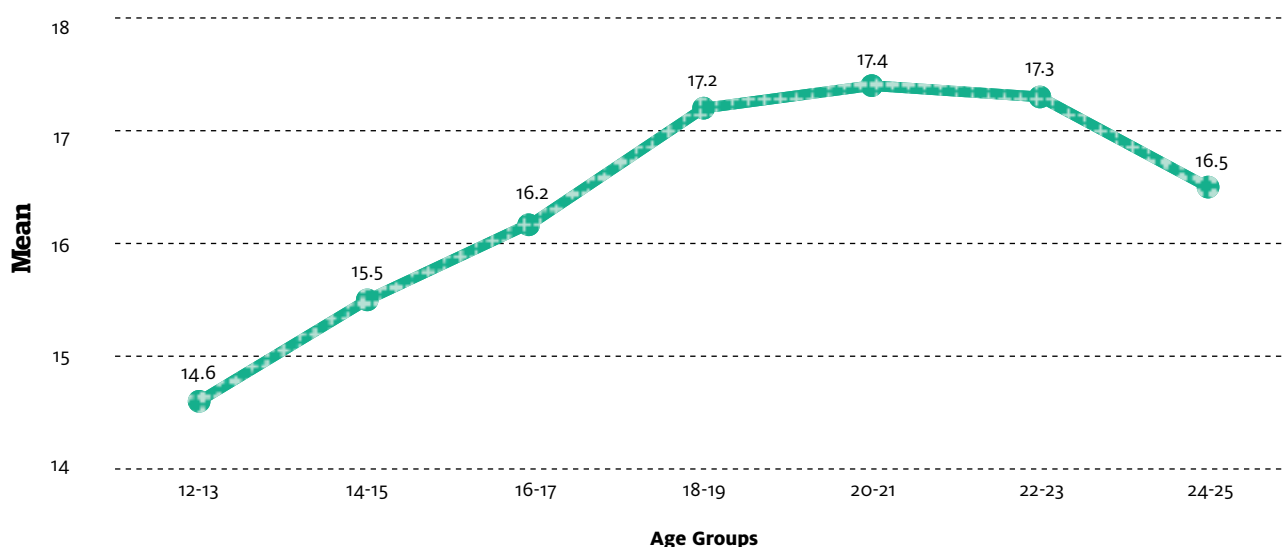


A shift appears to occur around the ages of 18-19, where levels of support drop significantly for the first time and remain stable at this lower level. In fact, the levels of support-seeking at each age group from 12 to 17 are higher than those at each age group from 18 to 25 years. This indicates that young people in their later teens and early 20s are significantly less likely to seek social support to solve problems than those in their early teens.

Avoidant coping

There were significant differences between age groups and reported levels of avoiding problems as a coping strategy. Scores ranged from 6 and 36 ($M=16.6$, $SD=6.1$), with higher scores indicating young people are more likely to avoid problems.

Figure 7.13: CSI scores for avoiding problems as a coping strategy across age groups



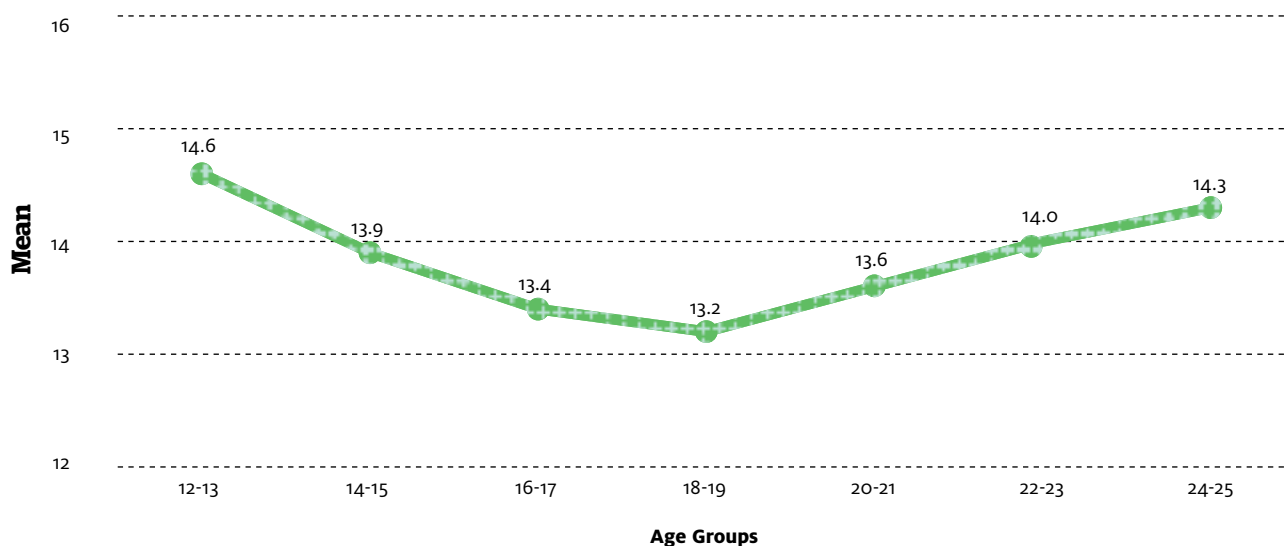
It can be seen in Figure 7.13 that, among 12-13 year-olds ($M=14.6$, $SD=6.1$), the reported levels of avoidance coping are significantly lower than among all other age groups. In addition, the levels for 14-15 year-olds ($M=15.5$, $SD=5.9$) are significantly lower than for all older age groups. These two findings suggest that those aged 12 to 15 years are much less likely to use avoidant coping strategies than older age groups.

A clear increasing trend can also be seen in Figure 7.13; avoidance is highest at 20-21 years ($M=17.4$, $SD=6.1$). Similar avoidance levels are reported at 18-19 years ($M=17.2$, $SD=6.2$) and also at 22-23 ($M=17.3$, $SD=5.9$), indicating that avoidance levels remain relatively high and stable for this period. Levels then drop significantly at 24-25 years ($M=16.5$, $SD=5.9$).

7.3.3. Optimism

Significant differences were found between age groups and reported levels of optimism. Scores ranged from 0 to 24 ($M=13.7$, $SD=5.1$), with higher scores indicating greater optimism.

Figure 7.14: LOT-R scores for optimism across age groups



In Figure 7.14, it can be seen that levels of optimism are highest at age 12-13 ($M=14.6$, $SD=4.3$) and lowest at 18-19 ($M=13.2$, $SD=5.3$), from which point they increase up to the age of 24-25 ($M=14.3$, $SD=5.5$).

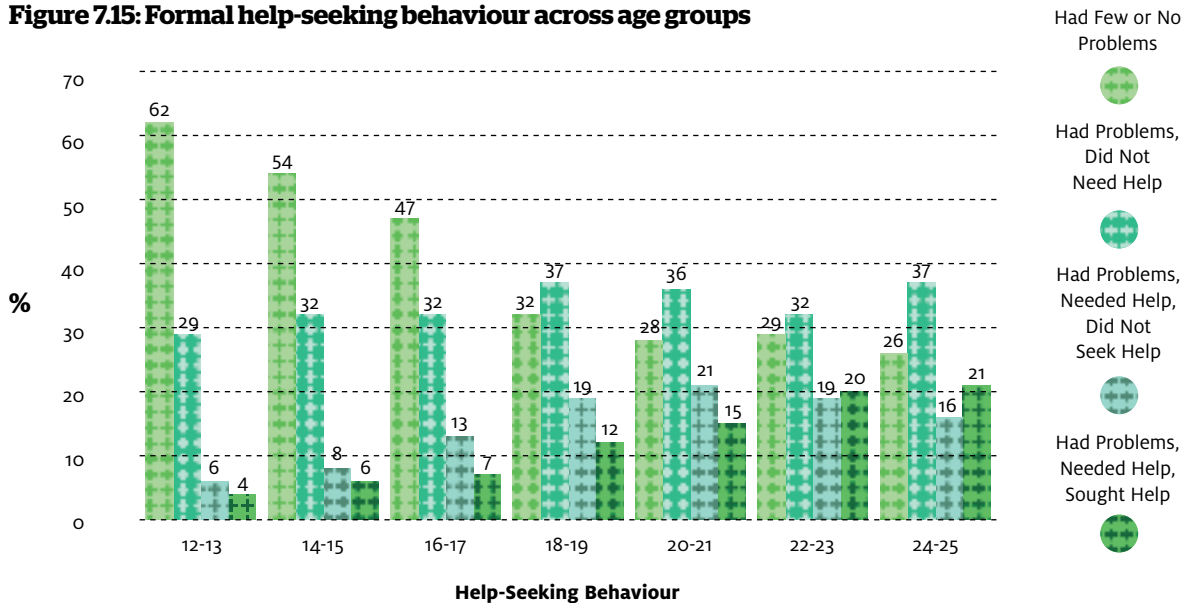
Interestingly, young people aged between 14 and 23 report significantly lower levels of optimism than the 12-13 year olds. This indicates a lower level of optimism over a 10-year period. In fact, only at 24-25 are levels of optimism on a par with those for 12-13 year-olds.

7.3.4. Formal help-seeking

Formal help-seeking

Young people were asked if they had any serious problems in the past year and a significant association was found with age group. From age 12 to 17, young people are more likely to report having 'few or no problems', with 62% of 12-13 year-olds, 54% of 14-15 year-olds and 47% of 16-17 year-olds reporting 'few or no problems'. See Figure 7.15.

Figure 7.15: Formal help-seeking behaviour across age groups



At 18-19 years, we see young people reporting that they are more likely to have had problems but did not feel they needed professional help (37%). However, this age group are also more likely to report having problems but not seeking professional help even though they felt they needed it (19%).

Although a similar pattern of having problems and not seeking help emerges in 20-21 year-olds, this age group were more likely (15%) to report having problems and seeking professional help.

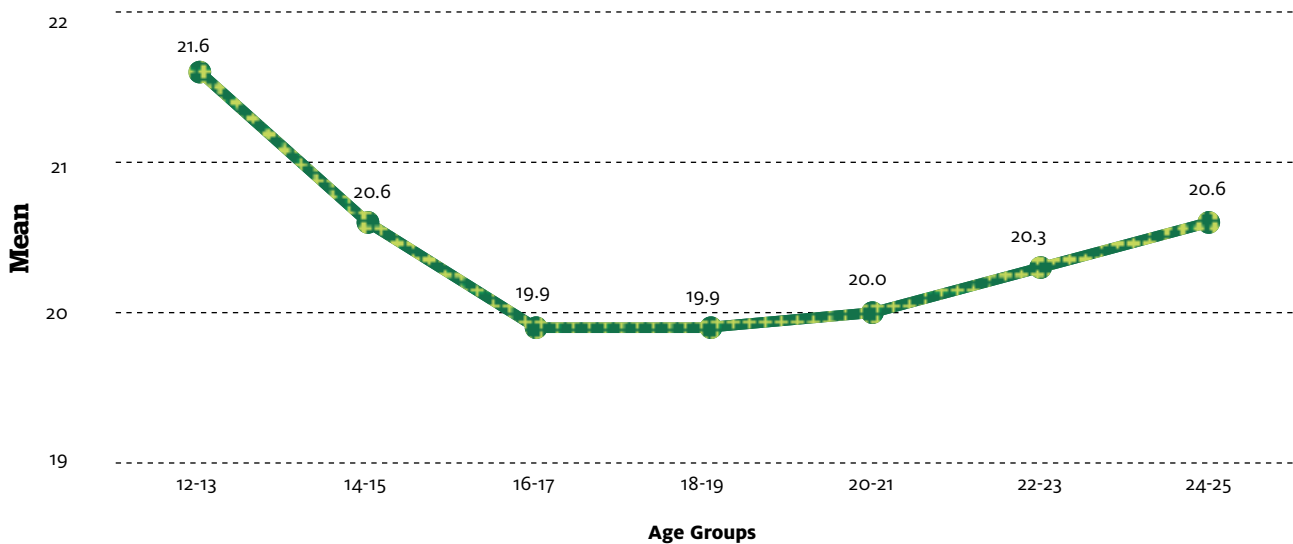
This trend continues over the next four years, as both 22-23 (20%) and 24-25 (21%) year-olds report being more likely to have problems and to seek professional help. However, 22-23 year-olds (19%) still report having problems and not seeking professional help.

7.3.5. Multidimensional scale of perceived social support

Social support from family

Significant differences were found between age groups and reported levels of social support from family. Scores ranged from 4 to 28 ($M=20.3$, $SD=5.9$), with higher scores indicating higher levels of family support. See Figure 7.16.

Figure 7.16: Self-reported levels of social support from family across age groups



At 12-13 years ($M=21.6$, $SD=5.8$), young people report the highest levels of social support from their family – these levels being significantly higher than for any other age group. Levels of support then decrease to their lowest at 16-17 years ($M=19.9$, $SD=5.6$) and 18-19 years ($M=19.9$, $SD=6.0$), after which a slight increase occurs up to the age of 24-25 ($M=20.6$, $SD=6.1$).

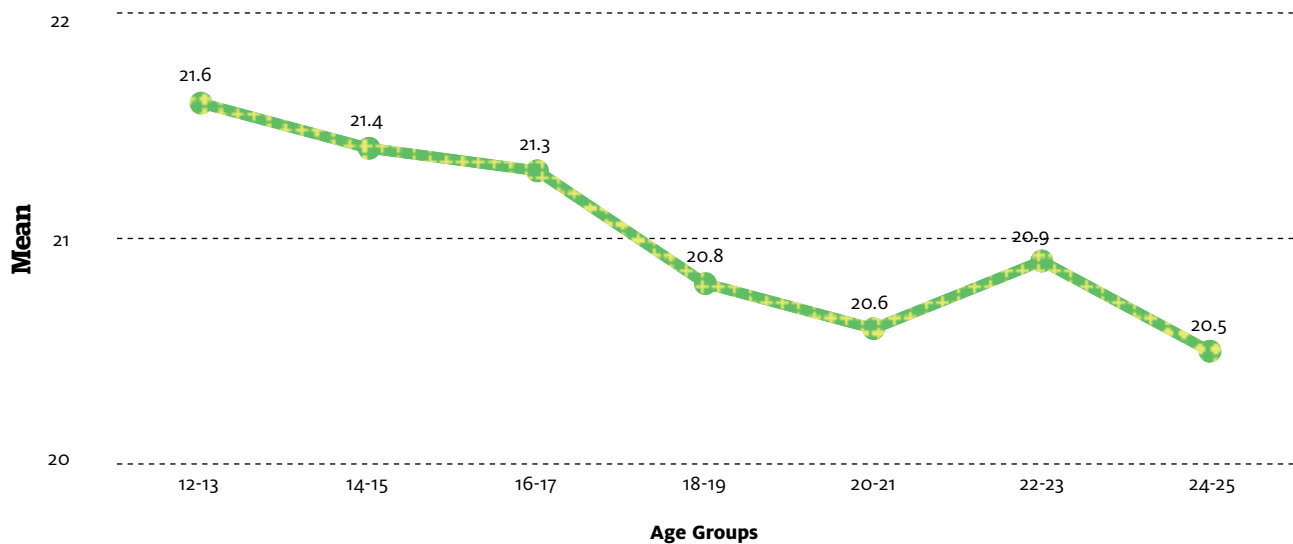
There were no significant differences in reported levels of social support from family between the 18-25 age groups, indicating that the support remains relatively stable.

The finding that those aged 12-13 years report higher family support than all other ages groups may suggest that, as young people become older and gain more autonomy, they rely less on their family for support or receive less social support from them.

Social support from friends

Significant differences were found between age groups and reported levels of social support from friends. Scores ranged from 4 to 28 ($M=21$, $SD=5.7$), with higher scores indicating higher levels of support from a friend. See Figure 7.17.

Figure 7.17: Self-reported levels of social support from friends across age groups

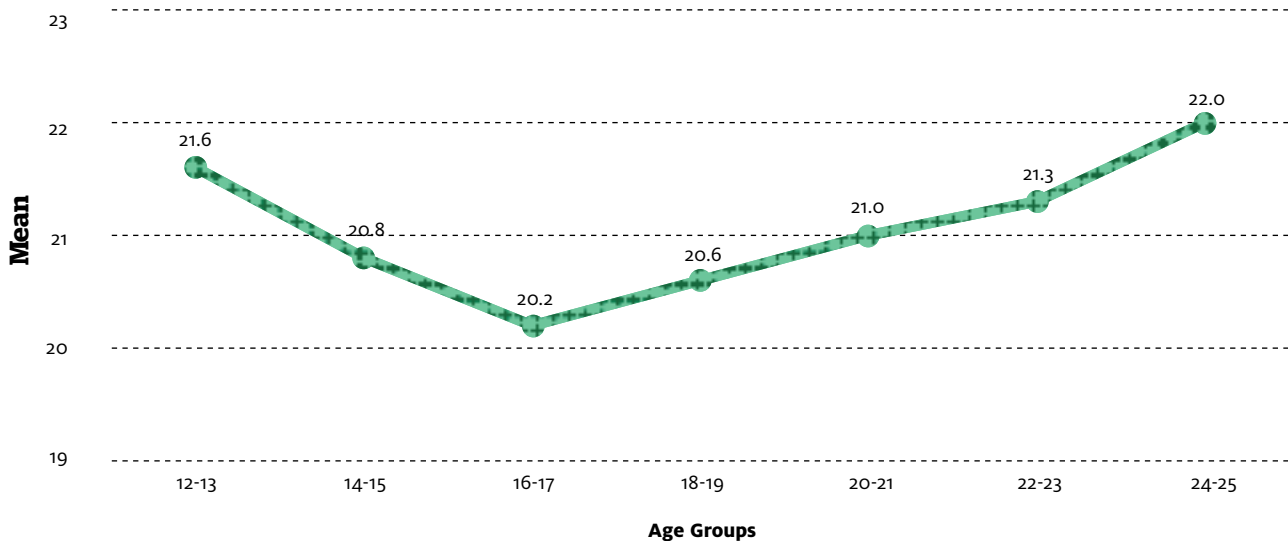


Young people aged 12-13 years ($M=21.6$, $SD=5.8$) reported the highest social support from friends; the levels were significantly higher than for all age groups between 18 and 25. A general decreasing trend in friends' support can be seen in Figure 7.17, where levels reach their lowest at 24-25 ($M=20.5$, $SD=5.8$).

Social support from a significant other

Significant differences were found between age groups and reported levels of social support from a significant other. Scores ranged from 4 to 28 ($M=20.9$, $SD=6.3$), with higher scores indicating higher levels of support.

Figure 7.18: Self-reported levels of social support from a significant other across age groups



In Figure 7.18, it can be seen that there is a decrease in reported levels of social support from a significant other from 12-13 ($M=21.6$, $SD=5.9$) to 16-17 ($M=20.2$, $SD=5.9$), where levels are at their lowest. For those aged 16-17, support is significantly lower than for 12-15 and 20-25 year-olds.

Support from a significant other then increases from 16-17 up to 24-25 ($M=22.0$, $SD=6.5$) where levels reach their peak at 24-25 years and are significantly higher than for those aged between 14 and 21. These results suggest that support from a significant other may become increasingly important during the early to mid-20s, where young adults begin to form significant relationships outside of the family.

7.4. Summary

- › Depression levels are outside of the normal range by the age of 18-19 years.
- › By age 18-19, alcohol behaviour has moved outside of the normal range, and remains outside of the normal range up to the age of 25.
- › Only 33% of young adults aged 18-23 years drink less than 5 drinks on a typical drinking occasion.
- › About 50% of those over 18 years reported using cannabis at some point.
- › Levels of avoidant coping were highest between the ages of 18 and 23 years.
- › Self-esteem and optimism are at their lowest at age 18-19 years.
- › Perceived social support remained relatively consistent from 12-25 years.

8 / **Emerging Themes from the My World Survey**



Introduction

The purpose of the My World Survey is to establish a national youth mental health database in Ireland. This database is intended to inform policy, allow us to measure the impact of innovative youth mental health services, such as Jigsaw, and provide a baseline for youth mental health, against which future national surveys can be compared.

The MWS allows us to do much more than simply identify how many young people are experiencing distress, and to what degree. The scope and richness of the data gathered also allows us to see how different elements and experiences in the life of a young person are related to their mental health. So, for example, while it may be of interest to know the percentage of young people who are drinking in a 'problematic' way, the data provide insights about this behaviour by identifying both key difficulties (risk factors) to which it may be related and key elements in a young person's life (protective factors) that may play a critical role in resolving it.

The complexity of the data gathered in the MWS will be mined and investigated in the coming year. A series of shorter publications will follow this current report, each dealing with a single issue of importance to young people, such as bullying and sexuality.

This chapter describes five key themes that emerged in the analysis of the data.

Theme 1: The importance of at least One Good Adult in every young person's life

The current literature shows that having at least one caring adult in a young person's life can act as a buffer against stress and lead to positive psychological functioning (Bogard, 2005). Therefore, a key question young people were asked in the MWS was to what extent they have a special adult in their life who is around when they are in need. This is what we have called the 'One Good Adult'.

Nearly 14,500 young people responded to this question. The majority indicated the presence of One Good Adult in their lives. In the adolescent sample (12-19 years), 71% reported high or very high support from One Good Adult while 16% reported low or very low support. Similarly, in the young adult sample (17-25 years) 72% reported high or very high support and 18% low or very low support.

This key question was analysed across a range of risk and protective factors related to mental health to help us understand the role that One Good Adult plays in a young person's life.

One Good Adult affects life satisfaction

Key findings emerged from our analyses of the MWS sample of nearly 14,500 young people aged 12-25. One Good Adult was highly related to a range of protective factors. These factors are reported in order of significance: perceived support from family, perceived support from friends, life satisfaction, self-esteem, seeking social support for problems, optimism, and using planning strategies to cope with problems.

When a young person reports a very high level of support from a trusted adult when in need, the level of support they perceive from their family and friends is significantly above the average. Therefore, the presence of One Good Adult is associated with a young person's connectedness with family and friends.

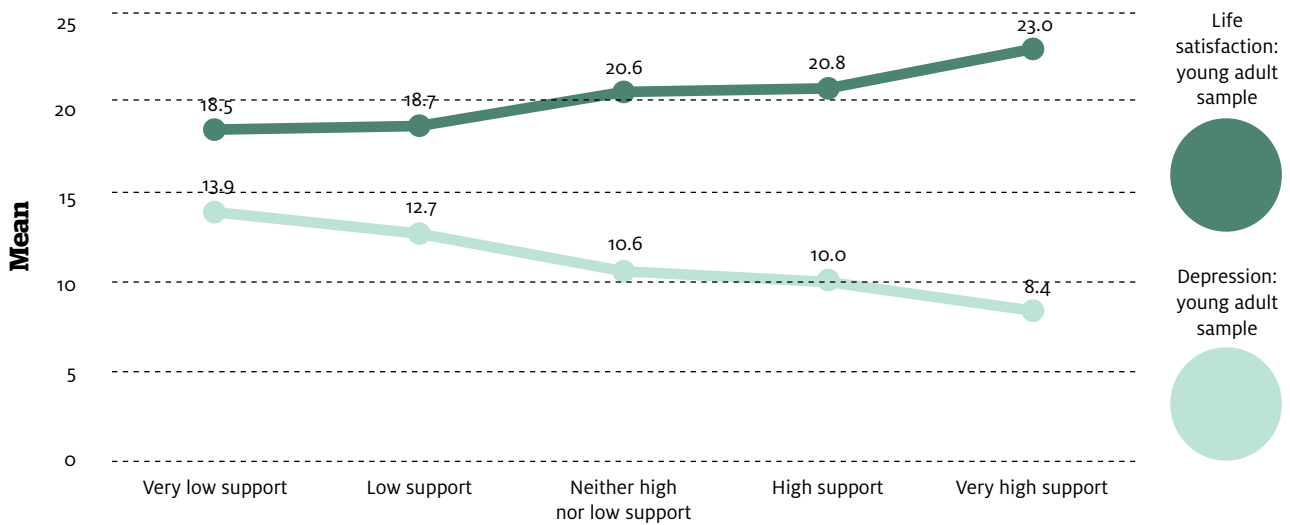
Life satisfaction is consistently related to positive well-being. Those who tend to be less satisfied with their lives use more self-defeating coping strategies such as avoidant coping (McCrae & Costa, 1986). Although life satisfaction was assessed with different scales for the adolescent and young adult sample, the findings are consistent: having high levels of support from One Good Adult enhances life satisfaction, while life satisfaction is low for those with low support from a good adult.

Young people who perceived very low support from a special adult when in need had significantly higher levels of depression compared to the typical young person in the sample.

The data showed that a young person with very low access to support had depression levels that were not in the normal range, whereas depression levels for a young person with high support from a good adult are well within the normal range. We saw the same pattern for anxiety. These variables are key indicators of psychological distress.

Figure 8.1 below illustrates the protective role that One Good Adult may have in a young adult's life. As the perceived support of One Good Adult increases, levels of depression decrease, and other protective factors – e.g. life satisfaction – increase. However, as the data are not longitudinal, cause and effect is not established; it is rather that these factors appear to be related.

Figure 8.1: One Good Adult by depression and life satisfaction for young adult sample



A sense of optimism – another indicator of life satisfaction – is linked to better adjustment, reduced depression and stress (Hirsch & Conner, 2007). Our data found significantly higher levels of optimism in young people who report very high levels of support from One Good Adult.

One Good Adult builds self-esteem

In the international literature, a consistent finding is the protective role that self-esteem plays in maintaining mental health. Self-esteem is a reflection of a person's belief in themselves. It has a direct effect on how they navigate themselves around their world, and affects all their relationships (Baumeister, Campbell, Krueger & Vohs, 2003).

In our data, we found that self-esteem in a young person who reports One Good Adult in their lives was significantly above average compared to the overall sample of young people. In fact, the self-esteem reported by a young person with very low support from One Good Adult is significantly below what we would expect. Self-esteem was assessed with the most widely used tool, the Rosenberg self-esteem scale.

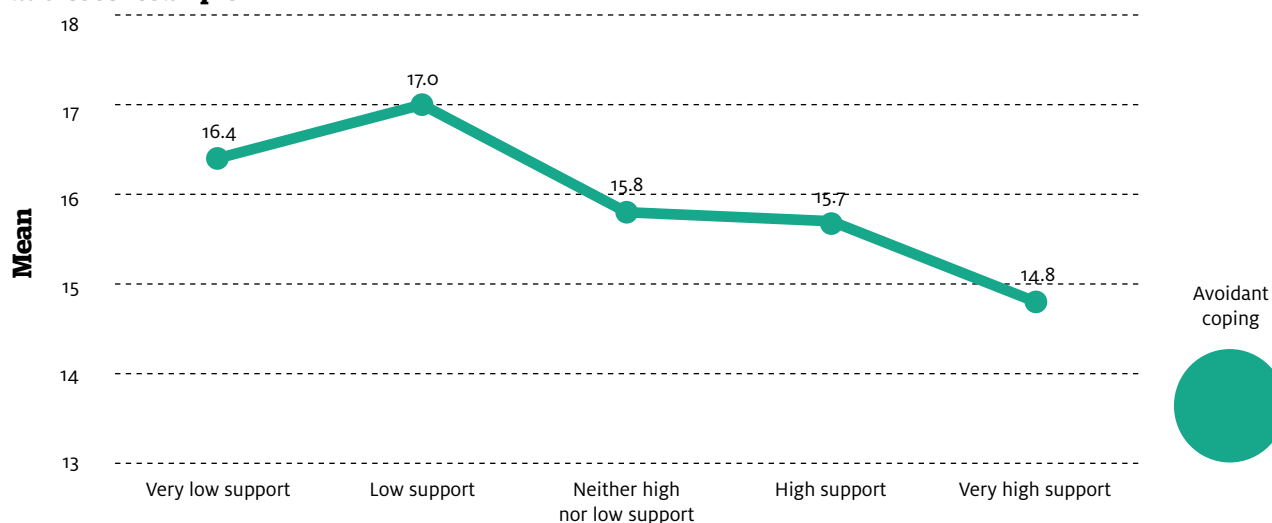
One Good Adult helps young people to cope better

All young people are likely to experience distress at some stage in their development. The MWS data showed how the presence of One Good Adult was associated with the likelihood of the young person being able to face their difficulties rather than turning away and trying to avoid them.

Active coping strategies are key to navigating through problems and stressors (Lohman & Jarvis, 2000). Two types of active coping strategies are: seeking support when encountering difficulties and engaging in planning strategies to deal with and solve problems. The presence of One Good Adult is linked to higher usage of these active coping strategies, highlighting the role that high support from a good adult may have in promoting positive coping strategies.

Avoidant coping is where a person denies that the event has happened or denies the impact that the event has on him or her (Lohman & Jarvis, 2000). This form of coping is often accompanied by the use of alcohol or drugs. Those young people who perceived very low levels of support from an adult when in need engaged in significantly higher levels of avoidant coping strategies (Figure 8.2).

Figure 8.2: One Good Adult and avoidant coping in the adolescent sample



One Good Adult promotes a sense of belonging

For a typical adolescent, most of their waking day is spent in the school environment during the school term. A sense of belonging within the school system is very important for adolescents and their adjustment, life satisfaction and peer relationships (Hall-Lande et al, 2007). The MWS measured adolescents' connectedness to school environment, peers and teachers. Very high support from One Good Adult was found to be related to higher levels of school connectedness, involvement with peers in school, and working and developing positive relationships with teachers.

Negative behaviour in school was significantly higher in a young person when their support from One Good Adult was very low. This shows us that there may be a link between the presence of One Good Adult and positive attitudes to school, peers and teachers, and that it may reduce negative behaviour at school.

The absence of One Good Adult is related to increased likelihood of self-harm and suicide

Deliberate self-harm is a major public health problem, with young people most at risk (McMahon et al, 2010). In Ireland, the mortality rate from suicide in the 15-24 age group is the fourth highest in the EU (NOSP, 2010), and the third highest among young men aged 15-19 (Eurostat, 2009). In the MWS young adult sample 22% (n=1575) reported self-harm.

The absence of One Good Adult was linked to an increased likelihood of self-harm. For males, the overall rate of self-harm was 17%, but it was 24% for those who reported low support from One Good Adult. For females, the rates were 24% and 30% respectively.

A high percentage (43%) of young adults have thought that their life was not worth living at some point. For the male sample, 40% had thought this at some point, but when the level of support from One Good Adult was very low, this figure rises to 57%. For females, the rates were 44% and 56% respectively.

A worryingly high percentage of young adults – 7% (n=576) – reported having made an attempt to take their own life. For males overall, the percentage was 6% but it was 11% when levels of support were very low from One Good Adult. For females, the rates were 8% and 11% respectively. Thus the absence of One Good Adult is more related to suicide attempts in the male sample than the female sample.

Key messages

- › The presence of One Good Adult is a key indicator of how well a young person is connected, self-confident and future-looking, and can cope with problems.
- › The absence of One Good Adult is linked to higher levels of distress and anti-social behaviour, and an increase risk for suicidal behaviour.

Theme 2: Problem drinking and its relationship to mental health

An international WHO measure, the AUDIT, was used to screen for excessive drinking among young people. It is the only screening test specifically designed for international use. The AUDIT classifies drinking behaviour into the following categories based on cut-off scores established across six countries:

- › Normal drinking behaviour (scores of 0-7)
- › Problem drinking behaviour (scores of 8-15)
- › Harmful drinking behaviour (scores of 16-19)
- › Possible alcohol dependence (scores of 20+)

The table below provides percentages for these categories across the samples in MWS.

Table 8.1: Drinking behaviour categories in the MWS

	Adolescent sample	Young adult sample	Overall sample
Normal drinking	79%	39%	55%
Problem drinking	15%	41%	31%
Harmful drinking	3%	10%	7%
Possible alcohol dependence	3%	10%	7%

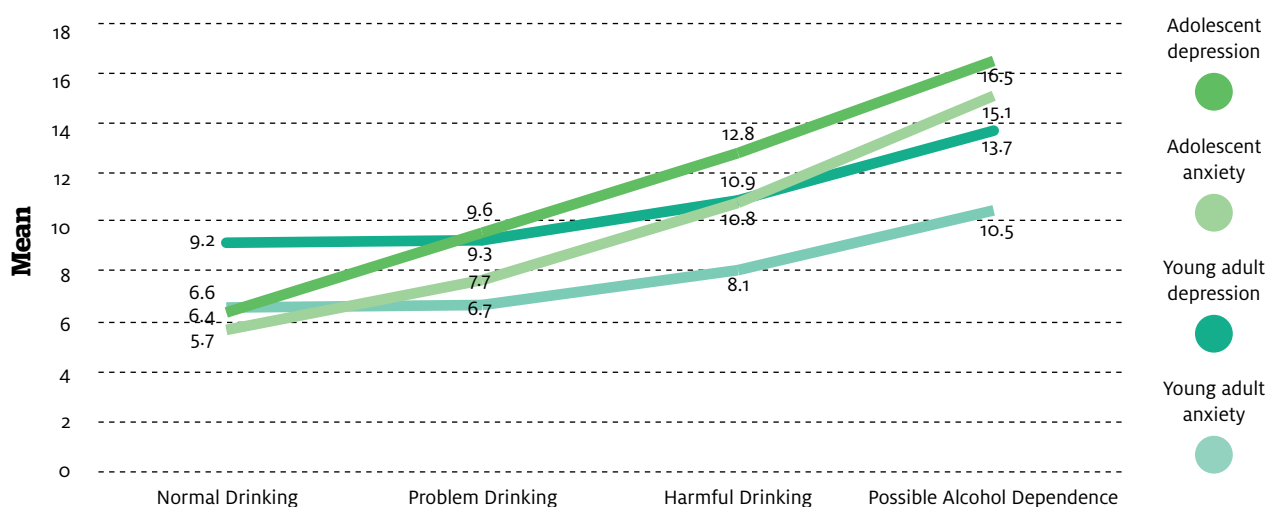
This is the first national study looking at young people from 12 to 25 years that tracks the emergence of drinking behaviour from early adolescence to young adulthood. For the cohort of young people aged 12-25, the average score on the AUDIT fell just outside the normal range for drinking behaviour ($M=7.5$, $SD=7.1$). The alcohol behaviour for a young person who reports having One Good Adult falls within the normal range ($M=6.8$), indicating the buffering role that One Good Adult may have in moderating alcohol behaviour.

The high levels of alcohol consumption and physical risks to young people are well documented (WHO, 2002). To date, there is a dearth of information on the effects of alcohol consumption on mental health. To further our understanding of the risk that alcohol presents to young people, we looked at the data on alcohol drinking behaviour in conjunction with mental health and well-being.

Alcohol behaviour and mental health problems

For the entire sample, depression and anxiety were significantly higher when a young person engaged in harmful drinking or was classified as possibly alcohol-dependent. A more worrying finding emerged when looking at the adolescent sample, particularly in relation to anxiety. A young person with normal drinking behaviour is likely to have normal levels of anxiety, but when he or she engages in harmful drinking, their anxiety levels are well in excess of normal, and, if classified as possibly alcohol-dependent, are in the severe range. The effect of excessive drinking on mental health is more significant in the adolescent sample than in the young adult sample (see Figure 8.3). This is important, as this is a time of significant biological, developmental, emotional, and social change in a young person's life.

Figure 8.3: Excessive drinking, depression and anxiety among adolescents and young adults



Alcohol and anti-social behaviour

Further evidence linking alcohol and other negative behaviours emerged when looking at substance misuse and taking cannabis. In the adolescent sample, 13% reported smoking cannabis, while 46% of young adults did so. For both samples, smoking cannabis was highly linked to excessive drinking behaviour. Looking at the link between cannabis use and mental health, the pattern that emerged for alcohol behaviour was replicated, thus giving further evidence of the effect that substance use has on mental health.

Excessive drinking was strongly linked to anti-social behaviours (i.e., having been in trouble with the gardaí, feeling so angry that you become violent to others) for both adolescents and young adults.

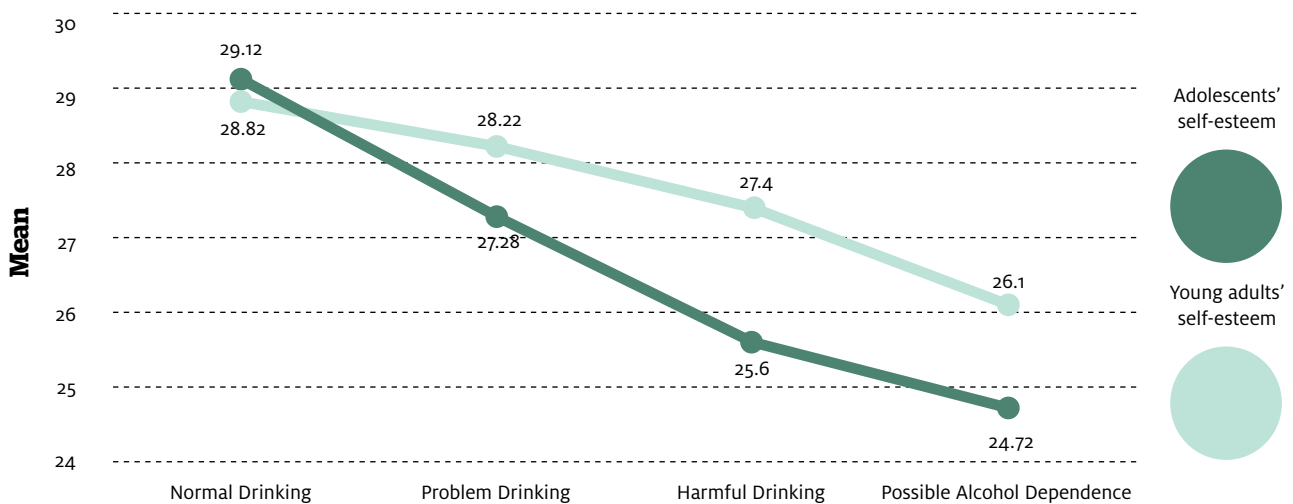
Alcohol and coping

Young people who had difficulty in coping are significantly more likely to be classified as engaging in harmful drinking behaviour or having possible alcohol dependence. One possible explanation is that a young person who feels they cannot cope engages in excessive drinking as a mechanism to manage their problems.

Alcohol behaviour and protective factors

Those with normal patterns of drinking behaviour were more likely to have high levels of self-esteem (see Figure 8.4), optimism, life satisfaction and perceived social support. As was reported with risk factors, this effect was more marked in the adolescent than the young adult sample, indicating that excessive drinking has significant negative impacts on adolescents' healthy functioning.

Figure 8.4: Alcohol behaviour and self-esteem



In the adolescent sample, a strong association was found between alcohol behaviour and connectedness with school and teachers. Excessive drinking was linked to negative feelings about school and teachers. Supporting this finding, high levels of deviant school behaviour, such as suspension or being expelled from school, were associated with increased levels of drinking behaviour. Therefore, excessive alcohol is related not only to a less positive attitude to school but also to increased negative behaviours such as being disruptive to peers and teachers.

In the young adult sample, strong links were found between excessive drinking and suicidal behaviour. Young adults classified as possibly alcohol-dependent were significantly more likely to have thought their life was not worth living, and to have reported self-harm and having made an attempt on their life. Pirkola et al (1999) found a significant relationship between alcohol, drug misuse and suicidal behaviour.

Key messages

- › The MWS provides clear evidence that excessive use of alcohol is associated with poor mental health and well-being.
- › The presence of one good adult may moderate drinking behaviour in adolescence.
- › Excessive drinking was strongly linked to anti-social behaviours.
- › For adolescents, high levels of deviant school behaviour, such as suspension or being expelled from school, were associated with increased levels of drinking behaviour.
- › For young adults, strong links were found between excessive drinking and suicidal behaviour.

Theme 3: Financial stress on young adults

The MWS asked young adults to what extent they feel stressed by their financial situation. The findings showed that 46% reported 'often' being stressed, and 14% being 'highly' stressed by their financial situation. Young adults who reported being stressed by their financial situation also reported pressure to work outside of college/training courses.

Three key positive factors of well-being – life satisfaction, optimism and self-esteem – were found to be the most highly related factors to financial stress. Young adults who were highly stressed by their finances had considerably lower levels of self-esteem than those who were experiencing low or no financial stress. These findings may indicate that the factors most significantly affected by financial stress were a young person's satisfaction with life, sense of optimism and self-esteem, which are key indicators of well-being and quality of life.

Financial stress and mental health

The second set of factors linked to financial worries was anxiety and depression; young adults who were highly stressed by their financial situation had significantly elevated levels of distress, beyond the normal range. They also used avoidant coping strategies more. This finding may suggest that the stress associated with financial worries may be preventing young adults from dealing with their problems effectively and engaging with their situation.

In terms of negative behaviours, young adults stressed by finances engaged in more excessive drinking and substance misuse than their peers experiencing less financial stress. Given the cross-sectional nature of this study, it is not possible to determine whether increased drinking and its associated cost may lead to higher financial stress, or whether higher financial stress may cause a young adult to engage in excessive drinking as a way of coping with their problems, or both.

Financial stress and perceived social support

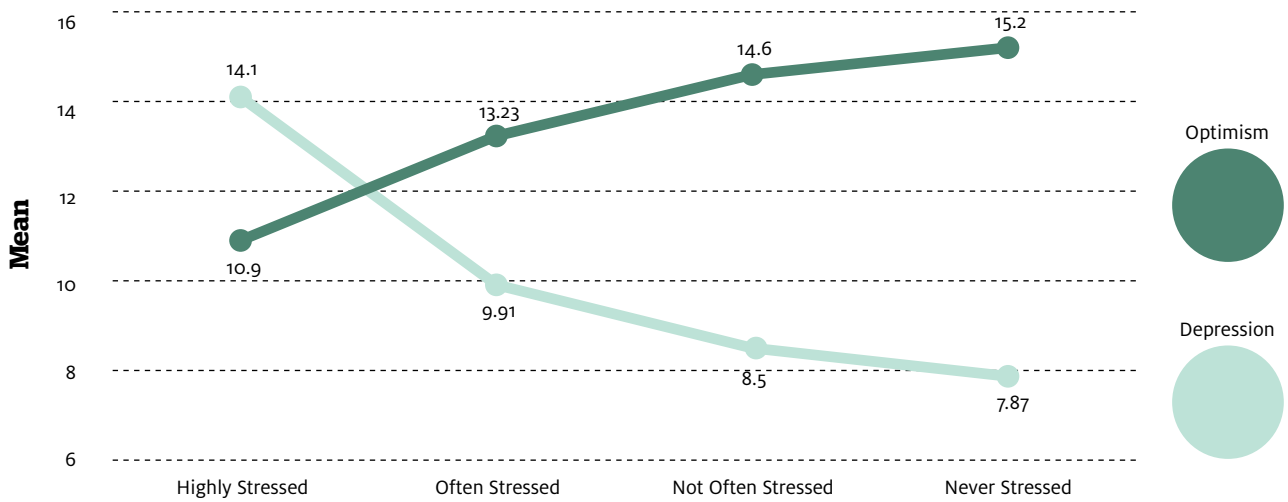
A final factor associated with financial stress was that of perceived social support. Young adults who were highly stressed reported lower levels of support. Again, we are unsure as to whether the financial stress prevented the young person from seeking support, or whether support was not available to the young person who was under financial pressure.

Overall, the data show us that for, whatever reason, a young person's perception of their financial situation, and the associated stress, is related to their well-being and mental health. Therefore, perceived financial stress should be considered as an indicator of poor well-being for services and organisations working with young adults.

Key messages

- › 60% of young adults reported being stressed by their financial situation.
- › Young adults' perceptions of their financial stress are related to their mental health and well-being.
- › Those stressed by their financial situation reported lower levels of positive well-being, such as optimism, and higher levels of distress, such as depression, and negative behaviours (Figure 8.5).

Figure 8.5 Financial stress: optimism and depression



Theme 4: Suicidal behaviour

In Ireland, the mortality rate from suicide in the 15-24 year age group is the fourth highest in the EU (NOSP, 2010), and the third highest among young men aged 15-19 (Eurostat, 2009). Three key questions on suicidal ideation, self-harm and suicide attempt were put to young adults in the MWS.

Table 8.2: Suicidal ideation, self-harm and suicide attempt by gender

	Males	Females
Suicidal ideation	41%	44%
Self-harm	16%	24%
Suicide attempt	6%	8%

Suicidal ideation and help-seeking

With regard to suicidal ideation, young adults were asked if they had ever thought that life was not worth living. Of the sample, 43% reported that they had thought this at some point; of these, 33% had thought this within the last year, 14% within the last six months, and 18% within the last month.

Having suicidal thoughts was linked to a young adult's perception of the problems they were experiencing. Young adults who had suicidal thoughts were more likely to have experienced serious problems while those who reported not having such thoughts were very likely to indicate they had few or no problems.

In addition, suicidal thoughts were linked to help-seeking behaviour; young people who experienced suicidal thoughts reported that they did not talk about their problems; those who reported fewer problems were more likely to seek help and talk about them.

Self-harm and help-seeking

Young adults were asked if they had ever engaged in self-harm. One-fifth (21%) indicated that they had; of these, 26% reported self-harm in the past year, 15% in the last six months, and 14% within the past month. Again, deliberate self-harm was linked to both formal and informal help-seeking behaviour; those who engaged in self-harm were more likely to report having problems and not seeking help, and were less likely to talk about their problems.

Suicide attempt and accessing help or support

Young adults were asked if they had ever made an attempt to take their own life. In the MWS-PSL, 7% (n=576) of young adults reported having made an attempt on their life at some point. The percentages of attempted suicide that occurred in the past year for these young adults were:

- › 24% (n=133) in the last year
- › 12% (n=67) in the last six months
- › just over 3% (n=18) in the last month

Therefore, approximately 220 young adults in our sample reported an attempt to take their own life in the past year.

Only 47% (n=265) had accessed help or support after a suicide attempt:

- › 36% (n=117) found it difficult or very difficult to get the support they needed.
- › 65% (n=217) found that the support had helped them.

In addition, those who had made an attempt to take their life were, in general, less likely to report talking about their problems.

Key messages

- › 7% of the young adult sample reported a suicide attempt.
- › Only 47% sought help following a suicide attempt.
- › 65% of those who sought help after a suicide attempt found it helpful.
- › Rates of suicidal thoughts, self-harm and suicide attempt were found to be higher in young adults who did not seek help or talk about their problems.

Theme 5: Young people's awareness of their distress

The MWS asked young people about problems they were experiencing and their need for professional help (formal help-seeking). In the overall sample, 39% reported having few or no mental health problems. A further 34% indicated that they had some problems but did not need professional help, and 16% indicated some problems that needed professional help but they did not seek it. The final 11% indicated that they had problems and had sought professional help (see Table 8.3).

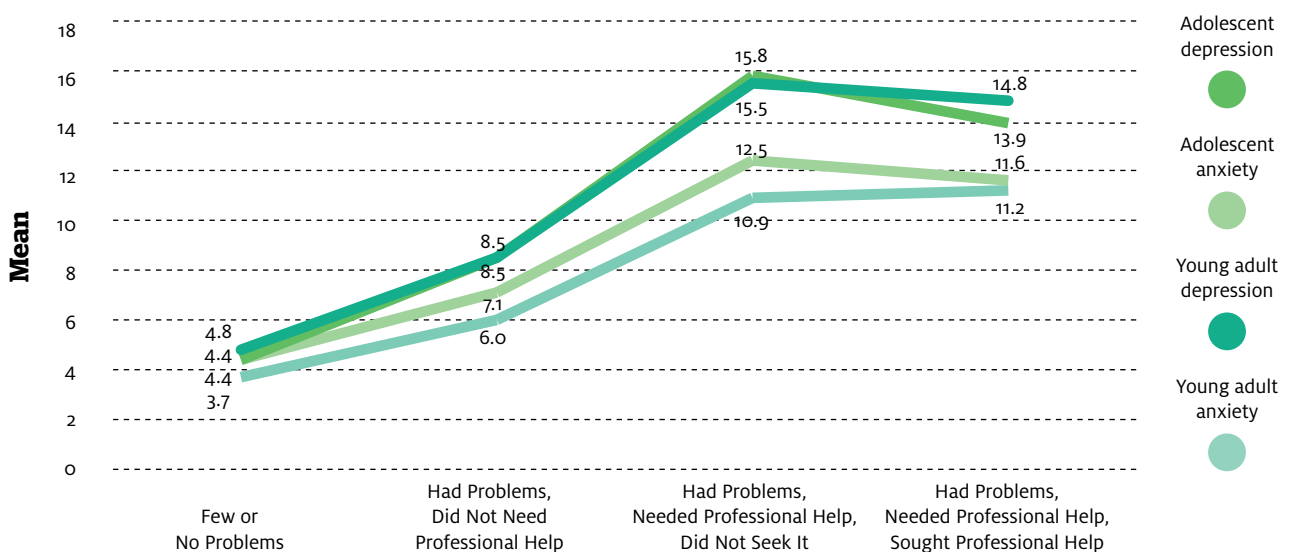
Clear trends emerged. Those who reported few/no problems or minor problems were found to consistently report higher levels of well-being and lower levels of distress and negative behaviours than young people who reported having emotional problems that required professional help but not seeking that help.

The MWS data revealed that young people are very aware of the problems they are experiencing and of their need for help. When this question was analysed it emerged that distress, measured using standardised questionnaires, was higher in those who knew they were encountering problems. Young people, it appears, are keenly aware of their moods.

Table 8.3: Perceived problems and formal help-seeking

	Adolescent sample	Young adult sample	Overall sample
Few or no problems	54%	29%	39%
Some problems but did not need help	31%	36%	34%
Problems that needed help but I did not seek it	9%	20%	16%
Problems and I sought help	6%	15%	11%

In general, in the overall sample, there was little difference in distress levels between those who had problems and sought help and those who had problems but did not seek help. It is difficult to work out why this is the case, as the data are not longitudinal. However, in the adolescent sample, depression levels in the group that sought help were significantly lower than in the group who did not seek help for problems. This was not evident in the young adult sample (Figure 8.8). This evidence supports the beneficial role of early intervention in youth mental health in adolescence.

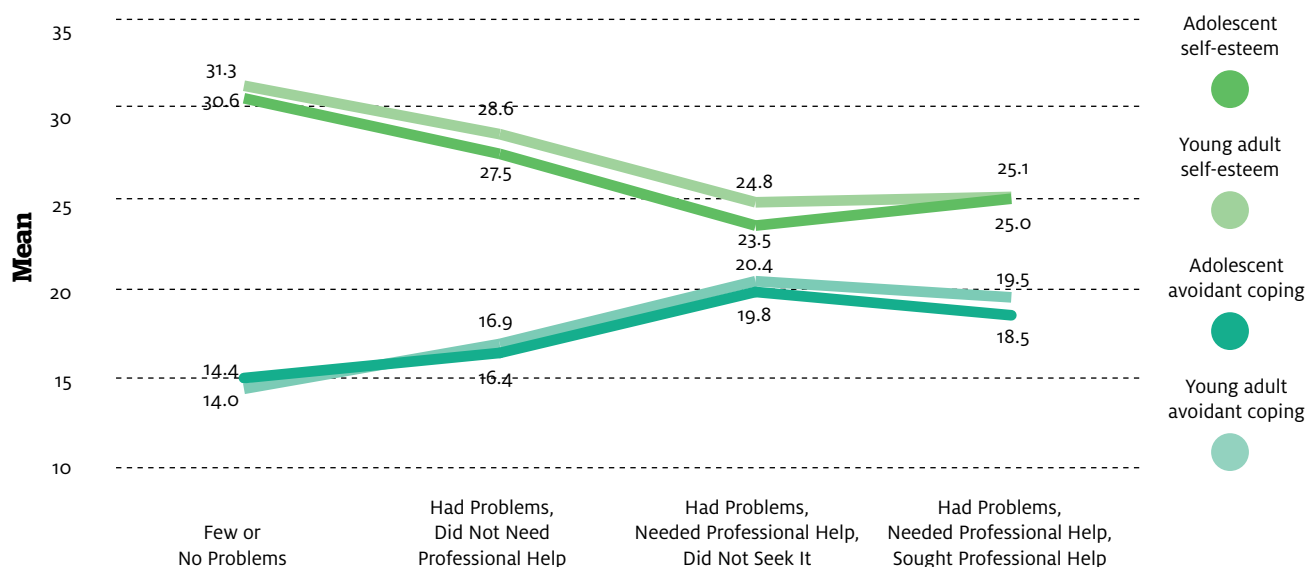
Figure 8.6: Problems, help-seeking and distress

Formal help-seeking and adolescents

In the adolescent sample, self-esteem was lower in the group that had problems but did not seek help compared to those who did seek help. This finding also emerged for avoidant coping strategies, where help-seeking was linked to a reduction in avoidant coping behaviour (Figure 8.7). Additionally, adolescents with problems who were not seeking help engaged in avoidant coping to a much higher degree than young people who reported few or no problems.

Not seeking help when needed was linked to two further protective factors in the adolescent sample: perceived social support and satisfaction with life. Social support and life satisfaction were lower in the group who did not seek help than among those who had sought help and those with few or minor problems. This indicates the benefit of seeking help for emotional difficulties.

Figure 8.7: Problems, help-seeking, self-esteem and avoidant coping



Formal help-seeking and young adults

In the young adult sample, not seeking help when needed was again shown to be statistically linked to the poorest outcomes as measured by: perceived social support, optimism, active coping strategies, avoidant coping style, and alcohol and substance misuse behaviour.

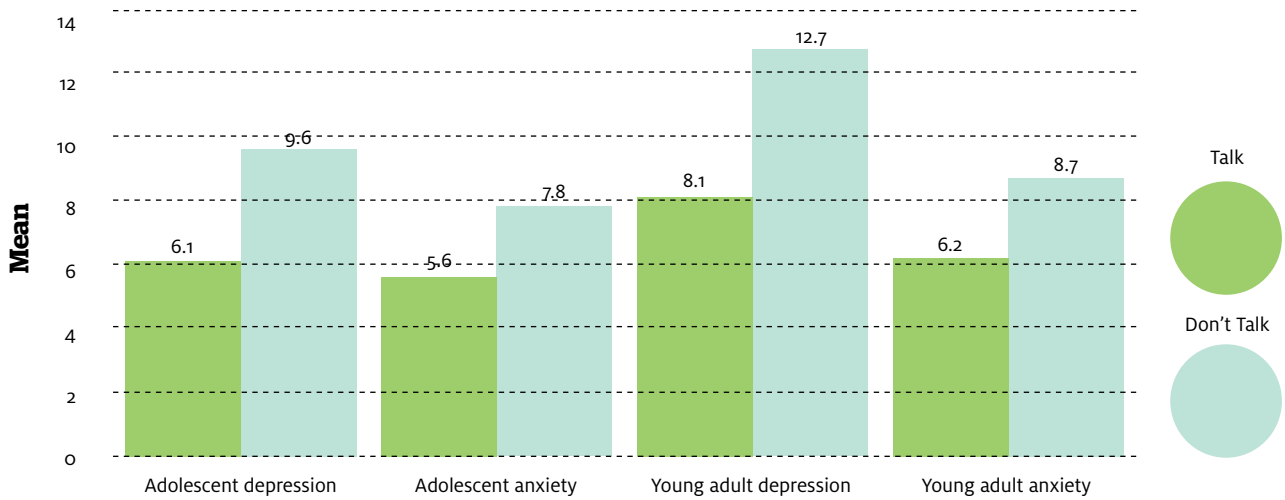
Alcohol and substance misuse factors were highest in young people who reported emotional problems but did not seek help. This group were outside the normal range for both alcohol behaviour and substance misuse. Those who had few or no problems or minor problems were within the normal range for alcohol and substance misuse.

Informal help-seeking - talking is good for you

The MWS asked young people to indicate whether or not they talked about their problems. Nearly two-thirds (64%) reported that they would talk to someone if they had a problem. This percentage was similar for both the adolescent and young adult sample. Therefore, over a third of young people do not talk or seek informal help when they have problems.

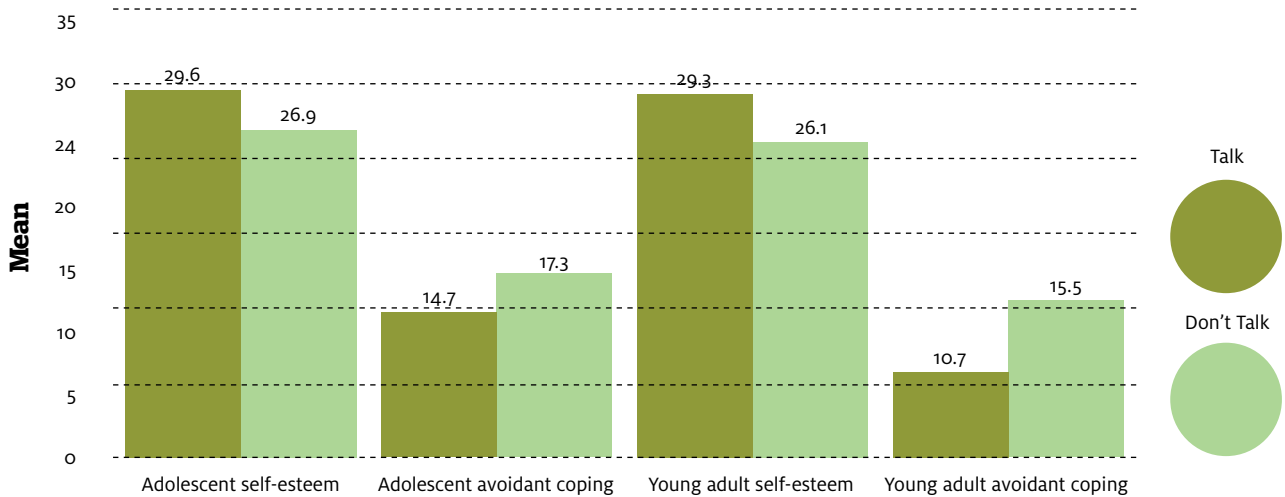
Young people who do not talk about their problems have elevated levels of distress, as shown by indicators of depression, stress and anxiety. Conversely, those who report that they talk when they have a problem have levels of distress within the normal range, which may indicate the positive benefits of talking and sharing problems (Figure 8.8).

Figure 8.8: Talking about problems and distress levels



Young people who talk about their problems report significantly higher levels of social support from family, friends and adults compared to those who do not. This was also evident for self-esteem, optimism, life satisfaction, and positive coping strategies. Additionally, talking about problems was linked to lower levels of avoidant coping behaviour. The patterns are the same for the adolescent and the young adult sample.

Figure 8.9: Talking about problems, self-esteem and avoidant coping



Talking about specific problems

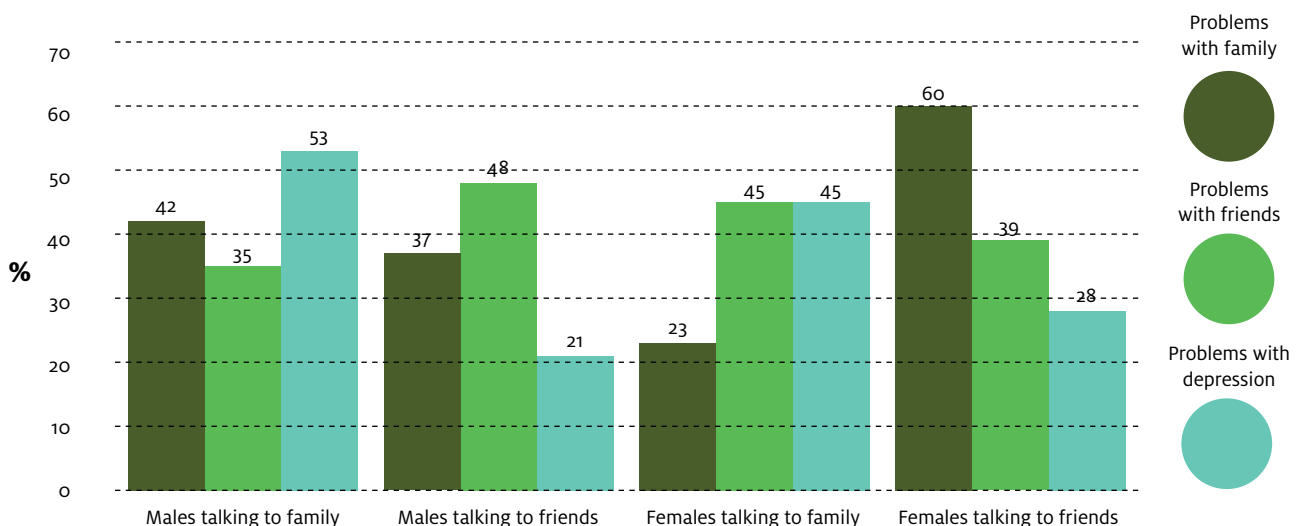
We also asked young people who they would talk to first if they had problems with family, friends, depression, alcohol and drugs. The response options were: family, friend, other or no-one.

Adolescents

Adolescents who reported problems with family were likely to turn to their friends for help (51%). However, this percentage is higher for females (60%) than for males (42%).

Overall, adolescents are equally likely to turn to friends and family when they have a problem with friends. However, subtle differences emerged when looking at males and females separately. A total of 45% of females turn to their family for a problem with friends, while 48% of males turn to their friends. If an adolescent has a problem with depression, they are likely to turn to their family (49%); 53% of males turn to their family compared to 45% of females, with only 4% reporting that they would talk to no-one. See Figure 8.10.

Figure 8.10: Who young people talk to about their problems



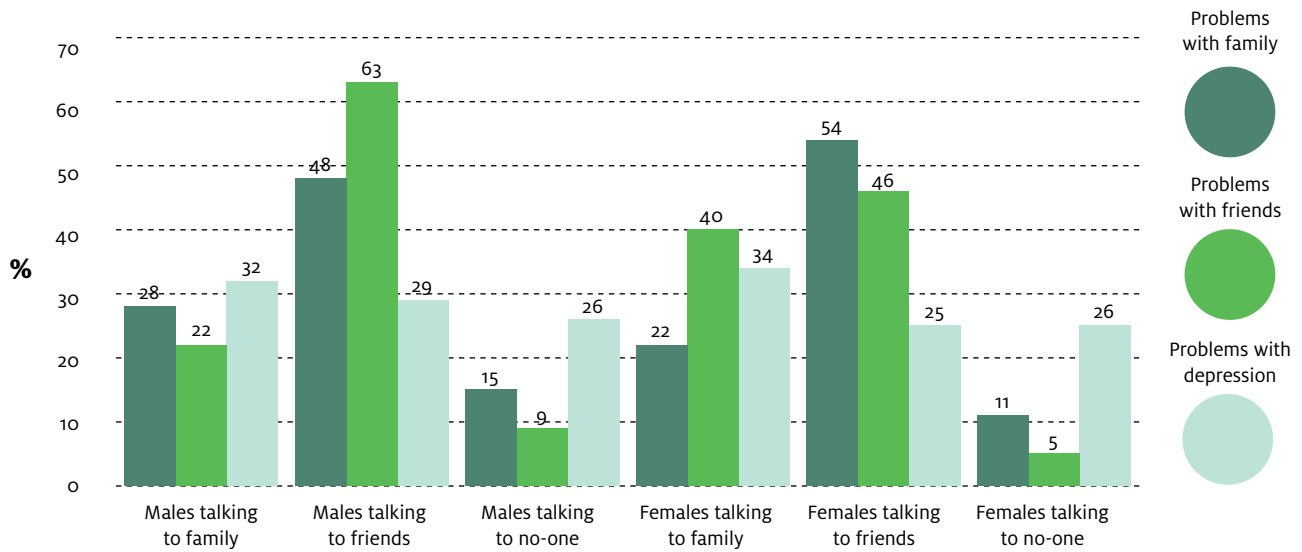
Young adults

In Figure 8.11 below, it is apparent that males turn to friends when they encounter problems with friends and family. Females also turn to friends but the percentage is lower for problems with friends and higher with family problems.

When a young person experiences depression, however, one-quarter will choose not to speak to anyone.

Thus, overall, young people are likely to talk about their problems but may not want to talk about being depressed.

Figure 8.11: Reluctance to talk about depression



Key messages

- › Asking young people about their problems and their need for help provides a good indicator of their mental health. Young people are very aware of how well they are doing, as evidenced by the data.
- › Young people who know they are experiencing emotional difficulties and do not seek professional help have the highest levels of distress and the lowest well-being.
- › Nearly two-thirds of young people talk informally about their problems and this was found to be associated with better mental health and well-being.
- › Depression is the one experience that young people are most likely not to talk to anyone about.

Summary

- › Having One Good Adult is important in the mental well-being of young people.
- › Excessive drinking has very negative consequences for the mental health and adjustment of young people.
- › Young adults' experiences of financial stress are strongly related to poor mental health and well-being.
- › Rates of suicidal thoughts, self-harm and suicide attempts are higher in young adults who do not seek help or talk about their problems.
- › Talking about problems is associated with lower mental health distress and higher positive adjustment.

9 / Summary and Conclusions

This chapter draws together MWS key findings for the adolescent sample and the young adult sample, as well as the developmental data for the entire sample of 12-25 year-olds.

9.1. Summary of findings on adolescents

The majority of adolescents (70%) were found to be functioning well across a variety of mental health indicators such as ability to cope well with problems, self-esteem, psychological distress, and help-seeking behaviours. More than two-thirds reported no problems with depression, anxiety or stress. Nearly 50% reported that they cope well with problems, while more than two-thirds indicated that they enjoy their family life, and talk to someone when they have problems. About 70% reported that they have support from a special adult when in need.

In general, adolescents who indicated they were in distress were more likely to report excessive drinking behaviour, and to have experienced being bullied at some point. These young people also reported low availability of a special adult when in need, and, while aware that they have problems, generally do not talk about them. Those who indicated the highest levels of distress were aware of needing support, but chose not to seek help.

Females have higher levels of distress and reported being bullied more frequently than males. In addition, females engaged in higher levels of avoidant coping behaviour than males. Males engaged in more 'acting out' behaviours in school when distressed than females.

Males were more likely to report that they cope well with their problems than females and engage in higher levels of problem-solving as a coping strategy. Females, for their part, reported higher levels of social support than males. They were also more likely to talk about their problems and to seek professional help.

Levels of psychological distress were generally found to increase with school year. Younger adolescents were shown to have more positive levels of well-being – including greater self-esteem, resilience, life satisfaction and optimism – than older adolescents, which is consistent with the international literature. Older adolescents reported higher levels of difficulties and lower levels of positive well-being than younger adolescents.

Problem drinking, substance use and behavioural problems were shown to increase across the school years. By 6th year, more than a third of adolescents were classified as engaging in problem drinking behaviour.

9.2. Summary of findings on young adults

Over half (53%) of young adults reported that they cope well with problems, while two-thirds (66%) indicated that they enjoy their family life. About 70% reported that they have support from a special adult when in need and 63% that they talk to someone when they are experiencing problems.

Although the majority of young adults were found to be functioning well, overall, this study revealed that young adults had higher levels of distress than adolescents, with approximately 40% of them experiencing elevated levels of depression and anxiety.

The study revealed high levels of alcohol and substance use among many young adults. Half were shown to engage in 'problem drinking' or 'hazardous drinking' and 10% were classified as having 'possible alcohol dependence'. Similarly, nearly half (45%) of young adults reported that they had used cannabis. Excessive drinking behaviour was linked to several mental health indicators. For example, for the 34% of young adults who engaged in harmful drinking behaviour, their anxiety levels were in the moderate-to-very-severe range.

Similar to their adolescent male counterparts, young adult males reported higher levels of self-esteem and optimism, and engage in more constructive planning and coping strategies than females. With regard to risk factors, males are more likely to engage in externalising or 'acting out' behaviours and to be violent towards others. Males were classified as having higher levels of alcohol problem behaviours than females, and less likely to talk about their problems and seek help.

Females reported higher levels of support from family and friends, and they were more likely to talk about a problem or seek professional help for a problem compared to males. They also reported a higher degree of mental health distress than males. A higher percentage of females (24%) also engaged in self-harm compared to males (16%). Similar to their adolescent female counterparts, young adult females engaged in higher levels of avoidant coping behaviour than males.

9.3. Emerging patterns across a young person's life

The developmental data provided by the MWS allow us to see, for the first time, the mental health difficulties that young people experience across this vulnerable timespan in their lives.

- › We see an increase in young people's levels of depression, anxiety and stress across the developmental period of 12-25 years.
- › We see a steady increase in levels of alcohol consumption, frequency and volume of drinking, number of alcoholic drinks typically consumed, and binge drinking across the 12-25 age group. Young people move outside the normal range for drinking at 18 and remain outside until about 24-25.
- › Avoidant coping, a negative coping strategy, peaks at 20-21 years, then declines towards age 24.
- › At 18-19 years, young people report a high level of substance use, which continues until they are 24-25.
- › Levels of both self-esteem and optimism generally decrease from 12-18 years, whereby at 18-19 both are at their lowest. Levels increase gradually from about 19 onwards.
- › A positive coping strategy (that is, the use of problem-focused coping) is at its lowest at 14-15 years, and gradually increases up to 24-25. Levels of seeking social support are highest at 12-13, drop at 18-19 and remain at this level up to 25.

It is evident from our findings that mental health difficulties emerge in early adolescence and peak in the late teens and early 20s. This peak in mental health difficulties, in general, is coupled with a decrease in protective factors such as self-esteem, optimism and positive coping strategies. The evidence indicates that this stage of a young person's life is a particularly vulnerable period. This profile of the emergence of mental health difficulties highlights the importance of early intervention.

9.4. Identifying young people at risk - the MWS At-Risk Index

Based on the data from the emerging themes (see Chapter 8), the MWS indicates that, by asking a young person a number of key screening questions, we may be able to determine their mental health status. These questions include asking the following:

- › Have you had any serious problems in the past year that you felt needed professional help?
- › Do you have a special adult who is there when you are in need?
- › When you have problems, do you talk about them with anyone?
- › Do you enjoy your family life?
- › Do you cope well with problems?
- › Have you ever been bullied?
- › Do you feel angry a lot?

Young people who report agreeing with some or all of the above statements are highly likely to be experiencing mental health difficulties. Schools, service providers and other professionals working with young people, who need to identify those at risk for mental health problems, should consider asking these very simple questions as an initial screen for a young person's mental health status. These questions make up what we have called the *MWS At-Risk Index*.

Finally, a key finding of the MWS concerns the role of 'One Good Adult' in a young person's life. Young people who do not feel connected or bonded to those around them, were more vulnerable in experiencing mental health difficulties. The MWS findings suggest that every young person needs at least one supportive adult in their lives. This One Good Adult could be someone in the young person's family, such as their mother or an older brother, or someone outside the family, such as a relative, a teacher or a close friend. This One Good Adult can change over time; for example, it could be a parent for a young adolescent or a boyfriend/girlfriend for a young adult. The MWS findings highlight the importance of having at least One Good Adult in a young person's life, to promote their mental health and well-being.

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Appendix 1: Methodology for Adolescent Sample

Overview

This appendix describes the methodology used to carry out the MWS-Second Level (MWS-SL) study. It begins with a description of the recruitment procedures for post-primary schools. This is followed by details of data collection in schools, characteristics of the schools and participants who took part, and the survey instrument used for data collection.

How were the schools and students selected?

The MWS-SL study sought to recruit a sample of adolescents enrolled in post-primary schools that would be representative of students enrolled in the 732 post-primary schools in the Republic of Ireland. Five criteria were identified that had to be met to achieve a nationally representative sample:

1. All post-primary schools in Republic of Ireland had to have an equal chance of being included in the sample.
2. The sample had to reflect the distribution of schools and students in all four Health Service Executive (HSE) areas (Dublin-Mid Leinster, Dublin-North East, West, South). The counties in each HSE area are shown in Table A1.
3. The sample had to reflect the national distribution of schools characterised as disadvantaged (DEIS) and non-disadvantaged in the four HSE areas. Schools that are part of the School Support Programme, under the Delivering Equality of Opportunity in Schools action plan, are referred to as DEIS schools or disadvantaged schools. Those that are not part of the School Support programme are referred to as non-DEIS schools or non-disadvantaged schools.
4. The sample had to reflect the distribution of schools with regard to gender composition (males only, females only, mixed gender).
5. The sample had to include at least one school in every county in the Republic of Ireland.

Table A1: Counties in each of the four HSE areas

HSE Dublin-Mid Leinster	HSE Dublin North East	HSE West	HSE South
Kildare	Cavan	Clare	Carlow
Laois	Louth	Donegal	Cork
Longford	Meath	Galway	Kerry
Offaly	Monaghan	Leitrim	Kilkenny
South Dublin*	North Dublin*	Limerick	South Tipperary
Westmeath		Mayo	Wexford
Wicklow		North Tipperary*	Waterford
		Roscommon	
		Sligo	

* Dublin and Tipperary are both divided in two.

This multi-stage sampling strategy thus reflects all students enrolled in DEIS and non-DEIS schools, organised by gender composition, across the counties in the four HSE areas. Based on these criteria, a random sample of 171 schools was selected that reflects the normal distribution of the 732 post-primary schools in the Republic of Ireland.

Data collection

The distribution of the research pack to schools was followed up by a phone-call to the school principal from one of the researchers, generally about one week later. If the principal expressed an interest in the school participating in the study, a contact person was identified in that school. A research information letter and consent form for both the student and his/her guardian were distributed to students by a researcher or staff member in the school. Once student and guardian consent forms had been returned, a date to collect data was agreed.

Schools were offered the choice of completing a paper-based or web-based version of the MWS-SL. Schools were also offered the choice to complete the survey themselves in class-time with students or to have a researcher come to the school to facilitate students completing the survey.

Response rate: school and individual level

From the initial sampling frame of 171 schools, a total of 72 schools agreed to take part in the study (42%). On the basis of the number of 'informed consent' forms delivered to the 72 schools for distribution to parents, and the number returned with parental approval, the final sample of 6,085 students constitutes a response rate for student participation of 45% (response rates varied across schools from 6% to 89%). Active parental and student consent was obtained in each school. The main reasons for non-participation were absenteeism and failure to return consent forms.

Characteristics of post-primary schools

DEIS and non-DEIS schools

- › 74% of schools in the sample (n=53) were classified as non-DEIS
- › 26% of schools in the sample (n=19) were classified as DEIS

HSE areas

- › Dublin-Mid Leinster HSE area (n=17, 24% of schools in sample)
- › Dublin North East HSE area (n=10, 14% of schools in sample)
- › Western HSE area (n=26, 36% of schools in sample)
- › Southern HSE area (n=19, 26% of schools in sample)

Gender classification of schools in final sample

- › Mixed gender (n=50, 70% of sample of schools)
- › Single-sex males (n=12, 16% of sample of schools)
- › Single-sex females (n=10, 14% of sample of schools)

School type

- › Secondary (n=39, 54% of schools in sample)
- › Vocational (n=23, 32% of schools in sample)
- › Community (n=10, 14% of schools in sample)

Description of MWS-SL

The MWS-SL version contains at least two large sections. The first section includes a range of demographic and personal well-being questions (see Table A2).

Table A2: Demographic characteristics included in MWS-SL version

Age	Mother/father employment
Gender	Are you adopted?
Ethnicity	Irish or foreign adoptee, how old when adopted, country adopted from
School year	Number of children in family
Who they live with	Marital status of parents
Where they live	A parent has experienced mental health problems
Mother/father education	Adolescent has experienced mental health problems

The participants are asked whether their mother or father ever had a mental health problem (for example, depression, alcohol or drug addiction); and whether they themselves have ever seen a mental health professional (for example, a therapist, psychologist, psychiatrist); and if so, how recently; and whether they had found it helpful (yes or no).

Other questions in the first section ask the adolescents about: 1) their academic position, 2) whether they enjoy their family life (yes, sometimes, no), 3) whether they cope well with problems, 4) whether they have ever been in trouble with the gardaí, 3) the three most significant stressors/problems in their life, and 4) the three ways that help them cope when things are tough.

A question on body dissatisfaction is also included in this section. Participants are asked: 'How satisfied are you with your body?'

Positive and negative domains of psychological functioning

The second major section of the MWS-SL contained a number of scales previously shown to have reliability and validity, organised into positive and negative aspects of psychological functioning.

The most common measure of reliability (i.e. the internal consistency of all of the items in a scale) is called Cronbach's alpha. The higher the value of alpha, the more reliable the scale is. Alphas below .65 mean that the scale has not met minimal criteria for reliability. Listed below in Table A3 are those scales, the number of items in each scale, and the alpha based on data from this MWS-SL study.

Table A3: Reliabilities of scales in the adolescent MWS-SL version

Scales in MWS-SL	Number of items in scale	Cronbach's alpha
POSITIVE DOMAINS +++++		
Rosenberg Self-Esteem Scale (RSE)	10	.89
Coping Strategy Indicator (CSI-15)	15	.74
CSI-Planned Coping	5	.84
CSI-Avoidance Coping	6	.79
CSI-Support-Focused Coping	4	.91
Life Orientation Test – Revised (LOT-R)	6	.74
Formal Help-Seeking Scale	2	.74
Informal Help-Seeking Scale	8	.73
Resilience Scale for Adolescents (READ)	28	.91
READ-Personal Competence	8	.77
READ-Social Competence	5	.74
READ-Structured Style	4	.58
READ-Social Resources	5	.76
READ-Family Cohesion	6	.86
Brief Multidimensional Students' Life Satisfaction Scale	6	.86
MSPSS-Multidimensional Scale of Perceived Social Support	12	.94
MSPSS-Family	4	.90
MSPSS-Friend	4	.93
MSPSS-Significant Other	4	.92
Support About Your Mental Health	2	na
NRI-RQV-Network of Relationships Inventory-Relationship Qualities Version		
NRI-RQV-Mother Approval	3	.82
NRI-RQV-Father Approval	3	.84
NRI-RQV-Best Friend Satisfaction	3	.80
NRI-RQV-Romantic Partner Satisfaction	3	.84
Hemingway Measure of Adolescent Connectedness (MAC)		
MAC-Peer Connectedness	6	.71
MAC-Teacher Connectedness	6	.83
MAC-School Connectedness	6	.82
NEGATIVE DOMAINS -----		
DASS-21		
DASS-Depression	7	.88
DASS-Anxiety	7	.80
DASS-Stress	7	.83
AUDIT-Alcohol Use Disorders Identification Test	10	.82
CRAFFT Substance Misuse	6	.74
Behavioural Adjustment Scale (BAS)	13	.86
PEBQ-Pupils' Experience of Bullying Scale	8	na
NRI-RQV-Network of Relationships Inventory-Relationship Qualities Version		
NRI-RQV-Mother Criticism	3	.84
NRI-RQV-Father Criticism	3	.85
NRI-RQV-Best Friend Criticism	3	.80
NRI-RQV-Romantic Partner Criticism	3	.79

POSITIVE DOMAINS +++++

1) Rosenberg's Self-Esteem Scale (RSE)

Self-esteem is assessed with the Rosenberg Self-Esteem scale (RSE; Rosenberg, 1965). The 10 items of the RSE assess a person's overall evaluation of his/her worthiness as a human being (Rosenberg, 1970). This scale uses 'strongly agree' to 'strongly disagree' as response alternatives to statements such as: 'On the whole I am satisfied with myself' and 'I wish I could have more respect for myself'.

Items are scored on a 4-point scale and scores range from 10 to 40.

2) Coping Strategy Indicator (CSI)

The CSI (Amirkhan, 1990) assesses three dimensions of coping strategies: problem-solving, seeking social support, and avoidance. This scale asks the adolescent to indicate how, when they have difficulties or problems, they respond from 'never' to 'always'. Responses are made on a 5-point scale. The items are focused on being proactive ('I plan how to solve the problems before I do anything else'), approaching a friend ('I go to a friend for advice') or avoidance ('I avoid the problem by spending more time alone').

The CSI Problem-Solving subscale consists of 5 items (scores range from 5 to 30), the CSI Support subscale consists of 4 items (range from 4 to 24) and the CSI Avoidance subscale consists of 6 items (range from 6 to 36).

The CSI has demonstrated good internal consistency, test-retest reliability and construct validity. The three-factor solution has been replicated (Clark, Bormann, Cropanzano & James, 1995). An adapted 15-item version of the CSI is used for the present study. The adapted version has previously demonstrated a three-factor structure in line with the original CSI and has shown good internal consistency for these factors.

3) Life Orientation Test Revised (LOT-R)

The LOT-R is a measure of dispositional optimism. This scale asks the adolescent to indicate on a 5-point scale the degree to which 'I agree a lot' or 'I disagree a lot' with items such as: 'In uncertain times, I usually expect the best' and 'I hardly ever expect things to go my way'.

Scores on the 6-item LOT-R range from 0 to 24. The LOT-R has acceptable internal consistency and 4- and 13-week test-retest reliability (Scheier & Carver, 1985; Carver & Gaines, 1987). Scores on the LOT-R are correlated positively with self-esteem and negatively with hopelessness, depression, and perceived stress.

4) Formal and Informal Help-Seeking Behaviour (HSB)

Formal help-seeking is assessed using a measure that was slightly adapted (see Saunders, Resnick, Hoberman & Blum, 1994) and had been previously used on a sample of Irish adolescents (Daly, 2006). Participants were asked: 'Have you had any serious problems in the past year?' – for example, 'personal, emotional, behavioural, problems that caused you considerable stress and you felt you would have benefited from professional help' (e.g. counsellor, psychologist, psychiatrist, GP). The response options were: 'I have few or no problems', 'I have had some problems but I did not feel I needed professional help', 'I have had some problems but I did not seek professional help although I thought I needed it', and 'I have had some problems and I did seek professional help'.

Informal help-seeking was assessed with 8 items adapted from Saunders et al (1994). Participants were asked two general questions: 'When you have problems, do you talk about them with anyone?' 'If yes, who would you talk

to ... family, friend, no one?' They were then asked who they would talk to first if they had problems with their family or a friend, had a romantic relationship problem, a school problem, or a problem with depression or with alcohol and drug use.

Saunders et al (1994) found kappa coefficients of .96-.99 across two independent coders.

5) Resilience Scale for Adolescents (READ)

The READ (Hjemdal, Friborg, Stiles, Martinussen & Rosenvinge, 2006) is a 28-item measure of adolescent resilience, and higher scores reflect a higher degree of resilience. This scale has 5 response options ranging from 'totally agree' to 'totally disagree' and focuses on how the adolescent relates to family and friends, and the degree to which they are goal-oriented. This scale consists of five factors: 1) personal competence (8 items), 2) social competence (5 items), 3) structured style (4 items), 4) family cohesion (6 items), and 5) social resources (5 items).

The Personal Competence factor assesses adolescents' general self-efficacy, self-esteem and ability to maintain a realistic orientation to daily life. The Social Competence factor assesses social adeptness, cheerfulness, communication skills and flexibility in social situations. The Structured Style factor examines how much the adolescent prefers to plan and structure daily routines. The Family Cohesion factor looks at support within the family and the family's ability to maintain a positive outlook. The Social Resources factor assesses perceived availability of social support.

Scores for the overall READ scale range from 28 to 140. Scores for the READ subscales are as follows: Personal Competence: 8-40; Social Competence: 5-25; Structured Style: 4-20; Family Cohesion: 6-30; and Social Resources: 5-25. The READ was developed using confirmatory factor analysis, and has shown adequate psychometric properties and promising validity (Hjemdal et al, 2006).

6) Multidimensional Scale of Perceived Social Support (MSPSS)

The MSPSS (Zimet et al, 1988) measures perceived social support from family, friends and significant others. This 12-item scale asks the adolescent to indicate on a 7-point scale the degree to which they 'very strongly agree' to 'very strongly disagree' with statements such as: 'There is a special adult who is around when I am in need', 'My friends really try to help me'.

The MSPSS yields an overall score (range from 12 to 84) and three subscale scores (perceived support from family, friends and significant others – range from 4 to 28), with higher scores indicative of higher levels of perceived social support. The reliability, validity and factor structure of the MSPSS has been demonstrated in different samples (Kazarian & McCabe, 1991; Zimet et al, 1990; Zimet et al, 1988).

7) Support About Your Mental Health

Two questions assessed 1) what places young people are likely to use and 2) what places they have actually used to get information and support about their mental health. The list of places included: parents, relatives, friend, internet, phone help-line, teacher/guidance counsellor, doctor/GP, psychologist/counsellor/therapist, or other. These items were included in the MWS based on a request from Inspire Ireland Foundation, a charitable organisation that helps young people lead happier lives (www.inspireireland.ie).

8) Brief Multidimensional Students' Life Satisfaction Scale (BMSLSS)

The BMSLSS (Huebner, Suldo, Valois, Drane & Zullig, 2004) is a 6-item measure which asks the adolescent to indicate on a 7-point scale the degree to which

they are 'very dissatisfied' to 'very satisfied' with family life, friends, school experience, 'myself', 'where I live' and with 'my overall life'.

The six items are summed to obtain a total life satisfaction score. Scores range from 6 to 42. The BMSLSS has adequate reliability and validity for adolescents (Seligson et al, 2003).

9) Network of Relationships Inventory – Relationship Qualities Version (NRI-RQV)

The NRI-RQV (Furman & Buhrmester, Unpublished Manual) assesses the quality of relationships with mothers, fathers, same-sex friends and romantic partners. Three subscales from the NRI-RQV assess two positive relationship features: approval (e.g. 'How often does this person seem really proud of you?') and satisfaction (e.g. 'How happy are you with your relationship with this person?'), and one negative relationship feature: criticism (e.g. 'How often does this person criticise you?'). Each subscale consists of three items, with responses ranging from 'never or hardly at all' to 'seldom'.

Positive relationship features

The approval subscale is used to assess relationships with mother and father. The satisfaction subscale assesses relationships with best friends and romantic partners.

Negative relationship features

The criticism subscale assesses relationships with best friend, romantic partner, mother and father.

Scores on each of the subscales range from 3 to 15. The NRI-RQV has previously been used among Irish adolescents and the internal consistency of all the subscales has been estimated to be good (Kenny, 2011).

10) Hemingway Measure of Adolescent Connectedness (MAC)

Three subscales from the Hemingway Measure of Adolescent Connectedness (Karcher, 1999) were used to assess adolescents' connectedness with their peers, teacher and school. Each subscale consisted of 6 items designed to measure the adolescents' degree of caring for and involvement in relationships with 1) peers and 2) teachers, and 3) involvement in school. Response options ranged from 'not true at all', 'not really true', 'sort of true', 'true', to 'very true'.

Scores on the 6-item peer, school and teacher subscales range from 6 to 30. The Hemingway is one of the few measures of adolescent connectedness in the published literature that has been empirically tested and found to demonstrate validity (Resnick et al, 1997; Roth & Brooks-Gunn, 2003).

11) Neighbourhood Safety

One item asks about adolescents' perception of neighbourhood safety: 'How safe do you feel living in your neighbourhood?' The response options are 'very unsafe', 'unsafe', 'neither safe nor unsafe', 'safe' and 'very safe'.

NEGATIVE DOMAINS -----

1) Depression, Anxiety and Stress Scale (DASS-21)

The DASS-21 is a self-report measure in which participants rate the frequency and severity of experiencing negative emotions over the previous week. Frequency ratings are made on a series of 4-point scales (0=does not apply to me at all, 3=applies to me most of the time). The scale contains items on depression ('I felt that I had nothing to look forward to'), anxiety ('I felt close to panic'), and stress ('I found it difficult to relax').

Using recommended cut-off scores (Lovibond & Lovibond, 1995), adolescents are classified as displaying normal, mild, moderate, severe, or very severe symptoms of depression, anxiety or stress (see Table A4). Analyses of the factor structure of the DASS have yielded strong support for the identified scales. The validity of the DASS-21 has been consistently demonstrated (Crawford & Henry, 2003; Henry & Crawford, 2005; Tully, Zajac & Venning, 2009).

Table A4: Cut-off scores for classification of depression, anxiety and stress

Classification	Depression cut-off scores	Anxiety cut-off scores	Stress cut-off scores
Normal	0-9	0-7	0-14
Mild	10-13	8-9	15-18
Moderate	14-20	10-14	19-25
Severe	21-27	15-19	26-33
Very severe	28-42	20-42	34-42

2) Alcohol Use Disorders Identification Test (AUDIT)

The AUDIT was developed by the World Health Organisation (Saunders, Aasland, Babor, de la Fuente & Grant, 1993) as a screening tool for hazardous alcohol consumption. The AUDIT consists of 10 items designed to measure three content domains: 1) alcohol consumption, 2) signs of alcohol dependence, and 3) alcohol-related harm. The maximum score on the AUDIT is 40.

The adolescents are asked first about how often they drink alcohol. Next, 6 questions are asked: how often they have six or more drinks in one sitting, whether they have experienced things like failing to do what was normally expected of them, whether they have injured someone, whether someone has been concerned about their drinking, and finally how many drinks they have when they are drinking – from ‘1 to 2’ to ‘10 or more’.

One of the strengths of the AUDIT is that it can be used appropriately with non-clinical samples. According to the WHO recommended cut-offs (Babor, Higgins-Biddle, Saunders & Monteiro, 2001), total scores of 8 or more indicate problem drinking, total scores of 16 or more indicate harmful and hazardous drinking, and total scores of 20 or more indicate possible alcohol dependence.

In 18 studies, the median value of Cronbach’s alpha fell well within the 0.80s (Reinert & Allen, 2002). The AUDIT is also valid with the three factors identified above (consumption, dependence, related harm) confirmed by data (Shields, Guttmanova & Caruso, 2004).

3) CRAFFT Substance Use Screening Scale

The CRAFFT is a valid measure to detect substance problem use, abuse and dependence among adolescent populations (Knight et al, 1999; 2002). This 6-item scale asks the adolescent if they have ever been in a car driven by someone who had been using alcohol or drugs, and experienced other types of problems because of alcohol or drugs. It uses a yes/no response scale and can be used with both clinical and non-clinical samples.

A total score for the CRAFFT is computed with a sum of 6 binary scores, ranging from 0 to 6. When evaluated in a general paediatric setting, a cut-off score of ≥ 2 correctly classified in 86% of cases whether the youth did or did not have a current substance abuse or dependence disorder (Knight et al, 2002). While Knight et al (1999; 2002) set the optimal cut-off score at 2,

Cummins et al (2003) suggest that a cut-off point of 3 is optimal for identifying substance use, abuse and dependence.

4) Cannabis Use

Adolescents are asked about whether they have ever used cannabis (yes/no) and, if yes, at what age they started using cannabis.

5) Behavioural Adjustment Scale (BAS)

A shortened version of the BAS (Brown, Clasen & Eicher, 1986) is used to assess the frequency over the past month that adolescents engaged in substance misuse and school misconduct. The adolescent is asked how many times over the past month (from never to almost every day) they have done various things that are harmful with regard to substances (cigarettes, alcohol, cannabis, other drugs); done things they shouldn't do at school (talked back to my teachers, cheated in an exam), been punished for things they did in school (been kicked out of class by a teacher).

The BAS has been shown to have acceptable validity (Bachman, Johnston & O'Malley, 1984; Brown et al, 1986). Scores for the total BAS range from 13 to 65.

6) Pupils' Experience of Bullying Scale (PEBS)

Experiences of bullying were assessed with items that had been used in previous research and were found to be reliable (Griffin, 2006). The adolescent is asked if they have seen anyone bullied and if they have been bullied and, if so, how recently (ranging from daily to within the last 4-5 years), and how they were bullied (physical, verbally, emotionally, via the internet, by text) and where they were most frequently bullied (in school, at home, internet, by text).

Appendix 2: Methodology for Young Adult Sample

Overview

This appendix provides further information on the recruitment procedures for the various groups of young adults who took part in the MWS-Post Second Level (MWS-PSL). They were: 1) young adults in third level education, 2) those enrolled on national training courses/schemes, 3) those who were unemployed, and 4) those who were employed. Further information on the measures included in the MWS-PSL instrument is also provided here.

Recruitment of third-level sample

How were the third-level institutions and students selected?

A high percentage of young people in Ireland are identified as students. A recent report revealed that 62% of those aged 15-24 are classified as 'students' (i.e. principal economic status) (The Quarterly National Household Survey, 2011). The MWS-PSL study thus sought to recruit a sample of third-level students.

Recruitment of third-level institutions

To geographically represent third-level institutions in each of the four HSE areas, a minimum of one university and one institute of technology (IT) were randomly selected from the Higher Education Authority's list of educational institutions, for the third-level sampling frame (n=8).

During the recruitment phase, five third-level institutions not included in the initial sampling frame expressed an interest in having their institution participate in the MWS-PSL. This interest was prompted by institutions requiring good data on the mental health needs of their students to enable appropriate planning. Thus, all universities, five institutes of technology and one college of education were included in the sampling frame (N=13).

The registrars of selected third-level institutions were contacted about the research. If the registrar was agreeable to the study, an email was sent to all registered students in that institution informing them of the study and inviting them to take part in the survey. All students aged 25 and under were invited via email to complete a web-based version of the survey. The email provided a web link to the MWS-PSL study, presented via the survey software tool Qualtrics (Qualtrics Labs Inc., Provo, UT, 2009).

Prior to commencing the web-based survey, an information page outlining the purpose of the study and a consent form were presented to prospective participants. Participants were required to provide their consent by clicking the on-screen radio buttons before moving on to complete the survey. A paper copy of the survey was provided as an alternative to the web-based survey

for those who requested it. A national prize draw of three Apple iPads was provided as an incentive to take part in the study.

Response rate: third-level and individual level

Twelve out of 13 third-level institutions agreed to participate in the MWS-PSL. Based on student registration numbers in participating third-level institutions, it is estimated that approximately 10% of students in each institution completed the MWS-PSL.

Characteristics of third-level students

The final third-level sample consisted of 8,195 students, of whom 98% completed the web-based survey. The sample represented 64% of female students. It ranged in age from 17-25, with a mean age of 20 years ($M=20.35$, $SD=1.91$). The age distribution of the students was similar between males and females, with 59% under 20, 33% aged 21-23 and 8% aged 24-25.

The sample represented 89% undergraduate and 11% postgraduate students; 35% were in first year, 27% in second year, and 38% in third year or higher. There was no difference in gender distribution across years.

The majority of students (81%) reported that they were single, 13% were in a relationship, 5% were living with a partner, and 1% were married. With regard to living situation, 46% of the sample lived at home, 38% in rented accommodation, and 13% on campus.

With regard to highest level of education achieved, 83% had a Leaving Certificate, 1% had a Technical/Vocational qualification, 4% had a Certificate or Diploma and 10% had a Primary Degree. In terms of parental marital status, 81% reported that their parents were married/cohabiting, 12% were separated/divorced, 2% were single, and 1% were remarried. Marital status of parents had a similar spread between males and females.

Table A5: Demographics of third-level sample by gender

No. of respondents	Males N=2926 %	Females N=5269 %
Gender	36	64
<i>Age category</i>		
17 years	2	3
18 years	14	14
19 years	22	21
20 years	21	21
21 years	15	17
22 years	10	10
23 years	7	6
24 years	5	4
25 years	4	4
<i>Year in college</i>		
1st year	34	35
2nd year	27	26
3rd year plus	39	39

Recruitment of trainee sample

How were the training centres and trainees selected?

Young people over 18 were recruited from the National Training and Employment Authority (NTA) training centres, using purposive sampling. The researcher contacted the managers of selected training centres to explain the purpose and rationale of the study. If the manager was agreeable to the study, they were provided with the option of receiving web-based or paper-based versions of the MWS-PSL, depending on the IT facilities available in the participating centre.

All centres completed the surveys without a data collector from the research study present. The manager or a staff member approached trainees in their centre either in person or via email and invited them to take part in the study. If the young person was contacted in person by the manager, they were provided with the option of receiving a paper copy of the survey, or else provided with a slip of paper with the web link to the survey. If the young person was contacted by email by the manager, the email provided a web link to the online survey. Posters were displayed in participating sites advertising about the research. A national prize draw of three Apple iPads was provided as an incentive to take part in the study. Similar to the recruitment of third-level students, all participants were required to provide their informed consent before completing the survey.

A total of 45 training centres were randomly selected from the NTA website and contacted about the research, of which 37 agreed to participate in the study.

Characteristics of trainees

Of the trainee sample (N=306), the majority were males (57%). The sample ranged in age from 17-25, with a mean age of 19 years (M=19.40, SD=1.55). The majority of trainees (75%) reported that they were single, 14% were in a relationship, 10% were living with a partner and 1% were married. Most trainees lived at home (71%), with about 26% living in rented accommodation. With regard to highest level of education achieved, 38% had a Junior Certificate, 54% had Leaving Certificate, 1% had a Technical/Vocational qualification, 6% had a Certificate or Diploma, and 1% had a Primary Degree. In terms of parental marital status, 60% reported that their parents were married/cohabiting, 22% were separated/divorced, 11% were single, and 2% were remarried.

Recruitment of unemployed sample

How were the unemployed organisations and unemployed young people selected?

Young people over 18 were recruited from Unemployed Organisations (e.g. JobClubs, Local Employment Service Networks, Social Welfare Offices) using purposive sampling. The researcher contacted the managers of selected organisations to explain the purpose and rationale of the study. If the manager was agreeable to the study, they were provided with the option of receiving web-based or paper-based versions of the MWS-PSL, depending on the IT facilities available in their organisation.

Recruitment procedures are similar to those described for the trainee sample.

More detailed information on the recruitment procedures for this group will be made available in a forthcoming report. In total, 92 general organisations for the unemployed were contacted about the MWS-PSL and 67 agreed to take part in the study.

Characteristics of unemployed young people

Of the unemployed sample (N=154), 40% were males. The sample ranged in age from 17-25, with a mean age of 21 years ($M=21.03$, $SD=2.27$). Looking at highest level of education achieved, 11% had a Junior Certificate, 49% had a Leaving Certificate, 3% had a Technical/Vocational qualification, 12% had a Certificate or Diploma, 20% had a Primary Degree, and 5% had a Postgraduate Master's. Of the sample, 82% reported that they were single, 8% were living with a partner, 8% were in a relationship, and 1% were married. With regard to living situation, 70% were living at home and 26% in rented accommodation. With regard to parental marital status, 64% reported that their parents were married/cohabiting, 21% were separated/divorced, 9% were single and 2% were remarried, and 1% reported that a parent was deceased.

Recruitment of employed sample

How were the employed organisations and employed young people selected?

Nineteen organisations identified as potentially employing individuals who had not attended third-level education were contacted about the research. Three of them agreed to participate in the research (response rate=16%). Similar to the recruitment procedures for the trainee/unemployed sample, the researcher contacted the managers of selected organisations to explain the purpose and rationale of the study. If the manager was agreeable to the study, they were provided with the option of receiving web-based or paper-based versions of the MWS-PSL.

Recruitment procedures for the employed sample are similar to those described for the trainee/unemployed sample (see above). More detailed information on the recruitment procedures for this group will be made available in a forthcoming report.

Characteristics of employed young people

Of the employed sample (N=170), 37% were males and 63% were females. The sample ranged in age from 18-25, with a mean age of 23 years ($M=22.50$, $SD=2.08$). Of the sample, 62% reported that they were single, 24% were living with a partner, 11% were in a relationship, and 3% were married. With regard to highest level of education achieved, 3% had a Junior Certificate, 38% had a Leaving Certificate, 3% had a Technical/Vocational qualification, 15% had a Certificate or Diploma, 32% had a Primary Degree, and 9% had a Postgraduate Master's. Looking at living situation, approximately half of the employed sample reported living in rented accommodation (47%) while another half lived at home (47%). With regard to parental marital status, 76% reported that their parents were married/cohabiting, 14% were separated/divorced, 4% were single, 1% of parents were remarried, and 3% had a deceased parent.

Description of MWS-PSL Study

In general, the MWS-PSL took the same format as the MWS-SL. A small number of scales in the MWS-SL version were not suitable for assessment with the post-second level sample and were excluded in the MWS-PSL. The additional scales that were relevant to young adults (i.e. eating disorders, gambling, suicidal behaviour) were included in the MWS-PSL. Thus, while most of scales included in the MWS-SL and MWS-PSL are identical for both surveys, some scales are unique to each. Scales previously described above, common to both the MWS-SL and MWS-PLS, are not reported here. Furthermore, some modifications were made to items in scales included in the MWS-PSL version, where appropriate. For example, 'in school' was modified to 'in college/workplace' and 'teacher/guidance counsellor' was modified to 'lecturer/student counselling services'.

Similar to the MWS-SL, the MWS-PSL version contains at least two large sections.

Table A6: Demographic characteristics included in MWS-PSL version

Age	Are you adopted?
Gender	Irish or foreign adoptee, how old when adopted, country adopted from
Ethnicity	Parental marital status
Living situation (e.g., rented accommodation)	Number of children in family
Where they live (e.g., town)	Do you have children?
Who they live with	Sexuality
Marital status	Comfortableness with sexuality
Current occupation status	Participant has experienced mental health problems
Highest level of educational attainment	

The first section of the MWS-PSL included a range of demographic and personal well-being questions (see Table A6). Other questions in the first section ask about: 1) whether they enjoy their family life (yes, sometimes, no), 2) whether they cope well with problems, 3) whether they have ever been in trouble with the gardaí, 4) the three most significant stressors/problems in their life, and 5) the three ways that help them cope when things are tough. The participant is asked to what extent they feel stressed by their financial situation, and, if relevant, how far they feel pressure to work outside of college/training course.

The participant is also asked whether they have ever seen a mental health professional (for example, a therapist, psychologist, psychiatrist) and, if so, how recently, and whether they had found it helpful (yes or no).

Positive and negative domains of psychological functioning

The second major section of the MWS-PSL contained a number of scales previously shown to have reliability and validity, organised into positive and negative aspects of psychological functioning.

Listed below in Table A7 are those scales, the number of items in each scale, and the alpha based on data from the MWS-PSL study.

Table A7: Reliabilities of scales included in the MWS-PSL version

Scales in MWS	Number of items in scale	Cronbach's alpha
POSITIVE DOMAINS +++++		
Rosenberg Self-Esteem Scale (RSE)	10	.90
Coping Strategy Indicator (CSI-15)		
CSI-Planned Coping	5	.86
CSI-Avoidance Coping	6	.82
CSI-Support-Focused Coping	4	.91
Life Orientation Test – Revised (LOT-R)	6	.83
Formal Help-Seeking Scale	2	.81
Informal Help-Seeking Scale	8	.70
Satisfaction with Life Scale	5	.90
Multidimensional Scale of Perceived Social Support (MSPSS)		
MSPSS-Family	4	.93
MSPSS-Friend	4	.95
MSPSS-Significant Other	4	.96
Support About Your Mental Health	2	na
NEGATIVE DOMAINS -----		
DASS-21		
DASS-Depression	7	.90
DASS-Anxiety	7	.81
DASS-Stress	7	.86
GHQ-General Health Questionnaire	12	.90
Alcohol Use Disorders Identification Test (AUDIT)	10	.83
Substance Misuse (CRAFTT)	6	.66
Gambling Attitude Scale (GAS)	5	.88
Eating Attitude Test-10 (EAT-10)	10	.89
EAT-Dieting	6	.90
EAT-Binging	4	.62
Body Dissatisfaction	1	na
Suicidal Behaviour	8	na
Experience of Bullying Scale	7	na
Sexual Health	6	na
Romantic Relationship Breakups	6	na

Additional scales not included in the MWS-SL are described below.

POSITIVE DOMAINS +++++

1) Satisfaction with Life Scale – SWLS

The Satisfaction with Life Scale (SWLS-Diener, Emmons, Larson & Griffin, 1985) is a 5-item self-report scale designed to measure life satisfaction. The scale uses a 7-point Likert scale with responses ranging from '1=very strongly disagree' to '5=very strongly agree'. Scores range from 5 to 35 and higher scores indicate greater satisfaction with one's life overall.

The scale has been found to have very good psychometric properties. Cronbach's alpha was reported at 0.84 and a clear single factor structure was identified (Diener et al, 1985) and confirmed (Compton, Smith, Cornish & Qualls, 1996). The SWLS correlates substantially with reports by family and

friends of the target person's life satisfaction, with number of memories of satisfying experiences, and with other life satisfaction scales. The SWLS was examined in a college student and elderly population and was found to be reliable and valid in both (Pavot & Diener, 1993).

NEGATIVE DOMAINS -----

1) General Health Questionnaire – GHQ-12

A shortened 12-item version of the GHQ (Goldberg & Blackwell, 1970) is used to assess current mental health. The scale asks whether the young person has experienced a particular symptom or behaviour recently. For example, 'Have you recently lost much sleep over worry?' Each item is rated on a four-point scale (less than usual, no more than usual, rather more than usual, or much more than usual). The GHQ-12 gives a total score of 36 or 12, based on the selected scoring methods. The most common scoring methods are bi-model (0-0-1-1) and Likert scoring styles (0-1-2-3).

The GHQ-12 has been extensively used in different settings and cultures (Goldberg & Blackwell, 1970; Goldberg & Williams, 1988; Schmitz, Kruse & Tress, 1999; Jacob, Bhugra & Mann, 1997; Donath, 2001). There is evidence that the GHQ-12 is a consistent and reliable instrument when used in general population samples (Pevalin, 2000). The GHQ focuses on breaks in normal functioning, rather than lifelong traits. It concerns itself with two major classes of phenomenon: the inability to continue to carry out one's normal 'healthy' functions and the appearance of new phenomena of a distressing nature.

2) Gambling Attitude Scale

A modified version of the Gambling Attitude Scale (GAS) – General Subscale was used to assess attitudes toward gambling (Kassinove, 1998). The 5 items were: 'I enjoy gambling', 'I gamble when the opportunity arises', 'I want to gamble', 'I feel excited when I am around people who gamble' and 'Gambling is acceptable to me'. Response options for each item are rated on a 6-point Likert scale ranging from 'strongly disagree' to 'strongly agree', where higher scores indicate more positive attitudes to gambling. GAS items are scored from 1 to 6. Items specific to the US were omitted for the purpose of the current study. Research has shown that having a positive attitude toward gambling was the best predictor of both being a gambler and being a problem gambler (Williams, Connolly, Wood & Nowatzki, 2006).

3) Eating Attitude Test – EAT-10

Eating behaviour was measured using 10 items from the Eating Attitudes Test-26 (EAT-26; Garner & Garfinkel, 1979). Examples of items included in the EAT-10 are: 'I am preoccupied with a desire to be thinner' and 'I have gone on eating binges where I feel that I may not be able to stop'. Response options range from 'never' to 'always'.

The EAT-26 is the most commonly used standardised self-report measure to assess eating behaviour. The full version of the EAT is designed to classify people as within the normal range for eating behaviour and those with possible eating disorder. On the basis of a factor analytic study on a large sample of Irish adolescents, the five top leading items from the female sample (N=1,712) and male sample (N=1,097) were included in the MWS (Dooley & McNicholas, personal communication, 2012). The highest loading items for the female sample corresponded to items 1, 11, 14 and 23 of the original EAT-26. The highest loadings for the male sample corresponded to items 3, 4, 9, 10 and 25. The five-item version, for both male and female samples, discriminated between those above and below the cut-off for possible eating disorders using the full EAT-26. Therefore the shorter version was included in the MWS.

4) Suicidal Behaviour

Four questions on suicidal ideation, self-harm and suicide attempt were used to tap into suicidal behaviour. The questions included: 'Have you ever deliberately hurt yourself without wanting to take your life?', 'Have you ever thought that life was not worth living?', 'Have you ever thought about taking your life, even though you would not do it?' and 'Have you ever made an attempt to take your life?'. Each question measured lifetime rate and frequency in the past year (i.e. within the last year, within the last 6 months, within the last month).

This approach was modelled on Osman et al's (2001) study. In addition, it concurs with several authors who make a chronological link between suicidal ideation, self-harm, non-fatal suicide acts (attempt) and suicide. This has been referred to as the suicidal process (Schrijvers, Bollen & Sabbe, 2011), where the process starts with suicidal ideation, progressing towards planning an act and often recurrent suicide attempts, and may end with a fatal suicide.

The respondent was also asked about whether they accessed help or support after a suicide attempt, how easy it was to get the support they needed, who they approached for support, and whether they felt that accessing support had helped them.

5) Sexual Health Behaviour

Information on sexual health behaviour was gathered by asking a series of questions, including: sexual activity status, age at which the young person first had sexual intercourse, number of sexual partners during the young person's lifetime, number of sexual partners in the past three months, condom use during sex, and use of other contraceptive methods during sex.

6) Romantic Relationship Breakups

The young person was asked 'Are you currently in a romantic relationship where you are emotionally involved?'. They were also asked a series of questions on romantic relationship breakups, if relevant, including: who ended the relationship, how long had the relationship lasted, how long ago did the relationship end, how emotionally involved were they with the person at the time of the breakup, and how distressing the breakup was for them.

Headstrong

The National Centre for Youth Mental Health

16 Westland Square, Pearse Street, Dublin 2, Ireland

T +353 1 4727 010 **www.headstrong.ie**

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