

# My World Survey 2

The National Study of **Youth  
Mental Health in Ireland.**

Dooley, B, O'Connor, C, Fitzgerald, A, & O'Reilly, A

my  
world.

Helping to understand...

my  
world.

# My World Survey 2

The National Study of **Youth Mental Health in Ireland.**

Developed by UCD School of Psychology and Jigsaw, with thanks to the ESB Energy for Generations Fund, My World Survey 2 is Ireland's largest and most comprehensive study of young people's mental health and wellbeing.

Capturing the views of more than 19,000 young people from across Ireland to understand what can lead to an increased risk of mental health difficulties, and what can help to protect and support a young person's mental health and wellbeing.

It builds on the findings of My World Survey 1, the first ever survey of its kind in Ireland, published in 2012.

Dooley, B<sup>1</sup>, O'Connor, C<sup>1</sup>, Fitzgerald, A<sup>1</sup>, & O'Reilly, A<sup>1,2</sup>

[MyWorldSurvey.ie](http://MyWorldSurvey.ie)

**JIGSAW** Young people's health in mind



# Foreword

Dr Joseph Duffy,  
Chief Executive,  
Jigsaw

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The last decade has seen a considerable growth in awareness and conversation about young people's mental health. As a result of the collective effort of government, elected representatives, the HSE, NGOs, civil society, the media, education settings and more, the public and political discourse is shifting. We are seeing a significant positive evolution in how communities view, talk about, respond to and support our young people's mental health.

However, beyond mental health, much more has changed in the last decade - increased political uncertainty, national and global economic upheaval, widespread societal and climatic changes, a relentless digital revolution and much, much more.

So, what has the effect been on our young people? How can we better understand the landscape for our young people in Ireland today and how can we analyse and interpret these insights to inform new responses and evolved thinking in the area of youth mental health? It is these considerations and more that make the publication My World Survey 2 so timely and so vitally important.

By capturing the views and opinions of over 19,000 young people in Ireland, we have the most comprehensive study of young people's mental health in this country. The work of UCD's School of Psychology in undertaking My World Survey 2 is to be commended. Their committed collective effort will build upon and improve our knowledge in the area of youth mental health. It has the potential to influence public policy and practice. In My World Survey 2 we have new insights into, and an understanding of, young people's mental health and wellbeing. In building upon the formative My World Survey (2012), this important publication identifies key trends that shine a light on Ireland's mental health like never before.

While we are seeing increased levels of anxiety and depression, the numbers of young people drinking alcohol, being bullied in school and stressing about finances have dropped. While there has been a drop in levels of self-esteem, optimism and life satisfaction, those getting support from supportive adults in their lives has increased.

In Jigsaw, we know that there is no easy fix for mental health difficulties. While Ireland has made significant progress in encouraging young people to talk about their mental health, that has led to an increasing awareness, it is clear that this alone is not enough and that there is still a long way for us to go. As a country, as communities, as people, we need to do better and we need to do more in how we support young people with their mental health, while putting young people at the centre of everything we do.

At Jigsaw, we believe that, if, as a society, we continue to make plans and policies without the insight and understanding that comes from good research, we run the risk of making a bad situation even worse. Now, more than ever, we need to make decisions that can have a lasting impact on our young people's mental health and that of the generations of young people to come.

At Jigsaw, we believe My World Survey 2 can shed light on issues we didn't know existed and can raise questions we hadn't realised needed asking. We believe it has the potential to protect and improve the country's health and wellbeing; turning research, evidence and knowledge into action. What is clear is that as the landscape around mental health evolves and changes so too must our responses. Now, more than ever, Ireland needs a systematic study to establish new facts and reach new conclusions in the area of youth mental health. My World Survey 2 is that study. It has the potential to be instrumental in building and improving our collective knowledge in the area of youth mental health and in establishing new responses. It has produced results and insights that will enable us all to better see the world through the eyes of our young people and identify how best we can offer support.

On behalf of Jigsaw, I would like to extend my thanks and appreciation to those involved. To our funding partner, ESB's Energy for Generations Fund; your decision to invest in this unique project is greatly appreciated. Funding research of this kind shows foresight and courage. And finally, to all those young people who took part and shared your world with us all - thank you.



# Young Person's Response to Findings



Rachel White,  
Jigsaw Youth Advisory Panel

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In 2012, when My World Survey 1 was published, I was 12. I have lived through our ever-changing world over the last decade or so. And, with the publication of this second wave of data, I wanted so badly to see some big progress that we could all be proud of. To be able to write a foreword that gives us all a nice, deserved, congratulatory pat on the back. To be able to celebrate the advances in young people's mental health over the last decade since the first wave of My World Survey. But I don't see it, and so I can't write that.

OK, there are some positive areas. A lower number of young people reported drinking alcohol, social media is not quite the demon that some would have us believe. Bullying in schools looks to be on the decrease and the presence of, and support from, One Good Adults® has increased by 5% among adolescents.

And it is true that over the past few years there has certainly been more awareness and discussion about mental health in the media and on the streets. We seem more willing to talk about it. The work of many must be applauded - the public discourse around youth mental is more open. The anti-bullying campaigning underway across schools, colleges, clubs and communities appears to be making an impact. Young people's relationships in some areas appear far healthier.

But it is clearly not enough.

My World Survey 2 shows rising levels of anxiety and depression, and lower levels of self-esteem. Resilience and optimism are down. Anger is on the rise. School connectedness is down. Self-harm, across the adolescent and young adult age groups, is significant with 2 in every 5 young adults having self-harmed. I was particularly saddened to read that females, in particular, indicated increased levels of anxiety and decreased levels of self-esteem, body esteem and resilience over their male counterparts.

All in all, one could argue that the report paints a difficult narrative of what's going on for many young people in Ireland today.

But, what is important is that we ask these questions and we get these insights. It is important to learn that adolescents are demonstrating positive awareness of mental health problems and help-seeking. It is important to learn that young people are predominantly using social media to enhance and continue friendships and relationships that they have made offline. It is important to learn that adolescents in this wave of the survey are receiving significantly higher levels of social support than their peers in My World Survey 1.

What is clear is that My World Survey 2 is hugely significant. In seeking to understand what can lead to increased risks of mental health difficulties, and what can help to protect and support a young person's mental health and wellbeing, it affords us all the opportunity to start new and honest conversations about what it is to be young in this country.

This, for me, is the opportunity that My World Survey 2 presents. This is the opportunity we must grasp.



# Acknowledgements

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**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.

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# Executive Summary

## Introduction

Adolescence and early adulthood is the peak time for the onset of mental health difficulties. It has been reported that 75% of all mental health disorders that persist into adulthood emerge before 25 years (Kessler et al., 2007).

Mental health is defined as a state of wellbeing in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community (WHO, 2019). Positive wellbeing is a requirement to allow young people to flourish; to develop and maintain meaningful social relationships, to learn effectively, to care for oneself and to contribute to society.

Understanding the wellbeing of young people in Ireland is critical to ensuring effective service provision and to ensure that young reach their potential.

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## Why conduct My World Survey 2 (MWS-2)?

MWS-2 is the second wave of a national study of youth mental health in Ireland. My World Survey 1 (MWS-1) was published in 2012 and it offered an insight into the positive and negative factors related to the wellbeing of young people aged 12-25 years in Ireland then. Before MWS-1, no previously published study had comprehensively profiled youth mental health functioning in the community, exploring both protective and risk factors.

The purpose of MWS-2 is to build and improve our collective knowledge in the area of youth mental health. The study aims to gain new insight into, and increase our understanding of, young people's mental health and wellbeing from a risk and protective perspective. MWS-2 builds on the knowledge gleaned from MWS-1 by including new questions on lifestyle factors which have come to the fore since 2012, such as the use of social media, physical activity and body image. Other factors studied in MWS-2 include pornography, sexual consent, and significant life events.

As well as building on our understanding of youth mental health, a repeat survey such as MWS-2 offers the opportunity to track potential changes in mental health outcomes since the publication of MWS-1. In this way, the findings from both waves of MWS can be used to inform and influence youth mental policy and practice in Ireland.

Furthermore, to build on MWS-1, the survey was conducted with various seldom heard groups in cross-sectional research such as young people with a physical disability, young people in Youthreach and young people in Colleges of Further Education. These groups have been seldomly heard in cross-sectional research such as this in Ireland, particularly in large scale national studies.

## Who participated in MWS-2?

A total of 83 second-level schools randomly selected from the Department of Education and Skills database participated in My World Survey 2 Second Level (MWS-2-SL).

- **10,459 adolescents completed MWS-2-SL**
- **Age range 12-19 years (M=14.86, SD=1.67)**
- **56% identified as female**
- **All school years were represented in the study**

Participants in My World Survey 2 Post-Second Level (MWS-2-PSL) consisted of the following samples: (1) young adults in third level education and (2) young adults who were employed.

- **8,290 young adults completed MWS-2-PSL**
- **Age range: 18 to 25 years (M=20.23, SD=1.83)**
- **69% were females**

Participants in My World Survey 2 Seldom Heard sample (MWS-2-SH) consisted of the following groups:

- **Young people in Youthreach (N=314)**
- **Young people in Colleges of Further Education (CFE)/community training (N=292)**
- **Young people with physical disabilities (N=52)**

## Key findings

- Levels of depression and anxiety in adolescents and young adults increased from MWS-1 to MWS-2. Adolescents and young adults in MWS-2 were much less likely to be in the normal range for depression and anxiety and much more likely to be in the moderate, severe or very severe ranges for depression and anxiety than adolescents and young adults in MWS-1.
- Levels of protective factors related to mental health such as self-esteem, optimism and resilience have decreased.
- Females, in particular, indicated increased levels of anxiety and decreased levels of self-esteem, body esteem, resilience and other protective factors than males of the same age.
- Young people from seldom heard groups showed a particular vulnerability with heightened anxiety and suicide attempts than their age-matched peers.
- Factors such as sleep, physical activity, social media use and pornography use were strongly associated with depression and anxiety.
- Fewer adolescents and young adults reported drinking alcohol in MWS-2 than MWS-1. However, adolescents in MWS-2 who reported more drinking engaged in more problematic drinking than adolescents in MWS-1. Alcohol use was strongly associated with drug use in young adults showing evidence of polysubstance use in young adults.
- Adolescents demonstrated good insight into their mental health, where awareness of problems and help-seeking behaviour was linked statistically to standardised measures of depression and anxiety.

# Glossary

AUDIT	Alcohol Use Disorders Identification Test
BESAA	Body Esteem Scale for Adolescents and Adults
CFE	College of Further Education
CHO	Community Healthcare Organisation
CSO	Central Statistics Office
CSI-15	Adapted Coping Strategy Indicator
DASS	Depression, Anxiety and Stress Scale
DAST	Drug Abuse Screen Test
DEIS	Delivering Equality of Opportunity in Schools
IoT	Institute of Technology
LGBAP	Lesbian, Gay, Bisexual, Asexual and Pansexual
LOT-R	Life Orientation Test-Revised
M	Mean
MAC	Hemingway Measure of Adolescents Connectedness
MSPSS	Multidimensional Scale of Perceived Social Support
MWS	My World Survey
MWS-1	My World Survey 1 (study published in 2012)
MWS-2	My World Survey 2 (present study)
MWS-2-SL	My World Survey Second Level sample
MWS-2-PSL	My World Survey Post-Second Level sample
MWS-2-SH	My World Survey 2 Seldom Heard sample
N	Sample Size
NRI-RQV	Network of Relationship Inventory - Relationship Qualities Version
NSRF	National Suicide Research Foundation
READ	Resilience Scale for Adolescents
RSE	Rosenberg Self-Esteem Scale
SD	Standard Deviation
SWLS	Satisfaction with Life Scale
UCD	University College Dublin
WHO	World Health Organisation
YAP	Youth Advisory Panel
YMH	Youth Mental Health

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# Chapter 1: Introduction

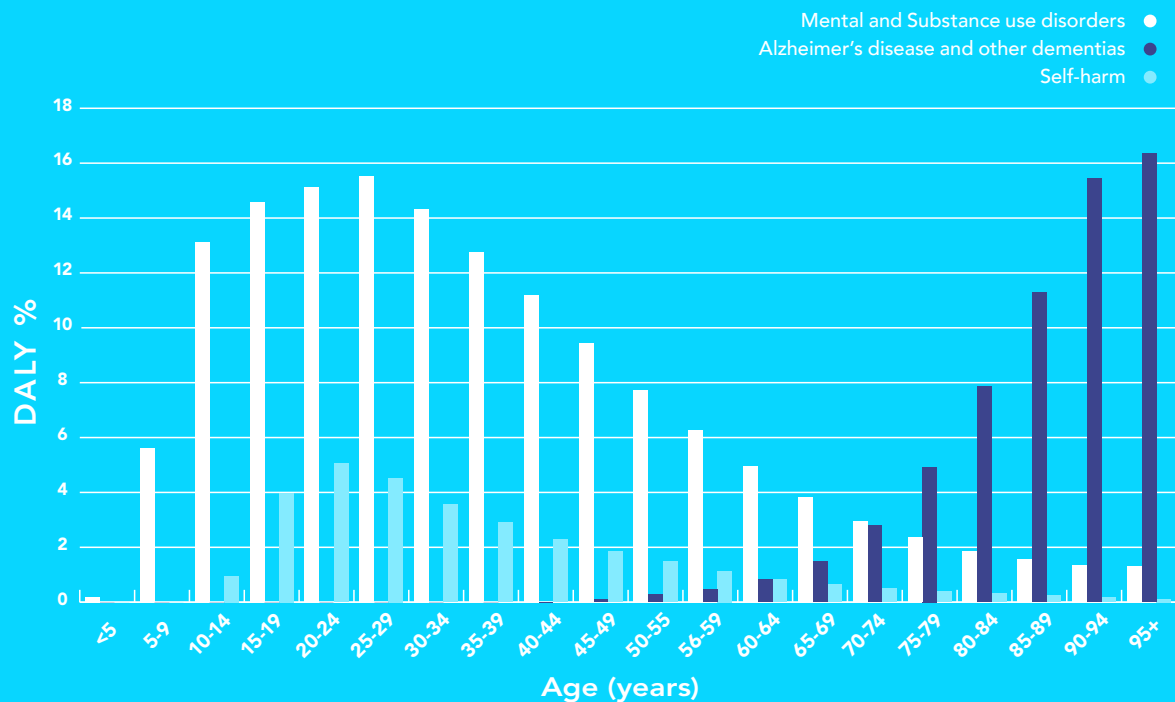
## Why Focus on Youth Mental Health?

At present, around a quarter of the total global population is comprised of young people aged between 10 and 24 years; the greatest proportion of this cohort in history (Abidi, 2017; World Health Organisation [WHO], 2009). In Ireland, one third of the population is aged under 25 years (Central Statistics Office [CSO], 2016). Given the vast number of changes that occur during adolescence and early adulthood, this is the peak time for the onset of mental health difficulties. It has been reported that 75% of all mental health disorders that persist into adulthood emerge before the age of 25 years (Kessler et al., 2007), although most remain undetected until later in life and many young people do not get adequate support at this critical time (Patel et al., 2007; WHO, 2014).

Figure 1.1.

### The global burden of mental and substance use disorders, self-harm and Alzheimer's disease (& dementia) in Disability-adjusted Life Years across the life course

(Patel et al., 2018)



As Figure 1.1 shows, mental and substance use disorders are significant contributors to disease burden and disability in youth across the globe (Erskine et al., 2015; Patel et al., 2018; World Health Organization, 2012). Mental health conditions account for more economic costs than other diseases such as cancer or diabetes (Bloom et al., 2011; Trautmann, Rehm, & Wittchen, 2016).

Mental health conditions can influence a young person's cognitive, emotional and social development, educational attainment and their potential to live a healthy and productive life (Department of Education and Skills, 2013; Patel, Flisher, Hetrick, & McGorry, 2007). Furthermore, the effects of mental ill health in adolescence and young adulthood can be long lasting and may become more severe with age (Erskine et al., 2015).

Despite this, mental health services have traditionally not been developmentally appropriate or youth oriented. In order to improve the youth mental health system, there is an international movement toward developing community-based service hubs that provide integrated, collaborative care to youth (Henderson, Hess, Mehra, & Hawke, 2019). Examples include Jigsaw in Ireland, headspace in Australia and in Denmark, Foundry and ACCESS Open Minds in Canada, and Youth One Stop Shops in New Zealand. Emerging evidence has demonstrated that these services are acceptable to young people and there are promising outcomes for those who attend (Hetrick et al., 2017).

There is also a need to understand the mental health of young people in general, rather than focusing on youth mental health disorders. To adequately and effectively address mental health conditions and problems, we need to understand all facets of youth mental health; the protective and risk factors.

## Defining Mental Health

Mental health is described as "a state of wellbeing in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community" (WHO, 2019). This definition represents substantial progress with respect to moving away from the conceptualisation of mental health as a state of absence of mental illness or a mental health disorder, generally characterised by abnormal thoughts, emotions, behaviours and relationships with others (WHO, 2018). It is also compatible with a whole population approach to mental health and highlights the importance of emotional wellbeing for young people. The definition aligns with the focus of the current research on positive aspects of mental health as well as risk factors.

## Risk and Protective Factors of Youth Mental Health

It is widely acknowledged that youth mental health is influenced by risk and protective factors within biological, psychological and social domains (Patel et al., 2007). However, researchers have indicated there is a need to better understand these risk and protective factors and how they influence the mental health of young people (Gunnell et al., 2018).

Risk factors refer to circumstances, characteristics or hazards that may increase the possibility of a person developing a mental health difficulty or disorder, such as problematic drinking behaviour, low social support or being bullied. Those considered to be 'at risk' for mental health problems are those who have a greater than expected number of risk factors affecting their lives at any given time. On the other hand, protective factors refer to a broad range of assets that may improve the likelihood that a person will respond successfully to life's stresses, and include high social support, high level of resilience and self-esteem.



In order to effectively intervene and impact on a young person’s mental health and wellbeing, it is important to consider both risk and protective factors. Bronfenbrenner’s (1979) Ecological Model of Human Development is widely acknowledged for demonstrating the multidimensional nature of the wellbeing of an individual (see Figure 1.2). This model emphasises the importance of studying the individual in multiple environments, thus taking a holistic perspective of individual mental health and wellbeing. In this model, the individual is situated at the centre, and the importance of the individual’s immediate relationships, as well as their interactions with the social context in which they are based are acknowledged. For instance, within their microsystem (immediate environments), a young person interacts with others in multiple environments, such as school, their family and their neighbourhood. In the mesosystem (society in general), young people’s lives and their wellbeing are influenced by educational systems, the government, political systems, etc. In this model, risk and protective factors are identified within each context and interact with one another to influence individual wellbeing. This perspective of mental health and wellbeing has been incorporated into the current research. As presented in Table 1.1, this research draws on various risk and protective factors from the multiple environments with which young people interact. Ultimately, the goal of this research is to gain a holistic perspective of youth mental health in Ireland.

Figure 1.2.

## Bronfenbrenner's Ecological Model of Human Development

Adapted from Bronfenbrenner (1979) and Junior Cycle Wellbeing Guidelines (2017)

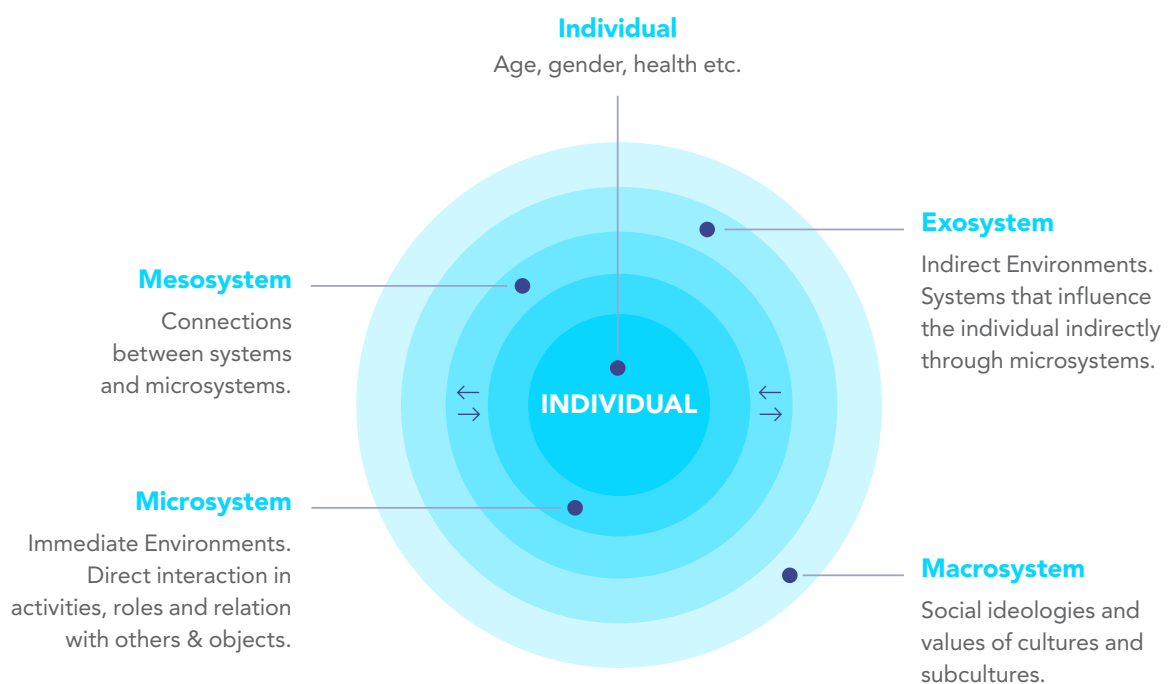


Table 1.1.

## Examples of selected risk and protective factors of youth mental health in MWS-2

Domain	Risk Factors	Protective Factors
<b>Individual</b>	Age Gender Long-term health difficulty	Age Gender
<b>Psychological</b>	Anger Avoidant coping Learning difficulty Financial stress	Self-esteem Optimism Resilience Copes well with problems Support-focused coping Problem-solving coping
<b>Social</b>		
<b>Family</b>	Low socioeconomic status Family status/structure Parental criticism Violence in the home Death of a family member	Enjoys family life Family support Parental approval
<b>Friends</b>	Bullying	Friend support Peer connectedness Satisfaction with friends/romantic partner
<b>School</b>	Academic failure	School connectedness
<b>Community</b>	Trouble with the Gardaí Discrimination	Neighbourhood safety Support from significant others

# Youth Mental Health in Ireland

Epidemiological studies (Cannon, Coughlan, Clarke, Harley, & Kelleher, 2013; McMahon et al., 2017) and extensive needs analyses (Illback & Bates, 2011; Illback et al., 2010) document that there is considerable mental ill-health within young people in Ireland, and a consequent need for immediate and accessible support (O'Reilly et al., 2015). Further, a recent study from the National Suicide Research Foundation (NSRF) which involved the participation of 1,112 adolescents aged 13-16 years reported that 7% of adolescents had experienced suicidal thoughts and 3.6% reported having attempted suicide at some point in their lives, with rates of suicidal thoughts and behaviour very similar in boys and girls (McMahon et al., 2017). In addition, this report found that risk behaviours such as alcohol and drug use were strongly associated with levels of anxiety, depression and suicidal behaviour. In young adults, a recent report on mental health from the Union of Students in Ireland (USI) observed that 38% of students are experiencing severe levels of anxiety and 30% are experiencing severe levels of depression (Price & Smith, 2019).

Compelling evidence regarding the mental health needs of young people in Ireland comes from the My World Survey 1 (MWS-1; Dooley & Fitzgerald, 2012), a large national survey-based study of mental health among young people 12-25 years in Ireland (N=14,306) which also found a similar pattern. This study, described in more detail in the following subsection, found mental health problems such as the severity of anxiety and depression increased across adolescence, peaking in late adolescence and early adulthood.

## My World Survey 1 (MWS-1)

MWS-1 (Dooley & Fitzgerald, 2012) aimed to provide the first national baseline of data on risk and protective factors of youth mental health in

Ireland through a large survey-based study. This research was a collaboration between University College Dublin School of Psychology and Jigsaw - the National Centre for Youth Mental Health (formerly known as Headstrong). The study, published in 2012, captured the views of almost 14,500 young people, making it, until now, the most comprehensive study of youth mental health for those aged 12-25 years in Ireland. The study was conducted in a rigorous manner and an extensive literature was reviewed, to ensure careful selection of standardised reliable and valid measures to assess a range of risk and protective factors among 12-25 year olds, thus taking a more positive approach to youth mental health research.

MWS-1 found that 1 in 3 young people reported levels of anxiety and depression outside the normal range. MWS-1 identified key factors associated with mental health. Of note, significant evidence was observed to indicate that One Good Adult® is important to the mental health of young people, with over 70% of young people reporting that they received very high or high support from a special adult. The study found over half (58%) of 16 year olds were engaging in excessive drinking, and this was linked significantly with depression and anxiety. Furthermore, MWS-1 highlighted that not talking about problems was linked to suicidal behaviour and that those who do share their problems enjoyed better mental health overall. Another key indicator of youth mental health observed was that many young people in distress were not seeking help.

The findings from MWS-1 have been disseminated by many organisations working with young people, to be read by those who work with young people and by young people themselves. Furthermore, key findings have contributed to the development of several policies which directly impact on young people and those working with young people, such as Healthy Ireland, Wellbeing in Post-Primary Schools: Guidelines for Mental Health Promotion and Suicide Prevention, and Action Plan on Bullying. The National Youth Mental Health Task Force Report specifically mentions MWS-1 in noting that more large-scale research

needs to be conducted in this area (p.20), thereby demonstrating the importance and impact of this research on the lives of young people.

Within Jigsaw, findings from MWS-1 have directly helped to shape the provision of supports and services for young people across Ireland and beyond, and have provided evidence for the need to invest in early intervention supports for adolescents and young adults. For example, on foot of MWS-1, Jigsaw has developed various workshops aimed at encouraging help-seeking among young people and building capacity among adults to support young people's mental health. To date, almost 125,000 young people and adults have attended these workshops around Ireland (Jigsaw, 2019).

## My World Survey 2 (MWS-2)

This report outlines findings from the second wave of this research - My World Survey 2 (MWS-2). The purpose of MWS-2 is to build and improve our collective knowledge in the area of youth mental health and to inform action, through improving how we engage with and educate our communities. The study aims to gain new insight into, and increase our understanding of, young people's mental health and wellbeing from a risk and protective perspective situated within their social context.

MWS-2 builds on the knowledge gleaned from MWS-1 by including new questions on areas around the use of pornography, consent, social media, physical activity, body image and significant life events. Questions about gender, family status, sexual orientation and other demographic characteristics have been reviewed, based on feedback received from young people involved in Jigsaw's Youth Advisory Panel (YAP) and experts working in this area. In addition, questions about suicide, sexual behaviour and sexual orientation are now included in the survey for adolescents, providing us with an insight into these issues among this group.

Repeat surveys, such as MWS-2, offer a distinct advantage over single cross-sectional surveys as they enable us to capture net effect changes. Net effect changes might be expressed as an overall increase or decrease in behaviours measured, such as the number of young people who report an intention to seek help for mental health problems they are experiencing. By repeating a survey and asking similar questions, it is possible to collect information that can easily be compared. In this way, the findings from both waves of the study can be used to inform and influence youth mental health policy and practice in Ireland.

## MWS-2: Key Aims

The aims of MWS-2 are to:

1. Profile youth mental health at a national level across the age spectrum 12-25 years. This profile is presented as follows:
  - a. Adolescent Sample - MWS-2-Second Level (MWS-2-SL)
  - b. Young Adult Sample - MWS-2-Post Second Level (MWS-2-PSL)
  - c. Seldom Heard (including young people with physical disabilities, young people in Youthreach, young people in Colleges of Further Education (CFE)/community training)
2. Compare MWS-2 data to MWS-1 to assess changes to risk and protective factors linked to young people's mental health.
3. To provide mental health indicator data that will inform policy and practice.

# Chapter 2:

# Methodology for Adolescent Sample

## Overview

This chapter describes the methodology for the adolescent sample who took part in the My World Survey 2 Second Level (MSW-2-SL). It outlines how schools were selected and recruited, and it lists the standardised measures which participants completed. Further information on the methodology for MWS-2-SL can be found in Appendix 1.

---

## 2.1. School selection

The MWS-2-SL study sought to recruit a sample of adolescents enrolled in post-primary schools that would be representative of students enrolled in the 716 post-primary schools in the Republic of Ireland during the academic year 2018/2019 (Department of Education & Skills, 2018). Five criteria were identified that had to be met to achieve a nationally representative sample:

1. All post-primary schools in the 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 nine Community Healthcare Organisation (CHO) areas. The regions and counties in each CHO area are presented in Appendix 1.
3. The sample had to reflect the national distribution of schools characterised as disadvantaged and non-disadvantaged in the nine CHO 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. Schools 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) for each CHO area and nationally.
5. The sample had to include at least one school in every county in the Republic of Ireland.

This multi-stage sampling strategy thus reflected all students enrolled in DEIS and non-DEIS schools, organised by gender composition, across the counties in the nine CHO areas.

---

## 2.2. Recruitment of schools

Based on the criteria outlined above, a random sample of 171 schools that reflected the distribution of the 716 post-primary schools in the Republic of Ireland was used for school selection. This random sample was also used in MWS-1. It was anticipated that approximately 50% of those schools would choose to participate. These schools were invited to take part in the study. First, an email was sent to the school principal outlining the details of the study. This was followed by a phone-call approximately one week later. If the principal expressed an interest in the school participating in the study, a contact person was identified in that school who would work directly with the research team to organise data collection within the school. Based on school acceptance rates, a further four schools, which were randomly selected, were added to the list to ensure adequate representation. From the sampling frame of 175 schools, a total of 83 schools agreed to take part in the study (47% response rate) and these schools represented the national distribution of schools based on the criteria outlined above.

---

## 2.3. School data collection

Data collection took place from October 2018 until May 2019. Procedures for data collection approved by UCD Ethics Committee were employed for data collection. A research information letter and consent form for students and their parent/guardian(s) were distributed to students by a researcher or staff member in the school. Once parent/guardian consent forms had been returned, a date to collect data in the school was agreed.

Data collection followed standardised protocols to ensure data were collected rigorously. Data were collected anonymously. Schools were offered the choice to complete the survey themselves during class-time with students or to have a researcher come to the school to complete the survey with students. Each participating school was offered the choice of completing a paper-based or web-based version of the MWS-2-SL survey. In total, 28 of the 83 schools chose the web-based survey (3,450 participants). Web-based surveys were delivered via Qualtrics (Provo, UT). Students typically spent 30-45 minutes completing the survey. If paper-based, the survey was presented to adolescents in a youth-friendly and accessible booklet. Following data collection, participants were given a support card with contact details for various mental health support services.

On the basis of the number of consent forms delivered to the 83 schools for distribution to parents, and the number returned with signed parental consent and student assent/student consent in each school, the final sample of 10,459 students constituted a response rate for student participation of 50% (response rates varied across schools from 8% to 97%). The main reasons for non-participation identified by schools and students were absenteeism and failure to return consent forms.

## 2.4. Description of MWS-2-SL

Paper-based and web-based MWS-2-SL surveys contained the same questions. The MWS-2-SL survey contained four major sections as follows:

1. Demographic characteristics
2. Personal wellbeing and lifestyle factors
3. Negative domains
4. Positive domains

For more information on each of the aforementioned sections, see Appendix 1. The measures used to assess negative and positive domains of mental health are standardised and have good psychometric properties (reliability and validity; see Table 2.1 and Table 2.2).

Table 2.1.

### Negative domains in MWS-2-SL showing number of items, Cronbach's alpha and score range for each measure

Negative Domains in MWS-SL	Number of items in scale	Cronbach's alpha*	Score range
Depression, Anxiety and Stress Scale (DASS)	14		
DASS-Depression	7	.88	0 - 42
DASS-Anxiety	7	.80	0 - 42
Suicidal <sup>**</sup>	3	n/a	n/a
Psychotic-like Experiences	3	n/a	0 - 3
Alcohol Use Disorders Identification Test (AUDIT)	10	.82	0 - 40
Problem Gambling Severity Index (PGSI) <sup>***</sup>	9	.84	0 - 27
Stressful Life Events	8	n/a	n/a
Network of Relationships Inventory-Relationship Qualities Version (NRI-RQV)	6		
NRI-RQV-Mother Criticism	3	.84	3 - 15
NRI-RQV-Father Criticism	3	.85	3 - 15

\* Alphas above .7 indicate that the scale has met minimal criteria for reliability (Taber, 2018).

\*\* The term suicidality covers suicidal ideation (serious thoughts about taking one's own life), suicide plans and suicide attempts (Slade et al., 2009).

\*\*\* Only presented to adolescents in Senior Cycle (i.e., fourth, fifth and sixth year).

Table 2.2.

### Positive scales used in MWS-2-SL showing number of items, Cronbach's alpha and score range for each measure

Positive Domains in MWS-2-SL	Number of items in scale	Cronbach's alpha*	Score range
Rosenberg Self-Esteem Scale (RSE)	10	.89	10 - 40
Body Esteem Scale for Adolescents and Adults (BESAA) - Appearance Subscale	10	.81	0 - 40
Life Orientation Test - Revised (LOT-R)	6	.74	0 - 24
Brief Multidimensional Students' Satisfaction with Life Scale - BMSSLS	5	.84	6 - 42
Adapted Coping Strategy Indicator (CSI-15)	15	.74	
CSI-Problem-Solving Coping	5	.84	5 - 30
CSI-Avoidance Coping	6	.79	6 - 36
CSI-Support-Focused Coping	4	.91	4 - 24
Resilience Scale for Adolescents (READ)			
READ-Personal Competence	8	.77	8 - 40
READ-Social Competence	5	.74	5 - 25
READ-Family Cohesion	6	.86	6 - 30
Hemingway Measure of Adolescent Connectedness (MAC)			
MAC-Peer Connectedness	6	.71	6 - 30
MAC-School Connectedness	6	.82	6 - 30
Multidimensional Scale of Perceived Social Support (MSPSS)	12	.94	12 - 84
MSPSS-Family	4	.90	4 - 28
MSPSS-Friend	4	.93	4 - 28
MSPSS-Significant Other	4	.92	4 - 28
Informal Help-Seeking Scale	8	.73	
Formal Help-Seeking Scale	2	.74	
Network of Relationships Inventory-Relationship Qualities Version (NRI-RQV)	6		
NRI-RQV-Mother Approval	3	.82	3 - 15
NRI-RQV-Father Approval	3	.84	3 - 15

\* Alphas above .7 indicate that the scale has met minimal criteria for reliability (Taber, 2018).



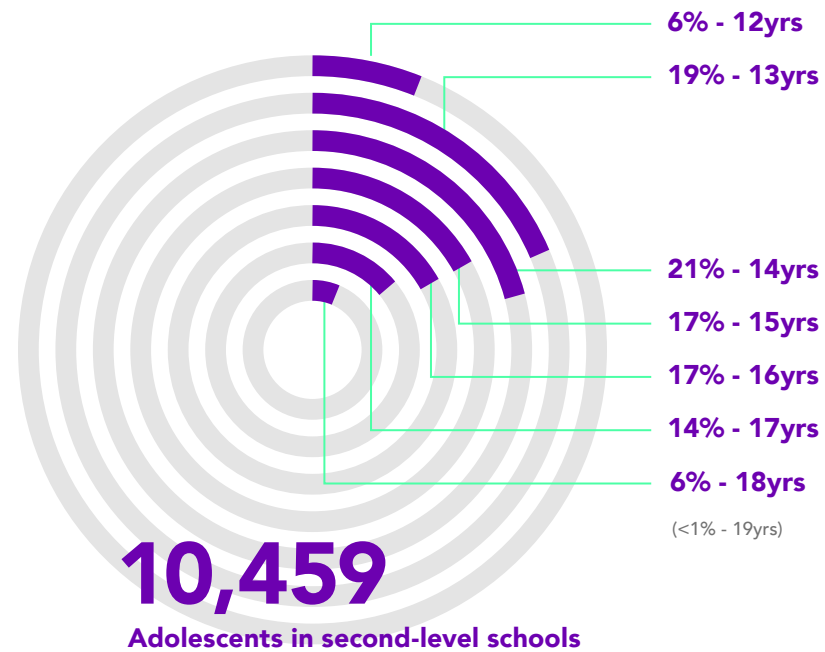
## Characteristics of Sample

### 2.4.1. Age

The sample consisted of 10,459 adolescents in second-level schools ranging in age from 12 to 19 years ( $M=14.86$ ,  $SD=1.67$ ). Figure 2.1 summarises the age breakdown of participants.

Figure 2.1.

### Percentage age breakdown of adolescent sample



### 2.4.2. Gender

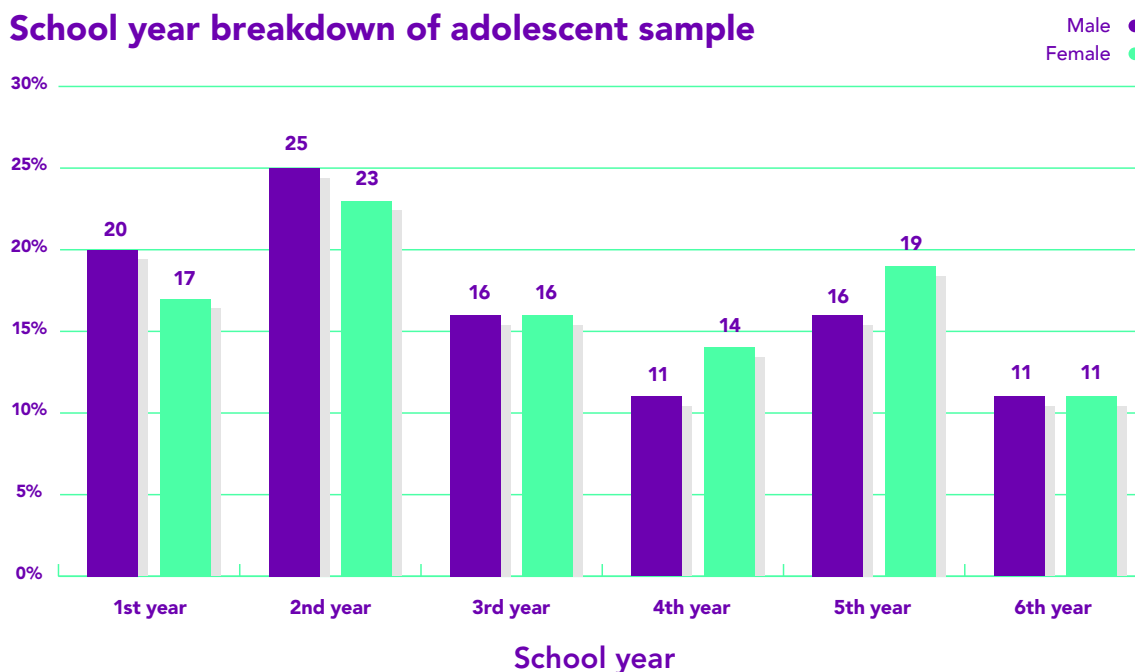
The gender breakdown was: 56% female, 42% male, <math><1\%</math> other (e.g., non-binary), <math><1\%</math> I'm not sure/questioning, <math><1\%</math> prefer not to say and <math><1\%</math> transgender male and transgender female.

Female  
Male  
Non-binary  
Questioning  
Transgender

### 2.4.3. School year

Overall, 19% of adolescents were in first year, 24% in second year, 17% in third year, 13% in fourth year, 16% in fifth year and 11% in sixth year. Figure 2.2 below shows the school year breakdown of the sample by gender.

Figure 2.2.



### 2.4.4. Ethnicity

Of the overall sample, 80% identified themselves as White Irish, 6% Any White Background other than Irish, 3% Black/Black Irish, 3% Mixed Background, 3% Asian/Asian Irish, 1% Irish Traveller, <1% Roma. Only 2% of the sample reported themselves as adopted, and of those, 26% identified themselves as adoptees from within Ireland.

### 2.4.5. Sexual orientation

In relation to their sexual orientation, 87% identified as heterosexual, 1% gay, <1% lesbian, 2% bisexual, 4% questioning, 2% prefer not to say, and less than 1% asexual and pansexual. Those in Junior Cycle years were much more likely to report prefer not to say and questioning.

Young people were asked to rate how comfortable they were with their sexuality on a scale of 1 (not at all comfortable) to 10 (very comfortable). Regardless of age, those who identified as heterosexual were most likely to report feeling comfortable with their sexuality, and those who identified as lesbian, gay, bisexual, asexual, pansexual (LGBAP) or indicated they were questioning their sexual orientation were more likely to report not feeling comfortable with their sexuality.

**87%**  
identified as  
heterosexual

## 2.4.6. Family composition

The majority (80%) of adolescents lived in two-parent families, 10% in single parent families, and 8% with their parent and other, such as a grandparent. A small percentage (2%) lived with their grandparents, in children's residential homes, and with other relatives or foster parents.

Approximately 70% of adolescents reported living in a family with 1-3 children, 24% in a family with 4-5 children, and 6% in a family with six or more children.

---

## 2.4.7. Parents

### Marital status of parents

The majority of adolescents indicated that their parents were married/living together (78%), while 10% reported that they were separated and 5% divorced. About 2% indicated that their parents were remarried/in a new relationship, while 2% reported that a parent was widowed.

### Parental educational level

Overall, adolescents reported that 50% of mothers and 40% of fathers had obtained a college/university degree, 18% of mothers and 16% of fathers had completed their Leaving Certificate while 6% of mothers and 12% of fathers had completed their Junior Certificate. Nearly 21% of adolescents reported not knowing their mother's education status, and 24% reported not knowing their father's status. Adolescents in the Junior Cycle group were more likely to report not knowing their parents' educational status.

### Parental employment status

Approximately 70% of adolescents reported that their mother was employed full- or part-time, compared to 85% for fathers. Nearly 2% reported that their mother was unemployed/looking for work and the same percentage was reported for fathers. While 19% of adolescents identified their mother as a stay-at home parent, only 2% did so for their father, and 2% reported that a parent was unable to work due to being sick/unwell, 1% reported that a parent was a student and 1% reported that a parent was retired.

---

## 2.4.8. Living situation

In terms of where adolescents are living, 30% reported they live in the countryside/outside of a town/city, 25% in a town, 20% in a city/suburb, 15% in a village, and 9% on a farm. Almost 88% of adolescents reported that they felt safe or very safe in their neighbourhood.

---

## 2.4.9. Religion

The most commonly reported religion amongst adolescents was Roman Catholic (73%), followed by Christian (8%), Church of Ireland (4%) and Muslim (2%). Approximately 4% reported that they had another religion, while 8% of adolescents reported that they did not have a religion.

---

# Chapter 3:

## Adolescent Findings

### Overview

This chapter presents descriptive data on personal wellbeing and lifestyle factors, as well as data on negative and positive domains of mental health. The chapter also examines key variables in relation to mental health outcomes.

---

### When reading this chapter, it is important to bear the following in mind;

- the data are illustrated for the overall sample by gender and by school year/cycle, where appropriate. In terms of school cycle, Junior Cycle refers to first year, second year and third year, while Senior Cycle refers to fourth year, fifth year and sixth year in the Irish educational second level system. As stated in the previous chapter, the sample consisted of 56% female, 42% male, <1% other (e.g., non-binary), <1% I'm not sure questioning, <1% prefer not to say and <1% transgender male and transgender female. For the purpose of analysis and to avoid drawing inaccurate conclusions about specific gender groups, gender groups other than male and female were omitted from analyses due to small sample sizes.
- statistical findings are reported at the  $p \leq .01$  level to guard against Type 1 errors. All data reported are statistically significant. Percentages reported in the Figures are rounded to the nearest whole number. In some places, percentages will not add to 100%. This is either because participants were allowed to choose multiple responses or participants chose the option 'other' and this has not been presented.
- in general, only findings which observed differences between gender groups or school years/cycles are presented.
- sections with '\*\*' include questions only presented to adolescents in Senior Cycle.

## Personal Wellbeing and Lifestyle Factors

A number of key questions assessed adolescents' perceptions of their personal wellbeing and the main findings from these questions are reported here.

### 3.1.1. Enjoying family life

Approximately 70% of adolescents reported that they enjoyed family life, while 26% reported that they sometimes did so and 4% that they did not. Looking to school year, first-years were more likely to report enjoying their family life (76%) with a gradual decrease in Junior Cycle (second-years 71% and third-years 70%), with a very small increase in Senior Cycle (66% in fourth-years, 68% in fifth-years and 69% sixth-years).

### 3.1.2. Anger

A total of 13% of adolescents reported that they felt angry a lot, 40% that they sometimes felt angry, while 47% said that they did not feel angry a lot. First-years (11%) were less likely to report feeling angry a lot.

### 3.1.3. Long-term health difficulty/disability

Among the sample, 15% reported that they had a long-term health difficulty/disability. Of those who reported this, 65% indicated they had a mental health difficulty, 26% reported a physical health difficulty and 4% reported both a mental and physical health difficulty. The remainder either did not disclose the long-term health difficulty or the difficulty they listed was not defined by the WHO as a long-term health difficulty. First-years (13%) and second-years (14%) were less likely to report having a long-term health difficulty.

### 3.1.4. Unpaid carers

Of the adolescents surveyed, 9% were providing regular unpaid help for a family member with a long-term illness, health problem or disability for an average of 6.43 hours (SD=18.34) per week. Males (11%) were more likely and females (8%) were less likely to report this.

### 3.1.5. Schoolwork

In terms of their schoolwork, 27% of adolescents ranked themselves as being at the top of the class, 67% as being in the middle and 6% as being at the bottom. Males (7%) were more likely to say they were at the bottom of the class than females (5%). Sixth-years (8%) were the most likely year group to rank themselves at the bottom of the class. Furthermore, 11% of adolescents reported that they receive additional teaching support in school (i.e., resource teaching and learning support).

**70%**

reported enjoying family life

### 3.1.6. Days absent

The mean number of days absent from school in the past month was 1 day (SD=2.4), with 49% of students reporting that they had not missed any days of school in the past month, 33% were absent once or twice, 13% were absent for 3-5 days and only 5% were absent six days or more. Males (52%) were more likely to report not missing any day of school in the past month and females (35%) were more likely to report missing one or two days of school in the past month while adolescents in Senior Cycle (approximately 16%) were more likely to report missing 3-5 days of school, with first-years (58%) and third-years (53%) more likely to report not missing any days of school.

The mean number of days absent for those with no long-term health difficulty/disability was 1.33 days in the past month (SD=2.31) and this was significantly different from adolescents who reported a mental health condition (M=1.88, SD=2.78) and a mental and physical health condition (M=3.33, SD=4.01). However, this was not significantly different from adolescents who reported that they had a physical health condition (M=1.7, SD=2.58).

### 3.1.7. Trouble with Gardaí

Of the sample, 9% reported that they had been in trouble with the Gardaí in the past, and males (14%) were more likely to report this than females (5%). Across school year, first-years (7%) were less likely to report having been in trouble with the Gardaí.

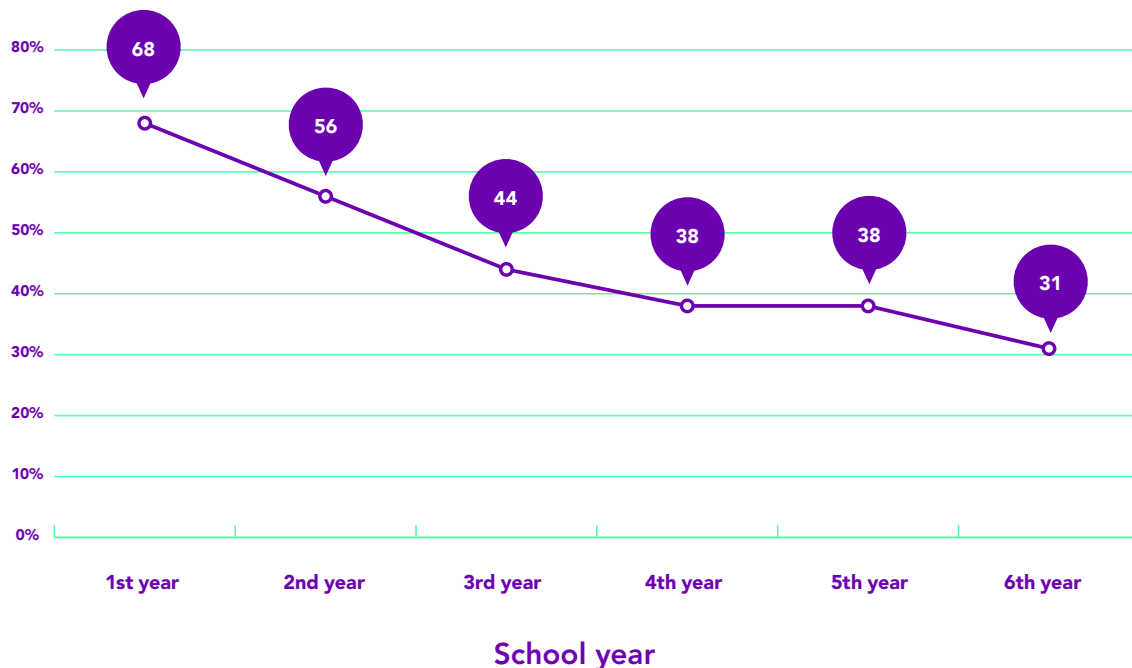
### 3.1.8. Sleep

The National Sleep Foundation in the US recommends that teenagers get 8-10 hours of sleep a night, referred to here as good sleep hygiene. Of the adolescents surveyed, 47% indicated good sleep hygiene, while 46% reported getting 6-7 hours of sleep and 7% getting between 0-5 hours of sleep a night.

Males (52%) were more likely to indicate good sleep hygiene and females (44%) were less likely to indicate this. First-years (68%) and second-years (56%) were more likely to report good sleep hygiene, while adolescents in Senior Cycle were more likely to report poor sleep hygiene, see Figure 3.1.

Figure 3.1.

### Adolescents with good sleep hygiene (8-10 hours) by school year



### 3.1.9. Body appearance, physical activity and hobbies

In relation to body appearance, 45% of the sample reported that they had tried to bulk up or maintain muscle mass. Males were much more likely to report that they had tried to bulk up or maintain muscle mass (63%) than females (31%). The main methods used to bulk up were exercising (97%) and taking steroids/supplements (3%).

In terms of weight management, 69% of adolescents reported that they have tried to lose weight or avoid gaining weight. Females were much more likely to report having tried to lose weight (77%) than males (56%). Those in Senior Cycle (72%) were also more likely to report trying to lose/avoid gaining weight than those in Junior Cycle (66%). The methods used to lose/avoid gaining weight were exercising (81%), eating less food, fewer calories or foods low in fat (69%), and/or taking supplements/pills (3%).

Just over three quarters of the sample (76%) reported that they played sports regularly in the past six months. Males were more likely to report this (83%) than females (72%). Those in Junior Cycle were also more likely to report this (85%) than those in Senior Cycle (65%).

In relation to going to the gym, 34% reported regularly attending the gym in the previous six months. Males (38%) were more likely to report this than females (31%). Those in Senior Cycle (42%) were much more likely to report this than those in Junior Cycle (29%).

With regard to participation in activities, seven out of ten adolescents reported having participated in other hobbies or volunteered at least once a week in the past six months. Those in Senior Cycle (68%) were less likely to report this. For more detail on gender and school year differences in relation to sport, gym and other hobbies, see Figure 3.2 and Figure 3.3 respectively.

Figure 3.2.

### Exercise and hobbies by gender

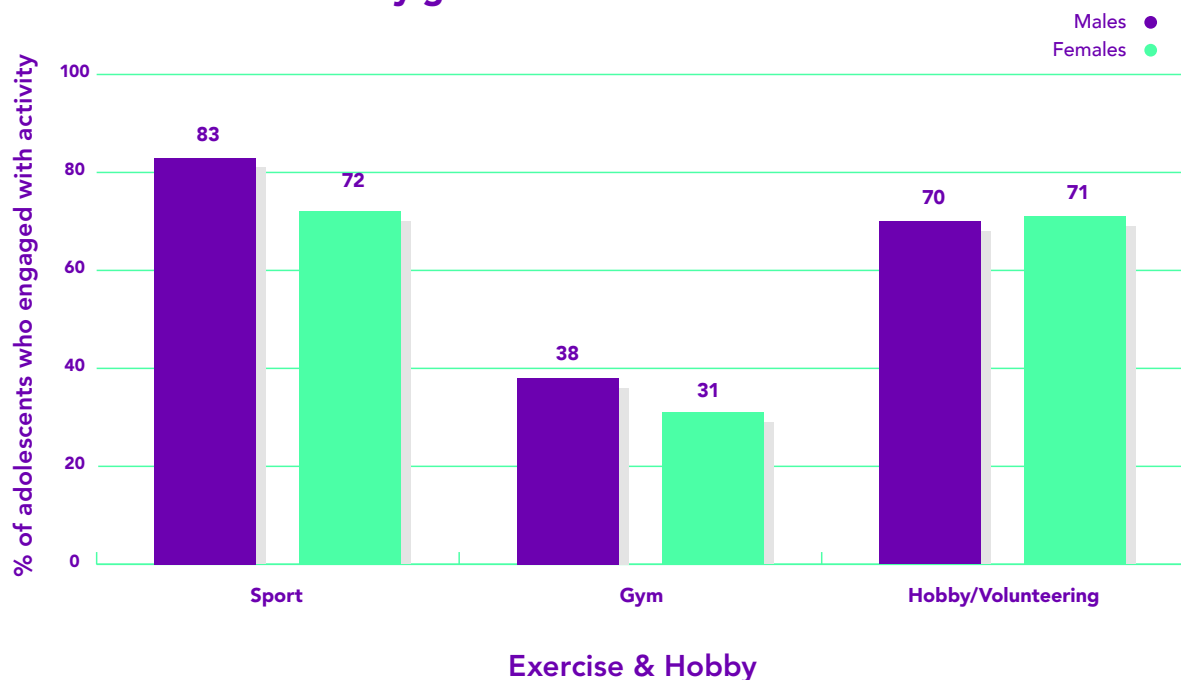
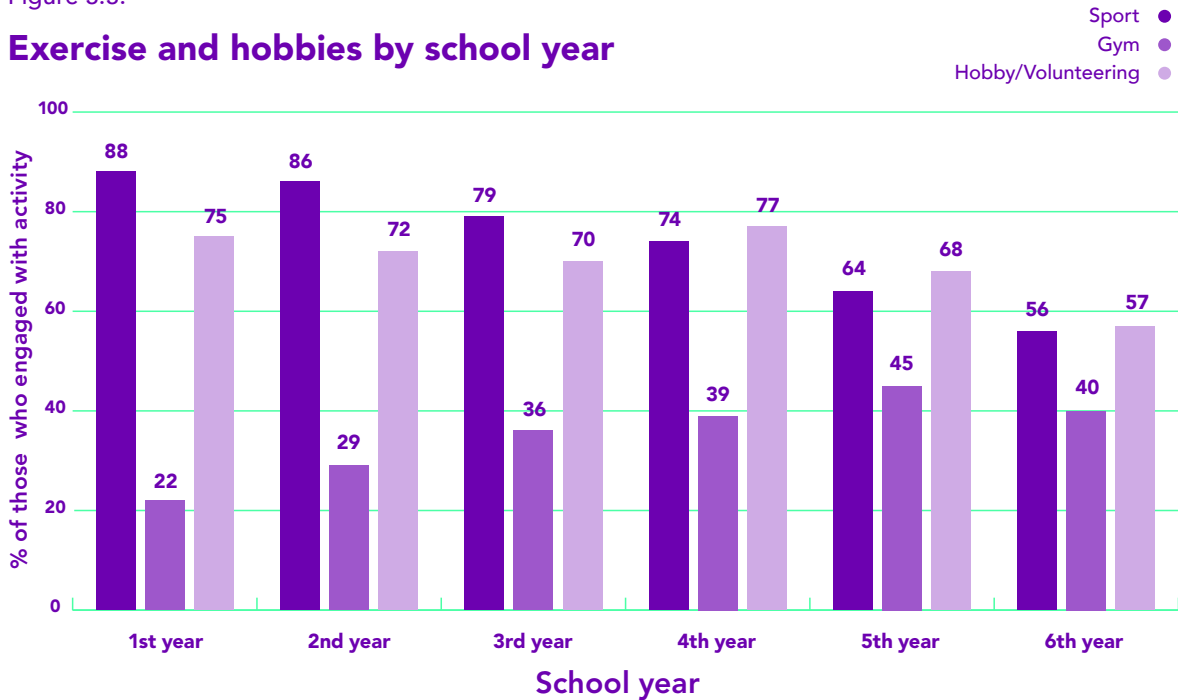


Figure 3.3.

## Exercise and hobbies by school year



### 3.1.10. Bullying

Overall, 39% of adolescents reported that they had been bullied at some point. Of these, 49% had experienced bullying within the last 4-5 years, 22% within the last 2-3 years, 10% within in the last year, 4% in the last six months, 3% in the past month, and 4% on a weekly (2%) or daily basis (2%). In terms of mode, 23% were bullied physically, 79% verbally and 52% emotionally.

With regard to where adolescents were most frequently bullied, almost three-quarters (73%) indicated school, 7% by text, 3% online, 3% at home, 2% by phone while 12% said elsewhere (such as local sports club). Fewer males (40%) reported that they had been bullied compared to 45% of females.

**39%**  
reported that they  
had been bullied

### 3.1.11. Social media use

Over 96% of adolescents reported having a social media profile or account. First-years (7%) were more likely to report not having a social media profile.

Of those who reported to have a social media profile, 96% reported having Snapchat, 90% Instagram, 54% Facebook, 28% Twitter and 4% had a Dating App.

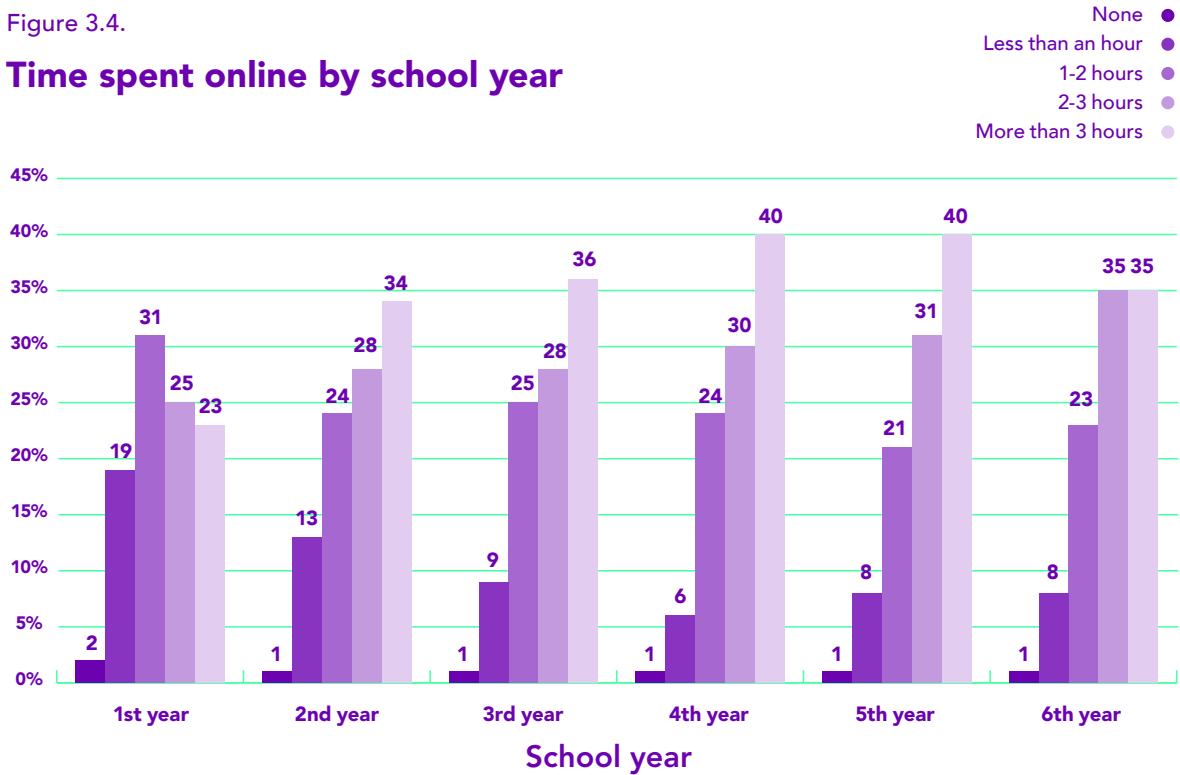
Just over one-third of adolescents (34%) reported spending more than three hours online per day, 29% reported spending 2-3 hours online a day,



25% reported spending 1-2 hours online a day and 12% reported spending less than an hour online a day. Females were more likely to report being online for more than three hours per day (38% vs 33% male) and males were more likely to report being online for less than one hour per day (12% vs 9% female). First-years and second-years were more likely to report spending less than one hour online and fourth-years and fifth-years were more likely to report spending more than three hours online per day. See Figure 3.4 for details on time spent online by school year.

Figure 3.4.

### Time spent online by school year



In relation to profile privacy, 12% of adolescents reported having their profile on the social media site they use most often set to public (15% male, 10% female), 18% reported having their profile set to partially private (19% male, 17% female), 67% reported having their profile set to private (61% male, 71% female) and only 3% reported that they did not know (4% male, 3% female). Adolescents in Senior Cycle (15%) were more likely to report setting their profile to public (10% in Junior Cycle).

**67%**  
have their profile  
set to private

In terms of how adolescents spend time online, 63% reported that they never meet people online for social interaction that they have not met in real life. Males (35%) were more likely to report that they meet people online occasionally (30% females). When asked about being sent mean messages, 60% reported they never experienced this and 32% reported that it happened once to them, while few young people (7%) reported being sent mean messages occasionally. Furthermore, 85% reported that they have never experienced someone taking nasty photographs of them and posting them online. Adolescents in Senior Cycle (18%) were more likely to report that this happened to them occasionally compared to Junior Cycle students (11%).

### 3.1.12. Pornography\*

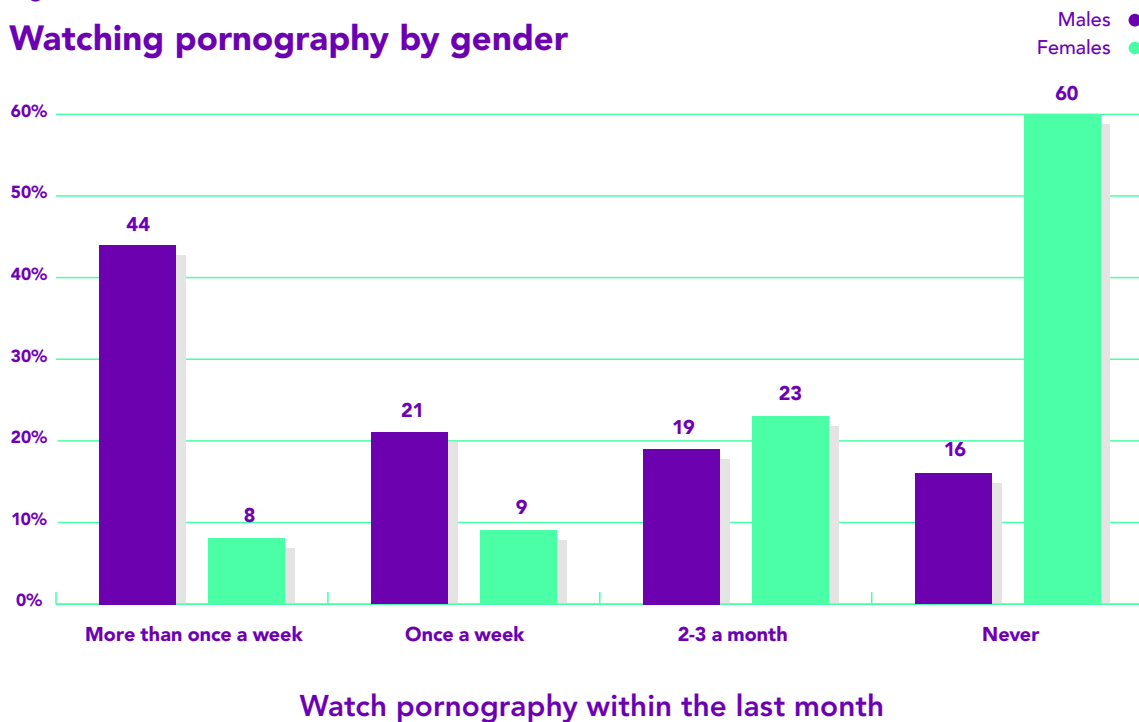
Of the young people in Senior Cycle, 48% reported that they had watched pornography. Of those who watched pornography, 88% searched for a website themselves, while 12% received an email or clicked on a link and viewed pictures of sex that they did not want to see. With regard to how frequently these students watched pornography, 33% reported doing so more than once a week, 17% once a week, 21% 2-3 times a month, and 14% less than once a month.

**48%**  
have watched  
pornography

A notable gender effect was observed, with 86% of males in Senior Cycle reporting having ever watched pornography compared to 24% of females. Males were more likely to watch pornography once a week (21%) and more than once a week (44%), while females were more likely to watch pornography less frequently, see Figure 3.5.

Figure 3.5.

#### Watching pornography by gender



### 3.1.13. Relationships

Of the sample surveyed, 24% said that they currently have a boyfriend/girlfriend (18% in Junior Cycle and 30% in Senior Cycle). When asked how they spend time with their boyfriend/girlfriend, multiple ways were reported: 84% reported that they spend time in person, 47% on social media, 44% by texting, 39% on the phone, 24% on the internet and 1% on email. Most (88%) were satisfied or very satisfied with the relationship and 9% were neither satisfied nor dissatisfied.

**24%**  
have experienced  
a break-up in the  
last year

Among all adolescents, 53% said they had never experienced a break-up, 21% reported that they had over a year ago and 26% had experienced one within the past year.

### 3.1.14. Sexual behaviours\*

Almost half of Senior Cycle students reported having had oral sex (49%). Of those in Senior Cycle who reported having had sex (30%), 68% were aged 15-16 years, 24% were 17+ years and 8% were 14 and under when they first had sex. In addition, 60% reported that they had had sex with one person, 17% two people, 9% three people, and 14% four people or more.

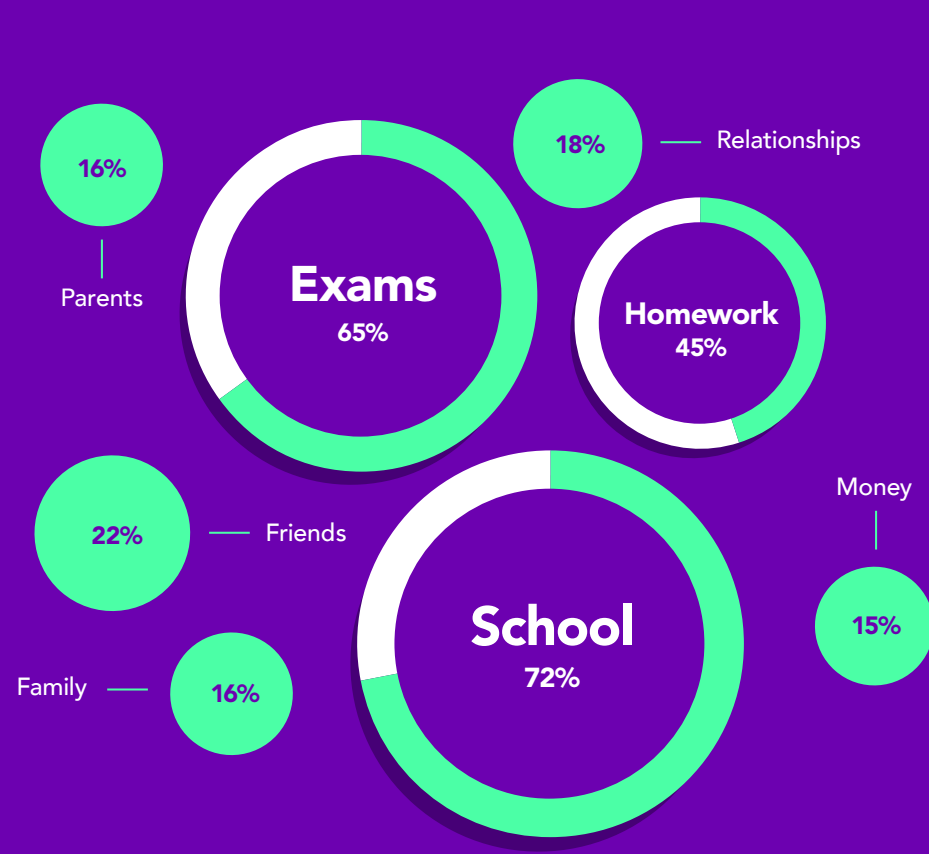
Within the past three months, of those who reported having had sex, 66% reported having one sexual partner and 8% reported having two or more sexual partners (26% reported that they had not had sex within the past three months). With regard to safe sex, 55% reported that they always used condoms/contraception, 13% said they did so most times, 13% sometimes, 11% never and 8% reported this was not applicable to them.

### 3.1.15. Top stressors

School, exams and homework were the top stressors endorsed in the survey (see Figure 3.6 below for breakdown).

Figure 3.6.

#### Top three stressors in adolescents' lives



### 3.1.16. Coping with problems

Almost half of adolescents (41%) reported that they generally coped well with problems, 51% that they sometimes coped well, and 8% that they did not cope well. Males (51%) were more likely to state that they coped well compared to females (33%).

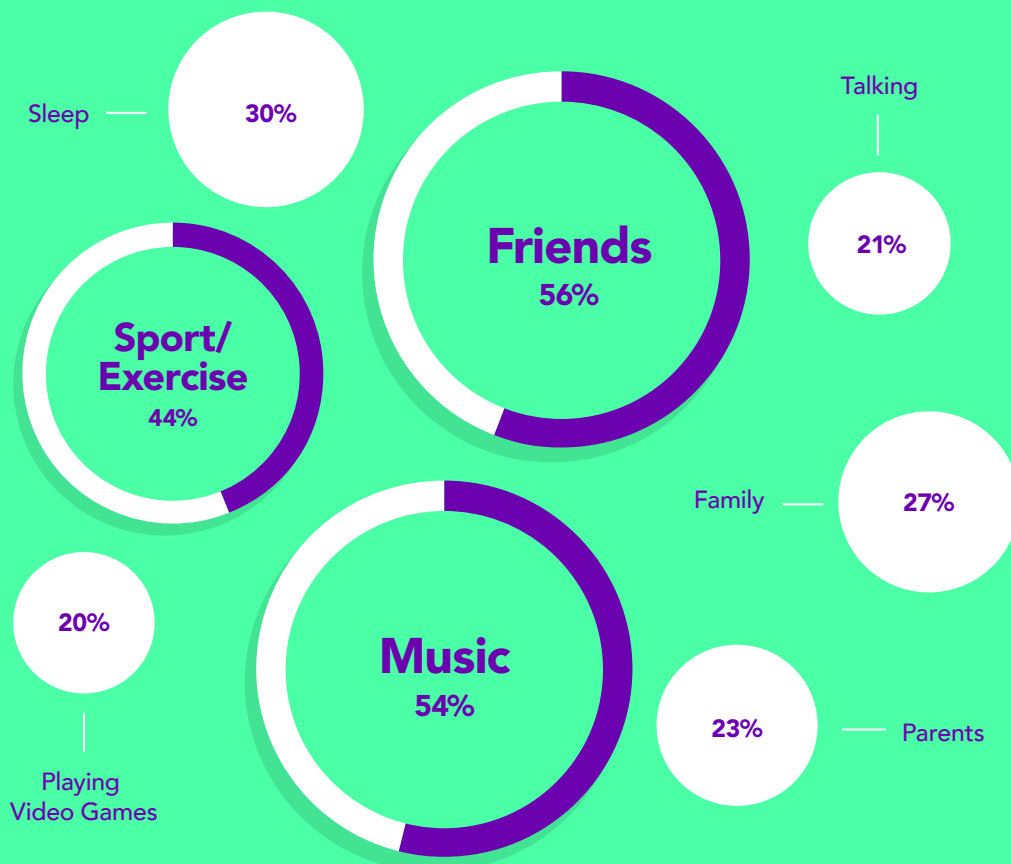
**41%**  
coped well with problems

### 3.1.17. Top coping strategies

Friends, music and sport/exercise were the most endorsed methods of coping.

Figure 3.7.

#### Top three coping strategies in adolescents' life



15%

reported having at least one parent/guardian who had experienced a mental health problem

### 3.1.18. Parents' mental health

Approximately 15% of adolescents reported having at least one parent/guardian who had experienced a mental health problem. In addition, approximately 2% reported that their mother had a long-term alcohol/drug addiction while 5% reported this for their father.

### 3.1.19. Parent approval and criticism

In general, adolescents scored above the midpoint of 9 in terms of mother approval ( $M=11.96$ ,  $SD=2.81$ ) and father approval ( $M=11.44$ ,  $SD=3.18$ ), showing a high level of approval. Adolescents scored below the midpoint of 9 for mother criticism ( $M=5.27$ ,  $SD=2.73$ ) and father criticism ( $M=5.22$ ,  $SD=2.8$ ) indicating a low level of criticism.

Males reported higher criticism from their father ( $M=5.45$ ,  $SD=2.79$ ) than females ( $M=5.07$ ,  $SD=2.79$ ).

First-years and second-years reported significantly lower levels of mother criticism and father criticism and higher levels of mother approval and father approval than all other year groups, see Figure 3.8 for mean scores on mother and father approval.

Figure 3.8.

### Mean score of approval by school year



# Negative Domains

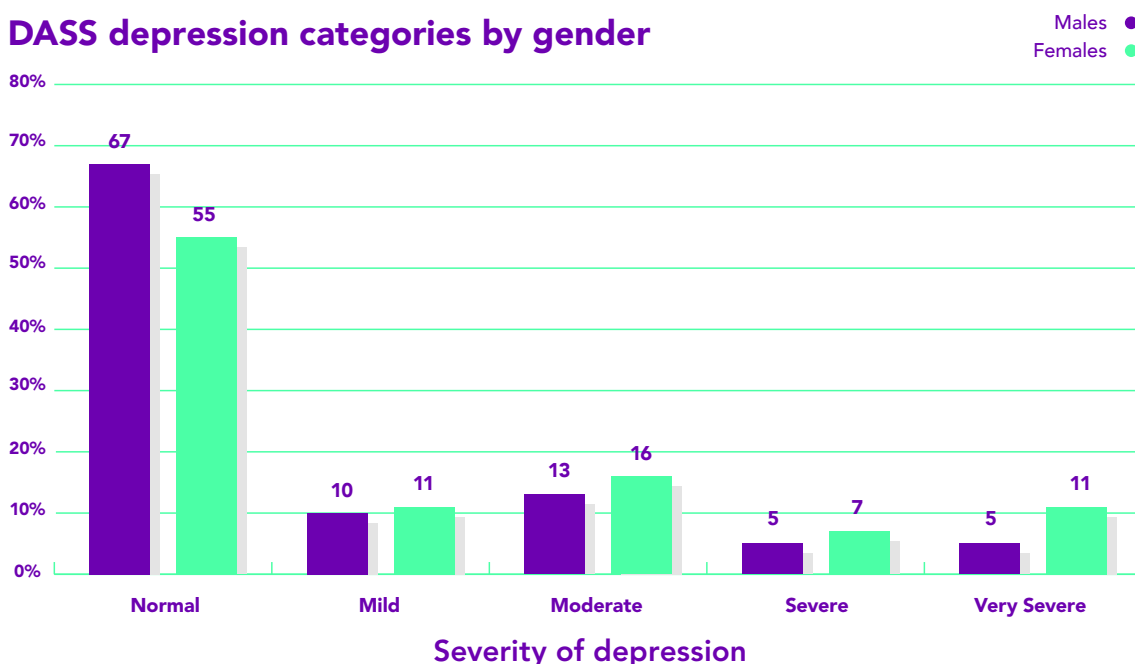
## 3.1.20. Depression and anxiety

### Depression Categories

Of the sample, 60% were classified in the normal range for depression. Approximately 11% were in the mild range, 15% in the moderate, and 15% in the severe (6%) or very severe (9%). Males were more likely to be classified in the normal range and females were much more likely to be in the severe and very severe categories (see Figure 3.9).

Figure 3.9.

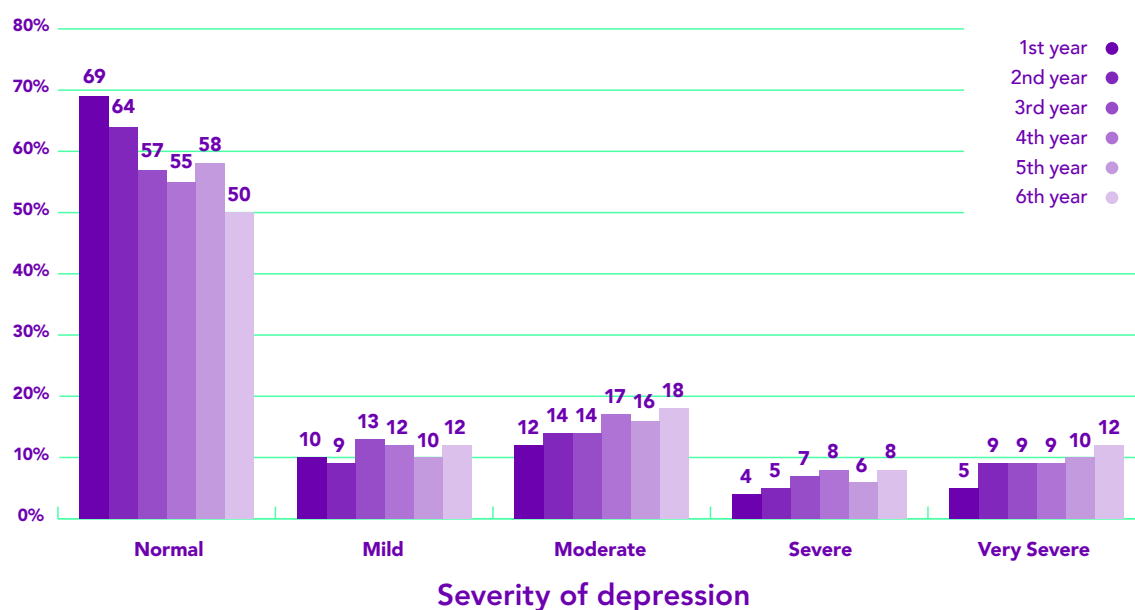
### DASS depression categories by gender



Depression increased across school year with 50% of sixth-years outside the normal range compared to 31% of first-years, 36% of second-years, 43% of third-years, 45% of fourth-years and 42% of fifth-years (see Figure 3.10).

Figure 3.10.

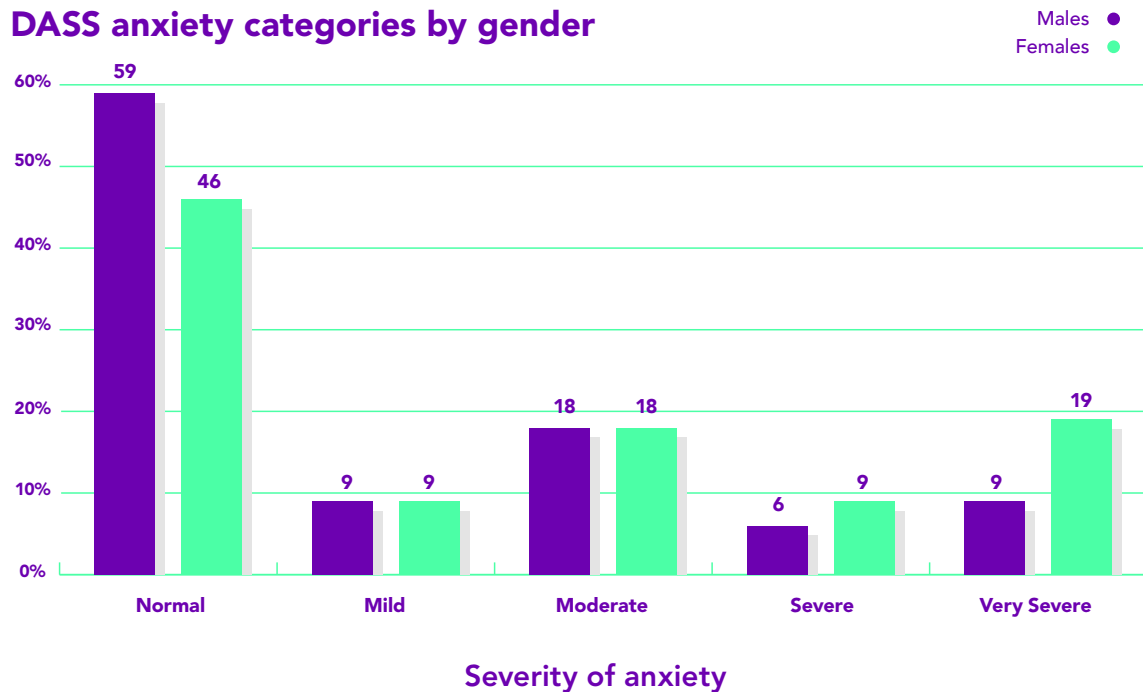
### DASS depression categories by school year



### Anxiety Categories

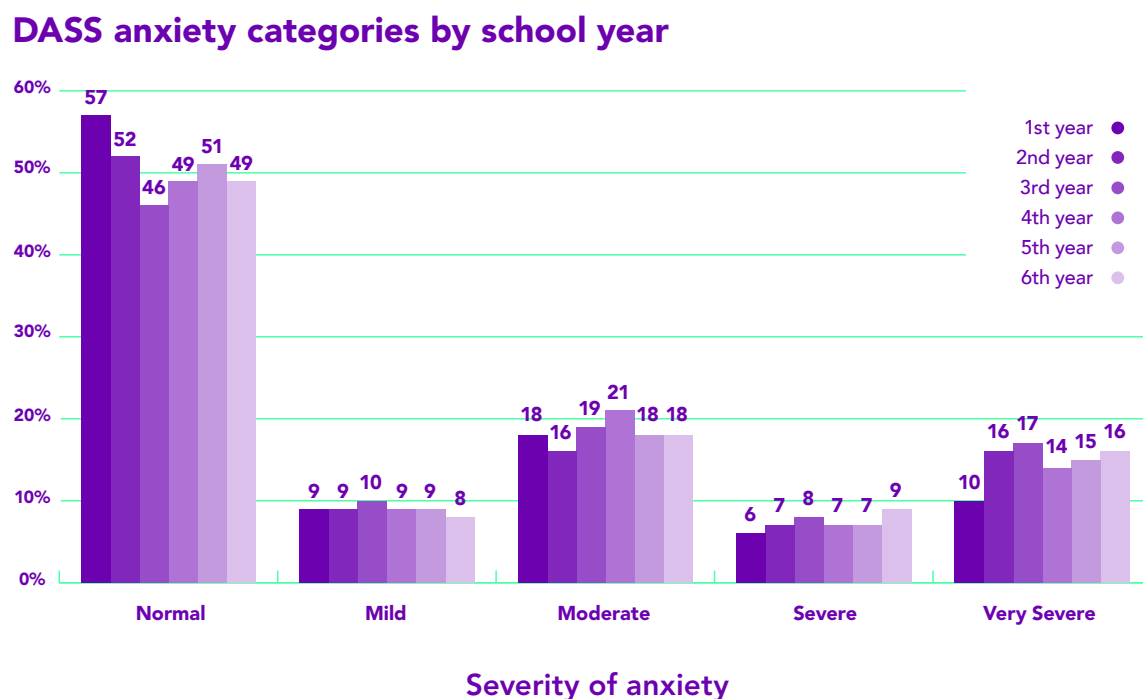
Similar to the breakdown for depression, 51% of adolescents were within the normal range for anxiety. Over one-quarter were classified as being in the mild (9%) and moderate range (18%), and about one-fifth in the severe (7%) or very severe (15%) range. Males were more likely to fall within the normal range for anxiety than females (see Figure 3.11).

Figure 3.11.



With regard to school year, first-years were more likely to be in the normal range for anxiety and less likely to be in the very severe range for anxiety. Although almost half of sixth-years were categorised in the normal range, they were also more likely to be in the severe range for anxiety. Finally, looking to third-years, they were less likely to be in the normal range for anxiety (46%; see Figure 3.12).

Figure 3.12.



### 3.1.21. Suicidality

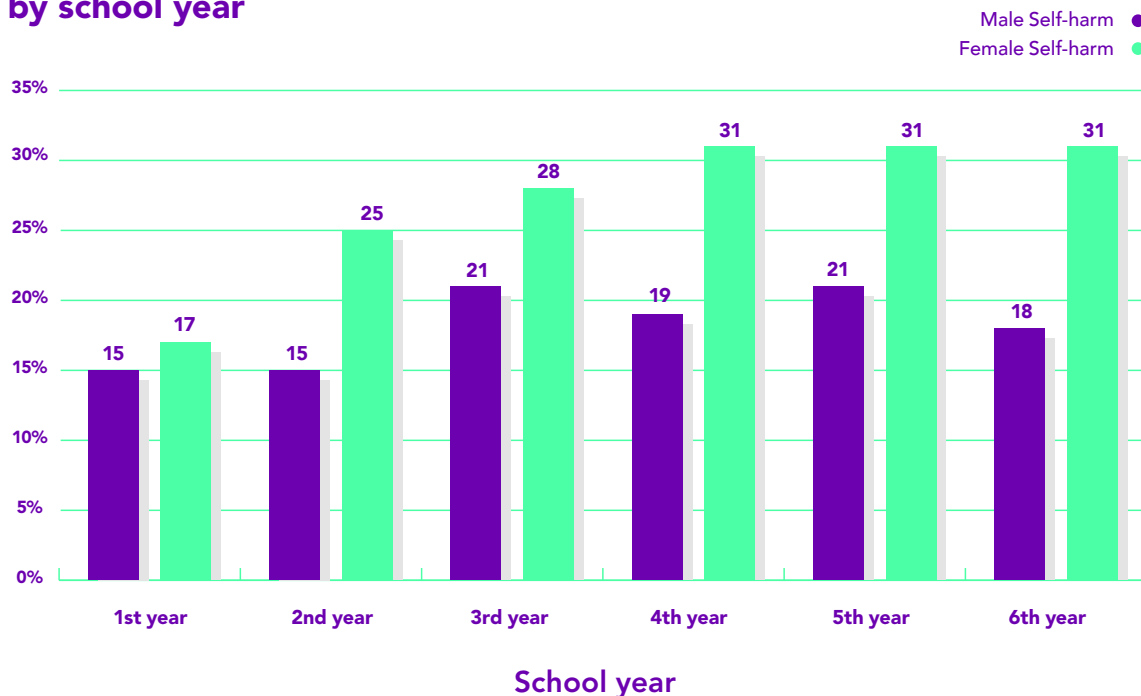
#### Self-harm without wanting to take own life

Among the adolescents surveyed, 23% reported that they had deliberately hurt themselves without wanting to take their own life at some point. Of those, 41% did so within the last year, 23% within the last six months, 19% within the last month, and 17% at some other time (typically over a year ago). Females (26%) were more likely to report deliberate self-harm than males (18%). Those in Senior Cycle (26%) were more likely to report this than those in Junior Cycle (20%).

**23%**  
reported deliberately  
hurting themselves

Figure 3.13.

#### Deliberate self-harm in males and females by school year



#### Suicidal ideation

In relation to suicidal thoughts, 41% had thought about taking their own life even though they would not do it. Here, 45% indicated that this was within the last year, 21% within the last six months, 19% within the last month and 16% at another time. Again, females (46%) were more likely to report this than males (34%) and those in Senior Cycle (48%) were more likely to report this than those in Junior Cycle (36%).

**41%**  
thought about  
taking their own life

#### Suicide attempt

It was observed that 6% of adolescents reported to have made a suicide attempt, with similar rates across gender and school cycle. Of these, 49% indicated it was within the last year, 21% within the last six months, 9% within the last month, and 20% at some other time.



### Support after suicide attempt

Where adolescents had made an attempt to take their life, 43% accessed help or support. When accessing support, 40% said it was difficult or very difficult to get the support they needed, 25% said it was neither difficult nor easy, and 36% reported that it was easy or very easy.

Among those who accessed support after a suicide attempt, 23% went to their family, 17% went to friends, 12% went to a psychologist/counsellor/therapist, 11% sought support from multiple sources, 10% GP, 5% a support service, 4% a school support, 2% a crisis service, 2% A&E, 2% phone helpline, 1% boyfriend/girlfriend and 11% did not specify. In terms of how helpful the support was, 44% reported that accessing this support was helpful, 46% said somewhat, and 10% said this support was not helpful.

---

### 3.1.22. Psychotic-like experiences

When assessing psychotic-like experiences, 14% of adolescents said that they had definitely thought that people were following or spying on them at some point (31% indicated maybe, while 55% said no), and 21% said they had definitely heard voices or sounds that no-one else could hear (24% maybe, 55% no). Furthermore, 16% had definitely seen things that other people could not see (20% maybe, 65% no).

Females ( $M=.92$ ,  $SD=.91$ ) scored significantly higher on the psychotic-like experiences indicator than males ( $M=.83$ ,  $SD=.91$ ).

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### 3.1.23. Alcohol behaviour

Of the sample, 57% reported never drinking alcohol, 22% reported doing so less than monthly, 16% monthly, 4% weekly and <1% daily.

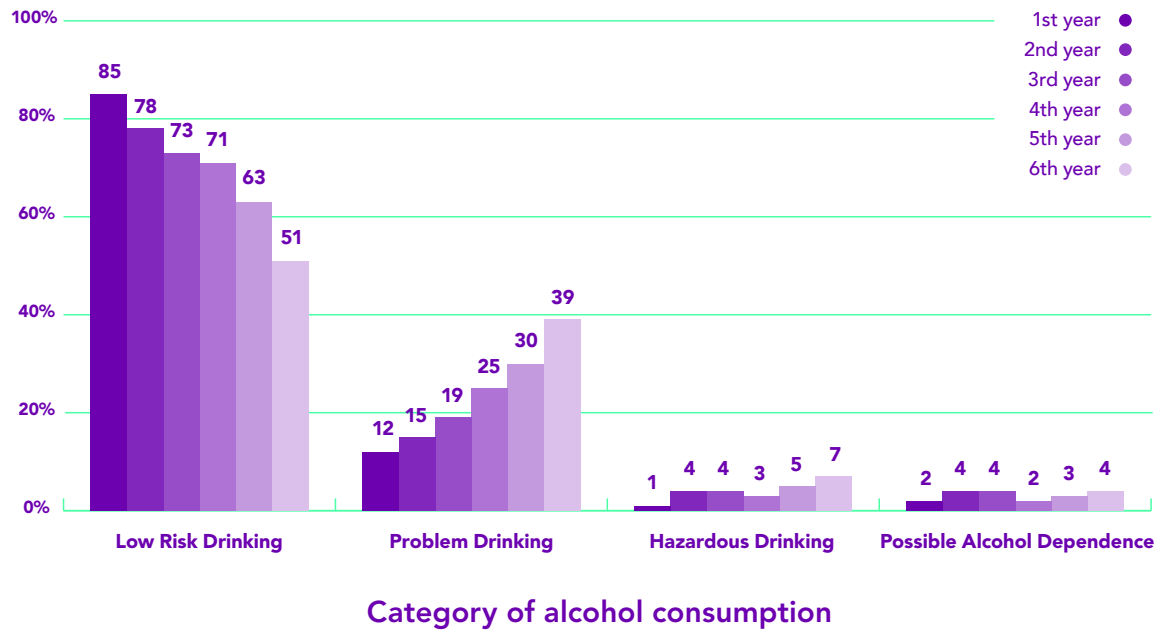
Most first-years (92%) reported that they had never drunk alcohol with 81% of second-years, 63% of third-years, 41% of fourth-years, 24% of fifth-years and only 13% of sixth-years reporting that they had never drunk alcohol.

Of those who had drunk alcohol, 65% fell into the low-risk drinking range, 28% were classified as problem drinkers, 4% as harmful and hazardous drinkers, and 3% as potentially alcohol-dependent.

Figure 3.14 shows a clear linear relationship between abnormal drinking behaviour and school year. Most first-years who drank alcohol (88%) fell into the low-risk drinking category, but this figure decreased with each school year, and, of those who drank alcohol in sixth year, only 51% fell into the low-risk drinking category.

Figure 3.14.

### Drinking behaviour by school year

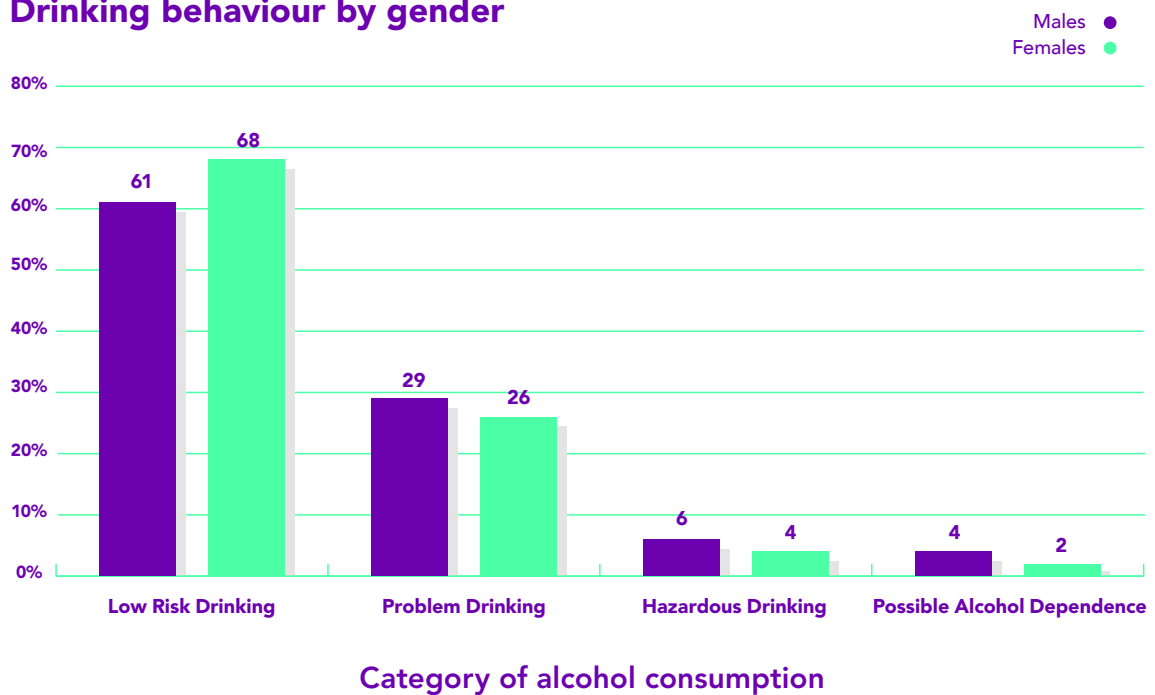


Males were more likely than females to fall into the possible alcohol dependence category, as shown in Figure 3.15.

**29%**  
of males exhibited  
problem drinking

Figure 3.15.

### Drinking behaviour by gender



---

**36%**

of 6th years  
used cannabis  
at some point

### 3.1.24. Cannabis use

Approximately 15% of adolescents reported that they had smoked cannabis; 18% of males reported this compared to 13% of females. A clear trend of increasing likelihood of having smoked cannabis was evident across school year. Reported use in first year was 3%, while this increased to 27% in fifth year and 36% in sixth year.

Of those who reported having smoked cannabis, 25% reported that they first tried cannabis at 16 years, 24% reported they were 15 years old, 19% reported that they were 14 years old and 10% reported that they were 17 years old.

---

### 3.1.25. Gambling\*

Of the Senior Cycle group who answered questions about gambling behaviour, 88% were categorised as non-gamblers, 7% as low-risk gamblers, 3% as moderate-risk gamblers, and 1% as problem gamblers. Males were more likely to be identified as low-risk, moderate-risk or problem gamblers (18%) and females were more likely to be identified as non-gamblers (93%).

---

### 3.1.26. Stressful life events

Approximately 21% of adolescents reported that they had not experienced any of the stressful life events listed, with 32% reporting one stressful life event, 23% reporting two stressful life events and 24% reporting three or more stressful life events.

The most common stressful life events for adolescents were having someone close to them die (55%), moving house within Ireland (32%), observing conflict between parents (32%), the serious illness/injury of a friend (17%), and moving country (11%). Smaller numbers of adolescents reported having their house broken into (9%), experiencing violence in the home/domestic violence (6%), violence in a romantic relationship (3%), and staying in a foster home/residential care (1%).

---

**24%**

reported 3 or more  
stressful life events

## Positive Domains

### 3.1.27. Self-esteem

Overall, adolescents scored two points above the midpoint of 25 on this measure, indicating average levels of self-esteem. Males ( $M=28.78$ ,  $SD=5.7$ ) displayed significantly higher levels of self-esteem than females ( $M=25.67$ ,  $SD=5.99$ ), as did first-years compared to all other year groups (see Figure 3.16).

**1st years**  
had the highest self-esteem levels

Figure 3.16.

### Self-esteem by school year

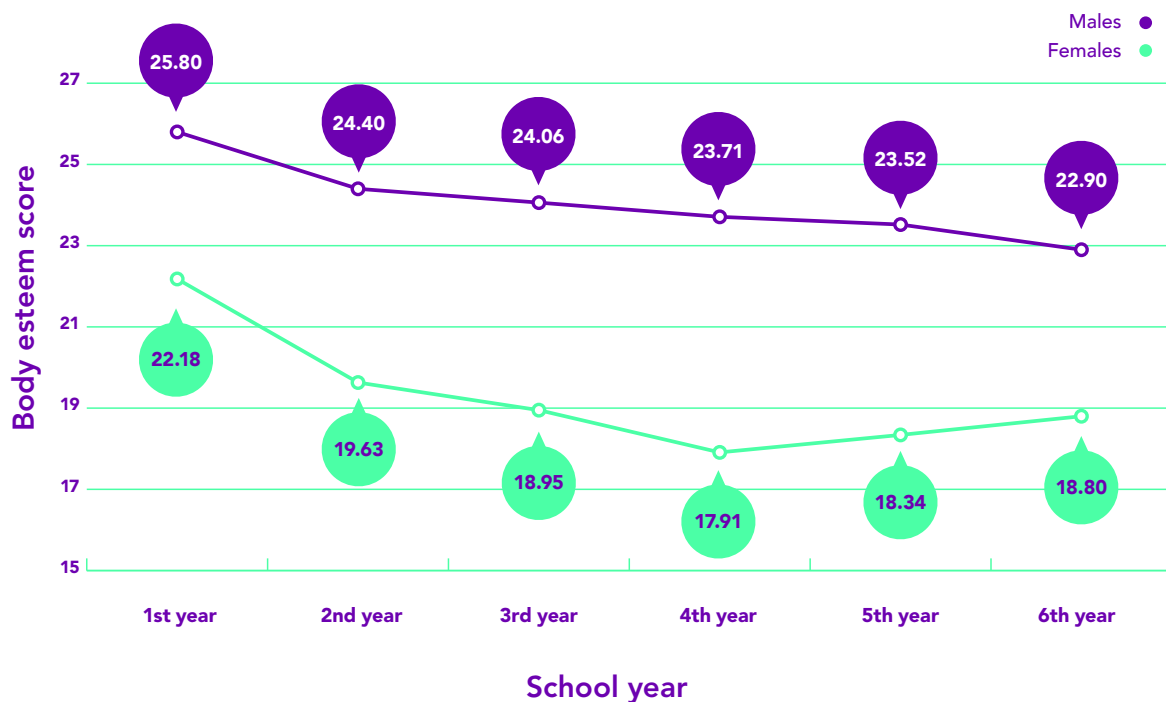


### 3.1.28. Body esteem

Overall, adolescents scored just above the mid-point of 20 for body esteem ( $M=21.37, SD=7.69$ ). Males reported significantly higher levels of body esteem ( $M=24.2, SD=.68$ ) than females ( $M=19.3, SD=7.66$ ; see Figure 3.17 for levels of body esteem by school year).

Figure 3.17.

#### Body esteem by school year and gender



**46%**  
satisfied with their bodies

Adolescents were also asked how satisfied they were with their bodies. Here, 46% of adolescents reported that they were satisfied/very satisfied with their body, 28% were neither satisfied nor dissatisfied, and 26% were dissatisfied/very dissatisfied.

Males (57%) were much more likely to be satisfied or very satisfied with their body than females (38%). There was a clear trend across school year with body satisfaction, with first-years (58%) more likely to fall into satisfied/very satisfied categories than sixth-years (39%).

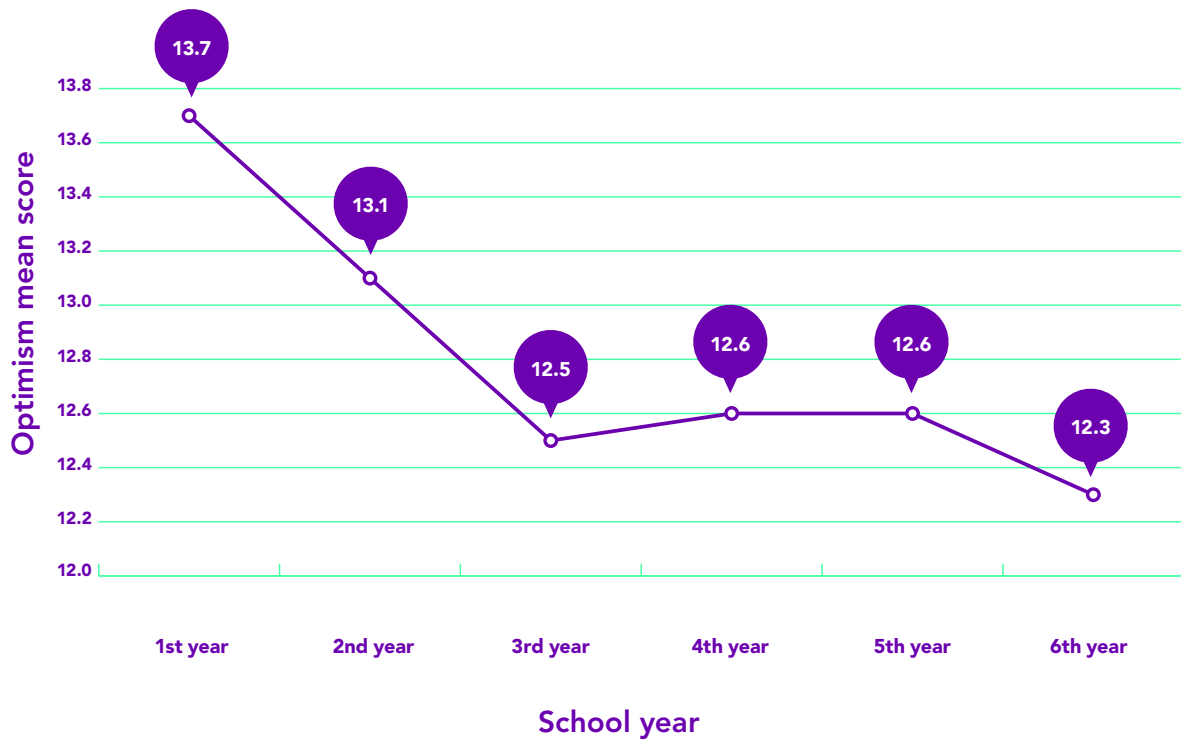
### 3.1.29. Optimism

Overall, adolescents scored above the midpoint on the optimism measure ( $M=12.85$ ,  $SD=4.78$ , score range 0-24). Males reported higher optimism ( $M=13.65$ ,  $SD=4.58$ ) than females ( $M=12.25$ ,  $SD=4.82$ ). As Figure 3.18 shows, there was a gradual decrease in levels of optimism across school year. First-years displayed significantly higher levels of optimism ( $M=13.66$ ,  $SD=4.72$ ) than those in later years (except second-years), while sixth-years ( $M=12.28$ ,  $SD=4.62$ ) displayed the lowest levels.

6th years  
displayed lowest levels of optimism

Figure 3.18.

#### Optimism by school year



Gradual decrease in levels of  
**optimism**  
across school year

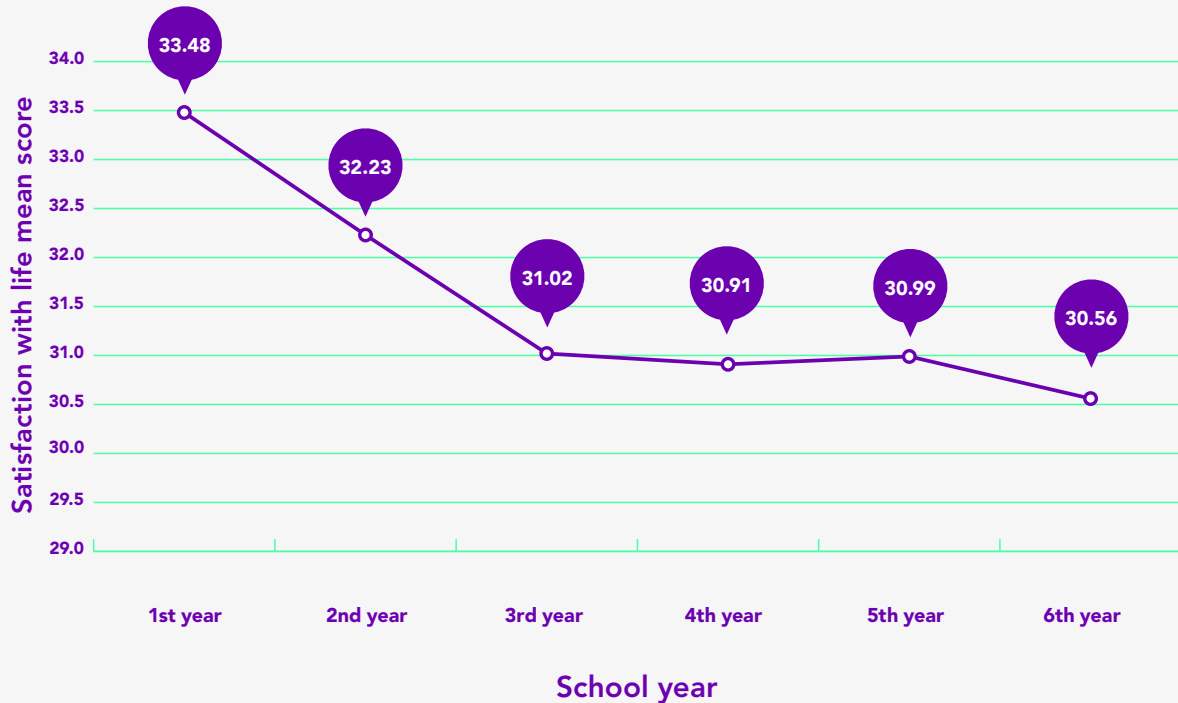
**Males**  
more satisfied with their  
lives than females

### 3.1.30. Satisfaction with life

Overall, adolescents scored much higher than the midpoint of 24 on the scale measuring life satisfaction ( $M=31.56$ ,  $SD=6.91$ ). Males ( $M=32.17$ ) reported being more satisfied overall with their lives than females ( $M=31.26$ ). First-years ( $M=33.48$ ,  $SD=7.12$ ) and second-years ( $M=32.23$ ,  $SD=6.94$ ) displayed higher life satisfaction than older year groups (see Figure 3.19).

Figure 3.19.

#### Satisfaction with life by school year



First and second years displayed higher

**life satisfaction**

than older year groups

### 3.1.31. Coping strategies

Three fundamental coping strategies were assessed in MWS-2-SL: problem-solving, seeking social support, and avoidance. High scores on problem-solving and seeking social support and low scores on avoidance coping factors indicate well-adjusted coping strategies.

#### Problem-solving

Adolescents scored just below the midpoint of 17.5 in their use of problem-solving as a means of coping (M=17.15, SD=5.5, score range 5-30). Males (M=17.5, SD=5.5) were significantly more likely to use problem-solving as a coping strategy than females (M=16.91, SD=5.51).

#### Seeking social support

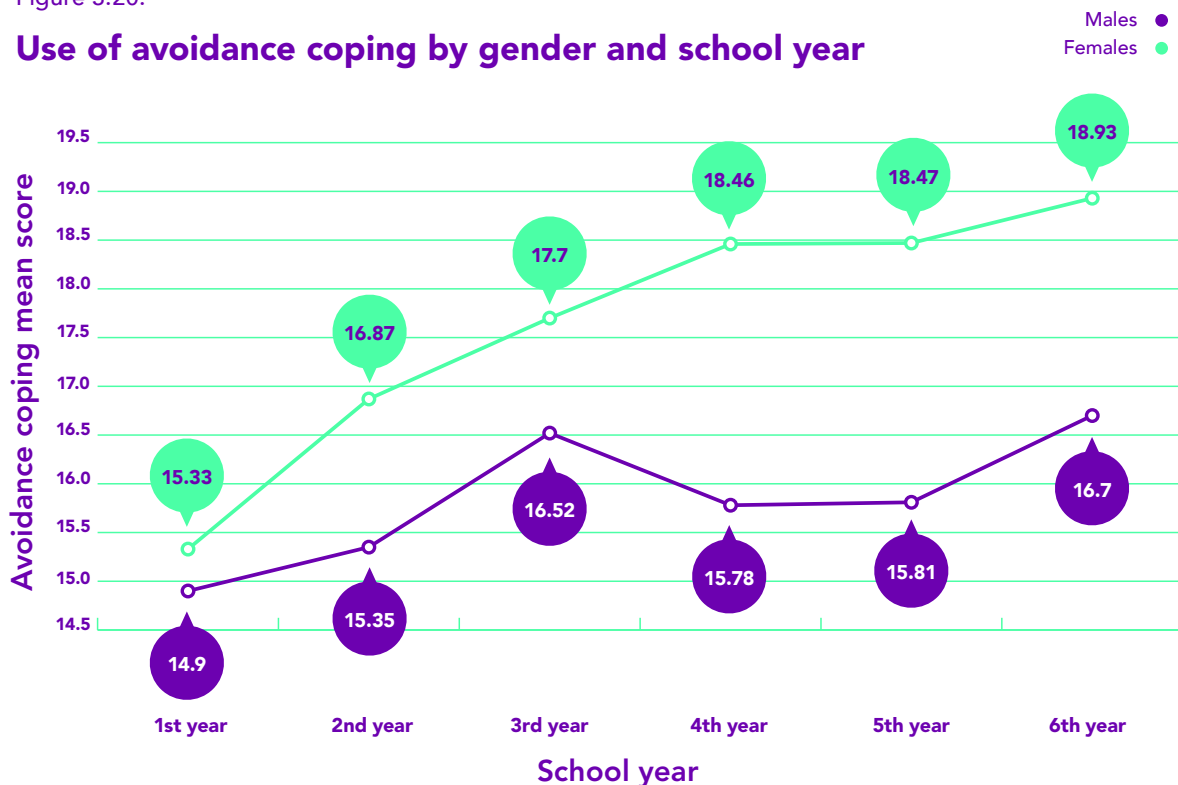
In relation to seeking support, adolescents scored just above the midpoint of 14 (M=14.5, SD=5.27, score range 4-24). Females (M=15.22, SD=5.33) showed a significantly greater tendency to use social support than males (M=13.43, SD=5).

#### Avoidance coping

Adolescents scored below the midpoint of 21 for avoidant-based coping (M=16.83, SD=6.17, score range 6-36). While females were more likely to use social support to deal with problems than males, they were also significantly more likely (M=17.57, SD=6.35) to avoid problems than males (M=15.75, SD=5.74). Levels of avoidance coping increased across school years for females and levels of avoidance coping were highest in third-year and sixth-year males (see Figure 3.20).

Figure 3.20.

### Use of avoidance coping by gender and school year





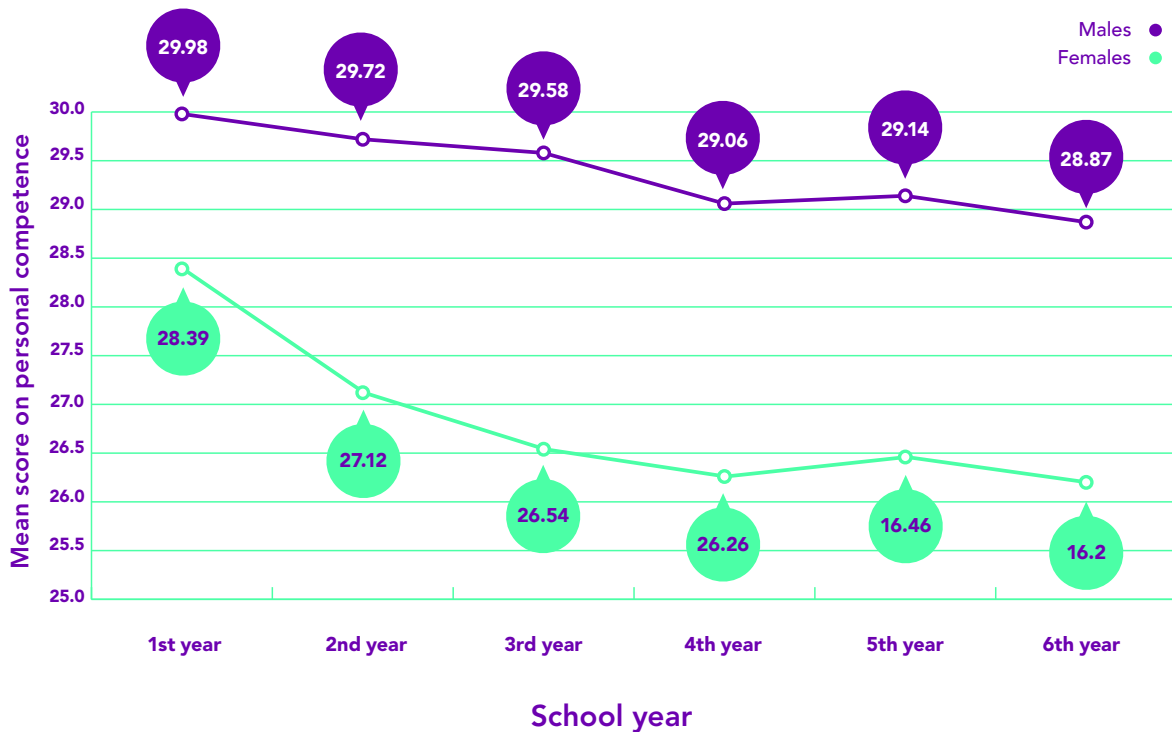
**Males**  
displayed significantly  
higher levels of personal  
competence than females

### 3.1.32. Resilience

Overall, adolescents scored above the midpoint of 24 on the personal competence resilience subscale ( $M=27.97$ ,  $SD=5.74$ , score range 8-40). Males displayed significantly higher levels of personal competence ( $M=29.48$ ,  $SD=5.3$ ) than females ( $M=26.87$ ,  $SD=5.8$ ). First-years displayed significantly higher levels of personal competence than those in all other years (see Figure 3.21).

Figure 3.21.

#### Personal competence by school year and gender



**1st**  
years displayed higher  
levels of social competence

Adolescents in general scored above the midpoint of 15 in terms of social competence ( $M=18.46$ ,  $SD=3.8$ , score range 5-25). Similar to personal competence, first-years showed significantly higher levels of social competence than all other years.

Overall, adolescents scored above the midpoint of 18 for family cohesion ( $M=23.41$ ,  $SD=4.84$ , score range 6-30). First- and second-years exhibited significantly higher levels of family cohesion than all other years.

### 3.1.33.

#### School and peer connectedness

In general, adolescents scored above the midpoint of 18 in terms of school connectedness ( $M=20.11$ ,  $SD=4.6$ , score range 6-30) and peer connectedness ( $M=22$ ,  $SD=4.14$ , score range 6-30). Females ( $M=20.42$ ,  $SD=4.62$ ) indicated a significantly higher level of school connectedness than males ( $M=19.67$ ,  $SD=4.56$ ).

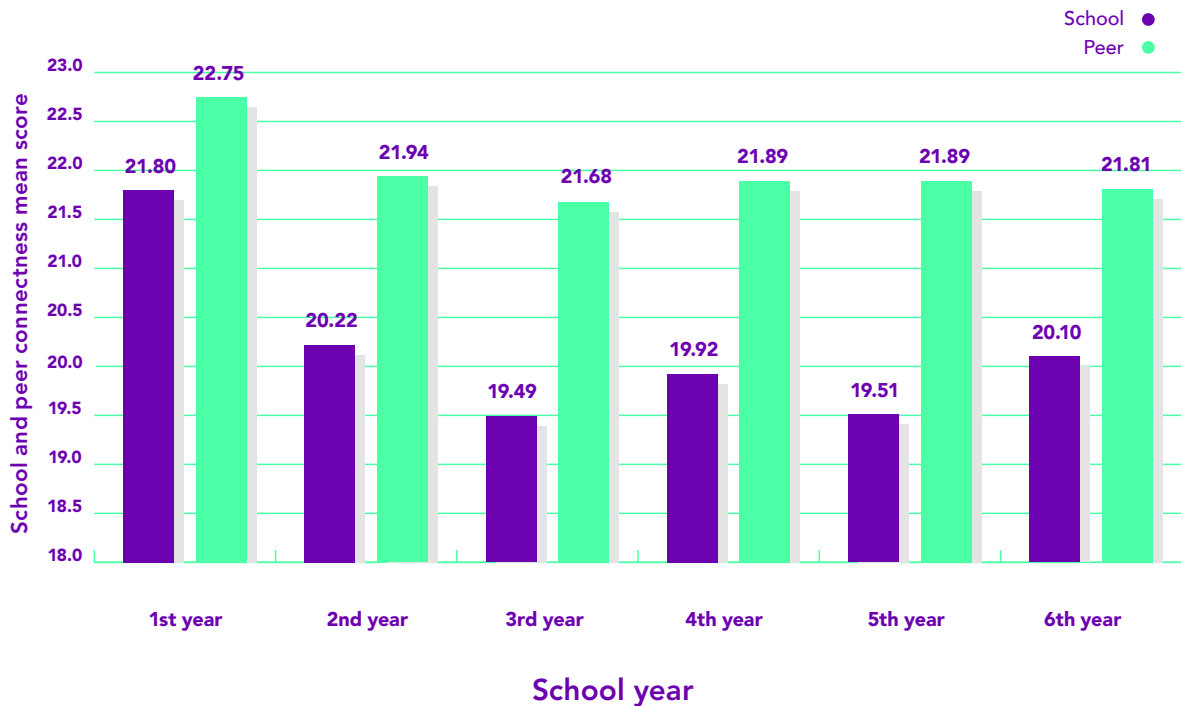
# Females

indicated a higher level of school connectedness than males

As Figure 3.22 shows, first-years displayed significantly higher levels of school and peer connectedness than other years. Third-years, fifth-years and sixth-years showed the lowest levels of school and peer connectedness.

Figure 3.22.

#### School connectedness and peer connectedness by school year



### 3.1.34. Social support

Overall, adolescents scored well above the midpoint of 48 for total social support indicating good social support (M=64.22, SD=15.23, score range 12-84). They scored above the midpoint of 14 in family support (M=19.54, SD=5.64), in friend support (M=20.73, SD=5.77) and in adult support (M=20.63, SD=6.05).

## Friend

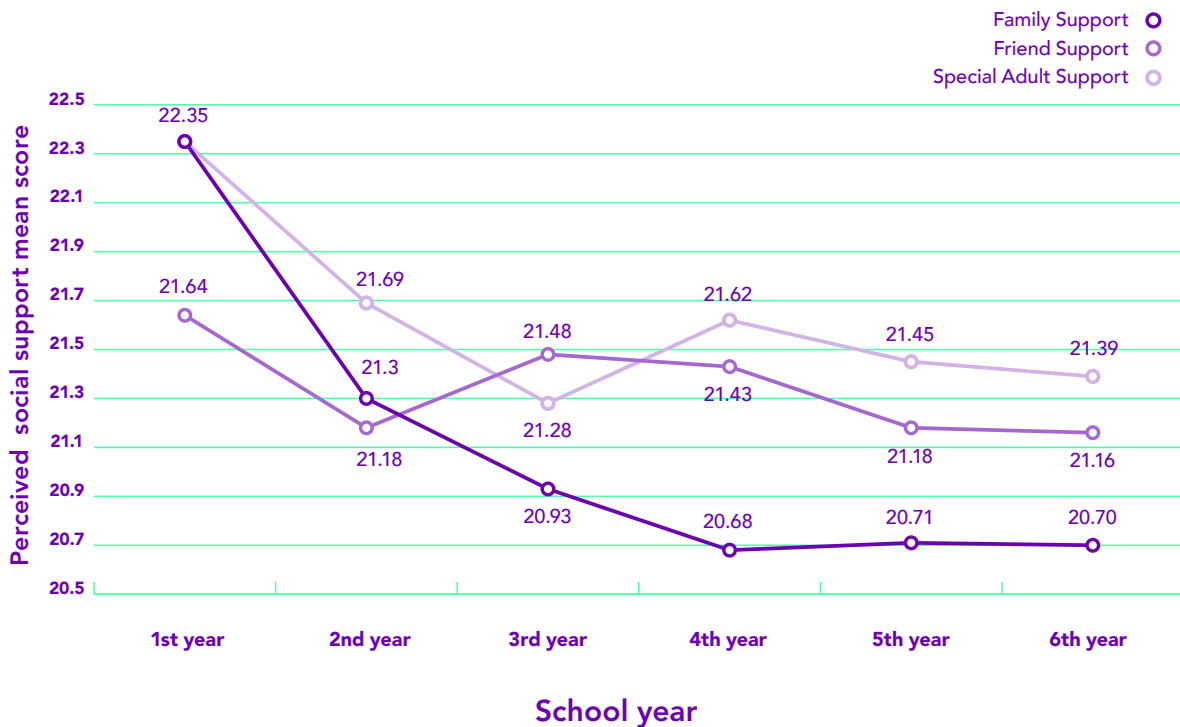
support remained relatively stable across school years

Females reported significantly higher levels of overall perceived social support (M=65.44, SD=15.21) than males (M=62.56, SD=15.1). Females perceived greater support from friends (M=21.91, SD=5.74) than males (M=20.55, SD=5.63). They also perceived greater support from a significant adult (M=22.24, SD=5.98) than males (M=20.85, SD=6.17).

A clear linear trend emerged for school year, where first-years reported the highest level of overall perceived support (M=66.44, SD=14.69) and sixth-years the lowest (M=63.3, SD=14.7). Figure 3.23 presents levels of perceived support from family, friends and adult by school year. In general, family and adult support decreased across the Junior Cycle. Family support stabilised in Senior Cycle while adult support increased slightly in fourth year. In comparison to family and adult support, friend support remained relatively stable across school years.

Figure 3.23.

### Support from family, friends and adult by school year



## One Good Adult®

### Presence of One Good Adult®

Over three-quarters (76%) of adolescents reported that they had a special adult in their lives when in need, 13% reported low support from a special adult and 11% reported neither high nor low support from a special adult.

When asked who their special adult was, 35% reported it was someone in their family (other than mother or father), 30% reported mother, 6% reported multiple sources and 4% reported father, while 17% did not report who their special adult was and 8% reported other.

Females (80%) were more likely to report the presence of a special adult while males (16%) were more likely to report low perceived support from a special adult. Third-years (17%) and sixth-years (16%) were more likely to report low perceived support from a special adult.

### Availability of One Good Adult®

In terms of how available their special adult was in times of need, 61% of adolescents reported that their special adult is always available to them, 19% said very regularly, 11% said regularly, 6% said sometimes and 3% reported that their special adult was irregularly available to them. Females (61%) were more likely to report that their special adult was always available to them and males (22%) were more likely to report that their special adult was regularly available to them. Adolescents in Junior Cycle (21%) were more likely to report that their special adult was very regularly available to them than adolescents in Senior Cycle (17%).

---

# 76%

have a special adult  
in their lives when in need

---

# 61%

reported their special  
adult is always available

### 3.1.35. Help-seeking

#### 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 wellbeing. The most commonly reported informal sources were parents (68%) and friends (68%), followed by relatives (37%) and online (20%).

Doctors/GPs were the most likely source of formal support with 21% reporting this. This was followed by a teacher or guidance counsellor (20%). Only 7% of adolescents reported that they would be likely to use a phone helpline. Approximately 36% of adolescents had heard of Jigsaw.

Adolescents were also asked what sources they had actually used to obtain information or support about their mental health and wellbeing. With regard to informal sources, parents were the most common source, with 67% of adolescents reporting this, followed by friends (66%), relatives (37%) and online (14%).

Teachers/guidance counsellors were the most common source of formal support accessed (28%), followed by doctors/GPs (21%) and a psychologist/counsellor/therapist (21%). Approximately 13% had accessed support from a psychiatrist, and 13% of adolescents had used a phone helpline.

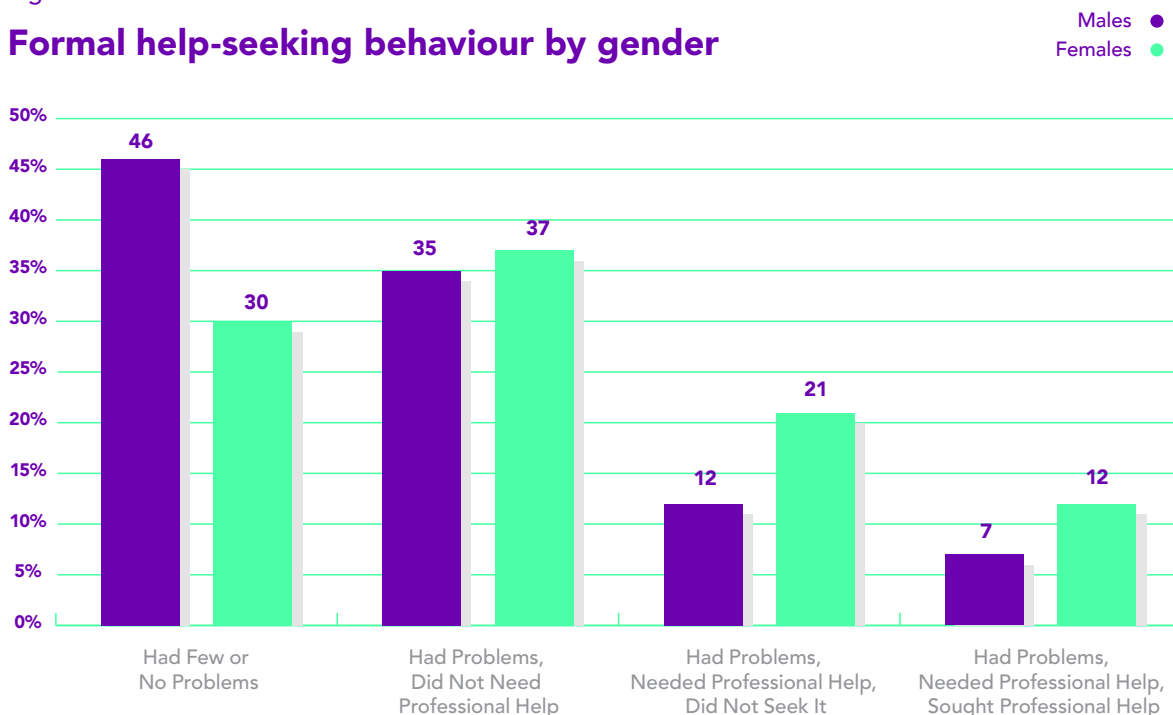
#### Problems

Over half of the sample (54%) 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.

As Figure 3.24 shows, males were more likely to report few or no problems compared to females. On the other hand, females were more likely to report needing professional help but that they had not sought it, and to report that they needed professional help and had sought it.

Figure 3.24.

#### Formal help-seeking behaviour by gender



#### Help-seeking behaviour

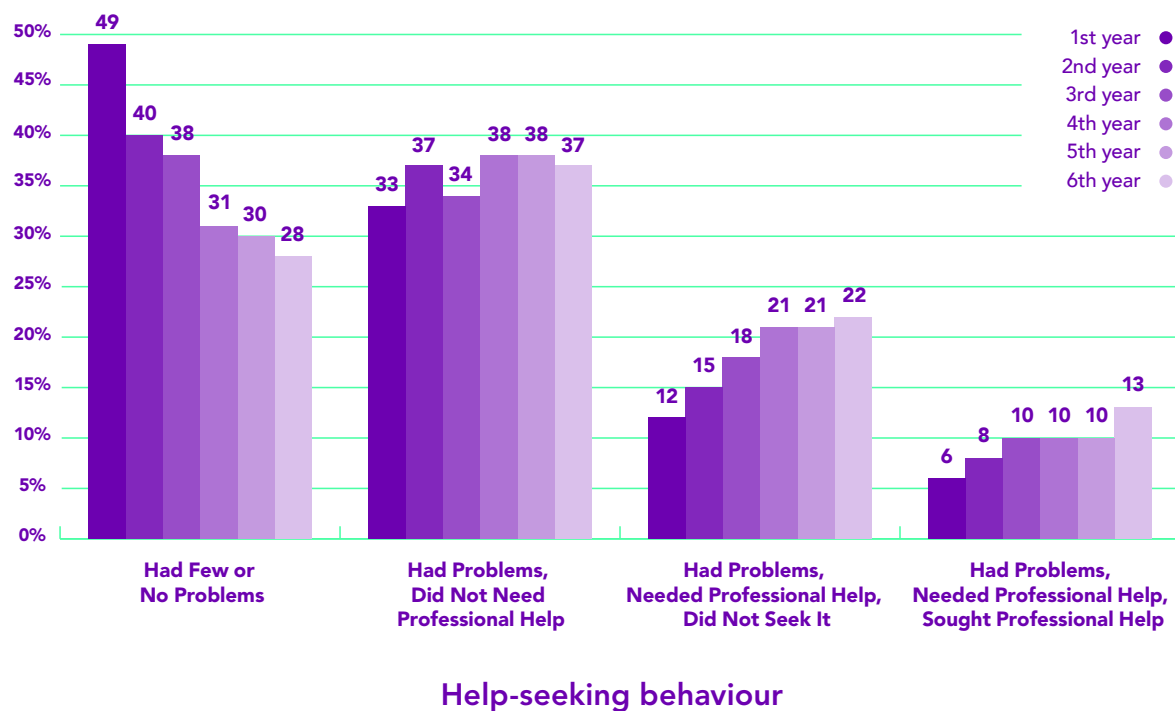
Across the school years (see Figure 3.25), first-years (49%) and second-years (40%) were more likely to report having few or no problems. Fourth-years (21%) and sixth-years (22%) were more likely to report that they had needed professional help but had not sought it. Fifth-years (13%) and sixth-years (13%) were more likely to report that they had needed professional help and had sought it.

22%

of sixth-years needed professional help but did not seek it

Figure 3.25.

### Formal help-seeking behaviour by school year



1st & 2nd

years reported having few or no problems

**60%**  
talk about  
their problems

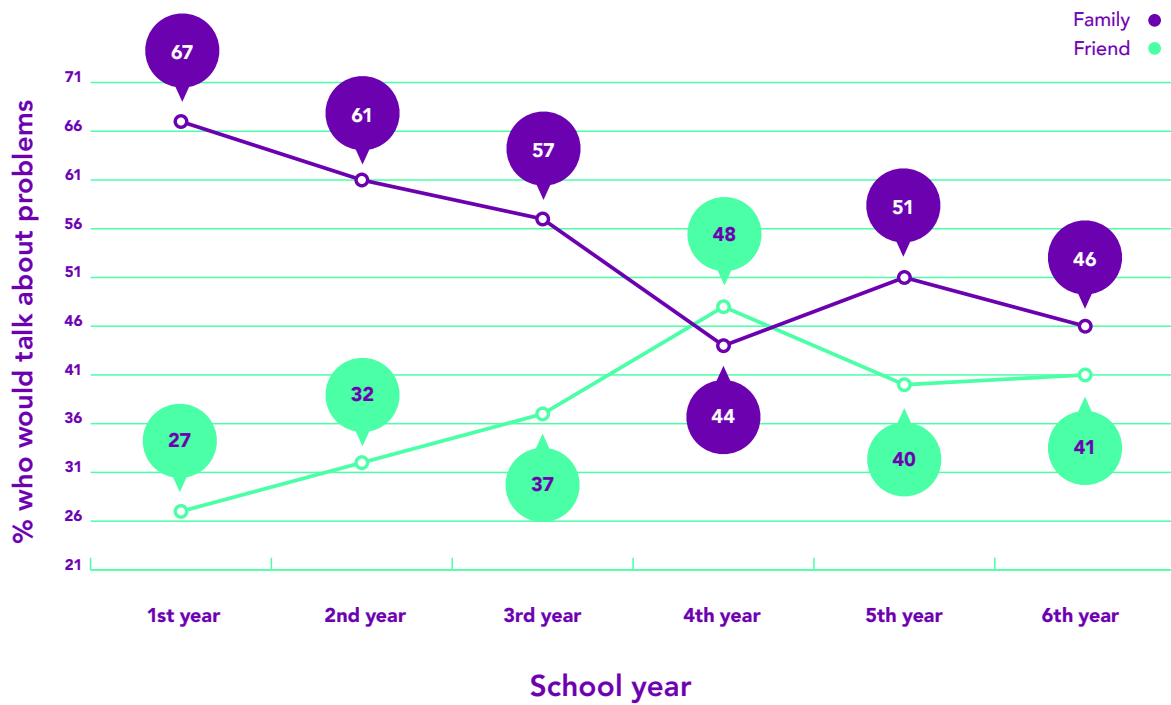
## Talking about problems

When adolescents are faced with problems, 60% reported that they talk about them with someone. Females (63%) were more likely than males (56%) to talk to someone about their problems.

Within this group who reported talking about their problems, 56% of adolescents indicated they would talk to their family, while 36% would talk to their friends. As Figure 3.26 shows, first-years would talk most to their family about their problems and this gradually decreases across school years, with the lowest percentage amongst fourth-years, and with the exception of fifth-years when family support is higher. Meanwhile, friend support becomes increasingly more common in the first four years of school and remains relatively stable from this year onwards.

Figure 3.26.

### Talking about problems with family and friends by school year



**Females**

more likely to talk about their problems

## Key Indicators of Mental Health Status

To obtain a comprehensive picture of adolescents' mental health, analyses were carried out on a range of risk and protective factors related to mental health outcomes. MWS-2 examined many potential factors, however, for the purpose of this report, nine of the most salient factors in young people's lives are described below. Each of the factors are presented in relation to various youth mental health (YMH) indicators. These are:

- |                     |                          |                                  |
|---------------------|--------------------------|----------------------------------|
| 1) Suicide          | 4) Stressful life events | 7) Alcohol behaviour             |
| 2) Social media use | 5) Sleep                 | 8) Parent approval and criticism |
| 3) Body esteem      | 6) Help-seeking          | 9) One Good Adult®               |

### 3.1.36. Suicide and YMH

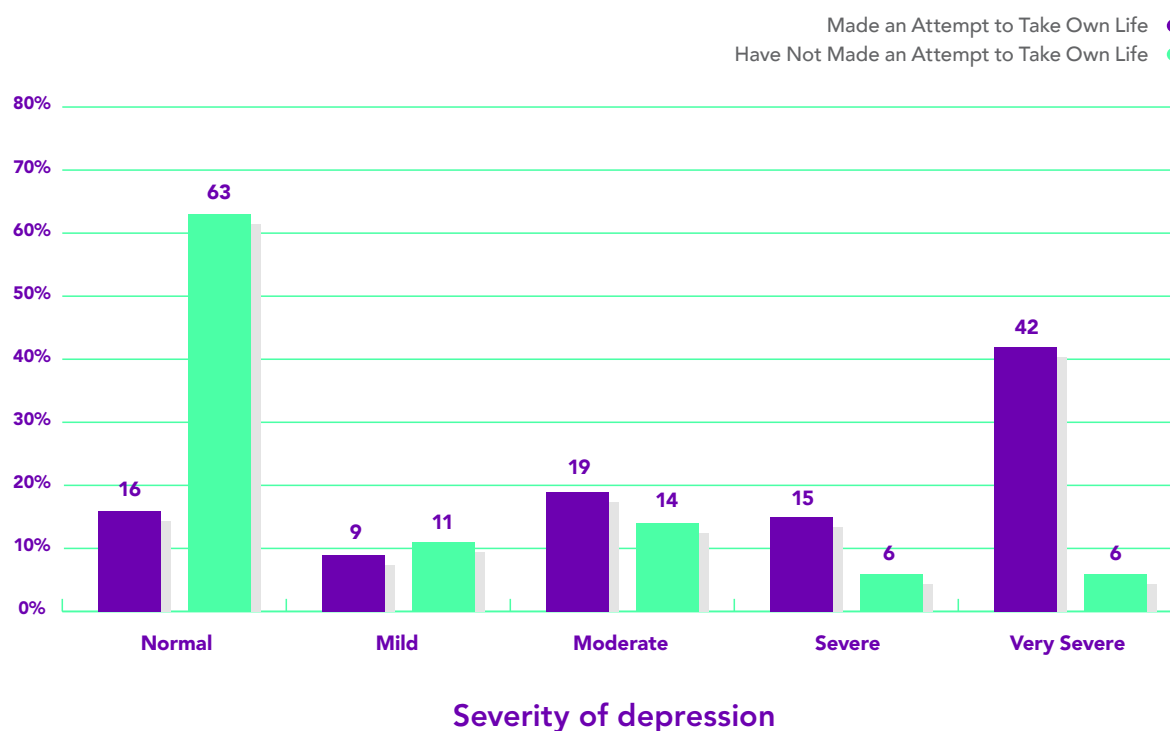
As stated previously, 6% of adolescents reported to have made an attempt to take their life. Males who reported to have made a suicide attempt were more likely to be in the moderate, severe or very severe categories for depression whereas females who reported this were more likely to be in the severe or very severe categories (see Figure 3.27) for data on adolescents who reported a suicide attempt and adolescents who did not report a suicide attempt.

6%

reported to have made an attempt to take their own life

Figure 3.27.

### Suicide attempt by depression

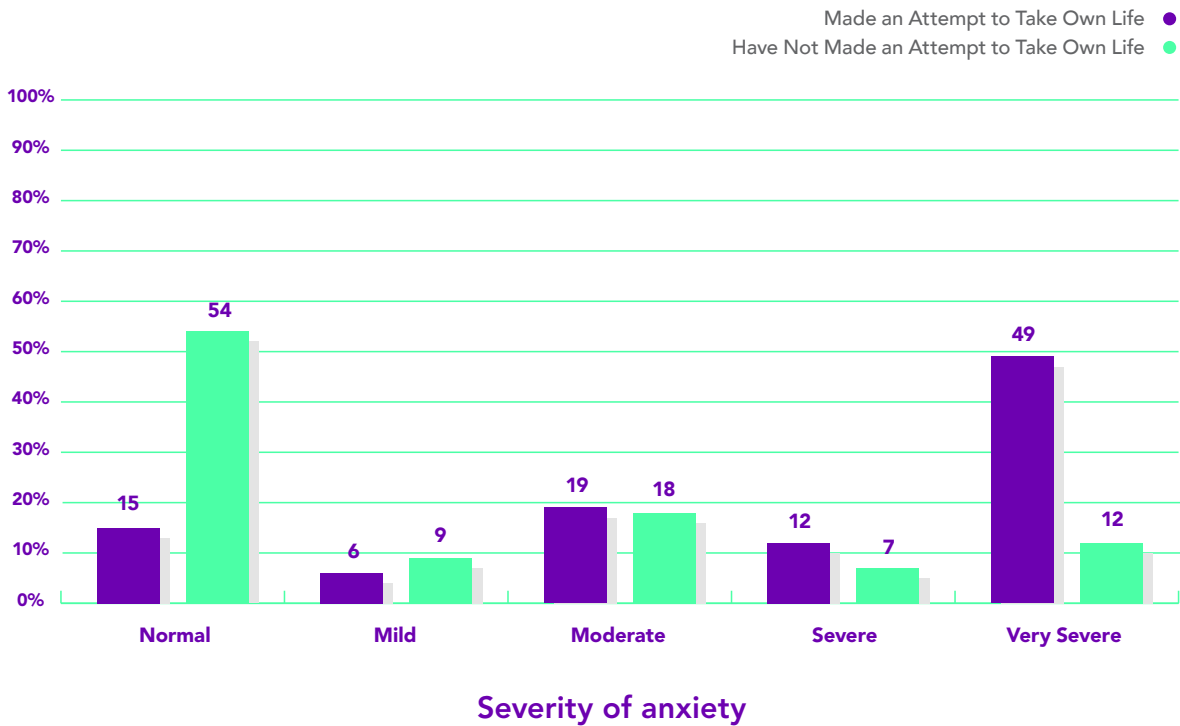




Similarly, young males who reported to have made an attempt to take their life were more likely to be in the severe or very severe range for anxiety, while young females who reported this were much more likely to be in the very severe range for anxiety (see Figure 3.28) for data on adolescents who reported a suicide attempt and adolescents who did not report a suicide attempt.

Figure 3.28.

### Suicide attempt by anxiety



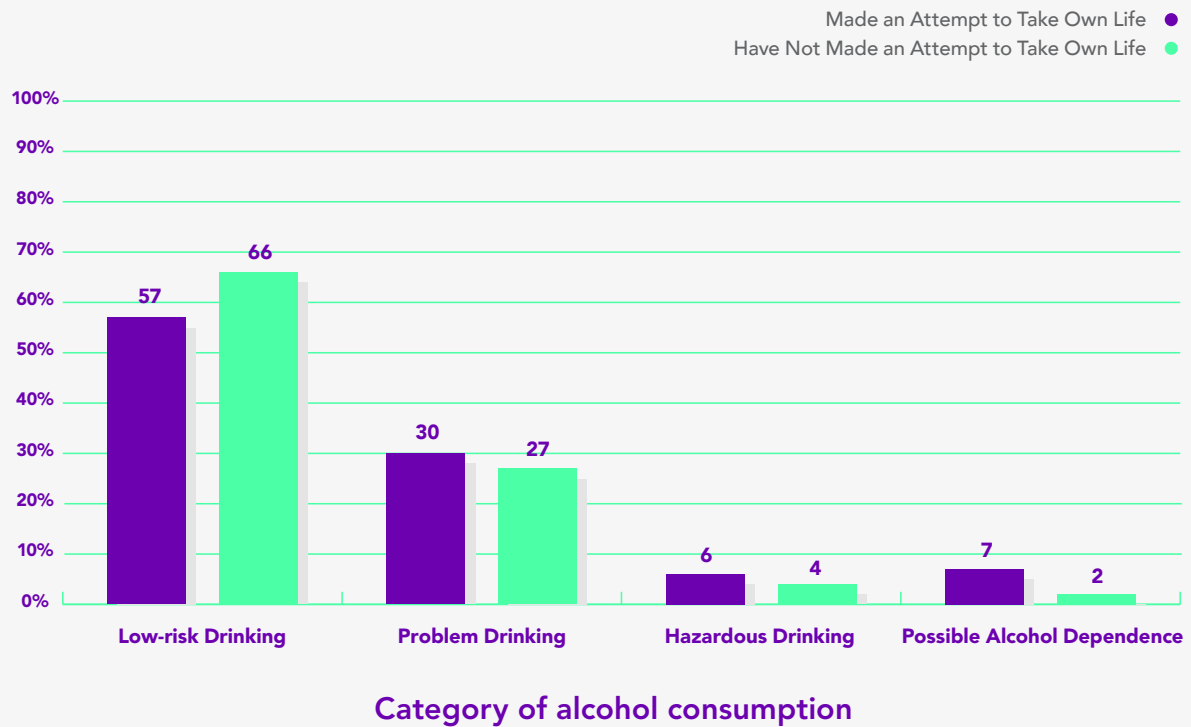
49%

who reported a suicide attempt reported having very severe anxiety

Adolescents who reported to have made a suicide attempt displayed significantly higher levels of problematic drinking ( $M=8.06$ ,  $SD=6.52$ ) than adolescents who did not report a suicide attempt ( $M=6.55$ ,  $SD=5.06$ ). Adolescents who reported this were more likely to be in the possible alcohol dependence category (7% vs 2% in adolescents who did not report this; see Figure 3.29). They were also more likely to have smoked cannabis (36% vs 14% in adolescents who did not report this).

Figure 3.29.

### Suicide attempt by alcohol behavior



Adolescents who reported that they had made an attempt to take their life exhibited significantly lower levels of school connectedness, peer connectedness, optimism, personal competence, social competence, family cohesiveness, family support, friend and adult support, self-esteem and body esteem in comparison to their peers who did not report having made an attempt to take their life.

Very similar patterns were observed in relation to deliberate self-harm.

**57%**  
 who reported a suicide attempt classified as low-risk drinking behaviour

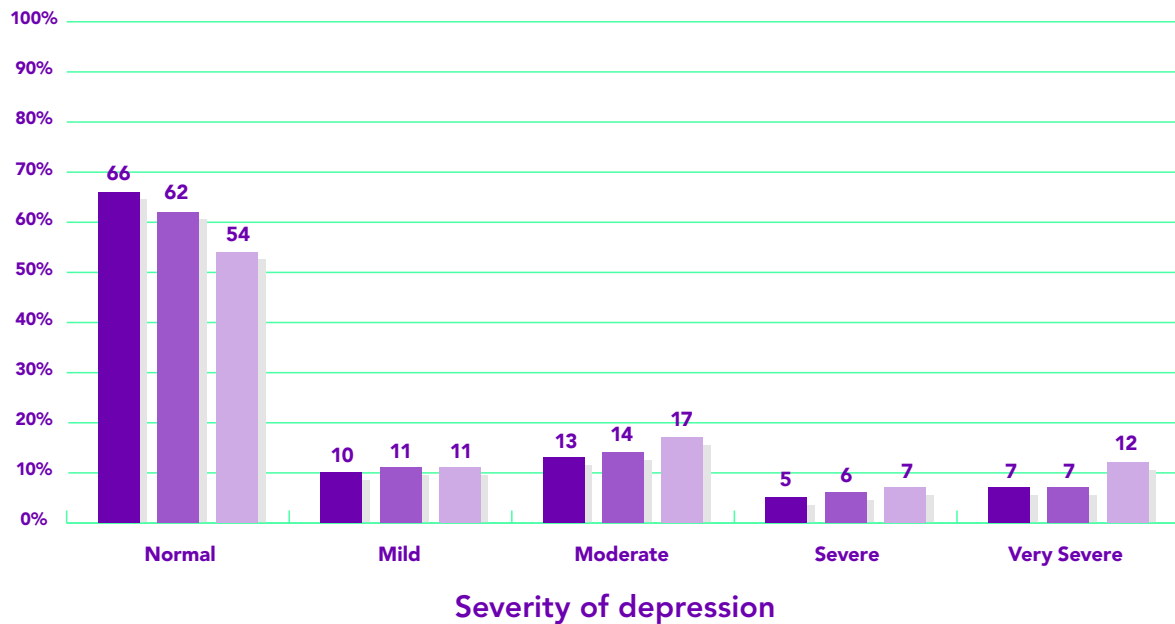
### 3.1.37. Social media and YMH

Approximately 35% of adolescents reported spending less than two hours online a day, 30% reported 2-3 hours and 36% reported spending more than three hours. Adolescents who reported spending less than two hours online were more likely to be in the normal range for depression, and adolescents who reported spending more than three hours online were more likely to be in the very severe range for depression.

Figure 3.30.

#### Time online by depression

- Less than 2 hours ●
- 2-3 hours ●
- More than 3 hours ●

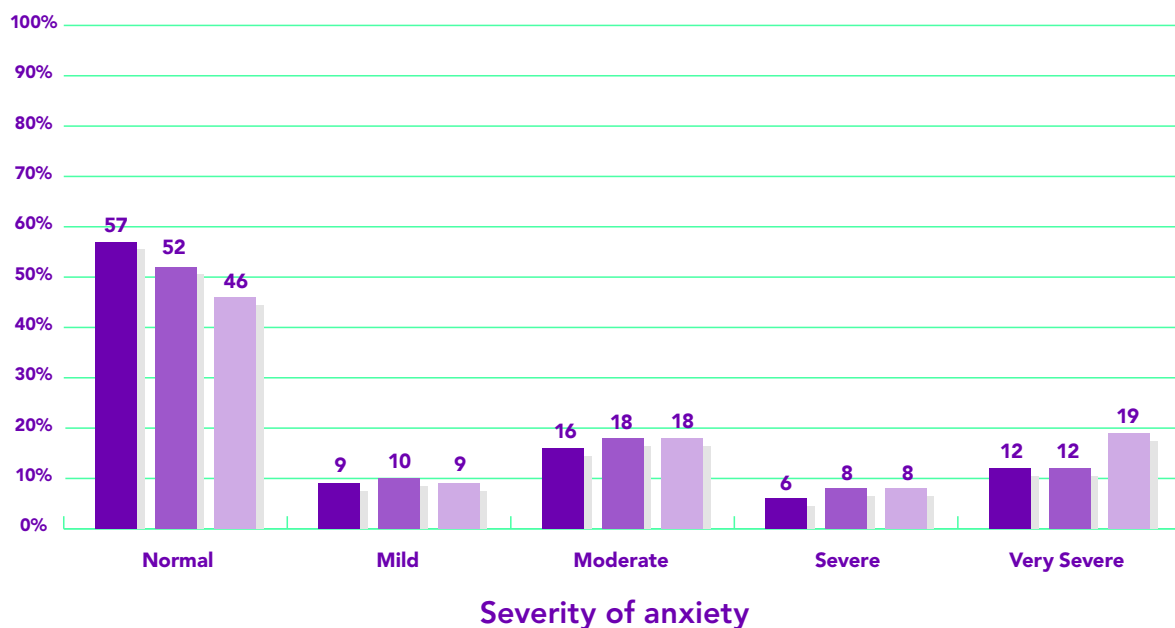


A similar pattern was observed for anxiety where adolescents spending more than three hours online were more likely to be in the very severe category for anxiety (see Figure 3.31 for details).

Figure 3.31.

#### Time online by anxiety

- Less than 2 hours ●
- 2-3 hours ●
- More than 3 hours ●



Adolescents who reported spending less than two hours online ( $M=17.92$ ,  $SD=5.48$ ) displayed significantly higher levels of problem-solving based coping than those who spent 2-3 hours ( $M=17.41$ ,  $SD=5.21$ ) and more than three hours online ( $M=16.19$ ,  $SD=5.53$ ). In terms of avoidance-based coping, adolescents who reported spending more than three hours online ( $M=18.06$ ,  $SD=6.31$ ) indicated significantly higher levels of avoidance-based coping than those who spend less than two hours ( $M=15.79$ ,  $SD=6.1$ ) or 2-3 hours online ( $M=16.61$ ,  $SD=5.87$ ).

Interestingly, adolescents who reported spending less than two hours online a day ( $M=14.12$ ,  $SD=5.28$ ) showed significantly lower levels of social support-based coping than those who spent 2-3 hours ( $M=14.91$ ,  $SD=4.98$ ) and more than three hours online ( $M=14.87$ ,  $SD=5.36$ ). This finding was consistent with reports of perceived social support from friends, whereby adolescents who reported spending less than two hours online ( $M=20.82$ ,  $SD=5.82$ ) showed significantly lower levels of perceived social support from friends than those who spent 2-3 hours online ( $M=21.5$ ,  $SD=5.66$ ).

In relation to social support in general, adolescents who reported spending more than three hours online a day ( $M=62.5$ ,  $SD=16.33$ ) displayed significantly lower levels of social support than adolescents who reported spending less than two hours online ( $M=64.01$ ,  $SD=15.35$ ) and 2-3 hours online ( $M=64.87$ ,  $SD=14.98$ ).

In terms of personal competence, adolescents who reported spending less than two hours online ( $M=28.63$ ,  $SD=5.41$ ) showed significantly higher levels of personal competence than adolescents who reported spending 2-3 hours online ( $M=28.16$ ,  $SD=5.31$ ) and more than three hours online ( $M=26.92$ ,  $SD=6.03$ ). Adolescents who reported spending more than three hours online showed significantly lower levels of family cohesion than adolescents who reported spending less than two hours online and adolescents who reported spending 2-3 hours online. They ( $M=12.1$ ,  $SD=4.73$ ) also displayed significantly lower levels of optimism than adolescents who reported spending less than two hours online ( $M=13.48$ ,  $SD=4.74$ ). Furthermore, adolescents who reported spending more than three hours online ( $M=25.61$ ,  $SD=6.05$ ) a day showed significantly lower levels of self-esteem than their peers who reported spending less than two hours online ( $M=28.05$ ,  $SD=5.95$ ) and 2-3 hours online a day ( $M=27.08$ ,  $SD=5.67$ ). A similar pattern was found for body esteem where adolescents who reported spending more than three hours online ( $M=19.73$ ,  $SD=7.7$ ) displayed significantly lower levels of body esteem than adolescents who reported spending less than two hours online ( $M=22.69$ ,  $SD=7.54$ ) and adolescents who reported spending 2-3 hours online a day ( $M=21.11$ ,  $SD=7.33$ ).

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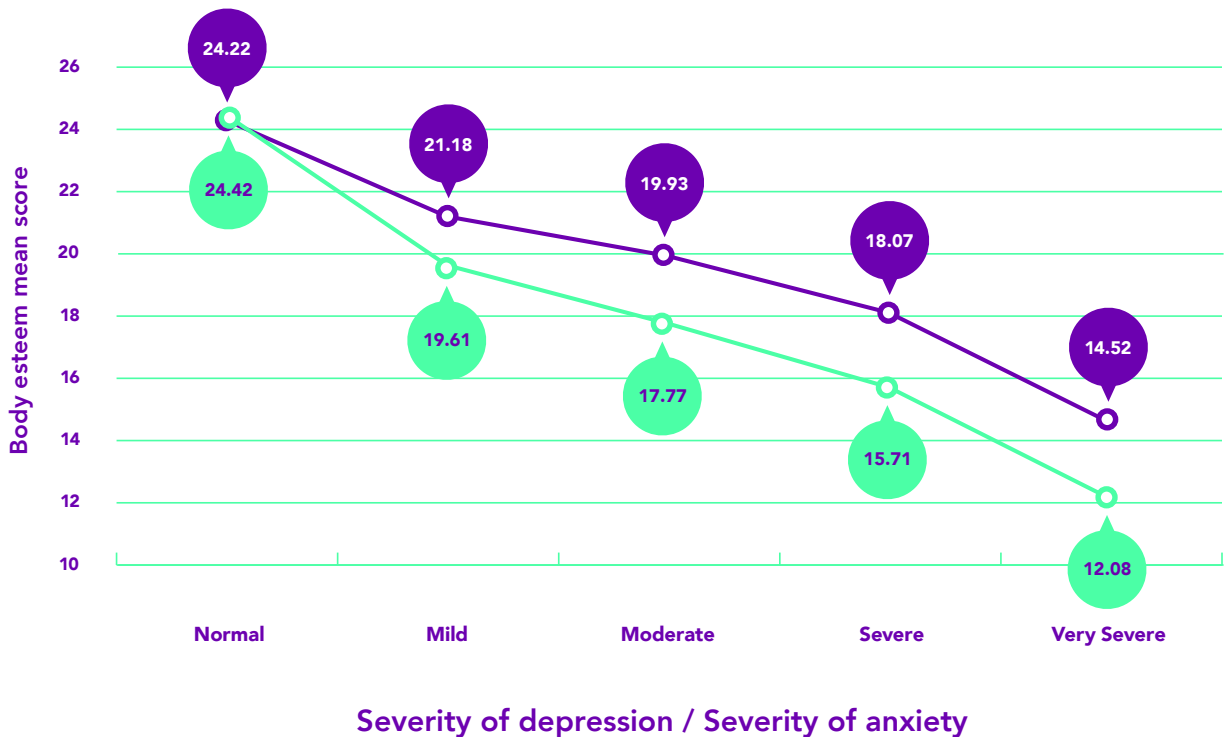
Clear linear trend between  
**body esteem  
& time online**

### 3.1.38. Body esteem and YMH

Overall, there was a clear linear relationship between body esteem and levels of depression and anxiety. Adolescents with low body esteem had higher levels of depression and anxiety than their peers (as shown in Figure 3.32 and Figure 3.33). Again, a clear trend was observed between body esteem and time spent online; adolescents who spent more time online had lower levels of body esteem.

Figure 3.32. & 3.33.

- Depression by body esteem
- Anxiety by body esteem



## Males

more likely to bulk up

Strategies for altering appearance were also related to body esteem. Males were more likely to report having tried to bulk up or maintain muscle mass than females; however, both males and females who reported this activity exhibited significantly lower levels of body esteem than those who had not. Both males and females who reported to have tried to lose weight showed significantly lower body esteem than those who had not.

### 3.1.39.

## Stressful life events and YMH

### Someone close to you die

Over half of the sample (55%) had experienced someone close to them dying. Adolescents who reported this were more likely to be in the very severe range for anxiety, while those who had not experienced this were less likely to be in the very severe category for depression. There were some other significant differences between those who had experienced someone close to them die and those who had not. Notably, those who experienced this showed significantly lower levels of self-esteem, body esteem, friend support, adult support, optimism, personal competence and social competence.

### Other stressful life events

Similar patterns emerged for those who had moved house within Ireland (32%), had experienced conflict between parents (32%), experienced violence in the home (6%) and experienced violence in a romantic relationship (3%). In general, these adolescents were more likely to be in the severe categories for anxiety and to be in the severe and very severe categories for depression. They displayed significantly lower school and peer connectedness, self-esteem, body esteem, life satisfaction, family support, adult support, personal competence and family cohesion than their peers who had not experienced these stressful life events. They were also more likely to report not getting the recommended amount of sleep and to report being absent from school for three or more days in the past month.

---

55%

experienced someone  
close to them dying

---

32%

experienced conflict  
between parents

---

6%

experienced  
violence in the home

---

3%

experienced violence in  
a romantic relationship

**56% of females**

have poor sleep hygiene

Those with poor sleep hygiene displayed lower levels of

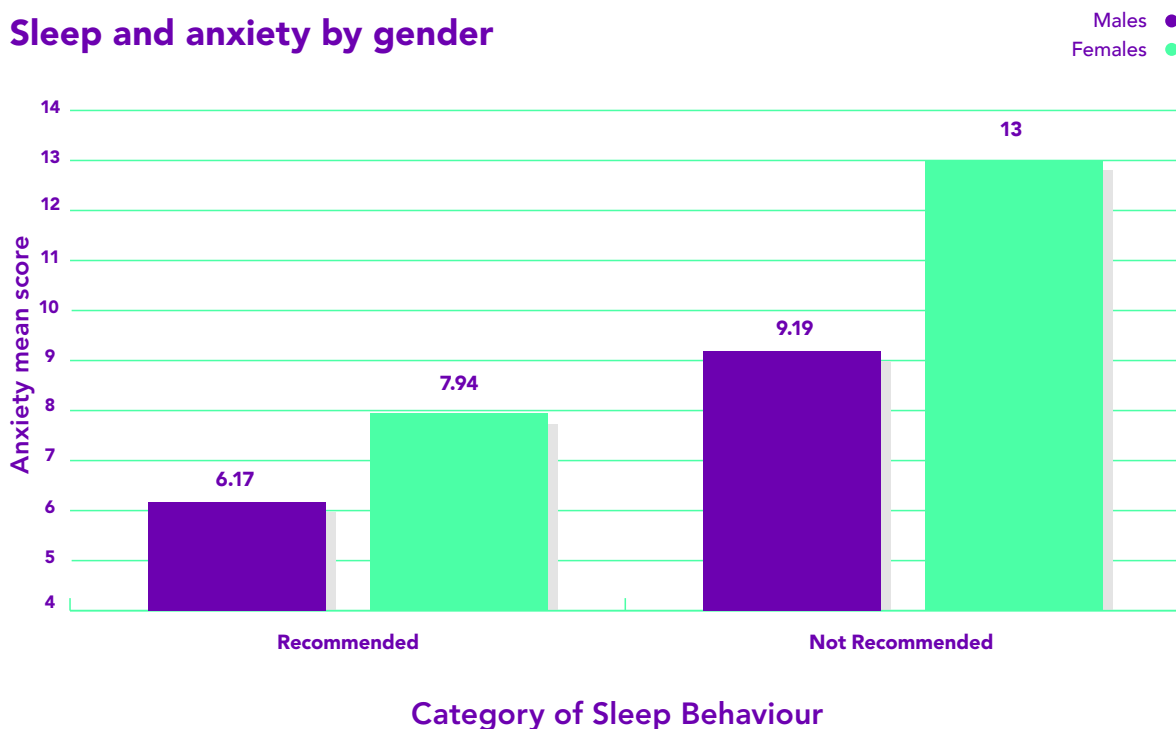
**body esteem**

### 3.1.40. Sleep and YMH

As noted earlier, females were less likely to get the recommended amount of sleep, with 56% being classified as having poor sleep hygiene. As Figure 3.34 shows, females who did not get the recommended amount of sleep were more likely to fall into the moderate category for anxiety (score range 10-14), while males who did not get sufficient sleep fell into the mild category for anxiety (score range 8-9). Similar patterns were observed for depression where females who were not getting the recommended amount of sleep fell within the moderate, severe and very severe ranges for depression. Males and females who reported poor sleep hygiene displayed significantly lower levels of body esteem than their peers who reported good sleep hygiene.

Figure 3.34.

### Sleep and anxiety by gender

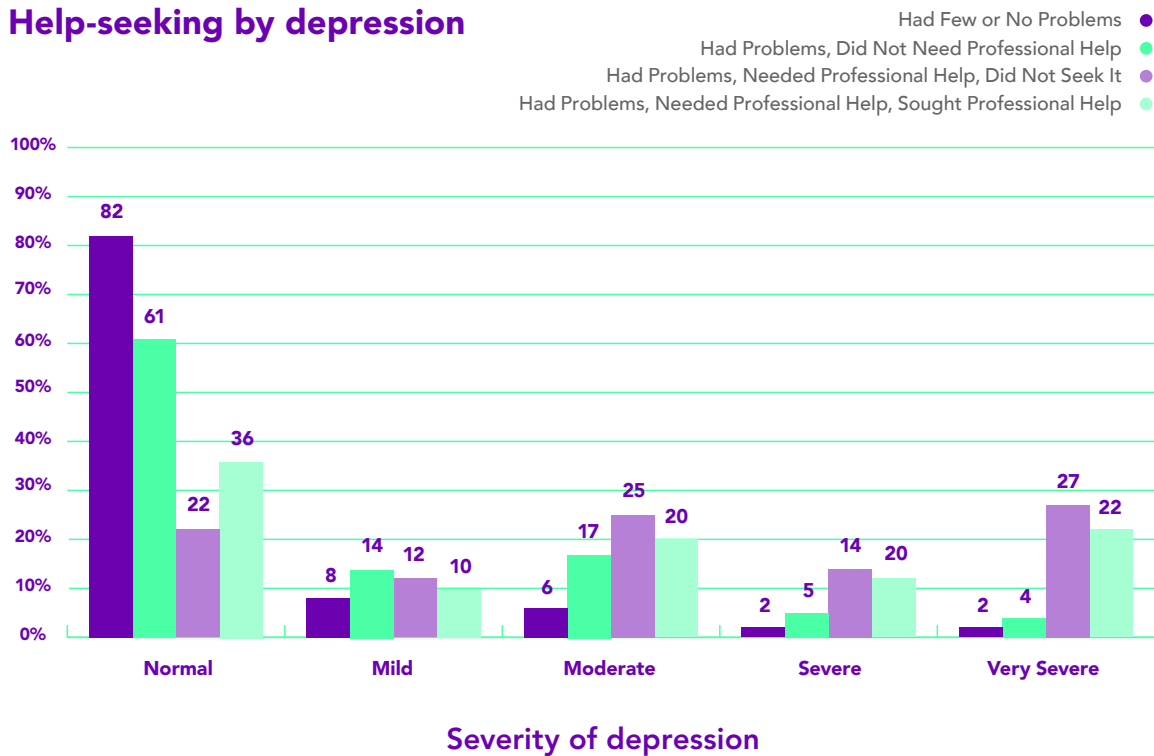


### 3.1.41. Help-seeking and YMH

As shown in Figure 3.35, adolescents who reported that they had no problems were more likely to be in the normal range for depression while adolescents who reported that they had some problems but did not feel they needed professional help were more likely to be in the mild range for depression. Adolescents who reported that they have had problems and sought professional help were more likely to be in the moderate, severe and very severe range for anxiety. Adolescents who reported that they had problems but did not seek the professional help they needed displayed significantly higher levels of depression than all other adolescents, including adolescents who reported that they have had problems and sought professional help.

Figure 3.35.

#### Help-seeking by depression



Adolescents who reported

**no problems**

were more likely to be in the normal range for depression

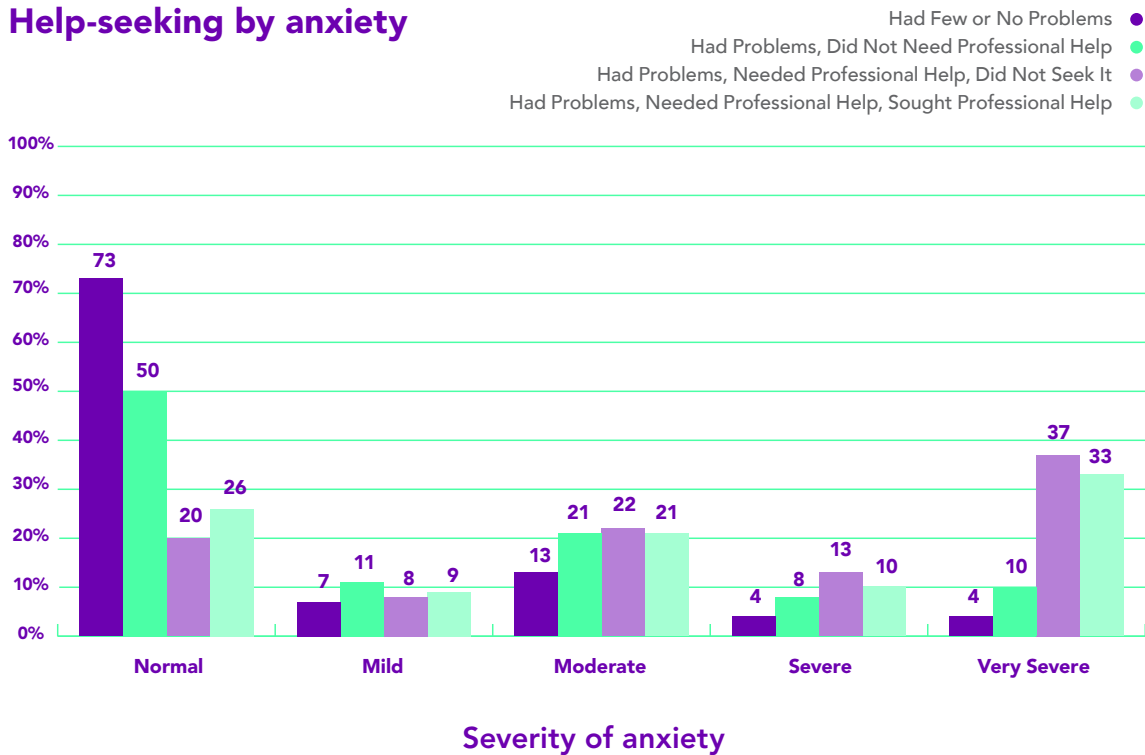


**37%**  
with very severe anxiety  
did not seek professional help

Similarly for anxiety, as shown in Figure 3.36, adolescents who reported that they have had no problems were more likely to be in the normal range for anxiety and less likely to be in the mild, moderate, severe range or very severe range for anxiety. On the other hand, adolescents who reported that they have had problems and did not seek help were more likely to be in the moderate, severe or very severe range for anxiety.

Figure 3.36.

### Help-seeking by anxiety



**73%**  
with normal anxiety  
levels had few  
or no problems

These data indicate that adolescents' responses to their perception of problems and need for help map statistically to the categories of the standardised measures of depression and anxiety; suggesting adolescents have a good insight into their mental health. This simple question, referred to as the Mental Health Barometer, is reliably linked to the DASS Anxiety and Depression subscales.

### 3.1.42.

## Alcohol behaviour and YMH

The AUDIT (Babor, Higgins-Biddle, Saunders & Monteiro, 2001) cut-offs found that of those who reported drinking alcohol, 65% fell into the low-risk drinking range, 28% were classified as problem drinkers, 4% as harmful and hazardous drinkers and nearly 3% as possibly alcohol-dependent.

Analyses revealed a clear link between harmful and hazardous levels of alcohol behaviour and psychological distress. As Figure 3.37 shows, adolescents classified as low-risk drinkers were more likely to fall within the normal range for depression (55%). In contrast, those classified as harmful and hazardous drinkers were more likely to fall within the severe category for depression (17%), and those classified as having possible alcohol dependence were more likely to be in the very severe category for depression (33%).

**28%**

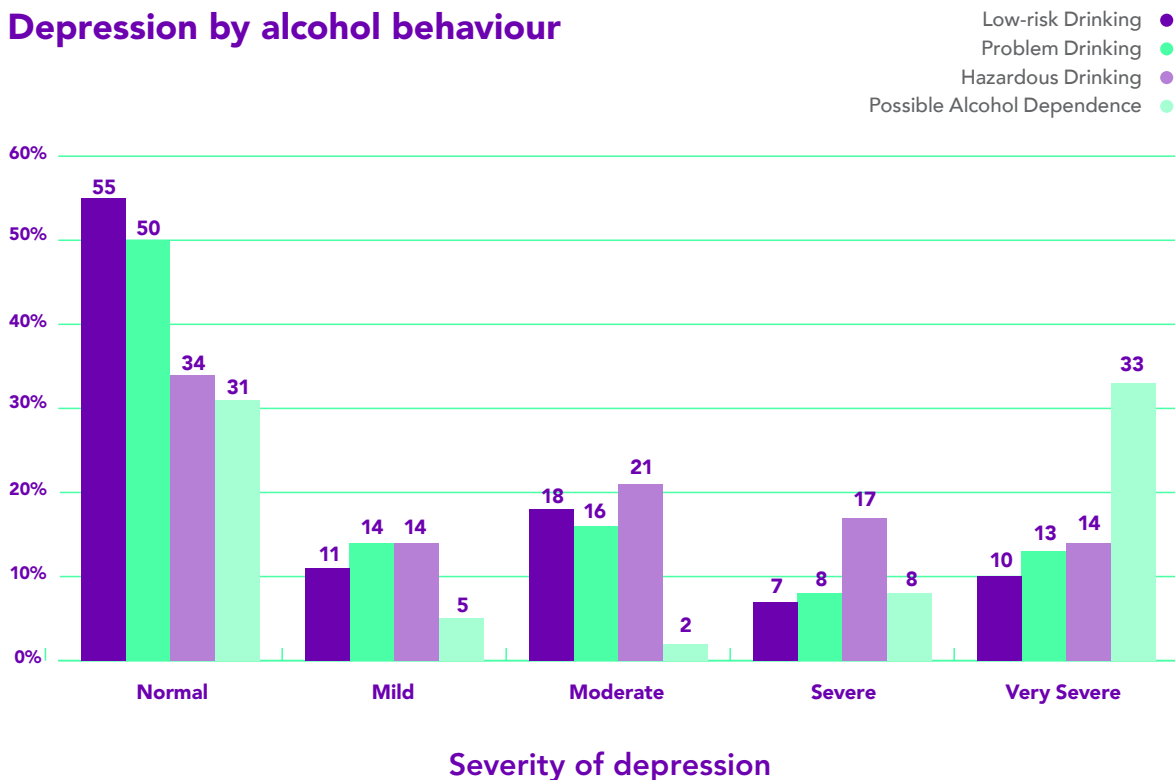
classified as engaging in problem drinking

**33%**

with possible alcohol dependence classified with very severe depression

Figure 3.37.

## Depression by alcohol behaviour

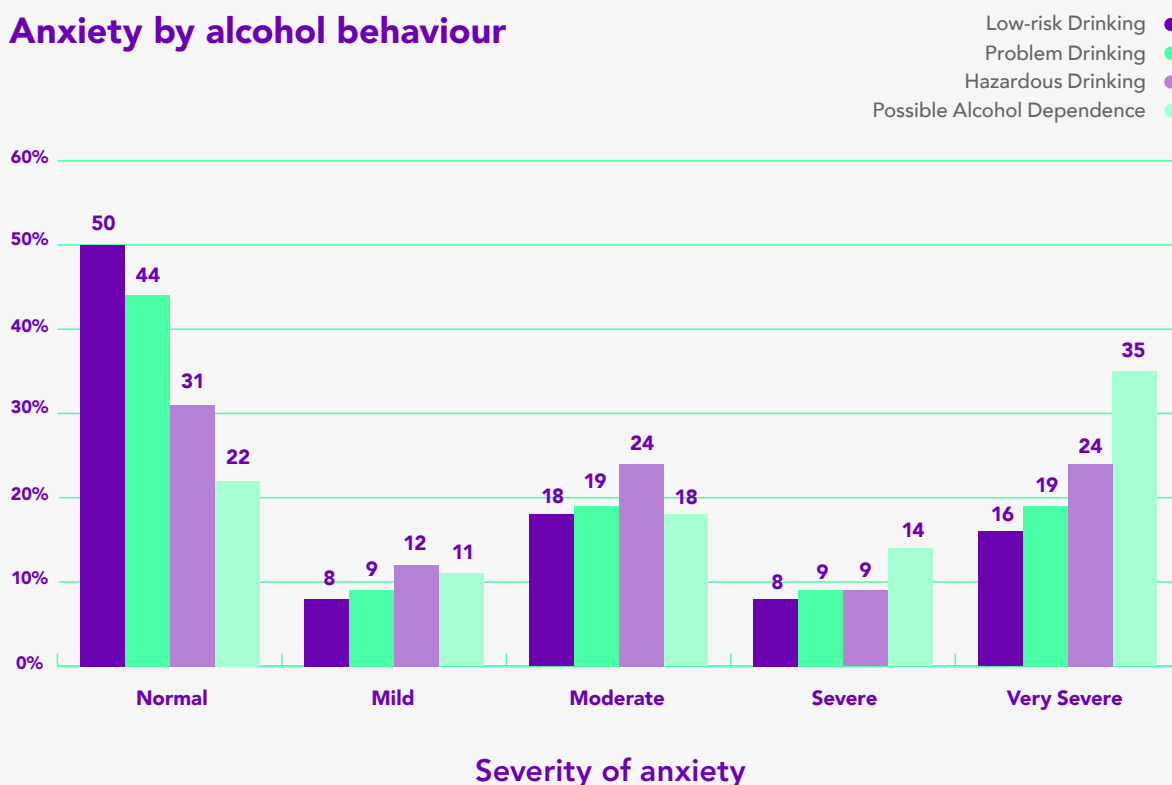


**50%**  
with low-risk drinking  
behaviour classified  
in normal range for  
depression

A similar pattern emerged for anxiety. As evident from Figure 3.38, 50% of those identified as low-risk drinkers fell within the normal category for anxiety, compared to only 22% of those with possible alcohol dependence. The reverse pattern was observed for the very severe anxiety category: 16% of those identified as low-risk drinkers reported very severe anxiety compared to 37% of those with possible alcohol dependence.

Figure 3.38.

### Anxiety by alcohol behaviour



In terms of daily life functioning, those categorised as problem drinkers, harmful and hazardous drinkers and possibly alcohol dependent were more likely to report being absent from school for six days or more. They also showed significantly higher levels of avoidance-based coping in relation to low-risk drinkers.

In relation to positive domains, those classified as low-risk drinkers showed significantly higher levels of school connectedness, peer connectedness, optimism, family support, adult support and family cohesiveness relative to all other categories of alcohol behaviour. Low-risk drinkers also displayed higher levels of personal competence, friend support and self-esteem than harmful and hazardous drinkers and those classified as possibly alcohol dependent.

### 3.1.43.

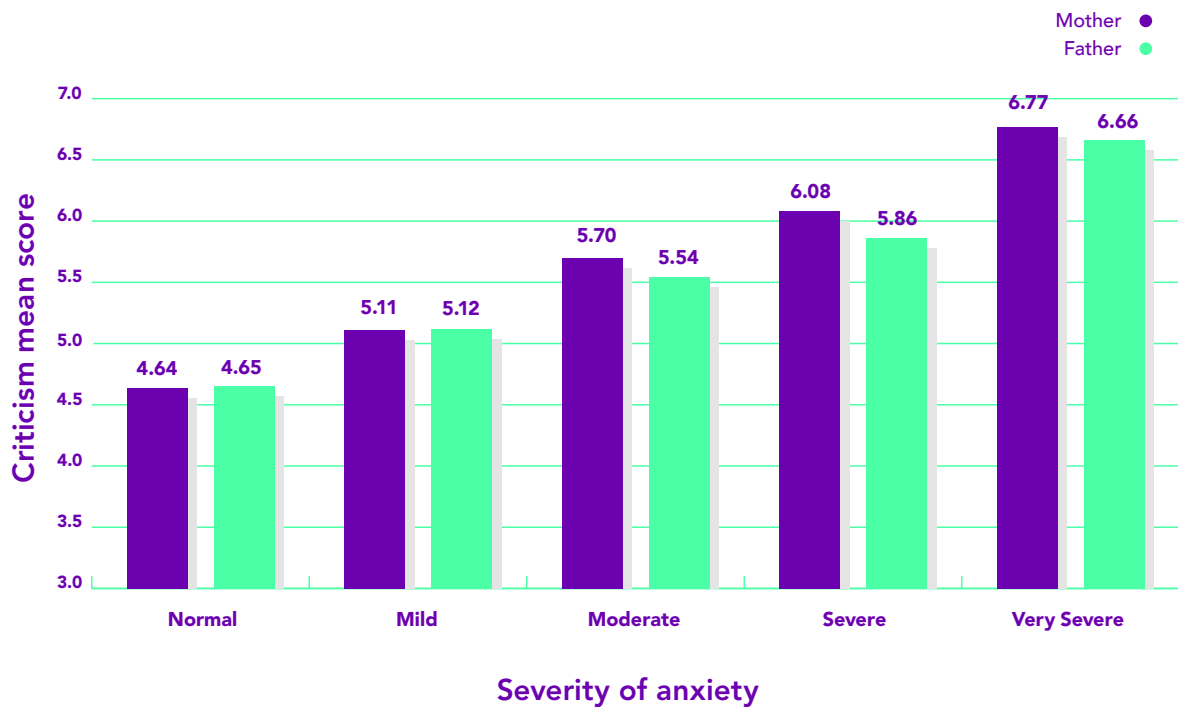
## Parent approval and criticism and YMH

There was a clear relationship observed between mother/father criticism and anxiety. Adolescents who reported high levels of criticism from their parents experienced significantly more anxiety than their peers (see Figure 3.39).

Those with high level of criticism from parents experienced more **anxiety**

Figure 3.39.

## Parent criticism and anxiety



The opposite pattern was observed in terms of mother and father approval, whereby those who reported high levels of parental approval had significantly lower levels of anxiety than their peers.

A similar significant pattern was observed in relation to depression with those experiencing criticism from a parent displaying more depression.

Those with high level of parental approval experienced less **anxiety**

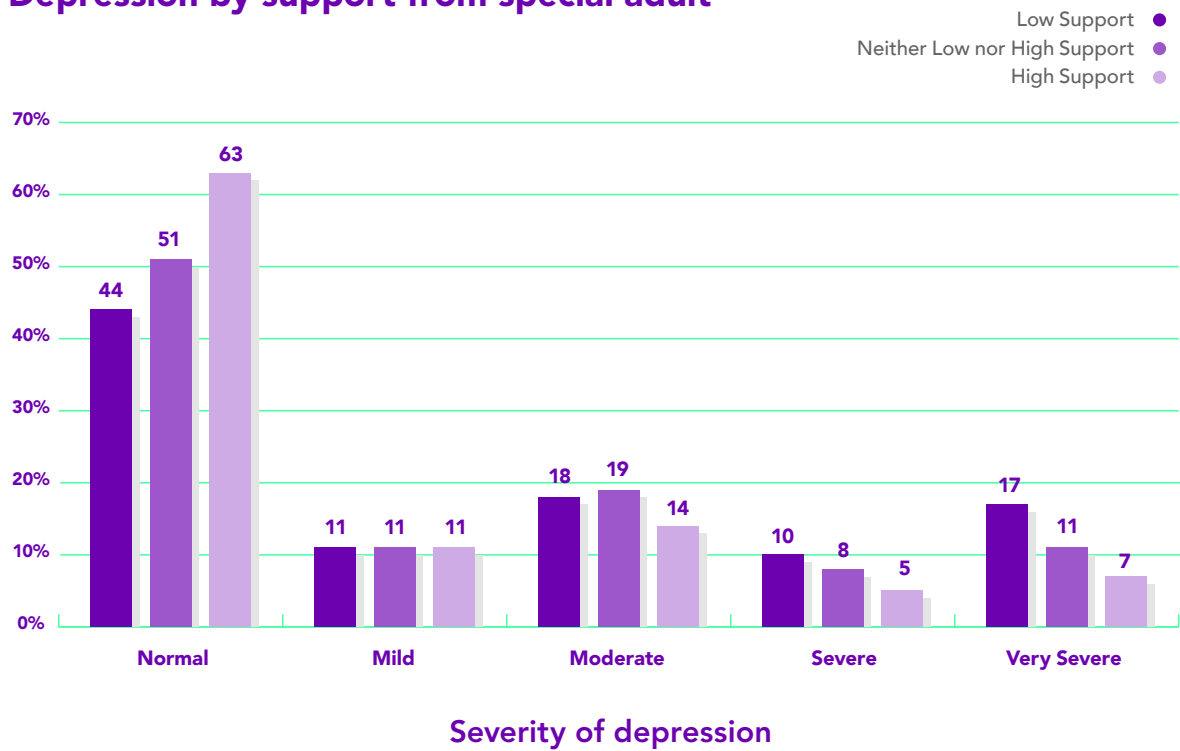
### 3.1.44. One Good Adult® and YMH

#### The Presence of One Good Adult®

As Figure 3.40 shows, adolescents who reported to have very high support from a special adult were much more likely to be in the normal range for depression.

Figure 3.40.

#### Depression by support from special adult



Those with very high support from a special adult in the normal range for

**depression**

A broadly similar result emerged for anxiety (see Figure 3.41). Again, adolescents who had very high support from a special adult were more likely to be in the normal range for anxiety.

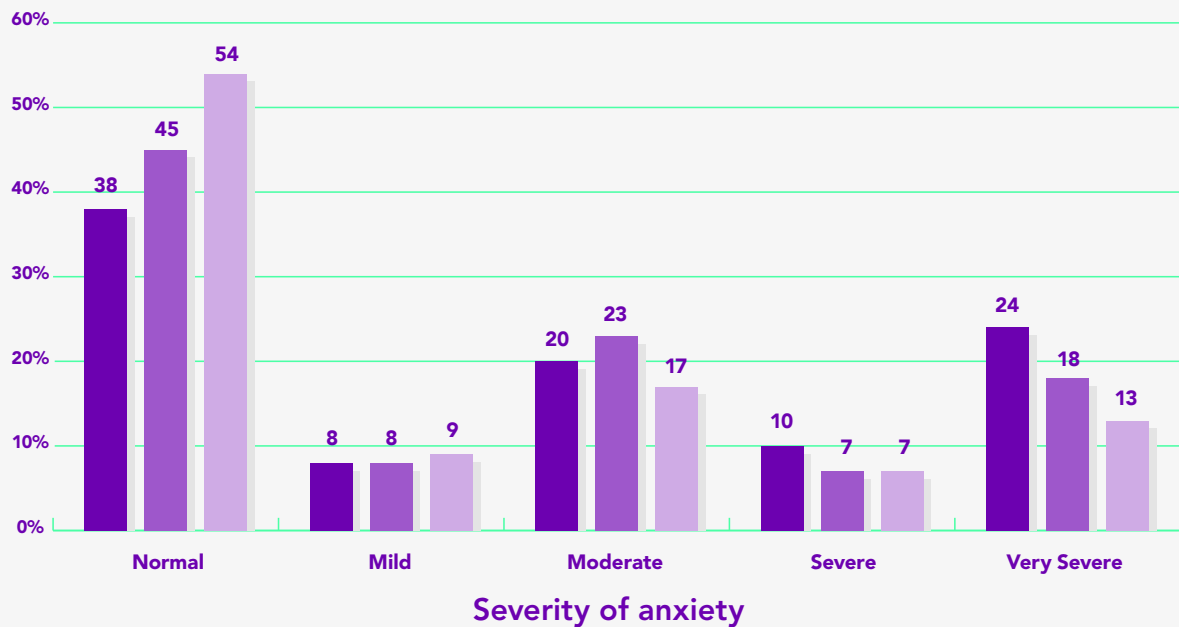
**54%**

of those with very high support from a special adult in the normal range for anxiety

Figure 3.41.

### Anxiety by support from special adult

Low Support ●  
Neither Low nor High Support ●  
High Support ●



Those who reported having very low or low levels of support from a special adult were more likely to fall into the possible alcohol dependence category. They also were more likely to engage in avoidance-based coping. Adolescents who reported having high/very high levels of support from a special adult displayed significantly higher levels of life satisfaction, self-esteem, body esteem, family cohesiveness, personal competence and optimism than their peers. In sum, the presence of a special adult is a key protective factor for youth mental health.

**24%**

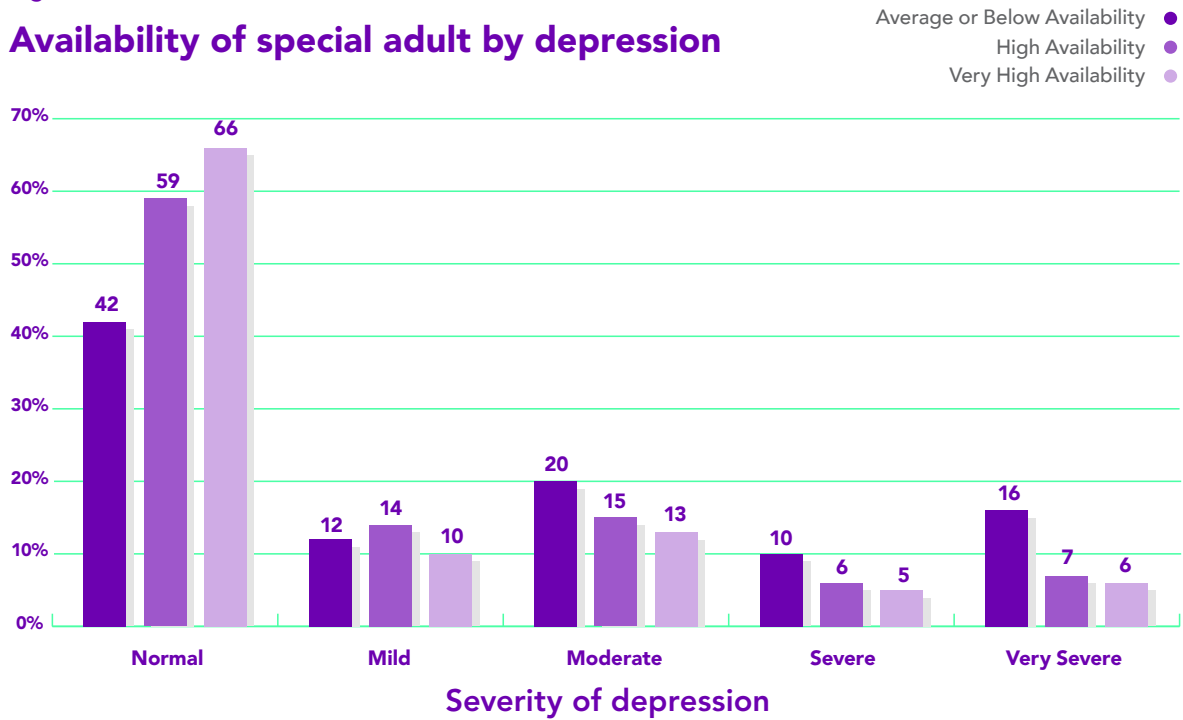
of those with low support from a special adult in the very severe range for anxiety

### Availability of One Good Adult®

Adolescents who reported very high availability from their special adult were more likely to be in the normal range for depression, whereas adolescents who reported average or below average availability from their special adult were more likely to be in the moderate, severe and very severe ranges for depression (see Figure 3.42).

Figure 3.42.

### Availability of special adult by depression



**66%**

of those with very high support from a special adult in the normal range for depression

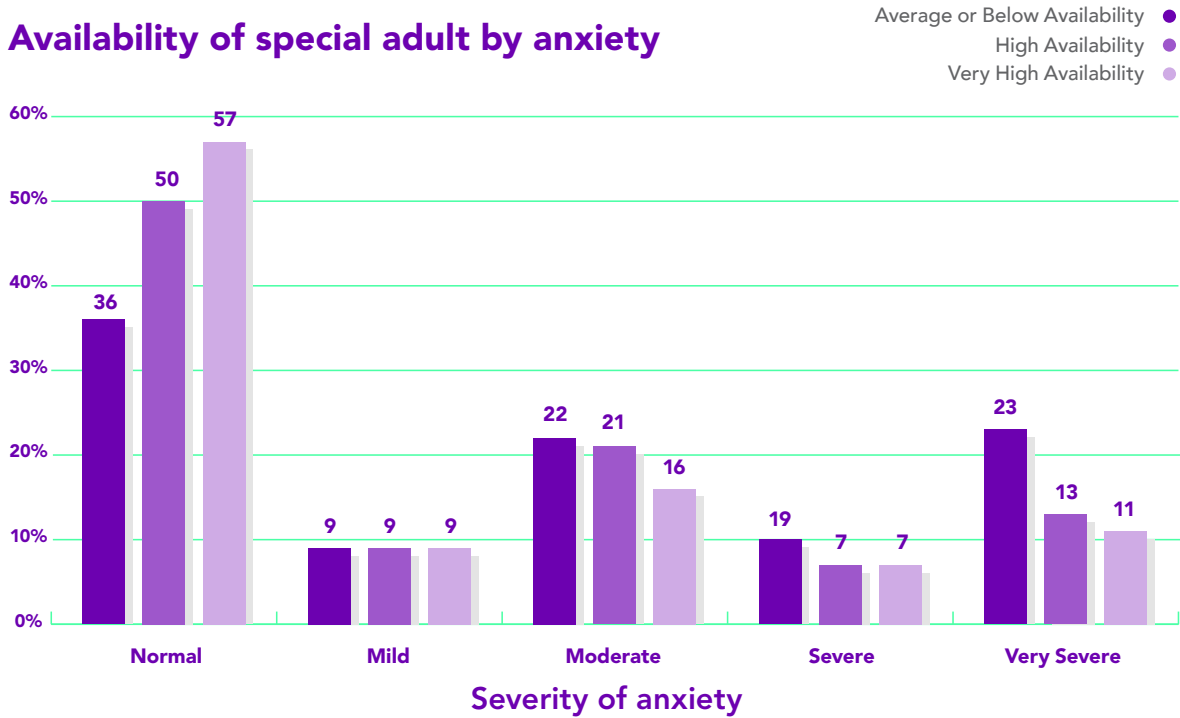
**16%**

of those with low support from a special adult in the very severe range for depression

For anxiety, a similar pattern emerged whereby adolescents who reported very high availability were more likely to be in the normal range (see Figure 3.43).

Figure 3.43.

### Availability of special adult by anxiety



Furthermore, adolescents who reported very high availability were more likely to report that they had few or no problems (41% vs 33% who had high availability and 25% who had average to low availability). In addition, adolescents who reported average or below average availability from their special adult were more likely to report that they had some problems, but they did not seek professional help although they thought they needed it (28% vs 16% with high availability and 14% with very high availability).

Adolescents who reported very high availability from their special adult displayed significantly higher levels of optimism, self-esteem, body esteem, problem-solving based coping, support focused coping, social competence and personal competence than their peers who reported high availability and their peers who reported average or below average availability from their special adult. They also showed significantly lower levels of avoidance-based coping than their peers who reported high availability and average or below average availability.

Therefore, while it is important for adolescents to have a special adult in their lives, it is integral that the special adult is available to them.



## Summary

- Males who reported to have made a suicide attempt were more likely to be in the moderate, severe or very severe categories for depression whereas females who reported this were more likely to be in the severe or very severe categories.
  - Adolescents who reported spending less than two hours online displayed significantly lower levels of depression and anxiety than adolescents who spent more than two hours online. However, they also showed significantly lower levels of perceived friend support and support-focused coping than adolescents who spent 2-3 hours online.
  - Adolescents with low body esteem experienced higher levels of depression and anxiety.
  - Females were less likely to have good sleep hygiene. Females who had poor sleep hygiene were more likely to be in the moderate range for anxiety, whereas males with poor sleep hygiene were more likely to be in the mild range for anxiety.
  - Adolescents' demonstrated good insight into their mental health, where the Mental Health Barometer was observed to be linked statistically to the DASS Anxiety and Depression subscales.
  - Adolescents classified as hazardous drinkers were more likely to fall within the severe category for depression (17%), and those classified as having possible alcohol dependence were more likely to be in the very severe category for depression (33%).
  - Adolescents who reported high levels of criticism from their parents experienced significantly more anxiety and depression than their peers.
  - The presence of One Good Adult® is important to 'young people's wellbeing. Additionally, the availability of One Good Adult® is also important to a young person's mental health. Adolescents who felt that their special adult was always available to them in time of need were more likely to be in the normal range for depression and anxiety.
-

# Chapter 4:

# Methodology for Young Adult Sample

## Overview

This chapter describes the methodology for the young adult sample (18-25 years) who took part in the MWS-2- Post Second Level (MWS-2-PSL) study. It provides an overview of the characteristics of the sample and outlines the measures used in the survey (for more detailed information on the methodology for this sample, see Appendix 2). The young adult sample consisted of young people from third-level institutions and young people from employed settings.

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## 4.1. Recruitment of third-level institutions

Initially, Registrars (or equivalent) of all third-level institutions were contacted about the research. If the Registrar was agreeable to the study, a designated member of staff within the institution was appointed to send an email to all registered students in that institution informing them of the study and inviting them to take part in the survey. The email provided a web link, unique to each institution, to the MWS-2-PSL study, presented via the survey software tool Qualtrics (Qualtrics, Provo, UT).

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 'yes' on-screen, before moving on to complete the survey. If participants clicked 'yes' to consent to participation, they were directed to the online survey.

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#### 4.1.1.

### Characteristics of university students

The sample of university students consisted of 9,879 students, however, 2,176 students were removed from the dataset for not meeting the inclusion criteria of being aged 18-25 years and a further 924 students were removed from the dataset as they were studying abroad in Ireland. Data from 6,779 students were analysed in this report. The sample consisted of 69% female students. It ranged in age from 18-25, with a mean age of 20 years ( $M=20.33$ ,  $SD=1.83$ ). The age distribution of students was similar between males and females, with 64% of students under 20, 31% aged 21-23 and 5% aged 24-25.

The university sample consisted of 91% undergraduate (41% first-years, 24% second-years, 20% third-years, 14% fourth-years and 1% fifth-years) and 9% postgraduate students. There was no difference in gender distribution across years or level of study.

---

**55%**  
lived at home

Almost two-thirds of the university sample (65%) reported that they were single, 34% were in a relationship, and less than 1% were either married or cohabiting. With regard to living situation, 55% of the sample lived at home, 31% in rented accommodation and 11% on campus.

---

#### 4.1.2.

### Characteristics of Institute of Technology students

The sample of students from Institutes of Technology (IoTs) consisted of 1,985 students. Students were excluded from analyses if they did not meet the inclusion criteria; 516 students were removed because they were not aged between 18 and 25 years and a further 80 students were removed for studying abroad in Ireland. Data from 1,389 students were analysed in this report. The sample consisted of 68% female students. It ranged in age from 18-25, with a mean age of 20 years ( $M=20.12$ ,  $SD=1.7$ ). The age distribution of the students was similar between males and females, with 63% under 20, 33% aged 21-23 and 4% aged 24-25.

The sample of students in IoTs represented 94% undergraduate (28% at level 7 and 72% at level 8) and 6% postgraduate students. Similar to the university sample, 40% were first-years, 26% second-years, 21% third-years and 14% fourth-years. There was no difference in gender distribution across years.

In terms of relationship status for this sample, 61% reported that they were single, 37% were in a relationship, and less than 1% were either married or cohabiting. With regard to living situation, 67% of the sample lived at home, 28% in rented accommodation and 2% on campus.

---

---

**67%**  
lived at home

## 4.2. Recruitment of employed young people

### 4.2.1. Selection and recruitment of employed young people

Fifteen organisations identified as potentially employing individuals of this age group were contacted about the research via convenience sampling. Three of them agreed to participate in the research (response rate=20%). After this, the researcher contacted the managers of selected organisations to explain the purpose and rationale of the study. Similar to the procedure for recruiting third-level students, each organisation sent an email to its members/employees with a link to the survey. Participants clicked on the link, which directed them to an information page and consent form. If participants clicked 'yes' to consent to participation, they were directed to the survey.

---

### 4.2.2. Characteristics of employed young people

The sample consisted of 159 young adults and 37 young adults were removed because they did not meet the inclusion criteria (aged 18-25 years). Data from 122 young employed people were analysed in this report. The sample consisted of 76% females. These young people ranged in age from 18-25, with a mean age of 21 years ( $M=21.19$ ,  $SD=2.3$ ). The age distribution was similar between males and females, with 45% under 20, 35% aged 21-23 and 20% aged 24-25. Although the employed sample is small when compared to the university and IoT samples, analyses were conducted on group differences in comparison to other groups. No group effects were found in relation to this sample on a variety of key indicators, including depression and anxiety. Therefore, as they had participated in the study, they have been included in the analyses.

In terms of relationship status for this sample, 52% reported that they were single, 44% were in a relationship and less than 4% were either married or cohabiting. With regard to living situation, 67% of the sample lived at home, 27% in rented accommodation and 6% reported other.

---

## 4.3. Description of MWS-2-PSL study

For the purpose of the MWS-2-PSL analyses, all samples (university, IoT and employed sample) were grouped together, which leads to a final sample of  $N = 8,290$  young adults in the report.

In general, the MWS-2-PSL took the same format as the MWS-2-SL. Thus, while most of the scales included in the MWS-2-SL and MWS-2-PSL are identical for both surveys, some scales are unique to each (see Appendix 2 for more detail).

Details of the scales used in MWS-2-PSL are reported in Table 4.1 and Table 4.2.

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Table 4.1.

### Details of negative domains

Negative Domains in MWS-2-SL	Number of items in scale	Cronbach's alpha*	Score range
Depression, Anxiety and Stress Scale (DASS)	14		
DASS-Depression	7	.91	0 - 42
DASS-Anxiety	7	.84	0 - 42
Suicidal behaviours	5	n/a	n/a
Psychotic-like Experiences	3	n/a	0 - 3
Alcohol Use Disorders Identification Test (AUDIT)	10	.82	0 - 40
Drug Abuse Screen Test (DAST)	10	.79	0 - 10
Gambling	9	.85	0 - 27
Stressful Life Events	8	n/a	n/a

Table 4.2.

### Details of positive domains

Negative Domains in MWS-2-SL	Number of items in scale	Cronbach's alpha*	Score range
Rosenberg Self-Esteem Scale (RSE)	10	.92	10 - 40
Body Esteem Scale for Adolescents and Adults (BESAA) - Appearance Subscale	10	.85	0 - 40
Life Orientation Test - Revised (LOT-R)	6	.83	0 - 24
Satisfaction with Life Scale - SWLS	5	.89	5 - 35
Adapted Coping Strategy Indicator (CSI-15)	15		
CSI-Problem-Solving Coping	5	.85	5 - 30
CSI-Avoidance Coping	6	.82	6 - 36
CSI-Support-Focused Coping	4	.92	4 - 24
Brief Resilience Scale	28	.88	5 - 30
Multidimensional Scale of Perceived Social Support (MSPSS)	12	.93	
MSPSS-Family	4	.92	4 - 28
MSPSS-Friend	4	.94	4 - 28
MSPSS-Significant Other	4	.95	4 - 28

\* Alphas above .7 indicate that the scale has met minimal criteria for reliability (Taber, 2018).

# Characteristics of Sample

## 4.3.1. Age

The sample consisted of 8,290 young adults. Participants were aged 18 to 25 years (M=20.23, SD=1.83).

**8,290**  
young adults sample

## 4.3.2. Occupation

Most of the sample (83%) identified as university students, a further 13% were IoT students, and 2% were employed. Some young people identified as both university/institute of technology and employed young people.

## 4.3.3. Gender

With regard to gender, 29% identified as male, 69% as female, 1% as other (e.g., non-binary), less than 1% indicated they were not sure/questioning, less than 1% selected preferred not to say, and less than 1% identified as transgender male or transgender female.

## 4.3.4. Ethnicity

Most of the sample (86%) identified themselves as White Irish, 7% identified as any White background other than Irish, 3% as Asian/Asian Irish, 1% Black, and 2% mixed background. The majority (82%) reported that they were born in Ireland.

**82%**  
were born in Ireland

## 4.3.5. Sexual orientation

Over three quarters (76%) of the sample identified themselves as heterosexual, 11% as bisexual, 5% were not sure or were questioning their sexual orientation, 3% identified as gay, 2% lesbian, less than 2% pansexual, less than 1% asexual and less than 1% indicated that they would prefer not to say.

Young people were asked to rate how comfortable they were with their sexuality on a scale of 1 (not at all comfortable) to 10 (very comfortable). Those who identified as heterosexual were much more likely to rate themselves as 9 or 10 on the scale (78%), indicating that they were very comfortable with their sexuality. Only 32% of those who identified as LGBAP indicated they were very comfortable with their sexuality, and 18% of those who selected not sure/prefer not to say/other indicated they were very comfortable.

**32%**  
LGBAP indicated they were very comfortable with their sexuality

### 4.3.6. Relationship status of young adults

Of this sample, 64% identified themselves as single, while 35% identified themselves as being in a relationship. Less than 1% were married and less than 1% were living with a partner.

---

### 4.3.7. Marital status of parents

Most young adults (77%) indicated that their parents were married/living together, 7% indicated their parents were separated, 6% divorced, 3% remarried/in a new relationship, less than 1% single, while 4% reported that a parent was deceased.

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### 4.3.8. Family composition

Just over three-quarters (76%) reported that they grew up in a family of 1-3 children, 21% lived in a family with 4-5 children, while 3% lived in a family with six or more children.

---

### 4.3.9. Religion

Of this sample, 44% identified themselves as Roman Catholic, 41% identified as having no religion/atheist, 7% as Christian, 2% as Church of Ireland, 1% as Muslim and approximately 5% identified as having another religion.

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### 4.3.10. Current living situation

Over half (56%) of young adults reported living at home, 31% in rented accommodation, and 9% on campus (if applicable).

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---

# 41%

identified as having  
no religion/atheist

# Chapter 5:

## Findings for Young Adult Sample

### Overview

This chapter presents descriptive data on personal wellbeing and lifestyle factors, as well as data on negative and positive domains of mental health. It also examines key variables in relation to mental health outcomes. The same statistical parameters used for the adolescent sample have been applied in conducting these analyses for the young adult sample (i.e.,  $p \leq .01$ , groups of less than 1% omitted from analyses etc.).

## Personal Wellbeing and Lifestyle Factors

### 5.1.1. Enjoying family life

About one-third (34%) of young adults reported that they enjoyed family life, nearly 60% indicated that they sometimes did, while 7% said that they did not.

### 5.1.2. Anger

Nearly 16% of young adults said that they feel angry a lot, while 39% reported that they felt somewhat angry and 45% reported that they do not feel angry a lot.

### 5.1.3. Long-term health difficulty/disability

Almost 30% reported that they had a long-term health difficulty or disability. Of those who reported this, 73% indicated they had a mental health difficulty, 16% reported a physical health difficulty and 8% reported both a mental and physical health difficulty, while 3% did not disclose the nature of the condition or the difficulty they listed was not defined by the WHO as a long-term health difficulty.

### 5.1.4. Unpaid carers

Approximately 5% of the sample reported that they provide regular unpaid personal help for a family member with a long-term illness for an average of 11.51 hours (SD=20.44) per week.

### 5.1.5. Days absent

The average number of days missed from college/work in the past 30 days was 2.4 days (SD=3.6), with 41% of young adults indicating that they had not been absent at all in the past month, 15% absent for one day, 12% for two days and 32% three days or more.

The mean number of days absent for those with no long-term health difficulty was 2 days in the past month (SD=3.14). The mean number of days absent for those who reported having a physical health difficulty (2.7 days, SD=3.85) was significantly lower than for those who reported having a mental health difficulty (3.4 days, SD=4.55). In addition, the mean number of days for those who reported having both a mental and physical health difficulty (4.5 days, SD=5.29) was significantly higher than those who had a mental health difficulty.

Young adults (5%) who reported providing unpaid personal help for a family member were much more likely to report being absent from college/work for six days or more in the past month than those who reported not being a carer.

### 5.1.6. Sleep

Good sleep hygiene for young adults is defined as seven to nine hours of sleep a night (National Sleep Foundation, 2019). Approximately 62% of young adults fell within this range; 12% reported getting 3-5 hours sleep a night, 25% getting 6 hours a night and 2% getting over 10 hours sleep a night. Males (35%) were less likely to report poor sleep hygiene than females (40%).



### 5.1.7. Body appearance, physical activity and hobbies

**33%**  
had tried to bulk up at some point

#### Body appearance

With regard to muscle building, 33% said they had tried to bulk up or maintain muscle mass at some point: 98% did this through exercise, 7% through steroids/supplements and 7% via other means (such as eating more food). Males (63%) were more likely to report having tried to bulk up than females (20%).

Nearly 80% of young adults had tried to lose weight or avoid gaining weight previously. Of these, 88% did this by eating less food, fewer calories and foods low in fat, 80% did this through exercise, while 8% did so by taking supplements. More females (88%) reported having tried to lose weight or avoided gaining weight than males (60%).

#### Physical activity and hobbies

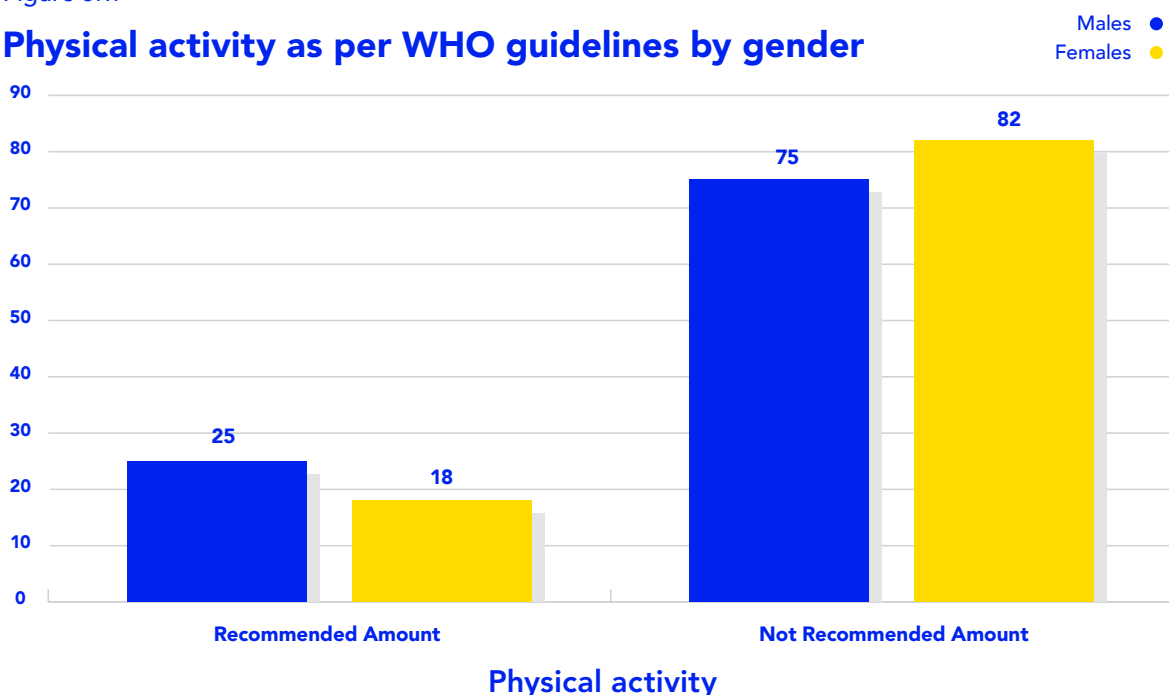
Nearly one-third (30%) of participants indicated they had regularly played sports in the last six months, while 37% of participants had regularly attended the gym in the last six months. Over 52% had regularly participated in other hobbies in the last six months.

**12%**  
did not engage in any physical activity in the past 2 weeks

WHO (2010) guidelines on physical activity recommend individuals aged 18-64 years do at least 150 minutes of moderate-intensity aerobic physical activity throughout the week (i.e., 300 minutes every two weeks). Using this criterion, 20% met these recommended guidelines; 12% of young adults did not engage in any physical activity in the past two weeks, 61% were active for at least 30 minutes 1-7 days, 22% were active 8-13 days and 5% were active every day. Males were more likely to report engaging in the recommended amount of exercise than females (see Figure 5.1).

Figure 5.1.

#### Physical activity as per WHO guidelines by gender



### 5.1.8. Bullying

Of those surveyed, 58% reported that they themselves had been bullied. Males (61%) were more likely to report this compared to females (57%).

Of these participants, 18% said they were bullied physically, 82% verbally and 75% emotionally. Most of the young adults who reported being bullied indicated that this happened in school (75%) whereas 5% indicated this happened at home, 2% in college and 2% in the workplace. Only 10% reported virtual bullying (online/by text/by phone). Over 80% of the sample reported that they had seen bullying previously.

---

**58%**  
reported being  
bullied

---

### 5.1.9. Social media use

Nearly all of the young adults (99%) who participated had a social media account, with 96% on Facebook, 89% on Snapchat, 87% on Instagram, 52% on Twitter, 28% on a dating app (e.g., Tinder, Bumble), and 9% on other apps including Reddit, Tumblr, Pinterest and Discord.

In this sample, 30% of young adults reported that they spent more than three hours online a day, 30% reported 2-3 hours, 29% reported 1-2 hours, 11% less an hour and less than 1% said they spent no time online a day. Females (66%) were more likely to report being online for more than two hours a day than males (45%).

Of the young adults surveyed, 58% said their status was private on the social media site they used most often so only their friends could see the content, while 23% said it was partially private (i.e., friends of friends can see) and 17% indicated it was public (i.e., everyone can see).

In relation to how they spend their time online, 71% of young adults reported that they never meet people online that they have not met in real life, while 26% did so occasionally and 3% said they did this every day. Males (35%) were more likely to report that they had met someone online at least once that they had not met in real life than females (27%).

Most participants (60%) said they had never had inappropriate photos of them posted online. However, 40% had experienced this occasionally. Females (43%) were more likely to report that this had happened to them occasionally than males (35%).

Over 60% of young adults reported never being sent mean messages, 35% indicated 'once a month' and 2% said 2-3 times a month. Less than 1% of young adults reported that they had been sent mean messages several times a week/daily.

---

**99%**  
had a social  
media account

---

**30%**  
spent more than 3  
hours a day online

**65%**  
have watched  
pornography  
on the internet

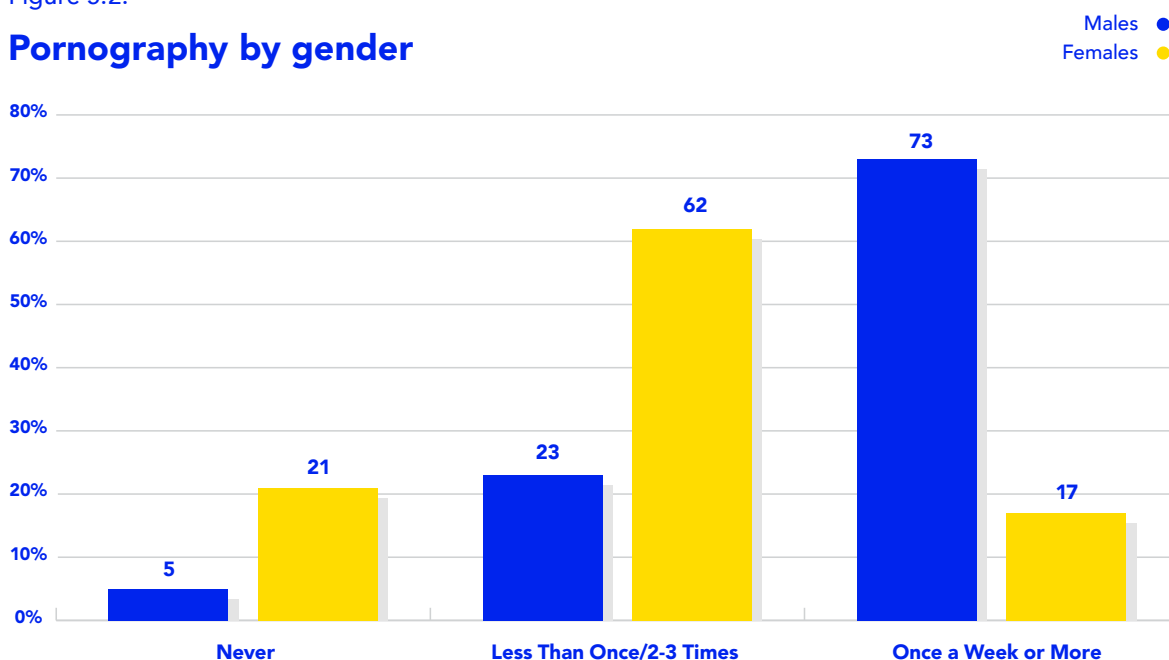
### 5.1.10. Pornography

Almost two-thirds of participants (65%) had ever watched pornography on the internet. Of those, 96% searched for the site themselves, 3% received a link that they did not wish to see and 1% watched pornography through other means.

With regard to watching pornography during the past month, 34% said they had not watched pornography in the past month, 26% said 2-3 times, 16% once a week and 24% more than once a week. There was a marked gender difference, with males more likely to regularly watch pornography online (see Figure 5.2).

Figure 5.2.

### Pornography by gender



### Watching pornography within the past month

**57%**  
reported  
experiencing  
a break-up

### 5.1.11. Relationships

Approximately 39% of young adults reported being in a romantic relationship. Over half (57%) of young adults reported having experienced a break-up of a romantic relationship, with 39% reporting that they had ended the relationship, 38% reporting their partner ended the relationship and 24% reporting that both partners ended the relationship.

Of those who had experienced a break-up, 40% reported that the break-up was very distressing, 25% distressing, 25% somewhat distressing and 10% reported that the break-up was not at all distressing.

### 5.1.12. Sexual behaviours and sexual orientation

Almost 66% of young adults reported having had sex and 69% reported having had oral sex while 22% reported having had anal sex. Of those who reported having had sex, 28% of participants reported having sex before the age of 17, the legal age of consent. In their lifetime, 60% of participants indicated that they have had three or fewer sexual partners. Furthermore, 97% of participants indicated that they have had three or fewer sexual partners in the previous three months.

Of those who have had sex, 10% reported that they never used contraceptive methods, 22% said they did so sometimes/most times and 68% reported that they always used contraceptive methods.

In terms of sexual orientation, 72% of young people who identified as bisexual reported having had sex, 68% of young people identifying as heterosexual, 67% of young people who identified as gay, 59% of young people who identified as pansexual, 56% of young people who identified as lesbian, 43% of young people who reported that they were not sure/questioning, 20% of young people who identified as asexual and 10% of young people who preferred not to say in relation to their sexual orientation reported having had sex.

---

**22%**  
reported having  
had anal sex

---

**10%**  
reported that they  
have never used  
contraception

---

### 5.1.13. Sexual consent

With regard to issues relating to sexual consent, 47% of young adults reported that they had been touched against their will or without their consent and 20% said they had been forced or pressured to have sex.

Females (56%) were much more likely than males (23%) to report that they had been touched against their will or without their consent. They were also more likely to report that they had been forced or pressured to have sex (25% for females, 10% for males).

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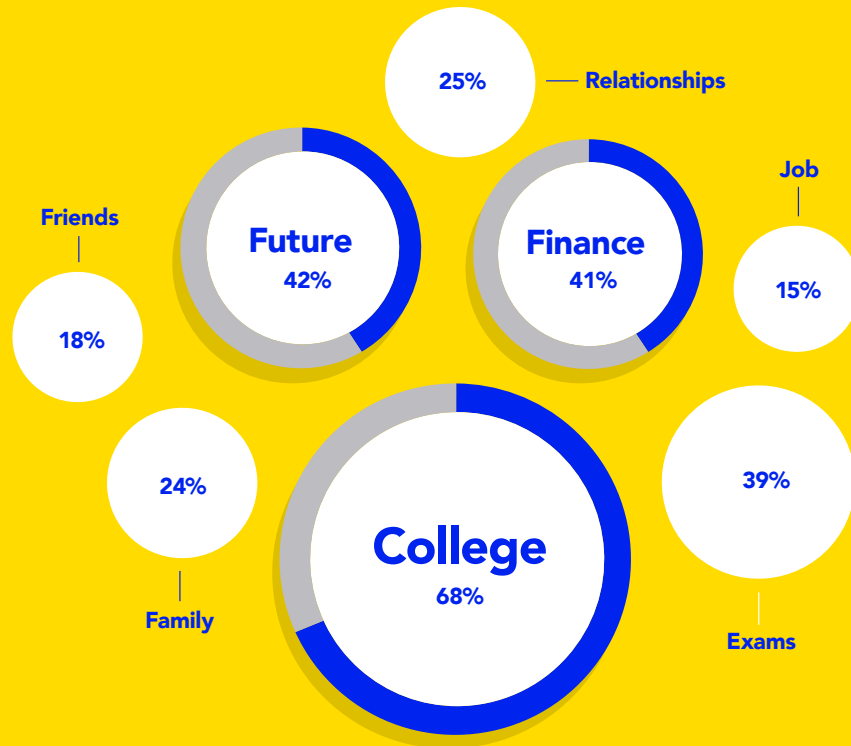
**47%**  
reported that they  
had been touched  
against their will

### 5.1.14. Top stressors

The top stressors endorsed by young adults are presented in Figure 5.3.

Figure 5.3.

### Top stressors for young adults



### 5.1.15. Financial stress

Overall, 37% of young adults indicated that they were often stressed by their current financial situation, and another 12% that they were highly stressed by it. Females (54%) were more likely to report feeling often/highly stressed about their current financial stress than males (40%). A similar pattern was observed in relation to future financial stress, with 37% of young adults reporting they were often stressed and 17% were highly stressed by this. Again, females (58%) were more likely to report this than males (43%).

**37%**  
indicated that they  
were often stressed  
by their current  
financial situation

Nearly 40% of those in college reported they were often stressed by the pressure to work outside their college course, and another 25% reported that they were highly stressed by it. Females (28%) were more likely to report feeling highly stressed about this than males (17%).

### 5.1.16. Coping with problems

Over half of young adults (56%) indicated that they coped well with problems, 33% that they sometimes did, and 11% that they did not. Females (60%) were more likely to state that they coped well compared to males (47%).

**56%**

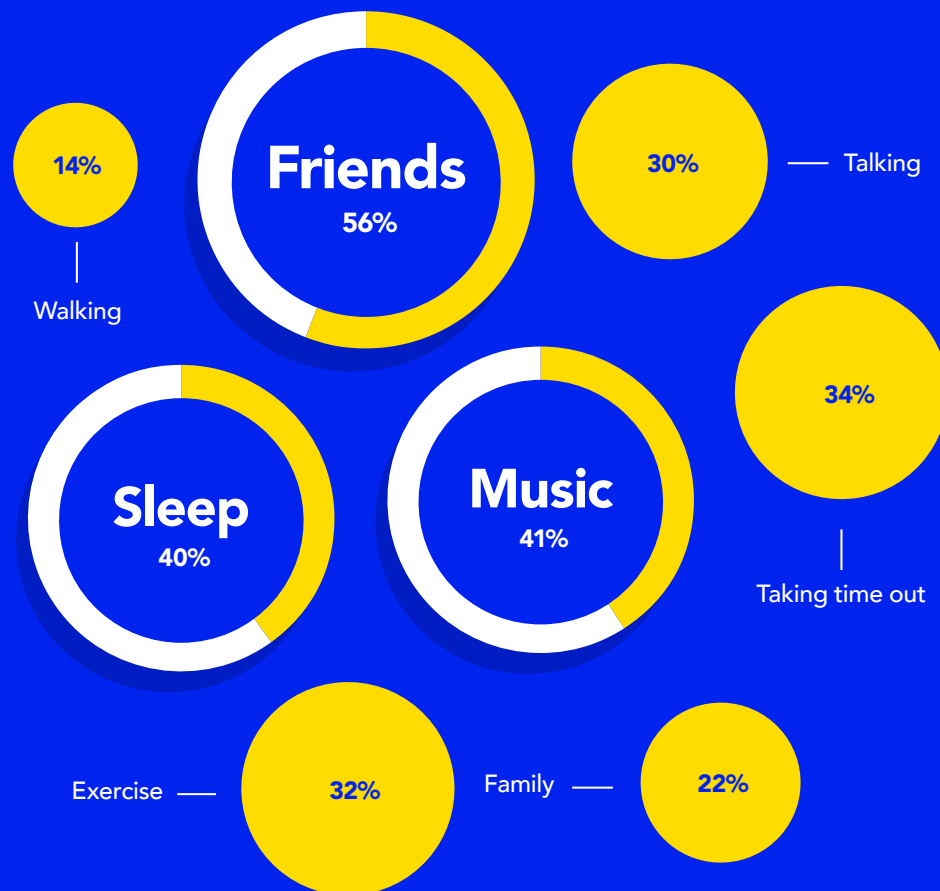
indicated that they coped well with problems

### 5.1.17. Top coping strategies for young adults

The top coping strategies endorsed by young adults are presented in Figure 5.4.

Figure 5.4.

#### Top three coping strategies for young adults



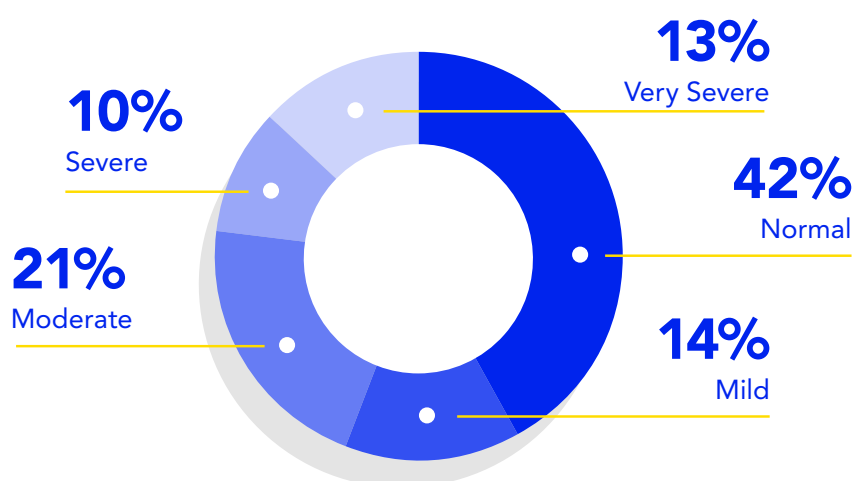
# Negative Domains

## 5.1.18. Depression and anxiety

Approximately 42% of young adults were classified as being in the normal range for depression, 14% in the mild range, 20% in the moderate range, and 23% in the severe (10%) to very severe (13%) range (see Figure 5.5). No association between categories of depression and gender was observed.

Figure 5.5.

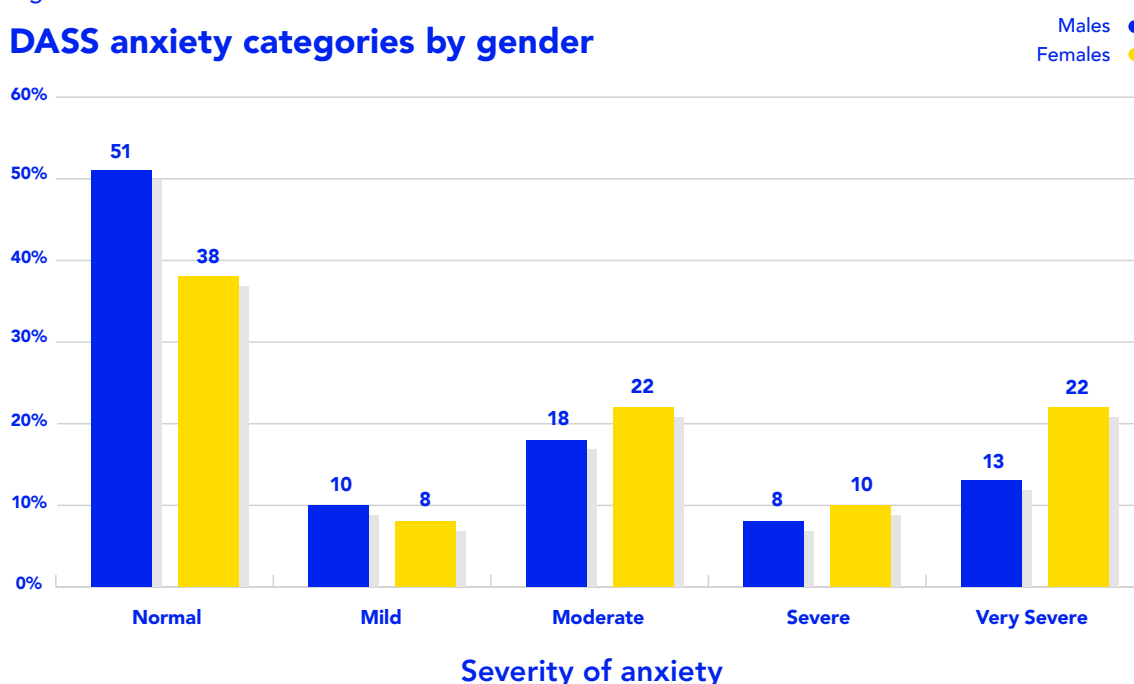
### DASS depression categories for young adults



Similarly, 42% of young adults were classified as being within the normal range for anxiety, 9% in the mild range, 21% in the moderate range, 9% in the severe range and a further 19% in the very severe range. As shown in Figure 5.6, males were more likely to be in the normal range while females were more likely to be in the very severe range for anxiety.

Figure 5.6.

### DASS anxiety categories by gender



### 5.1.19. Suicidality

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

#### Suicide ideation

Nearly two-thirds of the sample (63%) had ever thought about taking their life though they 'would not do it'. Of these, 35% indicated that they had thought this 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.

63%

had ever thought about taking their life though they 'would not do it'

#### Self-harm without wanting to take own life

A total of 38% of the sample reported that they had ever deliberately hurt themselves without wanting to take their own life. Nearly 30% reported that it happened within the last year, 14% within the past six months and 15% within the past month. A further 43% reported that they had hurt themselves without wanting to take their own life at some other time.

38%

reported they deliberately hurt themselves without wanting to take their own life

Females (42%) were much more likely to report ever deliberately hurting themselves without wanting to take their own life than males (22%).

#### Self-harm wanting to take own life

A total of 12% of young adults reported that they had ever deliberately hurt themselves wanting to take their own life. Of those, 29% reported that it happened within the last year, 11% within the last six months and 5% within the last month. A further 55% reported that they had hurt themselves wanting to take their life at some other time.

12%

reported they deliberately hurt themselves wanting to take their own life

Females (14%) were more likely to report ever deliberately hurting themselves wanting to take their own life than males (8%).

#### Suicide attempt

The majority of young adults (90%) reported that they had never attempted to take their life. Of the 10% who indicated that they had, 23% said it had been within the last year, 10% within the past six months and about 3% within the past month.

10%

reported they had made an attempt to take their own life

Males (8%) were less likely to report having attempted to take their lives, while 11% of females reported a suicide attempt.



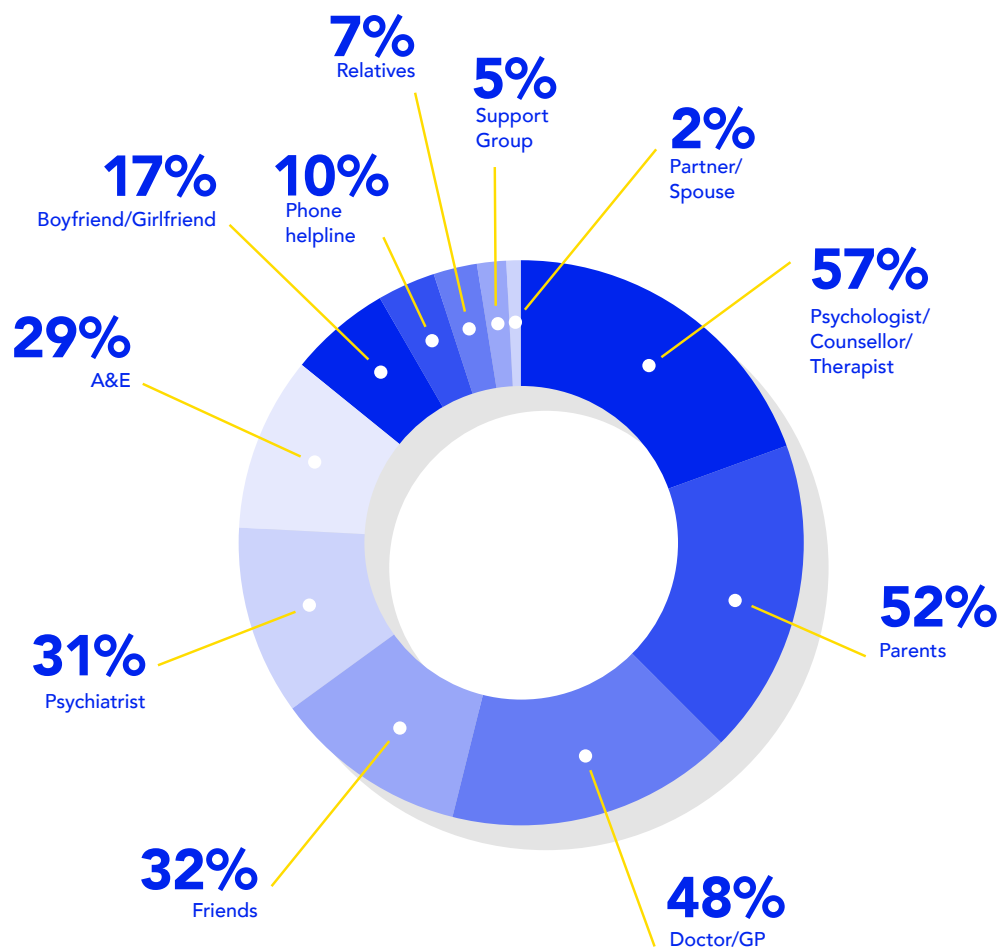
### Support after suicide attempt

More than half (54%) of those who attempted to take their life reported that they did access help or support.

For those who accessed help or support after a suicide attempt, nearly half (48%) found it difficult or very difficult to get the support they needed. Furthermore, 72% reported that the help they received was helpful/somewhat helpful. See Figure 5.7 for details on sources of support following a suicide attempt.

Figure 5.7.

### Support following suicide attempt



**52%**  
accessed help or support

## 5.1.20. Alcohol behaviour

One in ten young adults reported that they do not drink alcohol, 17% reported that they drink less than monthly, 29% monthly, 42% weekly and 2% daily or almost daily.

According to the AUDIT WHO cut-offs (Babor, Higgins-Biddle, Saunders & Monteiro, 2001), 49% of young adults fell into the range for low-risk drinking behaviour, 38% into the problem drinking range and 7% into the harmful and hazardous drinking range, while 6% were classified as having a possible alcohol dependence.

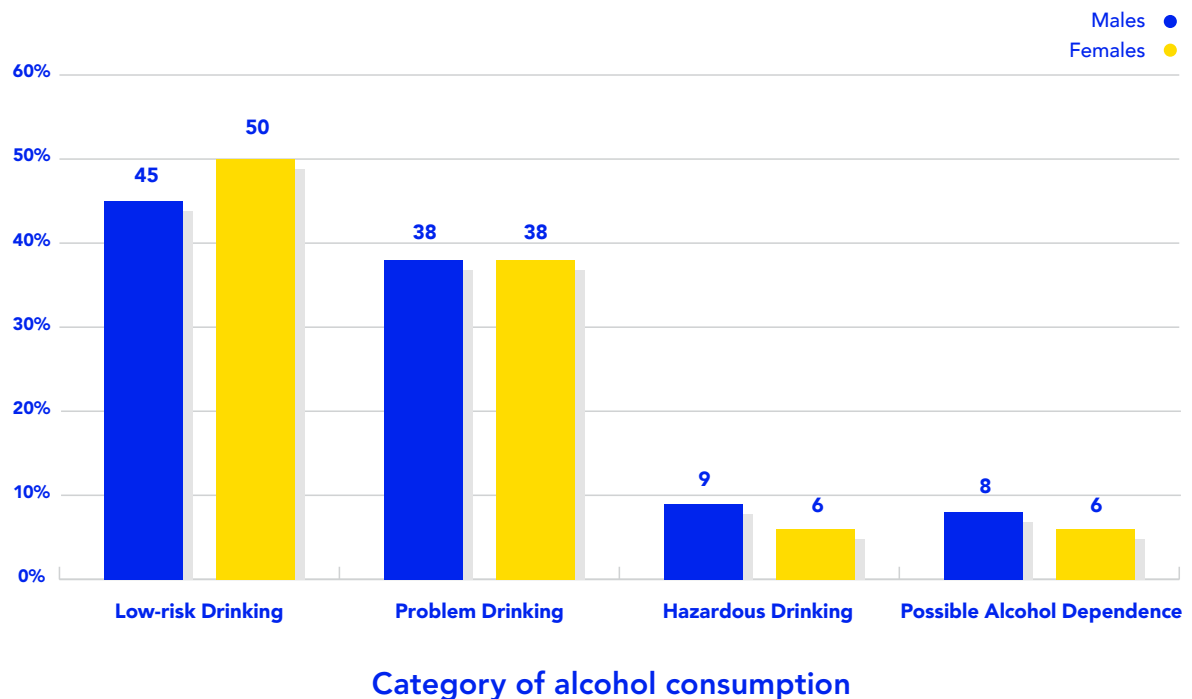
As Figure 5.8 shows, males were less likely to be in the low-risk range for drinking and more likely to be in the harmful and hazardous and possible alcohol dependence range.

**42%**  
drink alcohol weekly

**6%**  
classified as having a possible alcohol dependence

Figure 5.8.

### Alcohol behaviour based on AUDIT cut-offs by gender



### 5.1.21. Drug use

**53%**  
had smoked  
cannabis in  
their lifetime

A total of 53% of young adults reported that they had smoked cannabis in their lifetime. Males (59%) were more likely to do so than females (50%). Of those who reported ever smoking cannabis, 83% reported first trying cannabis between 15 and 19 years.

**40%**  
used drugs  
other than those  
required for  
medical reasons

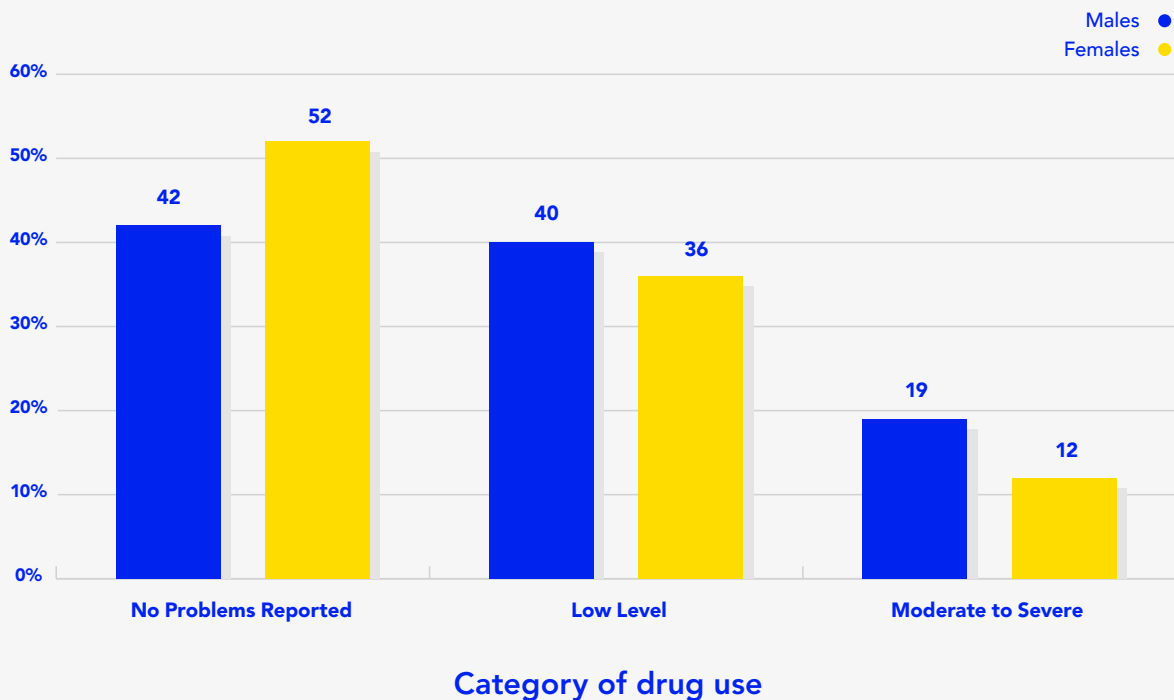
Of the sample, 40% reported that they had used drugs other than those required for medical reasons.

According to the DAST cut-off points (Skinner, 1982), 49% of young adults presented with no drug problems, 37% fell into the low level, 10% were in the moderate level, 2% were in the substantial level and just over 1% were in the severe level for drug problems. Given that few participants fell into the more severe categories, we combined those in the moderate, substantial and severe levels into a 'moderate to severe' category (i.e., 14%) to permit further statistical analyses.

These analyses indicated males were more likely to fall into the moderate to severe range for drug use, while females were more likely to report no problems (see Figure 5.9).

Figure 5.9.

### Drug use by gender



### 5.1.22. Gambling

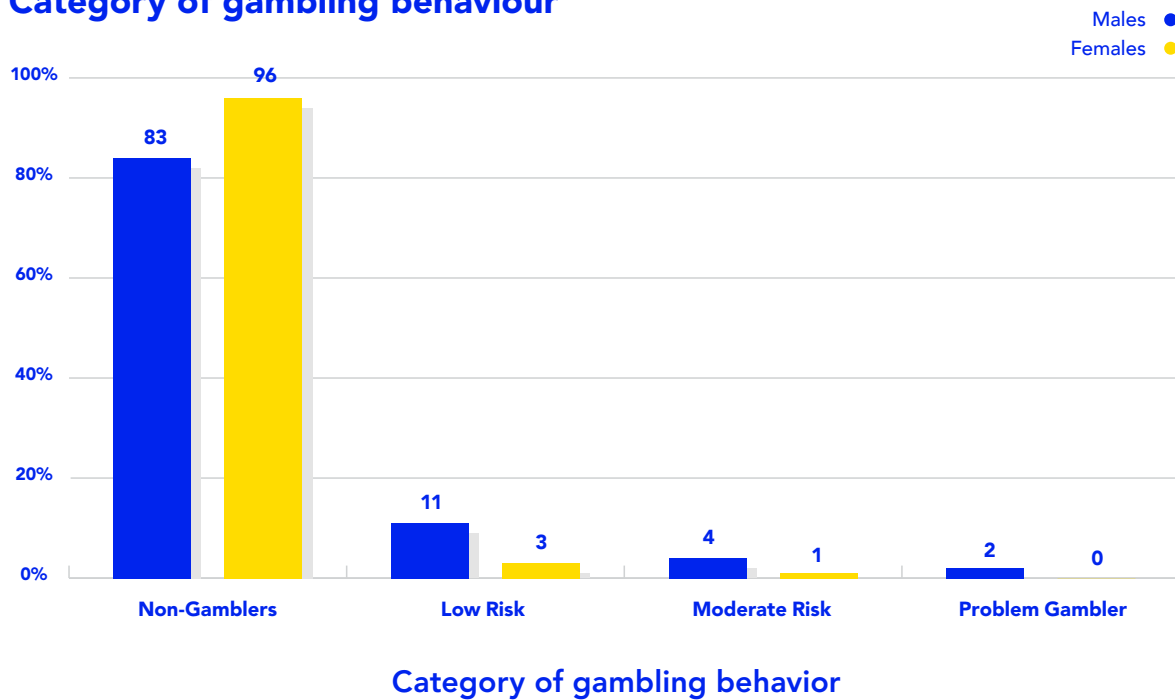
Most young adults (93%) identified as non-gamblers, 5% as low-risk gamblers, less than 2% as moderate-risk gamblers and less than 1% as problem gamblers.

As Figure 5.10 shows, males (6%) were much more likely to be categorised as moderate-risk or problem gamblers than females (1%).

**93%**  
identified as  
non-gamblers

Figure 5.10.

#### Category of gambling behaviour



### 5.1.23. Stressful life events

Almost one-third of young adults (29%) reported not having experienced any stressful life events, while 27% reported experiencing one stressful event, 21% two stressful events, 14% three stressful events and 9% reported experiencing four or more stressful life events.

Approximately 58% reported that someone close to them had died, which included 5% who reported a parent/guardian and 7% who reported a friend had died. The next most common stressful event experienced by young adults was conflict between parents (40%). Approximately 38% had moved house within Ireland, 19% had moved country, 19% had experienced serious illness/injury of a friend and 12% had experienced their house being broken into. A smaller number of young adults had experienced violence in the home (9%) and experienced violence in a romantic relationship (5%).

**58%**  
had someone  
close to them  
who died

**44%**  
were dissatisfied  
with their bodies

**Males**  
indicated  
higher levels of  
problem-solving/  
planned coping  
than females

## Positive Domains

### 5.1.24. Self-esteem

Self-esteem scores for the overall sample centred around the scale midpoint of 25 (M=25.71, SD=6.22), indicating average levels of self-esteem. Males reported significantly higher self-esteem (M=27.1, SD=6.53) than females (M=25.13; SD=6.01).

### 5.1.25. Body esteem

Overall, young adults scored below the mid-point of 20 on the body esteem scale (M=18.37, SD=7.25). Males (M=21.05, SD=7.04) reported significantly higher levels of body esteem than females (M=17.25, SD=7.07).

Almost a third of participants (31%) reported that they were very satisfied with their body, 25% reported that they were neither satisfied/dissatisfied, and 44% reported that they were dissatisfied with their body. Females (53%) were more likely to report being dissatisfied with their body than males (42%).

### 5.1.26. Optimism and satisfaction with life

The young adults' mean score on optimism was slightly below the mid-point of 12 (M=11.76, SD=5.28). Males reported significantly higher levels of optimism (M=12.50, SD=5.3) than females (M=11.45, SD=5.25). The young adults' mean score on satisfaction with life was marginally above the mid-point of 20 indicating average levels of life satisfaction (M=21.2, SD=6.25; range 5-35).

### 5.1.27. Coping strategies

In general, young adults scored below the midpoint of 17.5 on problem-solving coping (M=16.51, SD=4.77), below the midpoint of 14 on support-focused coping (M=12.99, SD=4.72) and below the midpoint of 21 on avoidance based coping (M=19.28, SD=6.21).

Males indicated higher levels of problem-solving/planned coping (M=16.98, SD=4.9) than females (M=16.32, SD=4.71), while females (M=13.39, SD=4.71) reported higher levels of support-focused coping compared to males (M=12.03, SD=4.61). However, females reported higher levels of avoidant coping (a negative coping strategy) than males (M=19.85, SD=6.26 vs M=17.89, SD=5.88).

### 5.1.28. Resilience

The overall group centred around the midpoint of 18 (M=17.65, SD=5.11) in terms of resilience, with males (M=19.1, SD=5.24) indicating higher levels of resilience than females (M=17.1, SD=4.96).

### 5.1.29. Social support

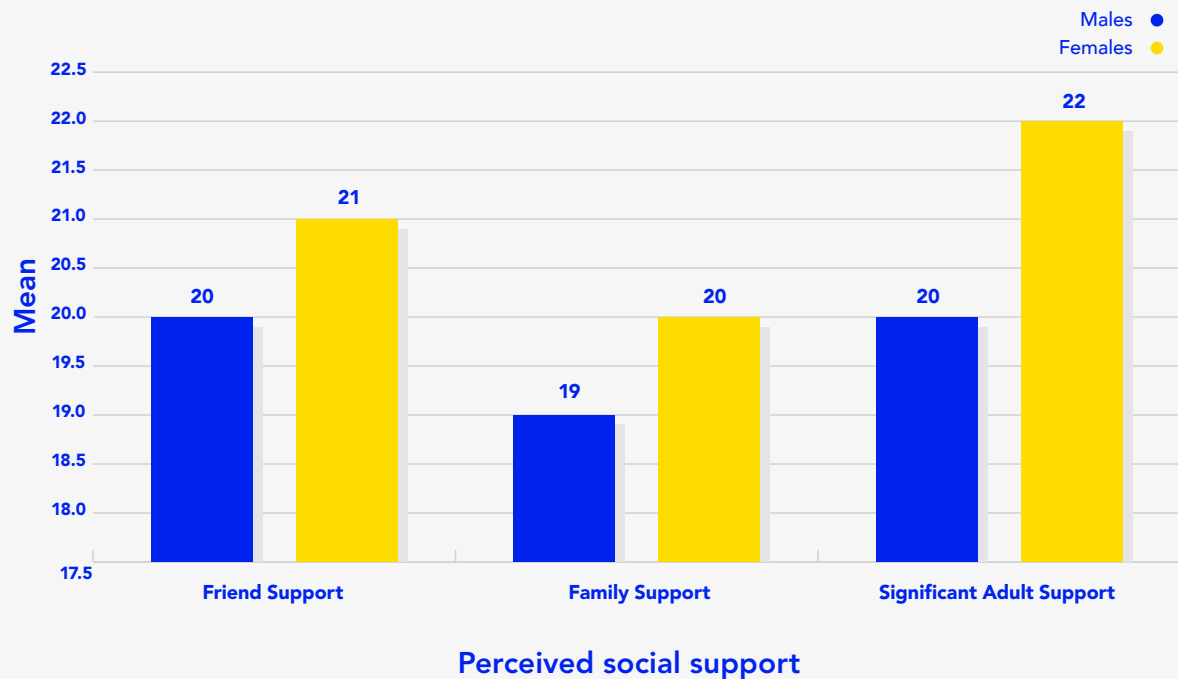
The average score for overall social support was 61.39 (SD=14.57). This was above the midpoint of 48 indicating high levels of social support among young adults. Females reported significantly higher levels of overall perceived social support (M=62.39, SD=14.46) than males (M=58.79, SD=14.47).

**Females**  
reported higher overall  
social support

Figure 5.11 shows perceived support from family, friends and a significant adult by gender. All differences between males and females were significant, with females reporting higher support.

Figure 5.11.

#### Perceived social support by gender



**76%**  
had a special  
adult in their lives  
when in need

## One Good Adult®

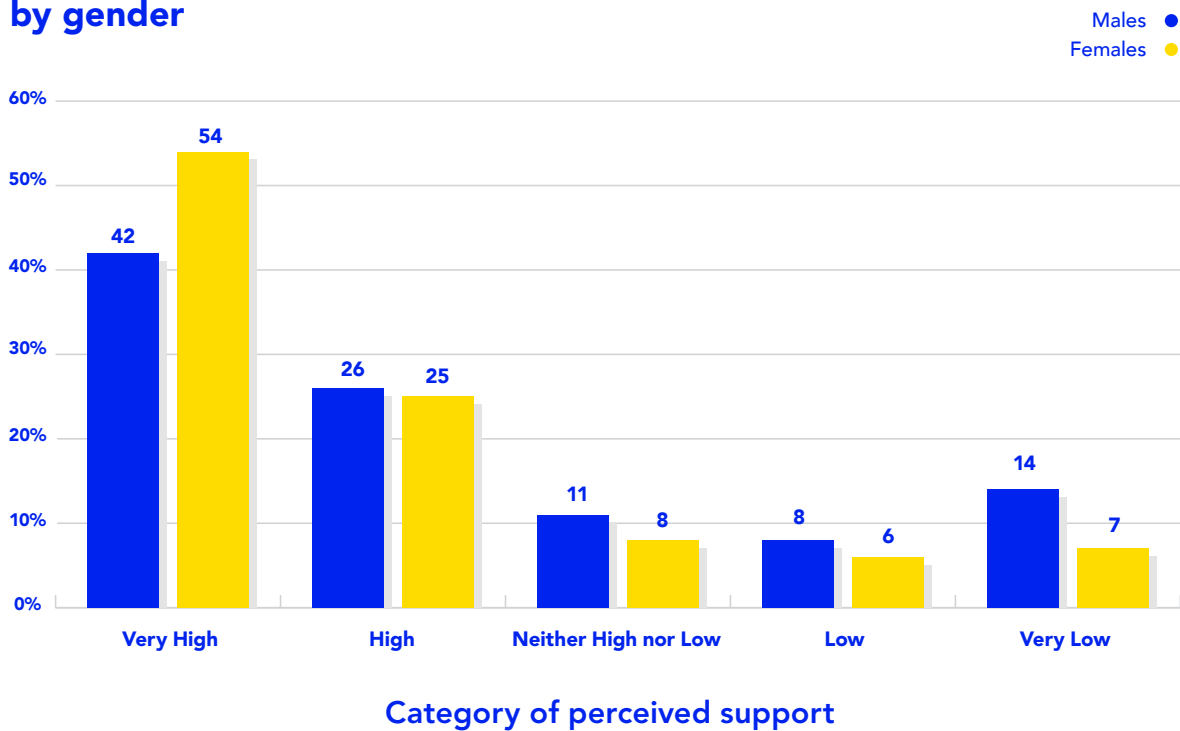
Over three-quarters (76%) of young adults reported that they had a special adult in their lives when in need.

When asked who their special adult was, 23% reported that a friend(s) was their special adult, 21% reported boyfriend/girlfriend/partner, 12% reported mother/father/parent(s) and 5% reported multiple sources, while almost 30% did not report their special adult and 9% reported other.

As Figure 5.12. shows, females were more likely to report the presence of a special adult (79%) and males were more likely to report they felt they did not have a special adult (22%).

Figure 5.12.

### Perceived level of social support from One Good Adult® by gender



**46%**  
said the person  
was always  
available to them

In terms of how regularly the person was available to them, 46% said this person was always available to them, 41% said regularly or very regularly, while 7% said sometimes and 6% said irregularly. Females (49%) were more likely to report that their special adult was always available to them (38%).

## 5.1.30. Help-seeking

### Sources of support

#### *Supports young adults are likely to use*

Young adults were most likely to identify informal sources of support as the places they would use to get information or support about their mental health. Of these sources of support, the most common were friends (63%), parents (49%), online (33%) and relatives (17%).

A psychologist/counsellor/therapist (45%) was the most cited source of formal support that young adults would be likely to use, followed by student counselling services (44%), doctors/GPs (38%), psychiatrist (27%) and Jigsaw (17%). Half of young adults (50%) had heard of Jigsaw. Only 14% indicated that they would use a phone helpline, and few reported that they were likely to obtain support from a tutor/teaching assistant (5%) or a lecturer (4%, where applicable).

#### *Supports young adults have used*

If young adults had sought support, they were also asked what sources they had actually used to obtain information. Here, 74% had used their friends, 70% their parents, 48% a psychologist/counsellor/therapist, 46% a doctor/GP, 42% relatives, 39% student counselling services, 30% psychiatrist, 26% online, 25% a phone helpline and 19% Jigsaw.

### Talking about Problems

Nearly 40% of young adults reported that they did not talk about their problems. Overall, males (47%) were less likely to talk about their problems than females (36%). Where young adults indicated they do talk about problems, 45% would talk to their friends, 39% would talk to their family and 16% to other sources such as boyfriend, girlfriend or counsellor.

### Help-seeking

Approximately 22% of young adults reported that they had few or no problems in the past year for which they felt they needed professional help, 27% that they had some problems but did not feel that they needed professional help, while 25% indicated that they had problems but did not seek professional help, despite feeling that they needed it. Finally, 26% of participants indicated that they had problems and had sought professional help.

---

**50%**  
had heard  
of Jigsaw

---

**74%**  
used their friends  
for support



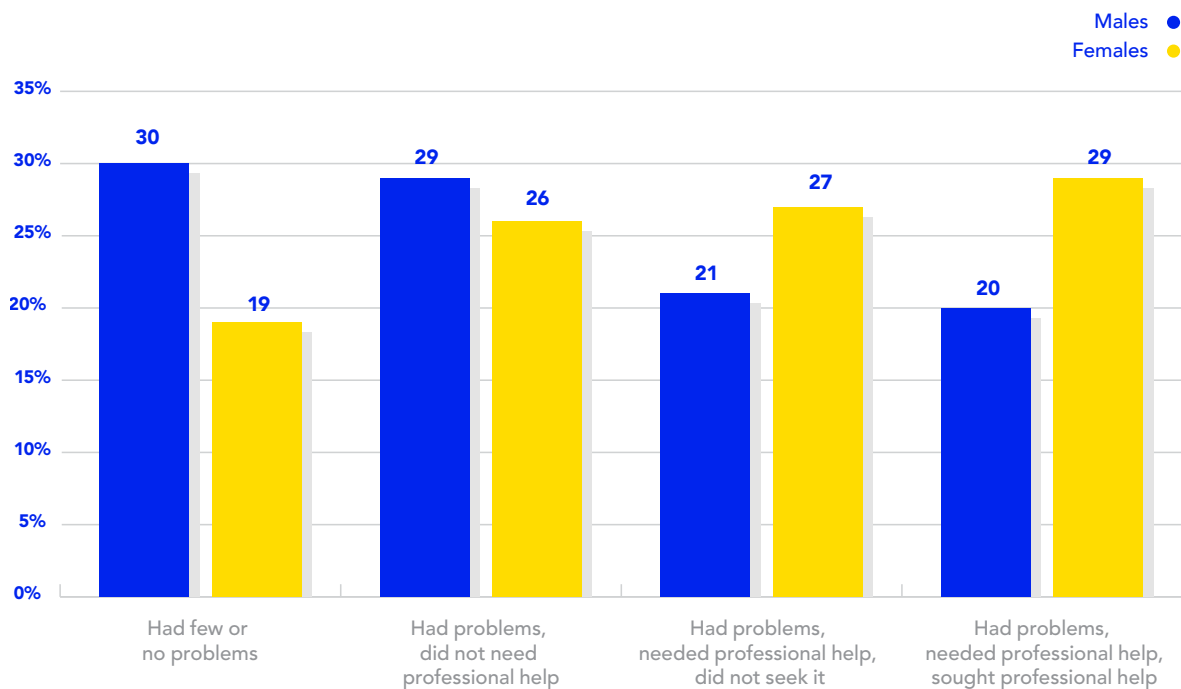
**30%**  
of males reported  
they had few or  
no problems

As Figure 5.13 shows, there was a clear association between gender and help-seeking behaviour:

- Males (30%) were much more likely than females (19%) to report that they had few or no problems.
- Females (27%) were more likely to report that they had problems and did not seek help even though they needed it compared to males (21%).
- Females (29%) were also more likely to report that they had sought professional help for their problems than males (20%).

Figure 5.13.

### Help-seeking by gender



### Help-seeking behaviour

**29%**

of females reported they had sought  
professional help for their problems

# Key Indicators of Mental Health Status

To obtain a comprehensive picture of young adults’ mental health, analyses were carried out on a range of risk and protective factors related to mental health outcomes. This research examined many potential factors; however, for the purpose of this report, seven factors in young adults lives are described below. Each of the seven factors are examined in terms of mental health indicators.

These are:

- |                                      |                                 |
|--------------------------------------|---------------------------------|
| 1. Self-harm and suicidal behaviours | 4. Alcohol and drug behaviours  |
| 2. Sexual orientation                | 5. Being online                 |
| 3. Stressful and traumatic events    | 6. One Good Adult®              |
|                                      | 7. Physical wellbeing and sleep |

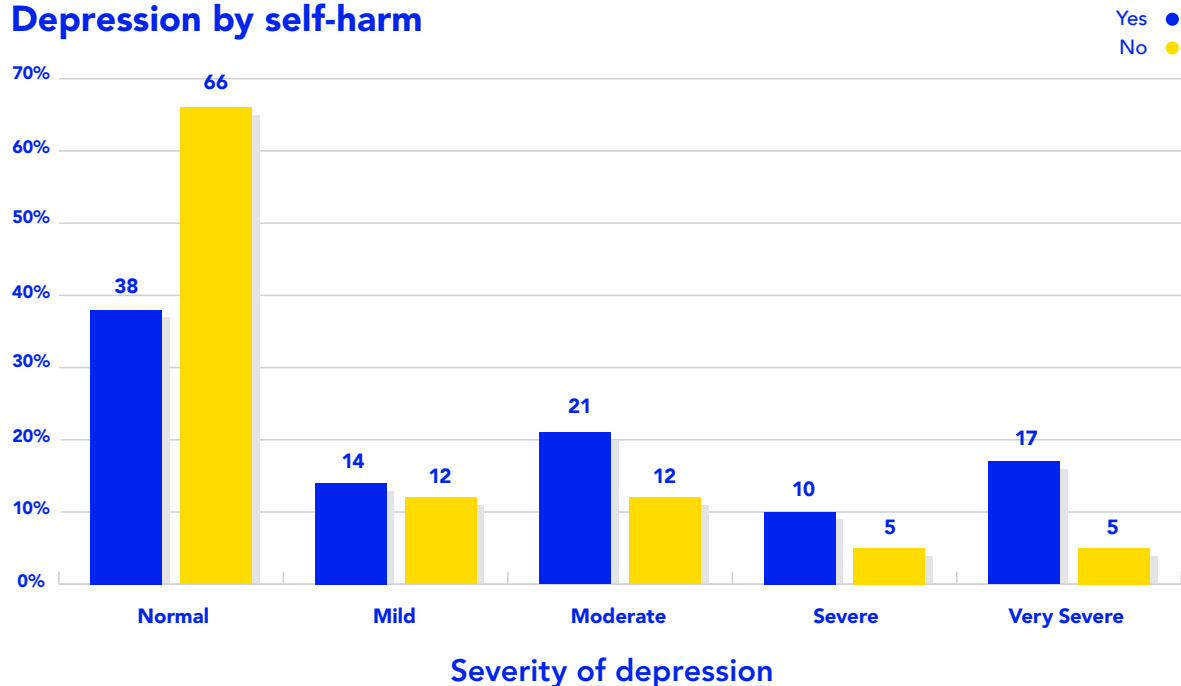
## 5.1.31. Self-harm, suicide and YMH

### Deliberate self-harm without wanting to take their life

Young adults who reported that they had ever deliberately hurt themselves without wanting to take their own life were much more likely to be in the moderate, severe or very severe categories for depression and anxiety. See Figure 5.14 for details on depression.

Figure 5.14.

### Depression by self-harm



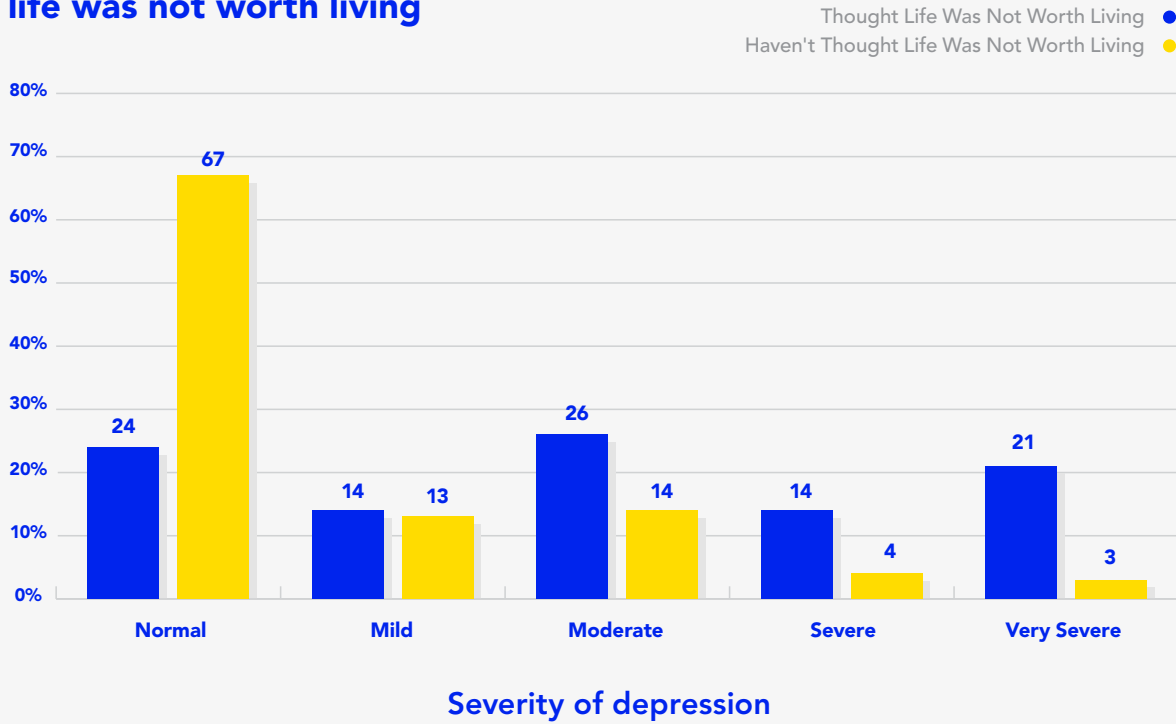
Young adults who had engaged in deliberate self-harm were also more likely to be in the harmful and hazardous drinking and possible alcohol dependence categories for alcohol behaviour. They were more likely to be in the moderate/substantial/severe category for drug abuse and to report low support from a special adult.

### Suicidal ideation

Young adults who reported that they had ever felt that life was not worth living were much less likely to be in the normal category for depression (see Figure 5.15), and very similar patterns were found for anxiety.

Figure 5.15.

### Depression by thought that life was not worth living



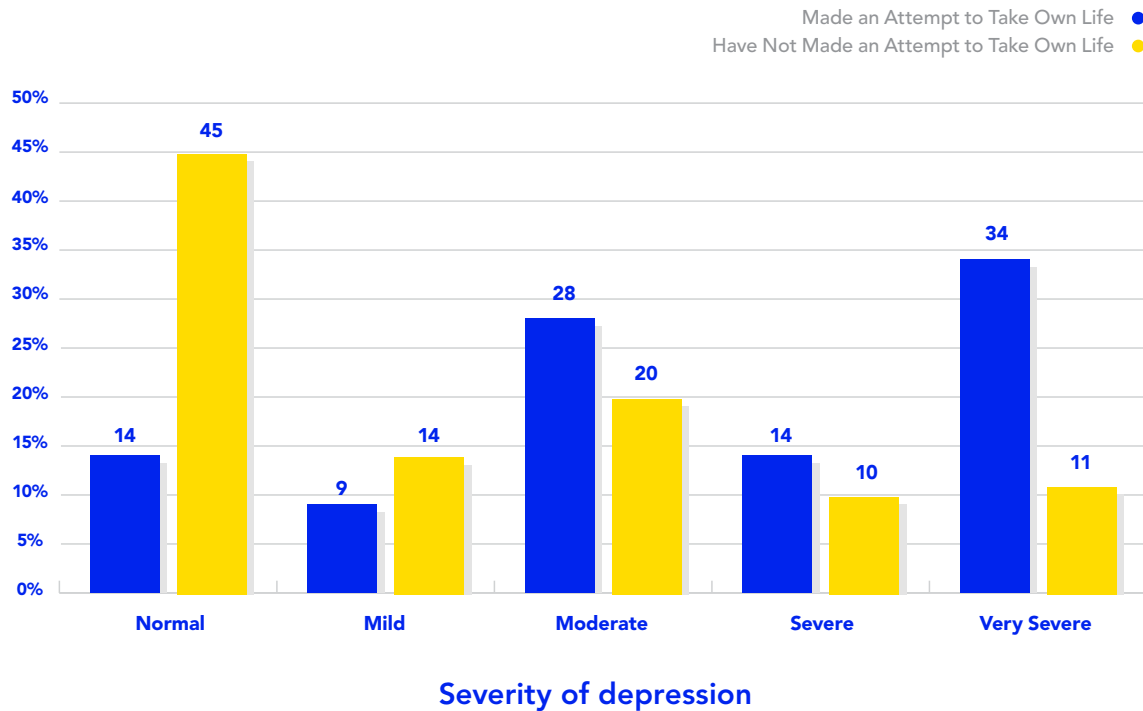
These young adults were also more likely to be in the moderate/substantial/severe categories for drug abuse (again, particularly prevalent for males) and more likely to be in the possible alcohol dependence category for alcohol behaviour. Finally, they were less likely than those who had not thought about suicide to report a high level of support from a special adult.

### Suicide attempt

Young adults who reported to have attempted to take their own life were more likely to be in moderate, severe or very severe category for depression (see Figure 5.16.) and for anxiety (this was particularly prevalent for females).

Figure 5.16.

### Depression by attempt to take own life



Young adults who made a suicide attempt were also much more likely to be in the moderate/substantial/severe category for drug abuse and were more likely to be in the possible alcohol dependence category for alcohol behaviour. Young males who reported this were more likely to be in the harmful and hazardous drinking category.

Young adults who reported a suicide attempt were more likely to report a low level of support from a special adult. Finally, they had significantly lower self-esteem (M=21.02, SD=5.81), body esteem (M=14.33, SD=7.58), resilience (M=14.97, SD=5), social support (M=55.62, SD=15.48) and optimism (M=8.75, SD=4.98) than their peers who reported no suicide attempt (self-esteem M=26.22, SD=6.07; body esteem M=18.79, SD=7.09; resilience M=17.96, SD=5.04; social support M=62.03, SD=14.32; and optimism M=12.09, SD=5.23).

**34%**

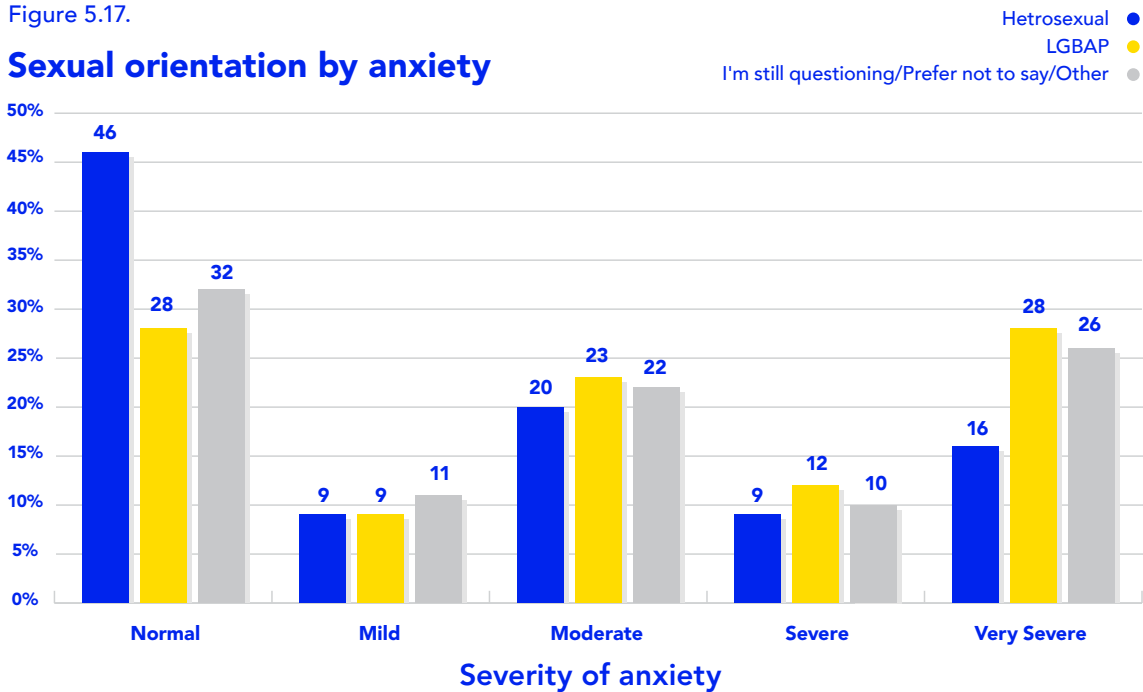
who made suicide attempt in very severe category for depression

Young adults with suicidal ideation less likely to be in normal range for **depression and anxiety**

### 5.1.32. Sexual orientation and YMH

Young adults who identified as LGBAP were less likely to be in the normal range and more likely to be in the moderate, severe or very severe range for depression. Additionally, this group was less likely to be in the normal range for anxiety and more likely to be in the very severe range. Young adults who identified as Other (not sure/prefer not to say/other) were less likely to be in the normal range for depression and anxiety and more likely to be in the very severe range for anxiety and depression (see Figure 5.17 for more details).

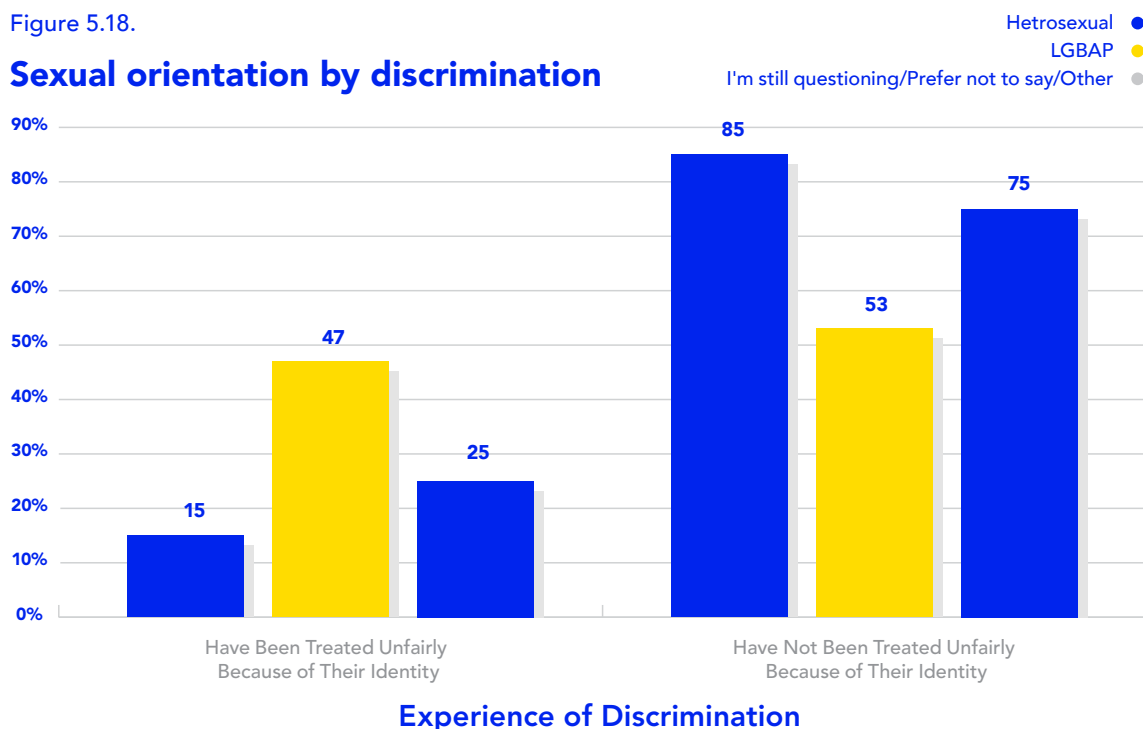
Figure 5.17.



LGBAP and young adults who identified as Other were more likely to report that they had deliberately hurt themselves without wanting to take their own life, while only the LGBAP group was more likely to report that they had ever made an attempt to take their own life.

Young adults identifying as LGBAP were much more likely to report that they had been treated unfairly because of their identity (see Figure 5.18) and more likely to report being bullied.

Figure 5.18.



### 5.1.33. Stressful life events and YMH

Although young adults identified experiencing a number of different stressful life events, only the most salient stressful life events are described here in relation to mental health indicators. In general, the greater the number of stressful life events a young person experienced, the more likely they were to experience increased depression and anxiety.

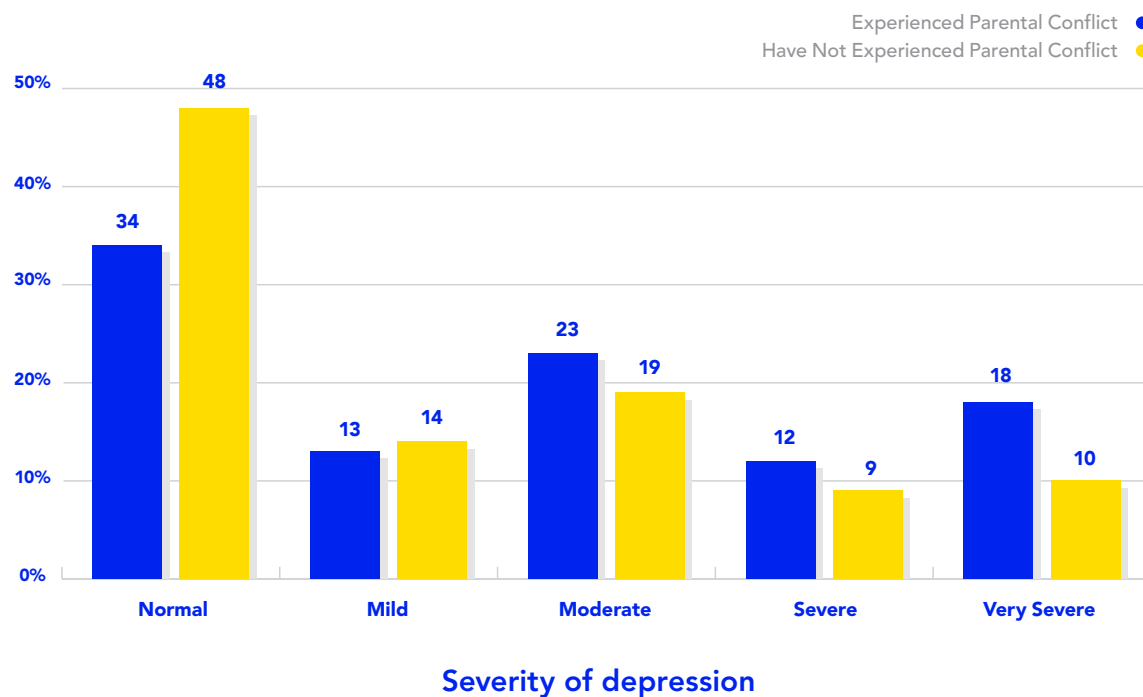
**40%**  
identified conflict  
between parents as  
a stressful event

#### Conflict between parents

As Figure 5.19 shows, young adults who identified conflict between parents as a stressful life event (40%) were more likely to be in the moderate, severe or very severe levels for depression, compared to young adults who did not experience this conflict. They were also more likely to report moderate or very severe levels of anxiety.

Figure 5.19.

#### Conflict between parents and depression



Furthermore, young adults who reported experiencing conflict between parents were more likely to be in the moderate/substantial/severe level for drug use (17%) compared to those who had not experienced this (11%), and to fall into the possible alcohol dependence for alcohol behaviour (8% compared to 6%). They were also more likely to be dissatisfied with life (49%) than young people who had not experienced conflict between parents (31%).

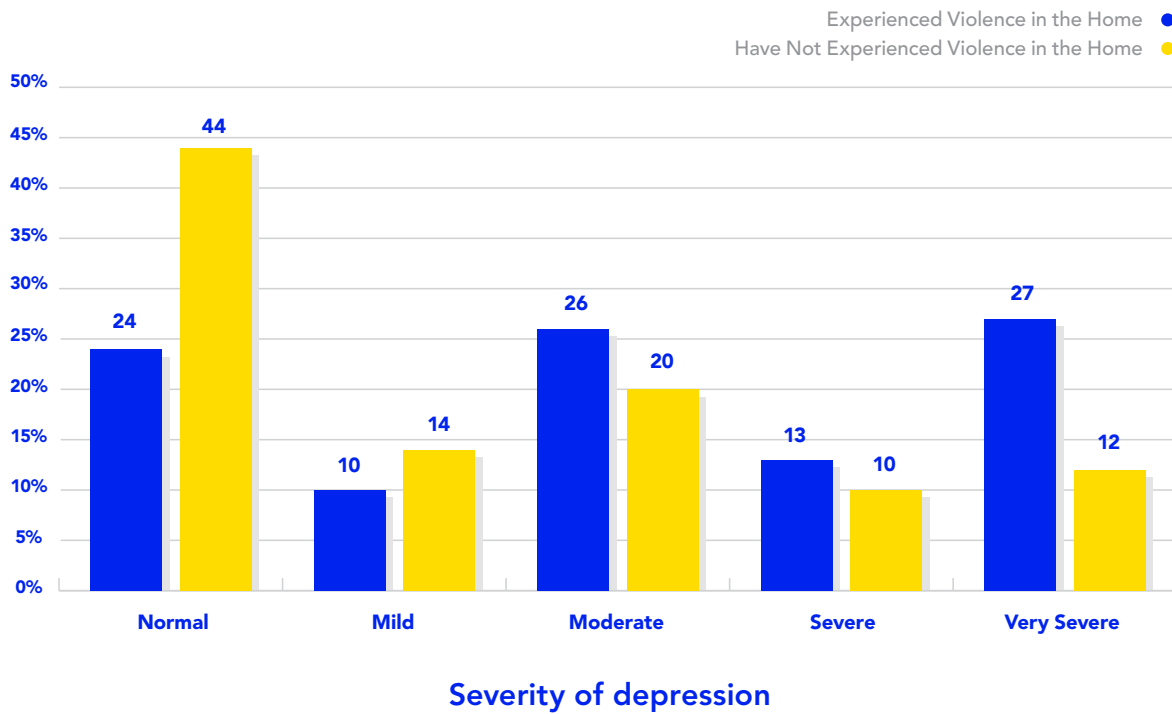
**9%**  
experienced  
violence in  
the home

**Violence in the home**

Young adults who indicated they had experienced violence in the home (9%) were more likely to be in the moderate, severe or very severe levels for depression compared to those who did not report this (see Figure 5.20). These young people were also more likely to report very severe levels of anxiety.

Figure 5.20.

**Violence in the home by depression**



**27%**  
who experienced violence  
in the home fell into very severe  
category for depression

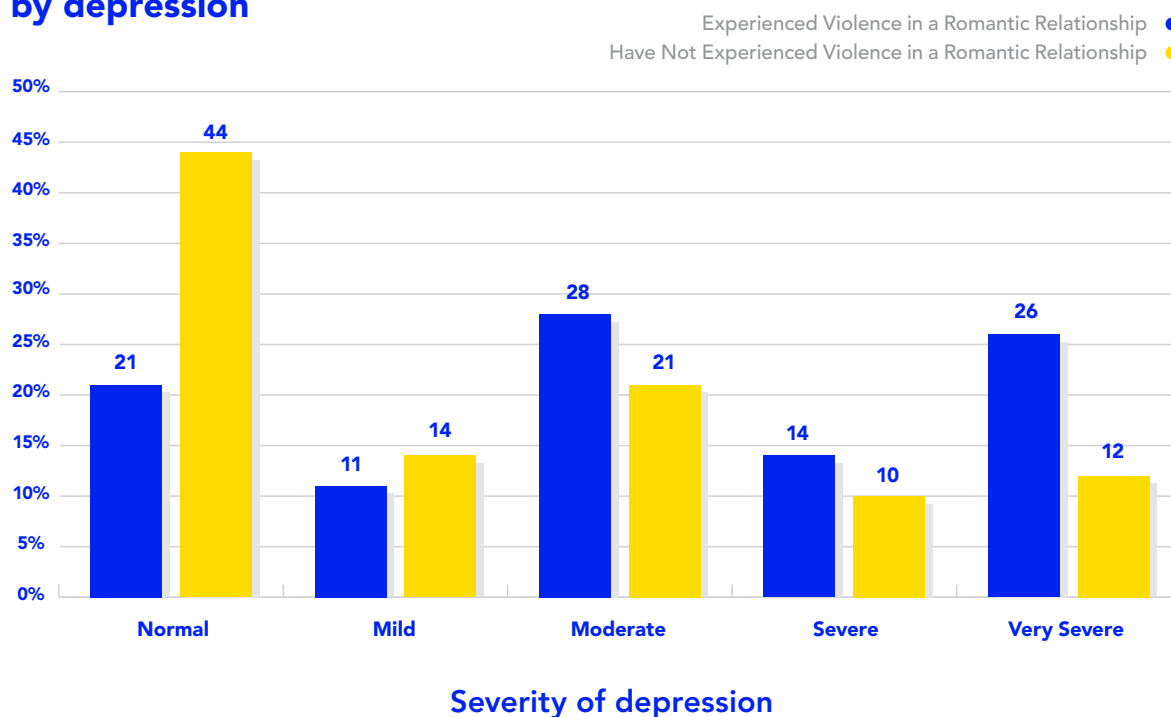
In addition, they were more likely to fall into the moderate/substantial/severe level for drug use and to be in the possible alcohol dependence category for alcohol behaviour. They were also more likely to be dissatisfied with life and to indicate poor sleep hygiene.

### Violence in a romantic relationship

As Figure 5.21 shows, young adults who had experienced violence in a romantic relationship (5%) were more likely to be in the moderate, severe or very severe levels for depression compared to those who had not experienced this. Similarly, they were more likely to report severe or very severe levels of anxiety.

Figure 5.21.

### Violence in a romantic relationship by depression



They were more likely to fall into the moderate to severe level for drug use and to be in the harmful and hazardous drinking or possible alcohol dependence categories for alcohol behaviour. They were also more likely to be dissatisfied with life and to indicate poor sleep hygiene.

### Sexual consent

Almost half (47%) of young adults reported that they had been touched against their will or without their consent and 20% said they had been forced or pressured to have sex.

Young adults who reported this were more likely to be in the very severe category and less likely to be in the normal range for depression than those who had not experienced either of these. Very similar patterns were found for anxiety. Females who reported that someone had touched them against their will were more likely to be in the very severe range for depression and anxiety. This pattern was not evident for males who reported this. However, males who reported to have ever been forced or pressured to have sex were more likely to be in the severe range for anxiety (24% vs 11% who did not report this) and females who said yes were more likely to be in very severe range (40% vs 30% who did not report this).

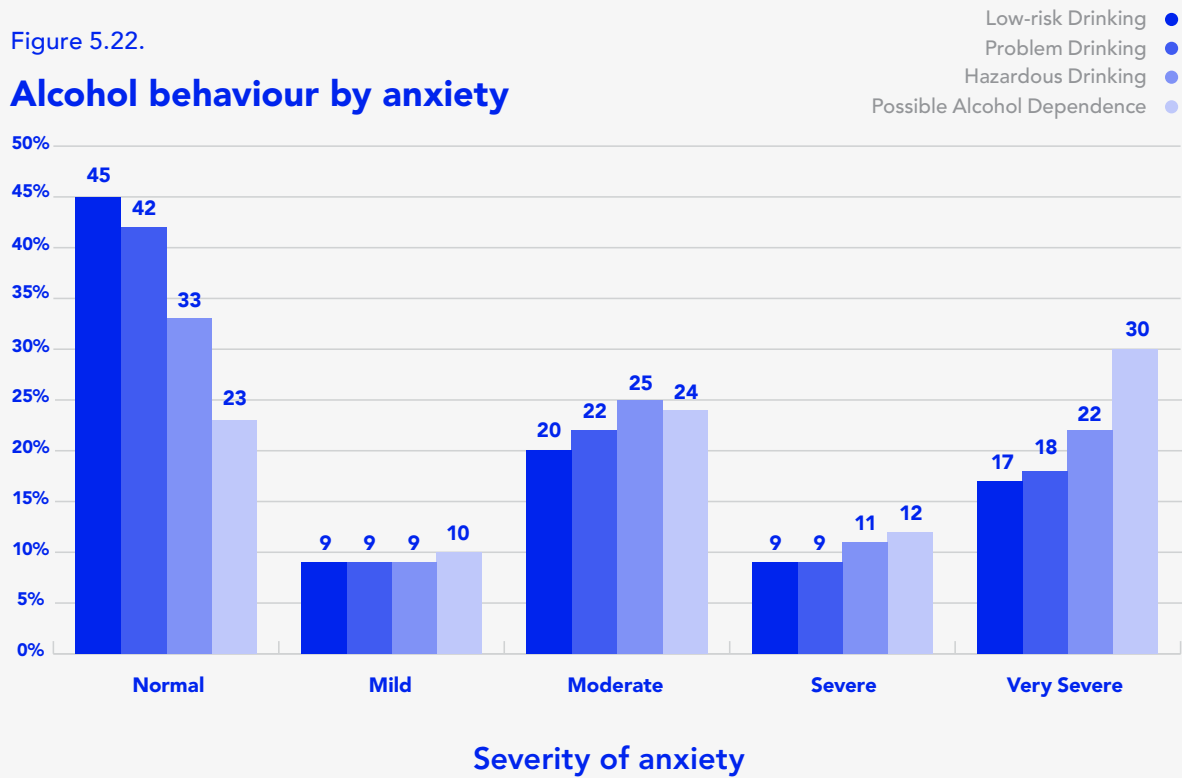


### 5.1.34. Alcohol and drug behaviours and YMH

Using the defined categories in the AUDIT, young adults classified as having possible alcohol dependence were more likely than any of the other groups to be in the very severe category for anxiety. Furthermore, young adults who were in the harmful and hazardous drinking category were more likely to be in the moderate range for anxiety.

Figure 5.22.

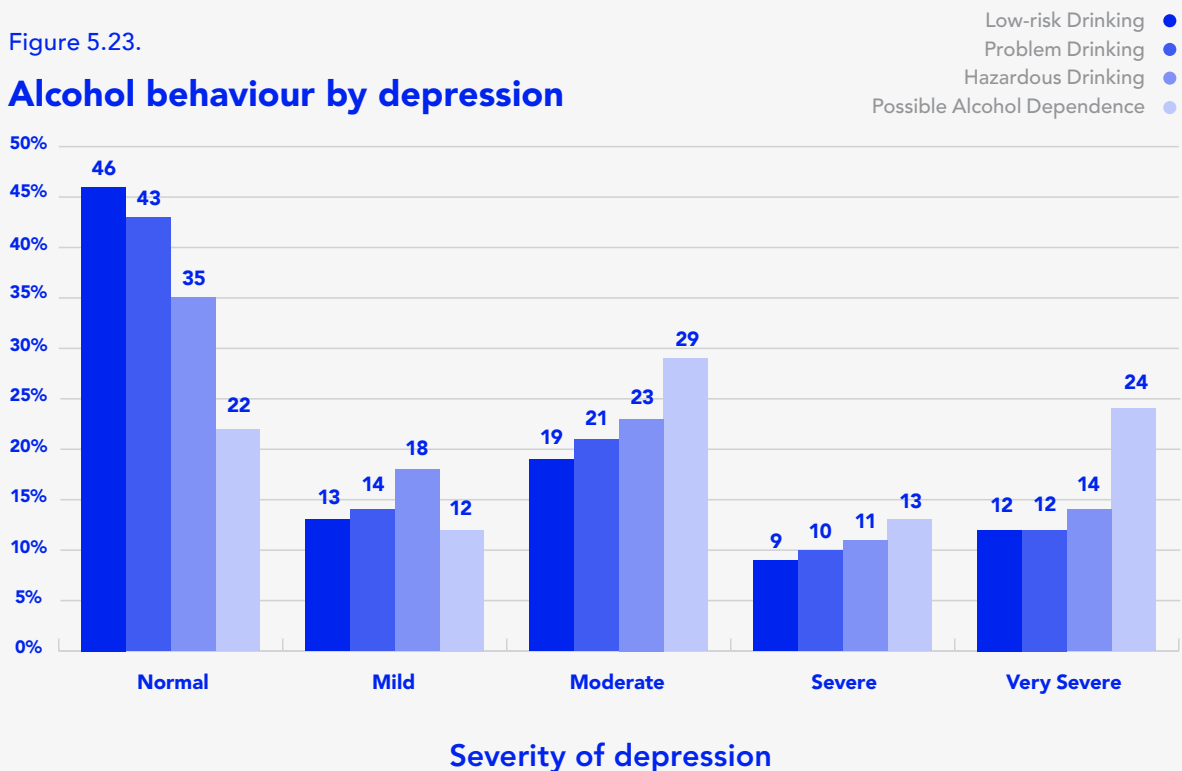
#### Alcohol behaviour by anxiety



Similarly, young adults in the possible alcohol dependence category were more likely to be in the moderate, severe and very severe ranges of depression than any other category (see Figure 5.23).

Figure 5.23.

#### Alcohol behaviour by depression



Furthermore, young adults in the harmful and hazardous drinking category and the possible alcohol dependence category reported significantly lower levels of family support than those in the low risk drinking category or the problem drinking category. However, there were no significant differences between these groups in terms of level of friend support. Young adults in the harmful and hazardous drinking and possible alcohol dependence categories also had significantly lower self-esteem, body esteem and resilience than those in the low risk drinking range or the problem drinking range. See Table 5.1 for mean scores.

Table 5.1.

### Mean scores on mental health indicators across alcohol behaviour categories

	Low-risk M (SD)	Problem drinking M (SD)	Harmful and hazardous M (SD)	Possible alcohol dependence M (SD)
<b>Family support</b>	20.33 (5.91)	19.83 (5.73)	19.28 (5.86)	18.18 (5.64)
<b>Self-esteem</b>	26.07 (6.44)	25.84 (6.03)	24.88 (5.72)	23.08 (5.56)
<b>Body esteem</b>	19.06 (7.3)	18.22 (7.11)	16.89 (6.99)	15.75 (7.2)
<b>Resilience</b>	17.91 (5.21)	17.7 (4.99)	17.05 (5.04)	16.11 (4.81)

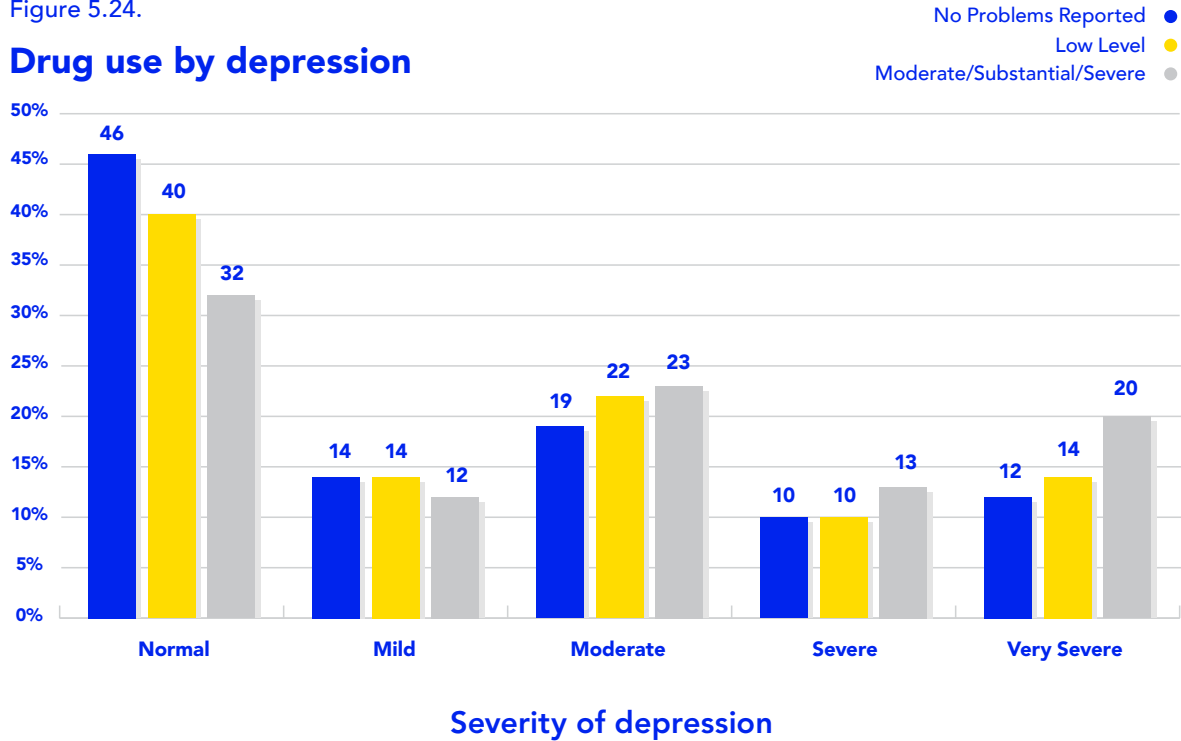
Young adults who indicated they had ever used drugs other than those required for medical reasons were more likely to be in the very severe category and less likely to be in the normal range for depression than those who never used drugs. A similar pattern was found for anxiety. These young adults were also more likely to report low life satisfaction and to fall into the problem drinking, harmful and hazardous drinking and potential alcohol dependence categories.

Significantly lower levels of family support for those in the **harmful & hazardous** drinking category

Similarly, using the defined categories with the DAST, young adults in the moderate/substantial/severe category for drug use were more likely to be in the severe and very severe range for depression (see Figure 5.24), and in the very severe range for anxiety than young adults with no reported drug problems.

Figure 5.24.

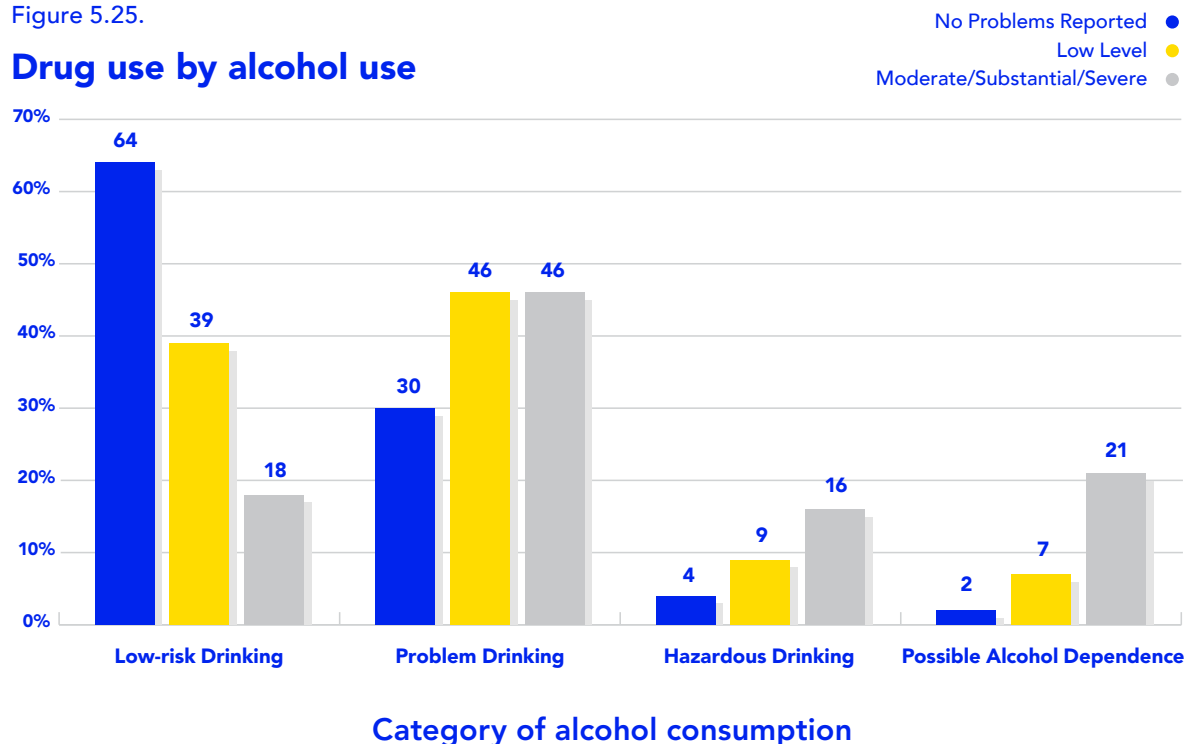
### Drug use by depression



Young adults classified in the moderate/substantial/severe category for drug use were more likely to be in the moderate risk, harmful and hazardous drinking or possible alcohol dependence category for alcohol use than young people with no reported drug problems.

Figure 5.25.

### Drug use by alcohol use



Young adults in the moderate/substantial/severe category for drug use reported significantly less family support than those with no problems or in the low-level range. However, similar to findings for alcohol behaviour, there were no significant differences between these groups in terms of friend support. Finally, young people in the moderate/substantial/severe category for drug use had significantly lower self-esteem, body esteem and resilience than those with no problems or in the low-level range for drug use. See Table 5.2 for mean scores.

Table 5.2.

### Mean scores on mental health indicators across drug use categories

	No problems reported M (SD)	Low Level M (SD)	Moderate/ substantial/ severe M (SD)
<b>Family support</b>	20.46 (5.84)	19.65 (5.79)	18.68 (5.74)
<b>Self-esteem</b>	26 (6.26)	25.68 (6.22)	24.64 (5.95)
<b>Body esteem</b>	18.53 (7.2)	18.31 (7.29)	17.82 (7.4)
<b>Resilience</b>	17.66 (5.12)	17.91 (5.15)	16.94 (4.96)

Young adults who indicated they had ever used drugs other than those required for medical reasons were more likely to be in the very severe category and less likely to be in the normal range for depression than those who never used drugs. A similar pattern was found for anxiety. These young adults were also more likely to report low life satisfaction and to fall into the problem drinking, harmful and hazardous drinking and potential alcohol dependence categories.

Young adults indicating drug use other than those required for medical reasons were more likely to be in the **very severe** categories for depression and anxiety

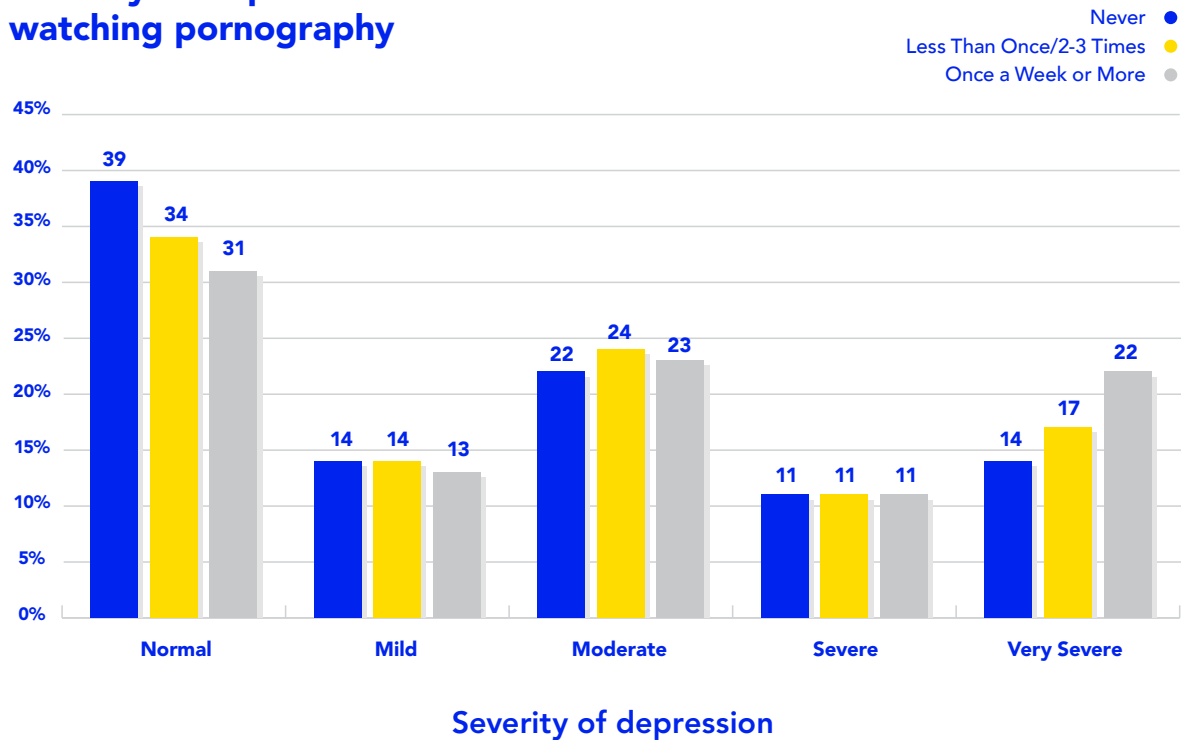
### 5.1.35. Being online and YMH

#### Pornography

Approximately 73% of males and 17% of females reported watching pornography once a week or more. Females who reported regularly watching pornography were more likely to be in the very severe category for depression (see Figure 5.26). This pattern was not evident for males.

Figure 5.26.

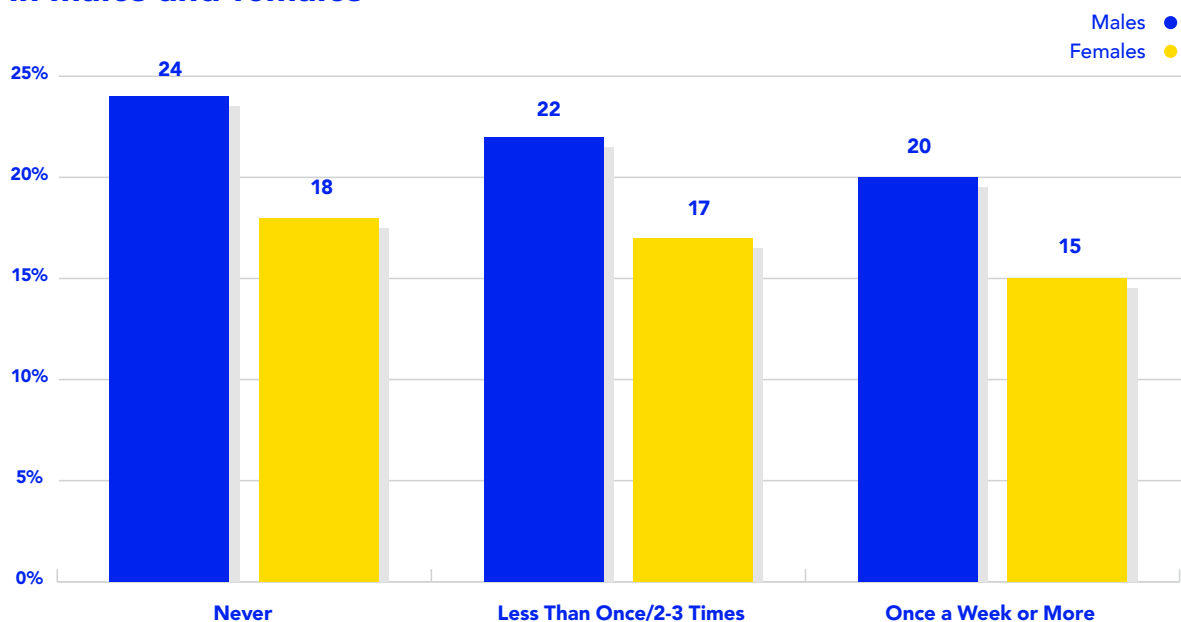
#### Severity of depression for females watching pornography



Regardless of gender, young adults who watched pornography weekly had significantly lower self-esteem and body esteem than those who had never watched pornography or watched pornography less than once a week (see Figure 5.27).

Figure 5.27.

#### Body esteem and watching pornography in males and females

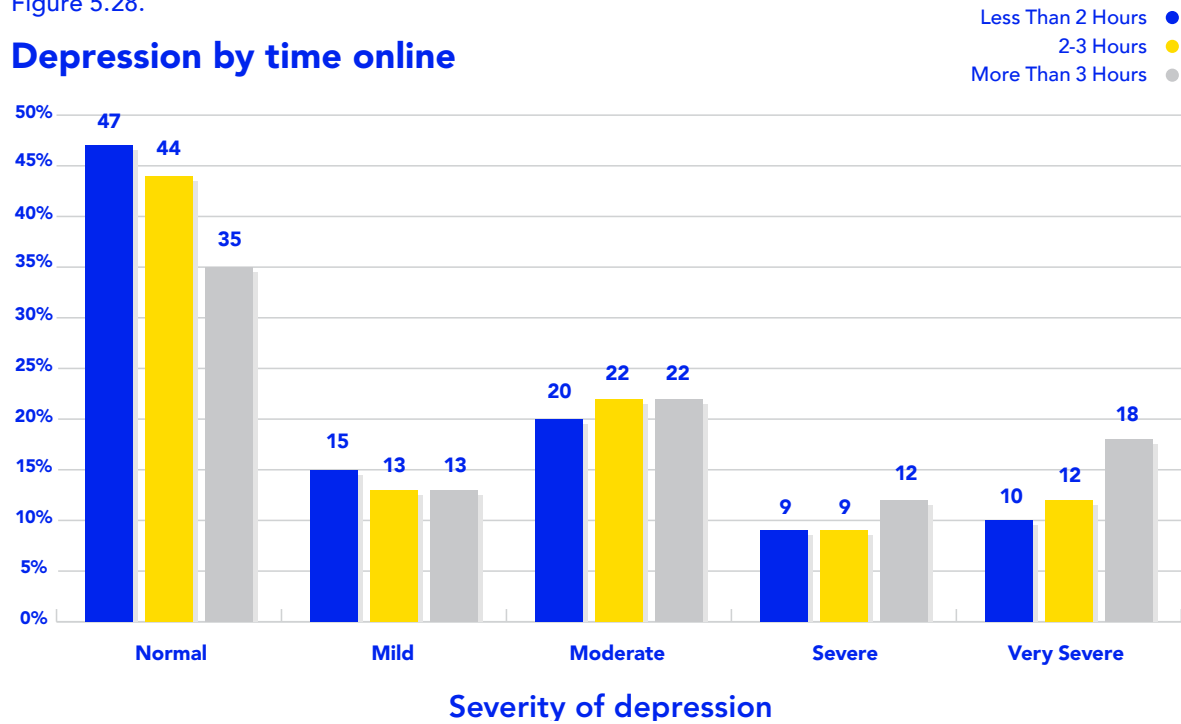


### Social media

Nearly one-third (30%) of young adults spent more than three hours online per day. Young adults who reported spending more than three hours online per day were more likely to be in the severe and very severe range for depression. As shown in Figure 5.28, young adults who reported spending less than two hours online were more likely to be in the normal range for depression.

Figure 5.28.

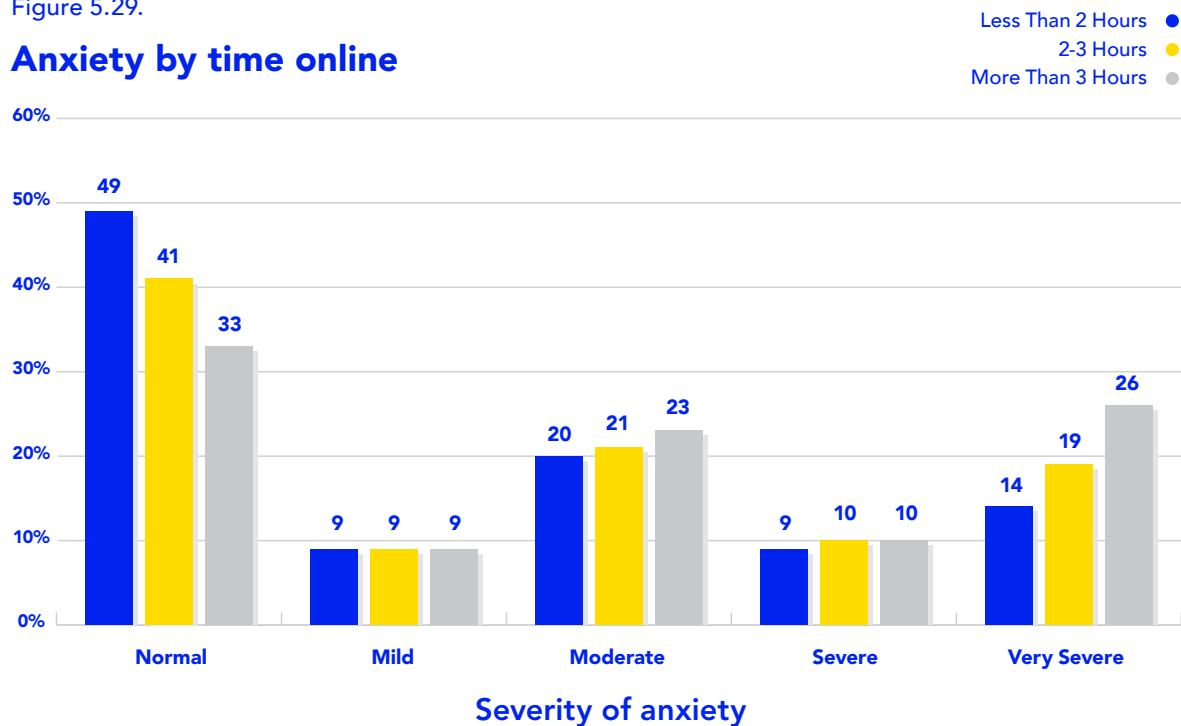
### Depression by time online



Young adults who reported spending less than two hours online were also more likely to be in the normal range for anxiety. As shown in Figure 5.29, young adults who reported spending more than three hours online were more likely to be in the very severe range for anxiety.

Figure 5.29.

### Anxiety by time online



Young adults who reported spending less than two hours a day online had significantly higher levels of self-esteem ( $M=26.78$ ,  $SD=6.36$ ) and body esteem ( $M=20.02$ ,  $SD=7.15$ ) than young adults who reported spending 2-3 hours (self-esteem  $M=25.74$ ,  $SD=6$ ; body esteem  $M=17.94$ ,  $SD=7.05$ ) and more than three hours online (self-esteem  $M=24.22$ ,  $SD=5.95$ ; body esteem  $M=16.46$ ,  $SD=7.08$ ).

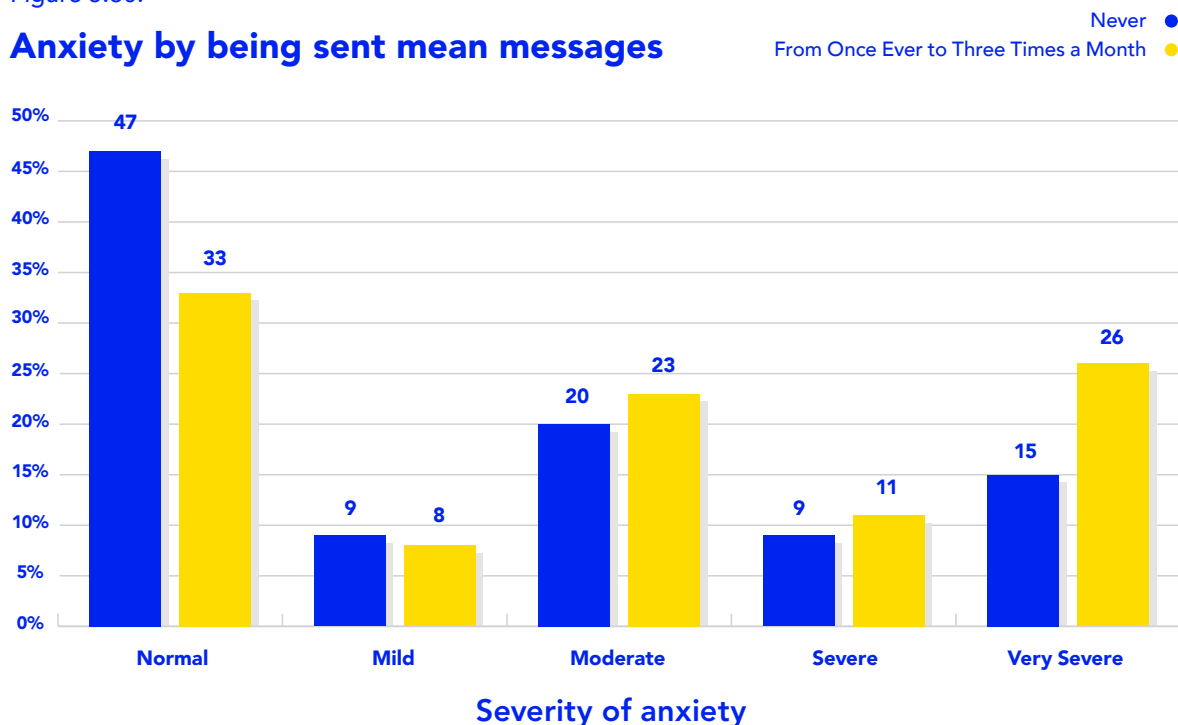
Young adults who reported spending less than two hours online per day expressed significantly higher levels of problem-solving focused coping ( $M=17.47$ ,  $SD=4.87$ ) than young adults who reported spending 2-3 hours ( $M=16.41$ ,  $SD=4.53$ ) and more than three hours online ( $M=15.28$ ,  $SD=4.6$ ) while young adults who reported spending more than three hours online per day showed significantly higher avoidance-based coping ( $M=20.75$ ,  $SD=6.19$ ) than young adults who reported spending less than two hours ( $M=18.05$ ,  $SD=6.06$ ) and 2-3 hours online a day ( $M=19.48$ ,  $SD=6.1$ ). Similar to adolescents, young adults who reported spending 2-3 hours online displayed significantly higher levels of support-focused coping ( $M=13.55$ ,  $SD=4.48$ ) than young adults who reported spending less than two hours online ( $M=12.6$ ,  $SD=4.85$ ) and young adults who reported spending more than three hours online ( $M=13.11$ ,  $SD=4.68$ ).

### Negative messages

Young adults who reported being sent mean messages 1-3 times a month were more likely to be in the moderate, severe and very severe categories for depression. They also were more likely to fall into the severe and very severe categories for anxiety.

Figure 5.30.

### Anxiety by being sent mean messages



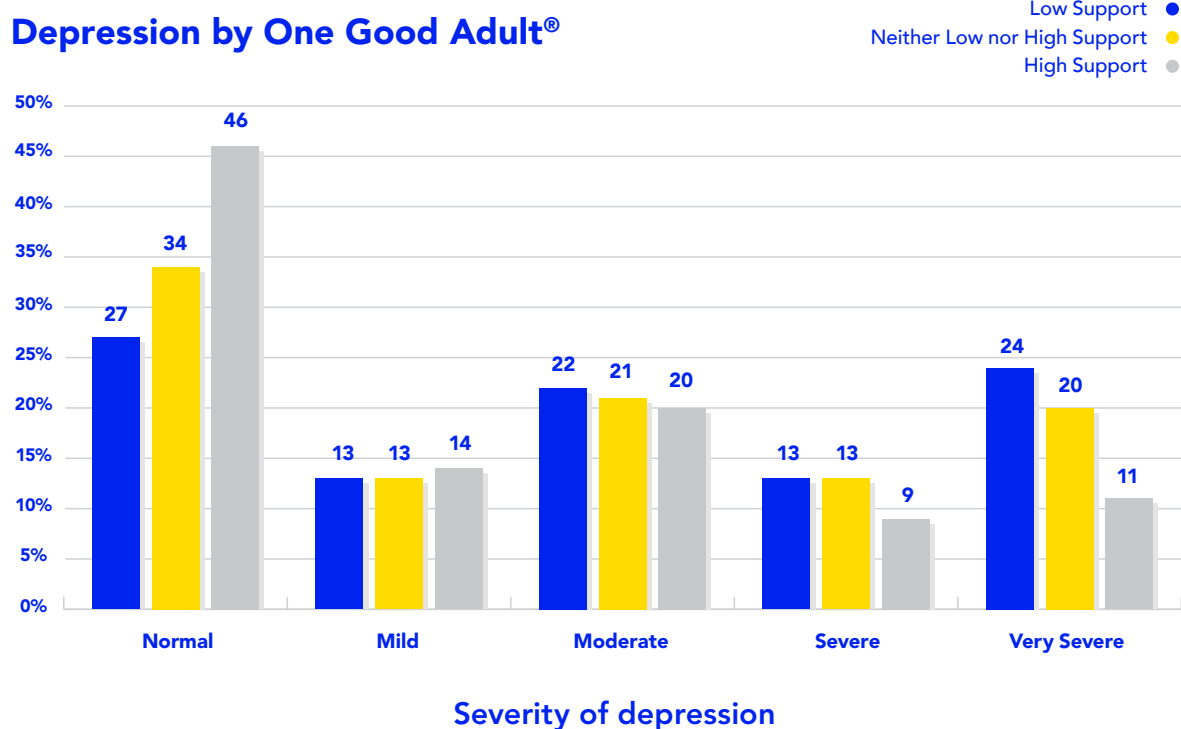
Young adults who reported being sent mean messages displayed significantly lower resilience ( $M=16.8$ ,  $SD=5.05$ ), social support ( $M=60.19$ ,  $SD=14.37$ ) and body esteem ( $M=16.92$ ,  $SD=7.20$ ) than young adults who did not report this (resilience  $M=18.18$ ,  $SD=5.07$ , social support  $M=62.17$ ,  $SD=14.58$ , body esteem  $M=19.24$ ,  $SD=7.14$ ).

### 5.1.36. Presence of One Good Adult® and YMH

As previously outlined, three in four adults (76%) reported that they had support from One Good Adult®, while 14% reported that they had low support.

As Figure 5.31 shows, young adults who reported that they had high support from a special adult in their lives were much more likely to fall into the normal range for depression, and young people who had low support were more likely to be in the severe and very severe categories for depression.

Figure 5.31.



Young adults with high support were also more likely to fall into the normal range for anxiety and to indicate significantly greater levels of life satisfaction. Young adults who reported high support from a special adult also had significantly higher self-esteem ( $M=26.29$ ,  $SD=6.12$ ) and body esteem ( $M=18.83$ ,  $SD=7.16$ ) than those who had neither high nor low support (self-esteem  $M=24.25$ ,  $SD=5.97$ , body esteem  $M=17.59$ ,  $SD=7.22$ ) and low support ( $M=23.6$ ,  $SD=6.53$ , body esteem  $M=16.62$ ,  $SD=7.48$ ). They had significantly higher resilience, optimism and social support than their peers who had some or no support from a special adult.

**24%**  
of those with low support indicated very severe levels of depression

On the other hand, those who had low support from a special adult were more likely to fall into the moderate/substantial/severe category for drug use and more likely to fall into the possible alcohol dependence category for alcohol behaviour.



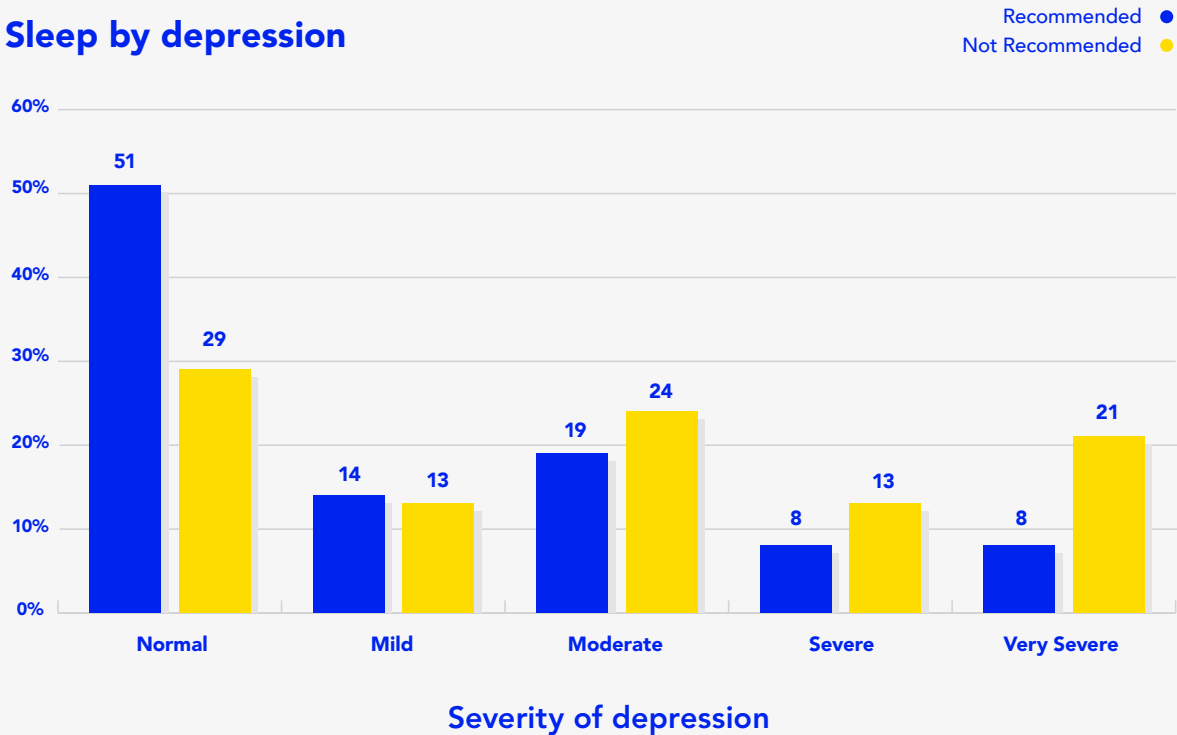
### 5.1.37. Physical wellbeing and YMH

#### Sleep

Young adults who reported good sleep hygiene (51%; 7-9 hours) were more likely to be in the normal range for depression than those who were not getting the recommended amount of sleep (see Figure 5.32). The same pattern was observed for anxiety, with young adults who had good sleep hygiene reporting lower levels of anxiety. These young adults reported higher resilience (M=18.17, SD=5), self-esteem (M=26.96, SD=6), body esteem (M=19.64, SD=7.01), optimism (M=12.72, SD=5.13) and social support (M=62.9, SD=14.3) than those with poor sleep hygiene (resilience M=16.83, SD=5.19, self-esteem M=23.72, SD=6.05, body esteem M=16.34, SD=7.2, optimism M=10.22, SD=5.15, social support M=58.97, SD=14.66). They were also less likely to report being absent from work or college in the past month.

Figure 5.32.

#### Sleep by depression



**21%**

who reported poor sleep hygiene indicated very severe levels of depression

On the other hand, those who reported poor sleep hygiene were more likely to be in the moderate/substantial/severe range for drug abuse and the possible alcohol dependence category.

## Physical activity

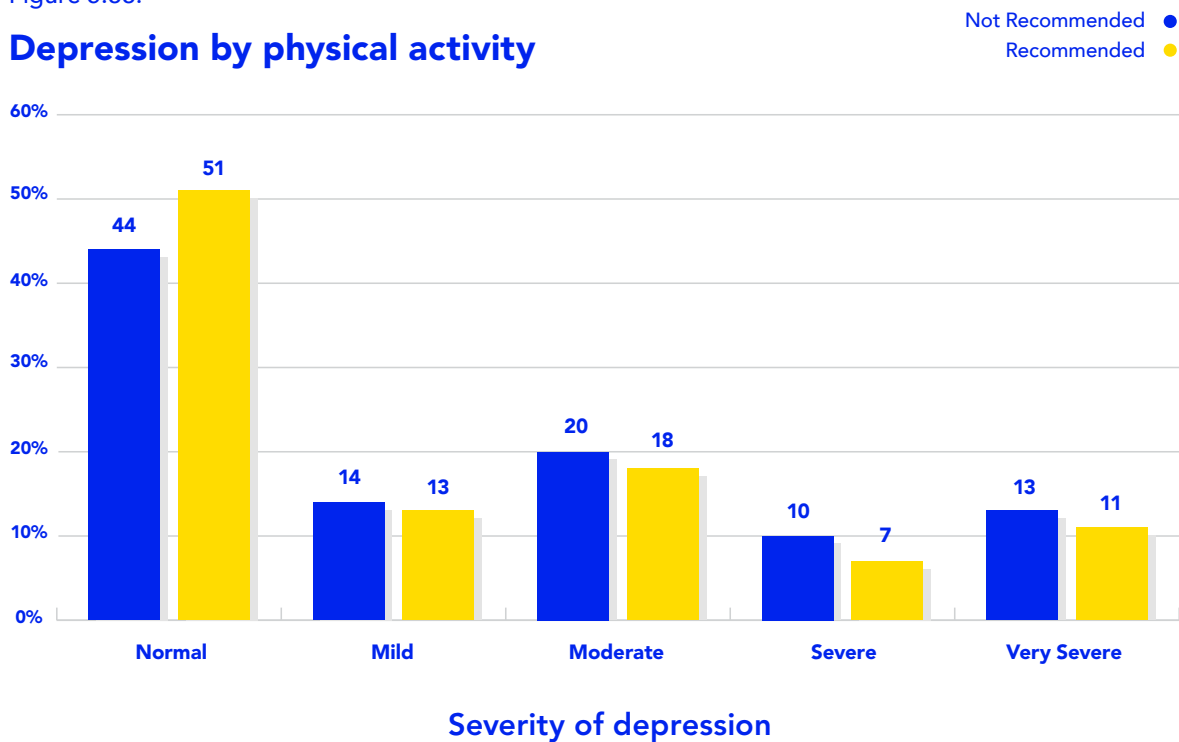
Young adults who reported getting the recommended amount of physical activity were more likely to fall into the normal range for depression and anxiety than those who did not. They were also less likely to fall into the problem categories for drinking behaviour. They had significantly higher self-esteem ( $M=26.69$ ,  $SD=6.53$ ), body esteem ( $M=19.47$ ,  $SD=7.57$ ), optimism ( $M=12.31$ ,  $SD=5.48$ ) and resilience ( $M=18.6$ ,  $SD=5.13$ ) than their peers who reported not getting the recommended amount of activity (self-esteem  $M=25.47$ ,  $SD=6.12$ , body esteem  $M=19.47$ ,  $SD=7.57$ , optimism  $M=11.62$ ,  $SD=5.22$ , resilience  $M=17.42$ ,  $SD=5.08$ ).

# 51%

who reported getting the recommended amount of physical activity indicated normal levels of depression

Figure 5.33.

## Depression by physical activity



## Summary

- Overall, only 42% of young adults were classified in the normal range for depression and anxiety. Females were more anxious than males.
- The top stressors reported by young adults were college, the future and finances. The top ways of coping endorsed by young adults were friends, music and sleep.
- Only 62% of young adults were found to have good sleep hygiene and just 20% met the WHO guidelines for physical activity. Good sleep hygiene and physical activity were linked to better mental health.
- Young adults who reported that they had ever deliberately hurt themselves without wanting to take their own life or made a suicide attempt were much more likely to experience high levels of depression and anxiety and engage in risky alcohol behaviour.
- Young adults who reported a suicide attempt were more likely to report a low level of support from a special adult, have significantly lower self-esteem, body esteem, resilience, social support and optimism than their peers who reported no suicide attempt.
- Young adults who identified as LGBAP were less likely to be in the normal range for depression and anxiety, and were more likely to report that they had been treated unfairly because of their identity and more likely to report being bullied.
- Young adults who identified experiencing any of the following stressful life events - conflict between parents, violence in the home, violence in a romantic relationship - were more likely to report higher depression and anxiety, higher drug use, risky alcohol behaviour and be dissatisfied with life than young people who had not experienced these stressful life events.
- Young adult females who reported that someone had touched them against their will were more likely to be in the very severe range for depression and anxiety.
- Young adult females who reported regularly watching pornography were more likely to be in the very severe category for depression. This pattern was not evident for males. Regardless of gender, young adults who watched pornography weekly had significantly lower self-esteem and body esteem.
- Young adults who reported spending less than two hours online were also more likely to be in the normal range for depression and anxiety and report high problem-solving focused coping strategies.
- The presence of a One Good Adult® is important in the lives of young adults. This was linked to low levels of depression and anxiety, greater levels of life satisfaction, higher self-esteem, resilience and optimism.



# Chapter 6:

## Methodology for Seldom Heard Groups

### Overview

This chapter describes the methodology employed for seldom heard groups who took part in MWS-2-SH. It also presents the characteristics of the samples that participated in MWS-2-SH. For more detailed information on the methodology for this sample, see Appendix 3.

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### Organisation selection and recruitment

The MWS-2-SH study sought to recruit a sample of adolescents who are seldomly heard in cross-sectional research. In many cases, this involved convenience and snowball sampling, whereby organisations working with young people from seldom heard groups were selected on the basis of proximity to the groups we wished to include. This methodology is less rigorous than other sampling methods and has impact on the potential to generalise findings. In addition, the sample sizes are small in comparison to the second level and young adult samples. Organisation selection was conducted based on one of the following methods:

#### 1. Direct contact from the research team:

The research team contacted an organisation directly and invited them to participate. This involved similar methods to school recruitment; that is, an invitation email was sent to the organisation and followed-up by a phone call.

#### 2. Contact via Jigsaw:

The research team was linked into some organisations via Jigsaw because of their already existent relationship. A staff member in Jigsaw, who was known to the organisation, contacted them on behalf of the research team. A member of the research team then followed-up with a phone call.

#### 3. Direct contact from the organisation:

In a few cases, an organisation heard of the study through another organisation and contacted the research team themselves to participate in the study. In other cases, organisations learned of the study when the study was launched in the media in September 2018. These organisations contacted the research team to express an interest in participation.

---

## Characteristics of organisations

This section presents the characteristics of the organisations that participated in the research.

**Youthreach:** This is an official education, training and work experience programme provided by the Department of Education for early school leavers aged 15-20. There are over 100 Youthreach centres in Ireland and 16 Youthreach centres chose to participate in this research.

**College of Further Education (CFE)/community training:** This group includes young people who are engaged in any further study after post-primary education that is not part of higher education. There are almost 200 CFEs in Ireland and five CFEs chose to participate in this research.

**Physical disability:** This group consisted of wheelchair users, young people living with deafness or hearing loss and young people who are visually impaired.

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## Data collection

Data collection took place from April 2019 until August 2019. Methods of data collection differed based on the age and needs of participants. All procedures for data collection were approved by UCD Ethics Committee and all data collected were anonymous.

### **Youthreach:**

A research information letter and consent form for students and their parent(s)/guardian(s) were distributed to students by a researcher or staff member in the organisation. Similar to MWS-2-SL, young people under the age of 18 required parent/guardian consent before participation. Once parent/guardian consent forms had been returned, a date to collect data in the organisation was agreed. Data collection followed standardised protocols to ensure data integrity. Youthreach was offered the choice to complete the survey themselves during class-time with students or to have a researcher come to the organisation to complete the survey with students. Each participating Youthreach was offered the choice of completing a paper-based or web-based version of the MWS-2-SH survey. Web-based surveys were delivered via Qualtrics (Provo, UT). Students typically spent 30-45 minutes completing the survey. Following data collection, participants were given a support card with contact details for various mental health support services.

### **Physical disability:**

All data were collected using the same protocol as Youthreach. Data were collected via web-based/paper-based survey. If web-based, some young people completed the survey at home. All paper-based surveys were completed within the organisation.

### **CFE/community training:**

Once a CFE agreed to participate in the study, a nominated staff member sent an email to students with information about the study and an online consent form which, once completed, directed participants to the online survey. Following completion of the study, participants were presented with contact details for various mental health support services.

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### 6.1.1. Description of MWS-2-SH

Young people in this sample completed a shorter version of the MWS-2-SL and MWS-2-PSL surveys to avoid burden for participants.

Similar to MWS-2-SL and MWS-2-PSL, the MWS-2-SH survey contained four major sections, where a number of items/standardised scales were included in each section. The sections were as follows:

1. Demographic characteristics
2. Personal wellbeing and lifestyle factors
3. Negative domains
4. Positive domains

For a full list of the questions asked in this survey, see Appendix 3.

#### Negative domains

A number of standardised scales were used to assess negative domains in relation to mental health, as shown in Table 6.1. The reliabilities of each standardised measure are presented in the table for each group.

Table 6.1.  
**Reliability scores for standardised measures in negative domains**

Negative Scales in MWS-2-SH	Youthreach	CFE	Physical disability
Depression, Anxiety and Stress Scale (DASS)			
DASS-Depression	.92	.93	.85
DASS-Anxiety	.84	.88	.81
Alcohol Use Disorders Identification Test (AUDIT)	.77	.86	.89

## Positive domains

Standardised measures of positive mental health indicators which were completed by this sample are outlined in Table 6.2., with more detail in Appendix 1 and 2.

**Table 6.2.**  
**Reliability scores for standardised measures**  
**in positive domains**

Positive Scales in MWS-2-SH	Youthreach	CFE	Physical disability
Rosenberg Self-Esteem Scale (RSE)	.88	.89	.83
Life Orientation Test - Revised (LOT-R)	.67	.72	.69
Adapted Coping Strategy Indicator (CSI-15)			
CSI-Problem-Solving Coping	.85	.84	.80
CSI-Avoidance Coping	.81	.82	.72
CSI-Support-Focused Coping	.90	.93	.89
Brief Resilience Scale	.73	.77	.71
Multidimensional Scale of Perceived Social Support (MSPSS)			
MSPSS-Family	.91	.91	.73
MSPSS-Friend	.94	.94	.91
MSPSS-Significant Other	.91	.95	.86

# Characteristics of Sample

## 6.1.2. Composition of sample

The sample includes young people from the following groups:

- Youthreach (N=314)
- Young people in Colleges of Further Education (CFE)/community training (N=292)
- Young people with physical disabilities (N=52)

## 6.1.3. Gender and age

Table 6.3 presents data on gender and age breakdown for each group.

As this shows, there were slightly more females than males and other gender groups were below 3%. The average age for most groups was 18/19 years.

Table 6.3.

### Gender and age for each seldom heard group

Group	Female	Male	Other*	Age (M;SD)
Youthreach	52%	46%	2%	18.15 (1.45)
CFE/community training	46%	46%	3%	19.8 (2.42)
Physical disability	51%	38%	2%	19.4 (3.94)

\*(e.g., non-binary)

## 6.1.4. Occupation

As Table 6.4 shows, most of the young people in the seldom heard sample were students or employed, as expected.

Table 6.4.

### Occupation for each seldom heard group

Group	Student	Employment	Trainee/Apprentice	Unemployed
Youthreach	90%	2%	5%	3%
CFE/community training	85%	7%	5%	3%
Physical disability	72%	14%	2%	12%



### 6.1.5. Ethnicity

Most young people in each group identified as White Irish, as Table 6.5 shows. A considerable number of young people in the Youthreach group identified as Travellers (13%).

**13%**  
of the Youthreach sample  
identified as Travellers

Table 6.5.

#### Ethnicity for each seldom heard group

Group	White Irish	Traveller	Any White Background	Mixed Background	Black/Black Irish	Asian/Asian Irish	Prefer Not to Say	Other
Youthreach	73%	13%	5%	4%	-	2%	2%	1%
CFE/ community training	86%	1%	4%	-	2%	-	2%	-
Physical disability	85%	-	4%	-	-	-	2%	-

### 6.1.6. Religion

As Table 6.6 shows, most young people identified as Roman Catholic.

Table 6.6.

#### Religion for each Seldom Heard Group

Group	Roman Catholic	Church of Ireland	Christian	Other	No religion/ Atheist
Youthreach	54%	5%	9%	5%	28%
CFE/ community training	51%	6%	11%	9%	22%
Physical disability	70%	-	2%	-	28%

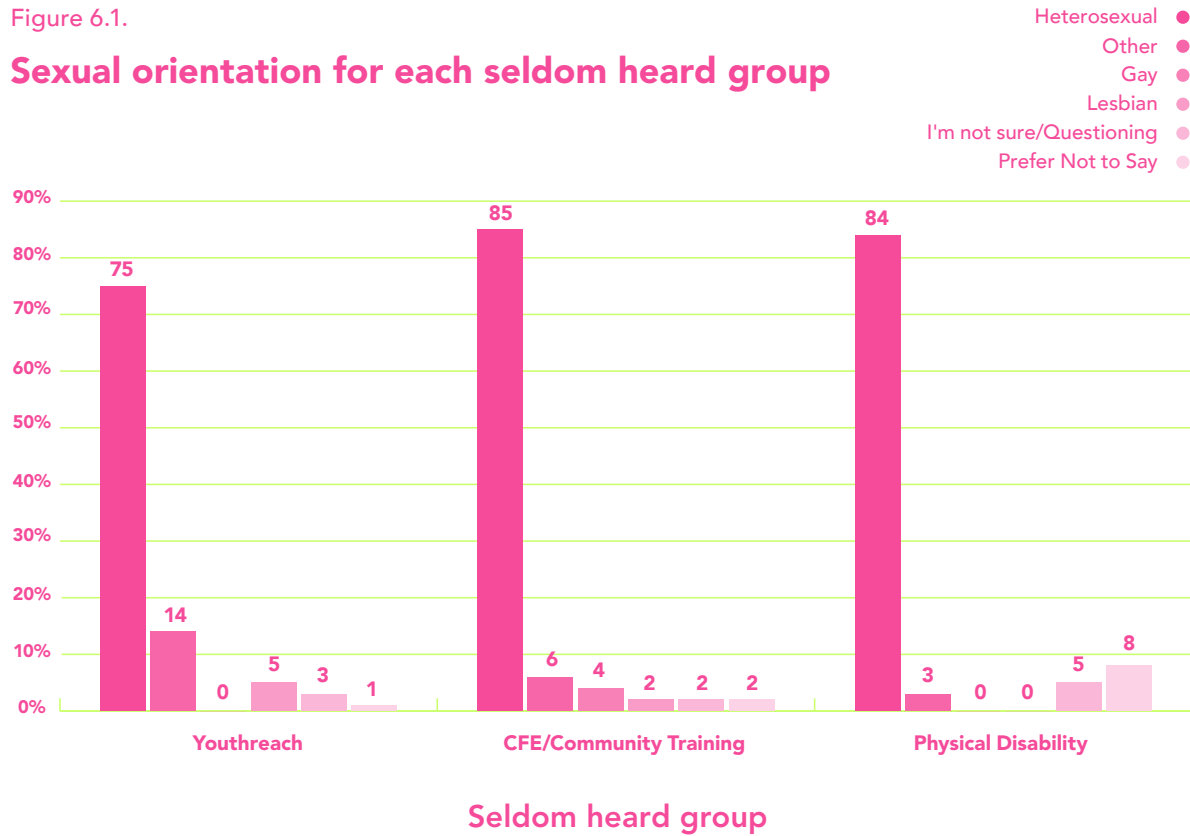
**28%**  
of the Youthreach sample  
identified as atheist

### 6.1.7. Sexual orientation

Most young people identified as heterosexual (see Figure 6.1). There was a notable proportion of young people who identified as 'other' in the Youthreach. A relatively high proportion of young people with a physical disability reported that they would prefer not to say.

Figure 6.1.

#### Sexual orientation for each seldom heard group



### 6.1.8. Relationship status

As Table 6.7 shows, the majority of young people within each group indicated that they were single.

Table 6.7.

#### Relationship status for each seldom heard group

Group	Single	In a relationship	Married	Living with partner	Other
Youthreach	51%	44%	1%	1%	3%
CFE/ community training	59%	34%	3%	3%	1%
Physical disability	71%	27%	-	2%	-

# Chapter 7:

## Findings for Seldom Heard Groups

### Overview

Descriptive data are presented on personal wellbeing and lifestyle factors, as well as negative and positive domains of mental health.

### When interpreting the findings, it is important to bear the following in mind:

- the data for each group are presented separately. Data from each seldom heard group (provided there was a sufficient number of participants) are compared to a random sample of the MWS-2-SL and MWS-2-PSL sample combined (SL/PSL sample). This random sample reflected the seldom-heard groups in terms of age and gender (N=500).

#### 7.1.1. Youthreach

##### Personal wellbeing and lifestyle factors

Young people in Youthreach were much more likely to report having a long-term health difficulty or disability (39%) than the SL/PSL sample (20%). They were also more likely to report providing unpaid personal help for a family member with long-term illness (11% vs 5% in SL/PSL). This group (43%) was much more likely to report having been in trouble with the Gardaí (9% in SL/PSL sample) and they were more likely to report feeling angry a lot (28%) than the SL/PSL sample (15%).

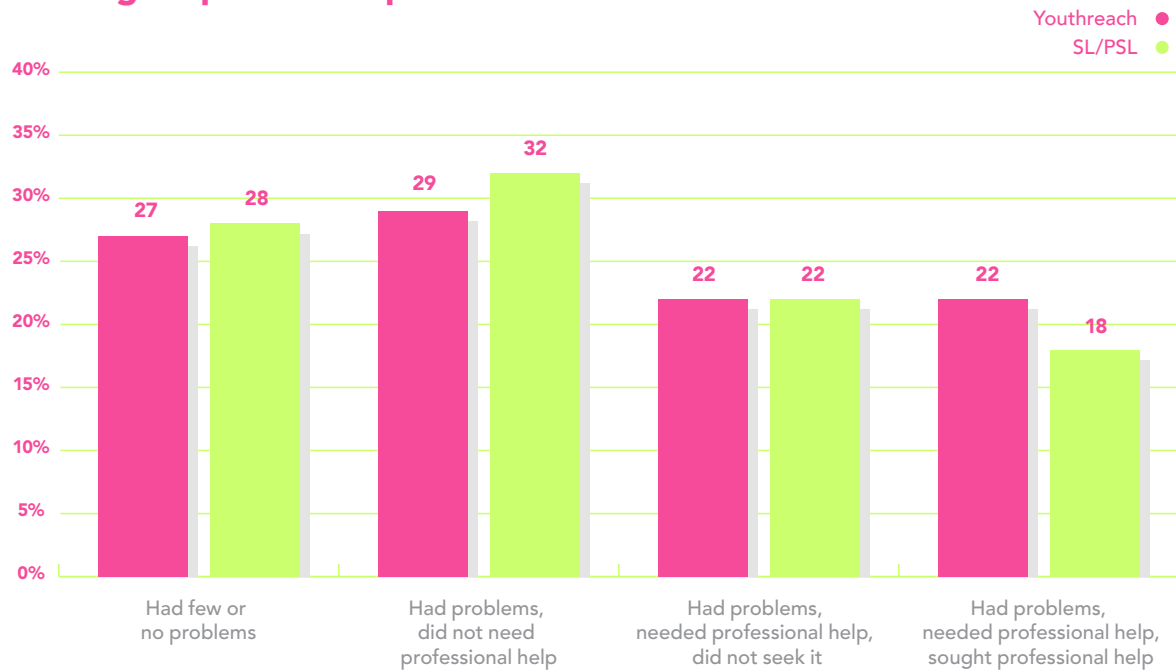
In terms of bullying, 54% of young people in Youthreach reported having been bullied, and almost one in five (19%) reported having been treated unfairly because of their identity.

When asked about stressors, young people in Youthreach selected that the future (53%), finance (42%) and family (38%) were top stressors for them. In terms of coping, young people in Youthreach were less likely to report that they cope well with problems (32%) than the MWS-2-SL/PSL sample (49%). They outlined that music (64%), friends (40%) and sleep (36%) helped them most with their problems, while 30% reported that talking helped them and 21% reported family as helping them with their problems.

Similar to the SL/PSL sample, over 70% of this group reported that they had experienced some problems (see Figure 7.1 for more detail). When faced with problems, approximately half of young people in Youthreach (51%) reported talking about them with someone (42% to their friends and 31% to their family).

Figure 7.1.

## Breakdown of young people seeking help for their problems



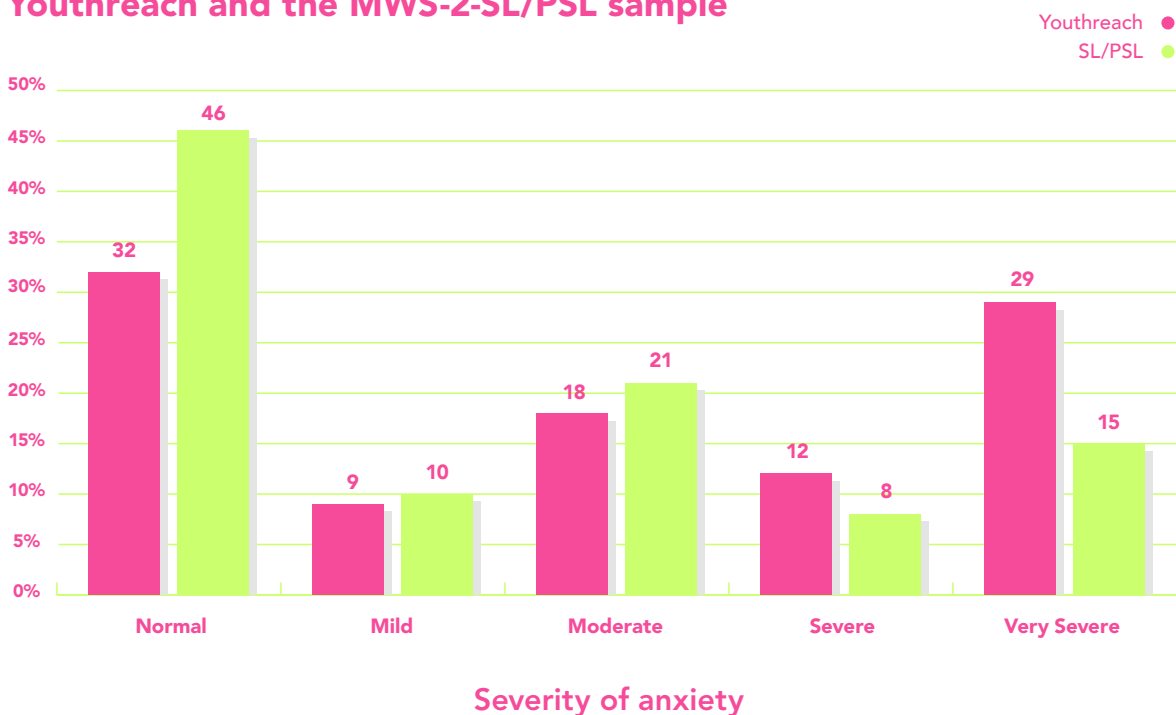
### Help-seeking behaviour

#### Negative domains

Young people in Youthreach (29%) were much more likely to be in the very severe range for anxiety than young people in SL/PSL sample (15%) with no significant differences between these groups in depression.

Figure 7.2.

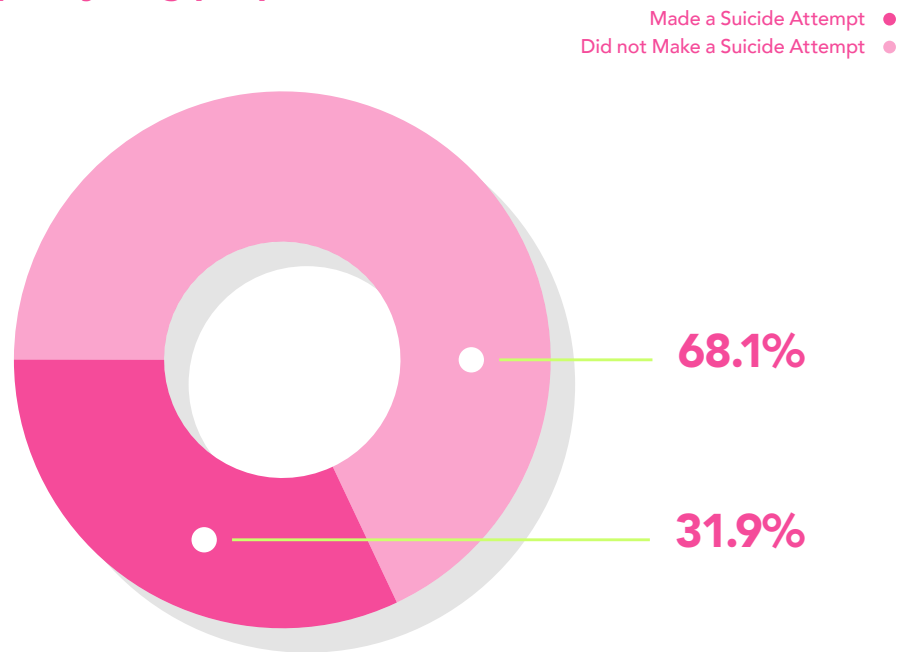
## Severity of anxiety for young people in Youthreach and the MWS-2-SL/PSL sample



This group was more likely to report having deliberately hurt themselves without wanting to take their own life (44% vs 32% in SL/PSL sample) and much more likely to report having made an attempt to take their own life (32% vs 9% in SL/PSL sample; Figure 7.3). Approximately half of the young people (52%) who had reported making an attempt to take their own life accessed help or support for this.

Figure 7.3.

### Suicide attempt in young people in Youthreach



There was no significant difference between Youthreach and SL/PSL in terms of alcohol behaviour with 46% in low-risk range, 39% in problem drinking range, 11% in harmful and hazardous drinking range and 5% in possible alcohol dependence range.

Similar to SL/PSL, approximately 45% of young people in Youthreach reported to have used drugs, other than those required for medical reasons and they were much more likely to report having smoked cannabis (66% vs 39% in SL/PSL sample).

#### Positive domains

There were no significant differences between Youthreach and SL/PSL in terms of self-esteem, optimism, resilience, coping strategies, friend support and adult support. However, there was a significant difference in family support with young people in Youthreach reporting significantly lower levels of family support ( $M=18.76$ ,  $SD=6.18$ ) than SL/PSL sample ( $M=20.57$ ,  $SD=5.46$ ).

## 7.1.2. CFE/community training

### Personal wellbeing and lifestyle factors

Young people in CFE/community training were much more likely to report having a long-term health difficulty (43%) than the SL/PSL sample (20%). These young people were more likely to have been in trouble with the Gardaí (17% vs 9% in SL/PSL sample). Similar to the SL/PSL sample, when asked about bullying and discrimination, 55% of this group reported having been bullied and 16% reported having been treated unfairly because of their identity.

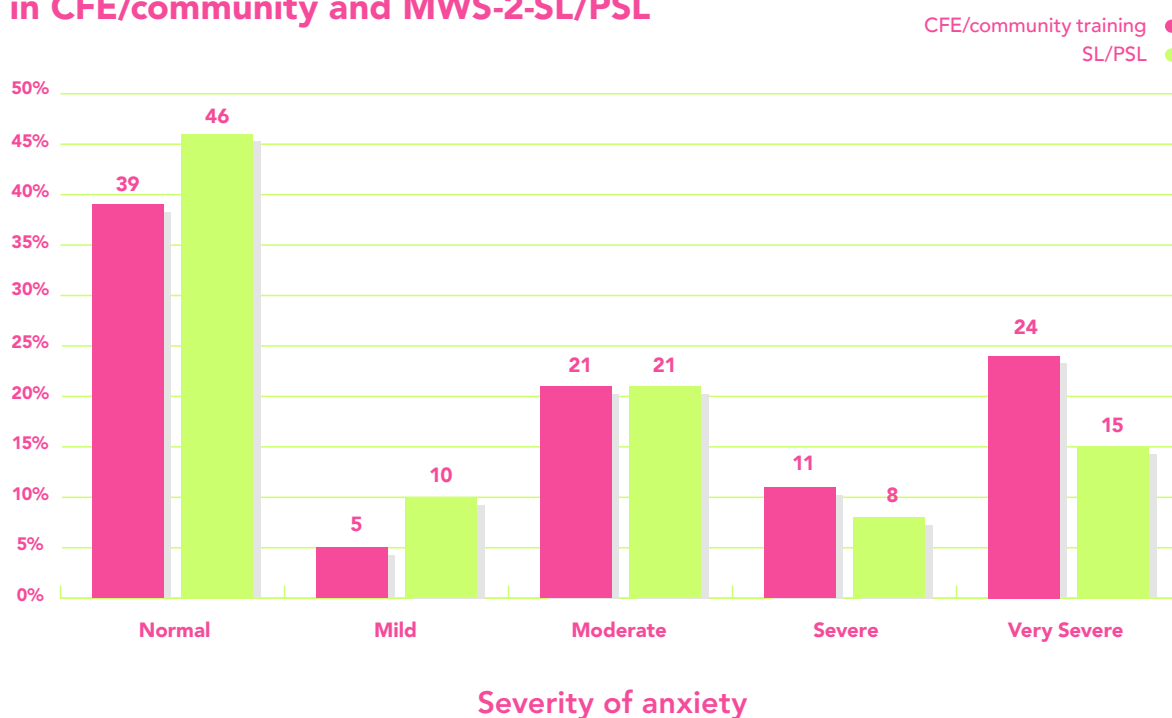
They were much more likely to report that they do not cope well with problems (15% vs 9% in SL/PSL sample). Approximately 34% of young people in CFE/community training reported that they had few or no problems while 24% reported that they had some problems and sought the professional help they needed. A further 18% reported that they had some problems but did not seek help. In terms of sources of stress, the future (53%), college (43%) and finance (38%) were among their top stressors while music (47%), friends (43%) and sleep (38%) helped them to cope with their problems. Just over half of young people in CFE/community training (51%) reported that when faced with problems, they talk about them with someone.

### Negative domains

Young people in CFE/community training (24%) were much more likely to be in the very severe range for anxiety than young people in SL/PSL sample with no significant differences observed between these groups in depression.

Figure 7.4.

### Severity of anxiety in young people in CFE/community and MWS-2-SL/PSL



The CFE/community training group was also more likely to report having made an attempt to take their own life with one in five young people reporting that they had made an attempt to take their own life.

Similar to the Youthreach group, there was no significant difference between this group and SL/PSL in terms of alcohol behaviour with 47% in low-risk range, 32% in problem drinking range, 11% in the harmful and hazardous drinking range and 10% in possible alcohol dependence range. However, young people in CFE/community training were less likely to report having used drugs (26%), other than those required for medical reasons, than the SL/PSL sample (40%).

### Positive domains

There were significant differences between young people in CFE/community training group and the SL/PSL sample in terms of family and friend support, with young people in CFE/community training reporting significantly lower levels of family (M=18.94, SD=5.78) and friend support (M=18.93, SD=5.76) than the SL/PSL sample (family M=20.57, SD=5.46; friend M=20.75, SD=5.55). There were no significant differences between CFE/community training and SL/PSL in terms of self-esteem, optimism, resilience, coping strategies and adult support.

---

**55%**

reported having  
been bullied

---

**10%**

have possible  
alcohol dependence

---

**1 in 5**

reported that they had made  
an attempt to take own life

---

### 7.1.3. Physical Disability

#### Personal wellbeing and lifestyle factors

Young people with a physical disability were more likely to report always enjoying family life (84%) than the SL/PSL sample (53%). A similar pattern of findings to the SL/PSL sample was observed in relation to feelings to anger, with 54% reporting that they felt somewhat angry a lot, 13% reporting that they felt angry a lot and 33% reporting that they did not feel angry a lot. Young people with a physical disability were more likely to report that they have few or no problems (46% vs 28% in SL/PSL sample). However, similar to the SL/PSL sample, when they do have problems, 76% reported that they usually talk about them with someone.

Similar to the SL/PSL sample, when asked about bullying and discrimination, 24% of young people with a physical disability reported that they had been treated unfairly because of their identity and 53% reported having been bullied.

Young people with a physical disability reported that the future (60%), exams (44%) and their job (25%) were sources of stress, and 46% reported that their friends and 40% reported that talking about their problems helped them deal with their problems. Similar to the SL/PSL sample, in relation to coping with problems, 61% reported that they somewhat cope well with problems while 32% reported that they cope well with problems and 7% reported that they do not cope well with problems.

One in four young people with a physical disability reported that their family was a source of stress while 37% reported that that their family helps them cope with their problems.

#### Negative domains

There were no significant differences between young people with a physical disability and the SL/PSL sample in terms of depression and anxiety. Similarly, in relation to deliberate self-harm, 66% of young people with a disability reported that they had never engaged in deliberately hurting themselves without wanting to take their own life. However, young people with a physical disability were more likely to report having made an attempt to take their own life (24% vs 9% in SL/PSL sample). Of the 24% who reported this, 78% reported that they accessed help or support.

There was no significant difference in alcohol behaviour between young people with a physical disability and the SL/PSL sample, with 57% in low-risk drinking range, 21% in problematic drinking range, 14% in the harmful and hazardous drinking range and 7% in possible alcohol dependence range. Young people with a physical disability (17%) were less likely than those in the SL/PSL sample (40%) to report having used drugs, other than those required for medical reasons.

#### Positive domains

Young people with a physical disability were less likely to report the absence of One Good Adult® with 82% reporting that they have a special adult in their lives. There were no other differences between this group and the SL/PSL sample in terms of self-esteem, coping strategies, resilience, optimism and social support.



## Summary

The following section provides an overall conclusion for this chapter. However, the findings from this chapter need to be considered in the context of the convenience sampling method and the small sample size within each group, thus reducing the potential to generalise beyond the participants in these samples. Despite the methodological difficulties mentioned earlier, this is the first study to capture both risk and protective factors in these samples.

- Young people in Youthreach reported more anxiety than matched peers, with 29% of this group in the very severe range for anxiety. In addition, this group was more likely to report having deliberately hurt themselves without wanting to take their own life and much more likely to report having made an attempt to take their own life than matched peers.
  - Young people in Youthreach reported significantly lower levels of family support than their matched peers and were much more likely than matched peers to report having a long-term health difficulty or disability, providing unpaid personal help for a family member with long-term illness, having been in trouble with the Gardaí and feeling angry a lot.
  - Similar patterns to Youthreach were observed for young people on CFE/ community training. Overall, this group was more anxious, more likely to report having a long-term health difficulty and more likely to have made a suicide attempt than matched peers and to report lower support from family and friends.
  - On the positive side, young people in CFE/community training were less likely to report having used drugs other than those required for medical reasons than matched peers.
  - Young people in the physical disability sample were not observed to differ from their matched peers in terms of depression, anxiety and deliberate self-harm. However, the rate of suicide attempt was higher.
  - Similar to young people in the CFE/community sample, young people with a disability were less likely to report having used drugs other than those required for medical reasons than matched peers.
  - Importantly, young people with a physical disability were less likely to report the absence of One Good Adult<sup>®</sup>, which is a positive finding, with 82% reporting that they have a special adult in their lives.
-

# Chapter 8:

## Findings from My World Survey 1 vs My World Survey 2

### Overview

This chapter presents analyses on the findings from MWS-2 in comparison to findings from MWS-1 (published in 2012) to give an insight into potential changes in youth mental health from MWS-1 to MWS-2. The findings for the adolescent samples are presented separately from the findings for the young adult samples. Data from seldom heard groups were not collected in MWS-1.

Given that there were differences between items and measures in the MWS-1 and MWS-2 surveys, analyses were only conducted on items and measures which were presented in both waves of data collection (2012 and 2019). For a full list of variables common to both MWS-1 and MWS-2, see Appendix 4.

---

### When interpreting the findings, it is important to bear the following in mind;

- the MWS study gathered and analysed data from adolescents (MWS-SL) and young adults (MWS-PSL) aged between 12-25 years in 2010/2011. The most recent data collection occurred in 2018/19. This chapter presents findings on risk and protective factors of mental health outcomes between these two waves.
- given the rigorous sampling strategy employed for the school sample, MWS-1-SL and MWS-2-SL (described in Chapter 2), the two samples were well matched in terms of age, gender and school year.
- the young adult sample from MWS-2 differed from MWS-1 in terms of gender (69% female in MWS-2 vs 65% in MWS-1) and sexual orientation (76% identified as heterosexual in MWS-2 vs 89% in MWS-1). For this reason, a random sample of young adults who took part in MWS-2-PSL sample was selected for analyses to reduce the risk of bias in our findings accounting for the differences above.

The final sample for MWS-1 was  $n=7,728$  and for MWS-2 was  $n=5,394$ . The following steps were undertaken to adjust for the differences outlined above:

- *Step 1 Gender*  
To assure a ratio of 65:35 female to male ratio, a random sample of females was deleted from analyses in MWS-2 dataset.
  - *Step 2 Sexual orientation*  
To assure a ratio of 89:11 heterosexual:non-heterosexual orientation, a random sample of non-heterosexual participants was deleted from analyses in MWS-2 dataset.
  - Where differences are reported, they were significant at the  $p \leq .01$  level. Caution should be exercised not to over interpret significant differences that can be observed with large samples sizes, such as MWS-1 and MWS-2. Small mean differences can be statistically significant but may not be meaningful in practice.
-

# Adolescent Findings

## 8.1.1. Personal wellbeing and lifestyle factors

### Anger

Adolescents in MWS-2 (13%) were more likely to report that they felt angry a lot than adolescents in MWS-1 (10%). Those in MWS-1 (44%) were also more likely to report that they sometimes felt angry than those in MWS-2 (40%).

### Trouble with Gardaí

Adolescents in MWS-2 (10%) were less likely to report being in trouble with the Gardaí than adolescents in MWS-1 (13%).

### Bullying

Overall, adolescents in MWS-2 (39%) were less likely to report having been bullied than adolescents in MWS-1 (45%) with reports of online bullying remaining stable.

### Relationships

Adolescents in MWS-2 (23%) were less likely to report having a boyfriend/girlfriend than adolescents in MWS-1 (29%).

## 8.1.2. Negative domains

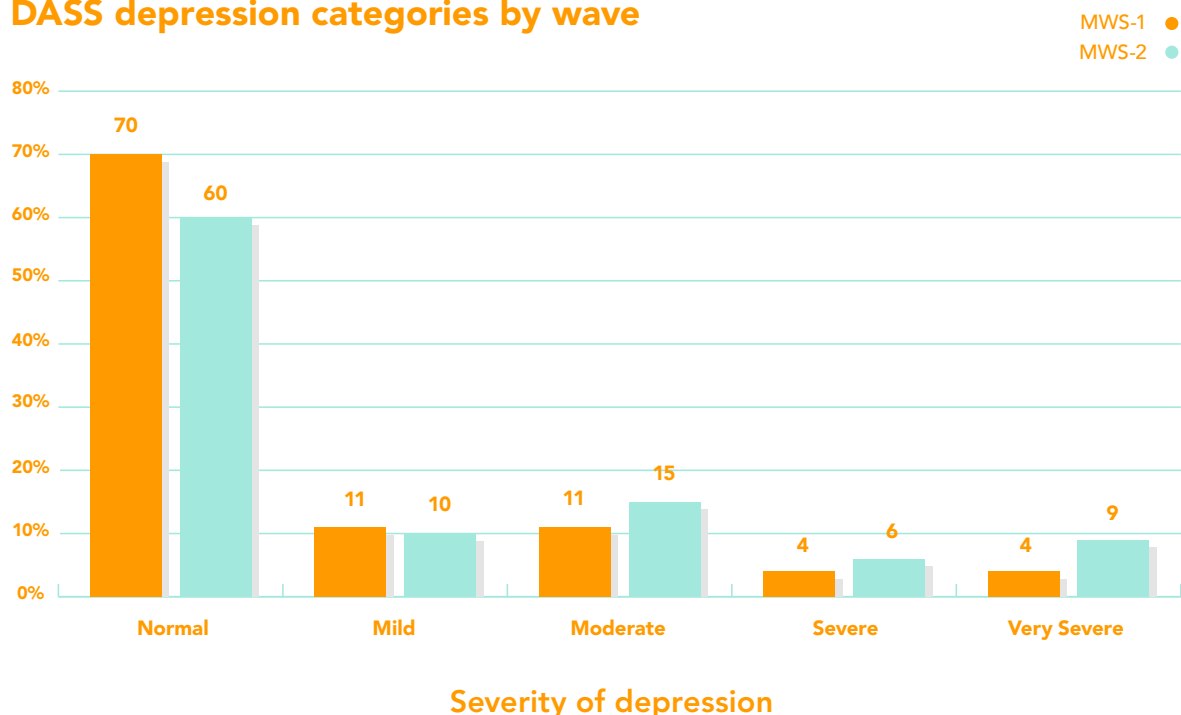
### Depression and anxiety

#### Depression categories

Adolescents in MWS-2 reported significantly higher levels of depression (M=9.85, SD=10.43) than adolescents in MWS-1 (M=7.25, SD=8.56). Using the DASS categories, adolescents in MWS-2 were much less likely to be in the normal range for depression and much more likely to be in the moderate, severe or very severe ranges for depression than adolescents in MWS-1 (see Figure 8.1).

Figure 8.1.

### DASS depression categories by wave



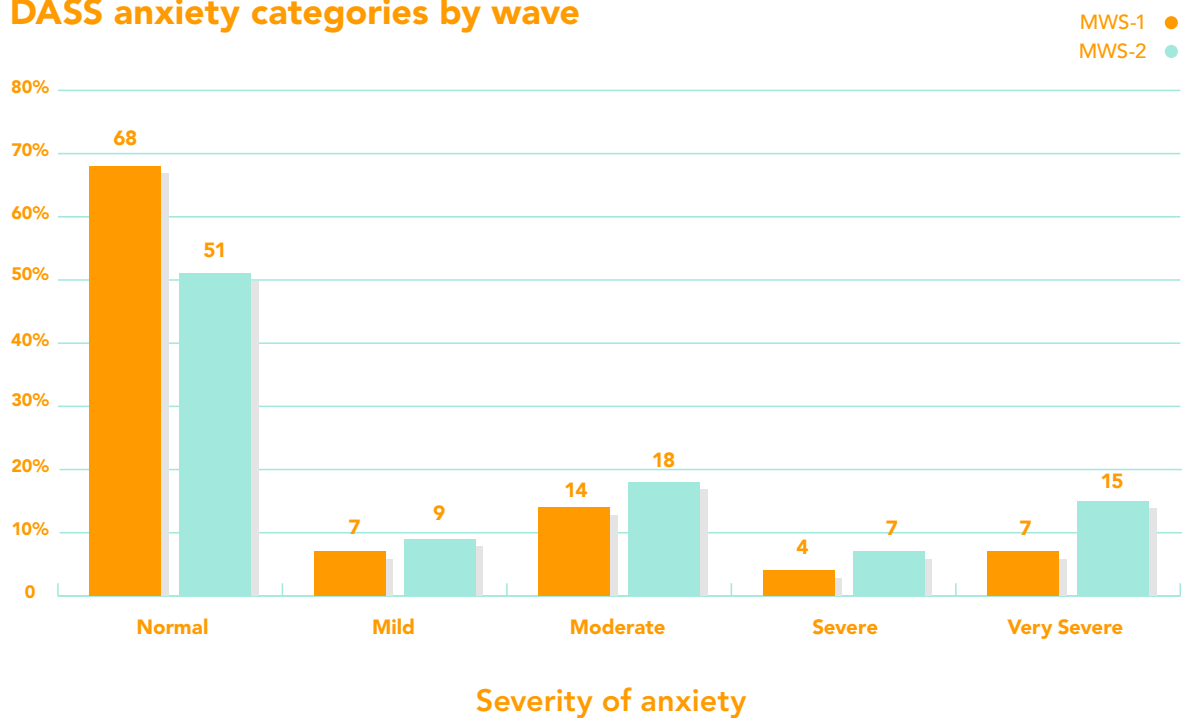
### Anxiety categories

Similar to the findings on depression, adolescents in MWS-2 exhibited significantly higher levels of anxiety (M=9.38, SD=8.95) than adolescents in MWS-1 (M=6.37, SD=7.33). They were less likely to be in the normal range and more likely to be in the mild, moderate, severe or very severe ranges for anxiety (see Figure 8.2).

The proportion of adolescents reporting very severe anxiety has more than doubled

Figure 8.2.

### DASS anxiety categories by wave



Adolescents are now more likely to be in the

**mild, moderate, severe or very severe**

ranges for depression and anxiety

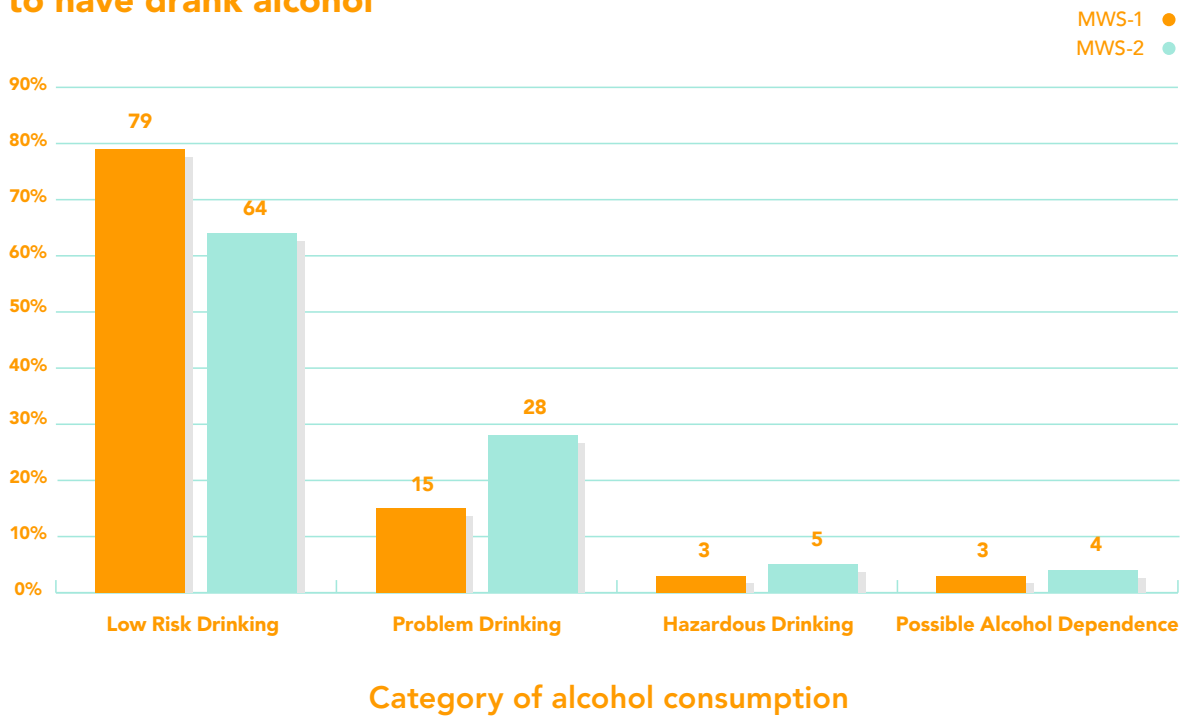
More likely to report that they never drank alcohol

### Alcohol behaviour

Adolescents in MWS-2 were more likely to report that they never drank alcohol (58%) than adolescents in MWS-1 (49%). They were also less likely to report drinking monthly (15% vs 18% in MWS-1) and weekly (4% vs 10% in MWS-1). However, of those who reported drinking alcohol, adolescents in MWS-2 were more likely to be in the problem drinking and hazardous drinking categories for alcohol behaviour than adolescents in MWS-1 (see Figure 8.3).

Figure 8.3.

### Alcohol behaviour by wave, in those who reported to have drunk alcohol



Increase in those reported to have smoked cannabis

### Cannabis use

For MWS-2, 15% of adolescents reported to have smoked cannabis whereas 12% of adolescents in MWS-1 reported this. The reported age of first use was similar across both samples (15 years).

### 8.1.3. Positive Domains

#### Self-esteem

Adolescents in MWS-2 (M=26.99, SD=6.09) displayed significantly lower levels of self-esteem than adolescents in MWS-1 (M=28.67, SD=5.7).

#### Optimism

Similar to self-esteem, adolescents in MWS-2 (M=12.85, SD=4.78) showed significantly lower levels of optimism than adolescents in MWS-1 (M=13.83, SD=4.69).

#### Satisfaction with life

Adolescents in MWS-2 (M=31.61, SD=7.09) showed significantly lower levels of life satisfaction than their peers in MWS-1 (M=32.19, SD=7.08).

#### Coping strategies

Adolescents in MWS-2 (42%) were less likely to report coping well with problems than adolescents in MWS-1 (49%). Although adolescents in MWS-2 (M=17.06, SD=5.55) engaged in significantly higher levels of planned coping than adolescents in MWS-1 (M=16.21, SD=5.64), they also showed significantly higher levels of avoidance-based coping (MWS-2 M=16.83, SD=6.22 vs MWS-1 M=15.56, SD=6.07). Females in MWS-2 reported significantly lower levels of support-focused coping (M=15.01, SD=5.23) than females in MWS-1 (M=16.13, SD=5.34) while males in MWS-2 reported significantly higher levels of support-focused coping (M=13.31, SD=4.99) than males in MWS-1 (M=12.98, SD=5.1).

#### Resilience

Adolescents in MWS-2 displayed significantly lower levels on all subscales of resilience (personal competence M=28.03, SD=5.8, social competence M=18.49, SD=8.79 and family cohesion M=23.33, SD=4.93) than adolescents in MWS-1 (PC; M=29.07, SD=5.26, SC; M=19.17, SD=3.5 and FC; M=23.05, SD=4.78).

#### Connectedness

Adolescents in MWS-2 (M=20.05, SD=4.65) showed significantly lower levels of school connectedness than adolescents in MWS-1 (M=20.40, SD=4.41). There was no significant difference observed in peer connectedness.

#### Social support

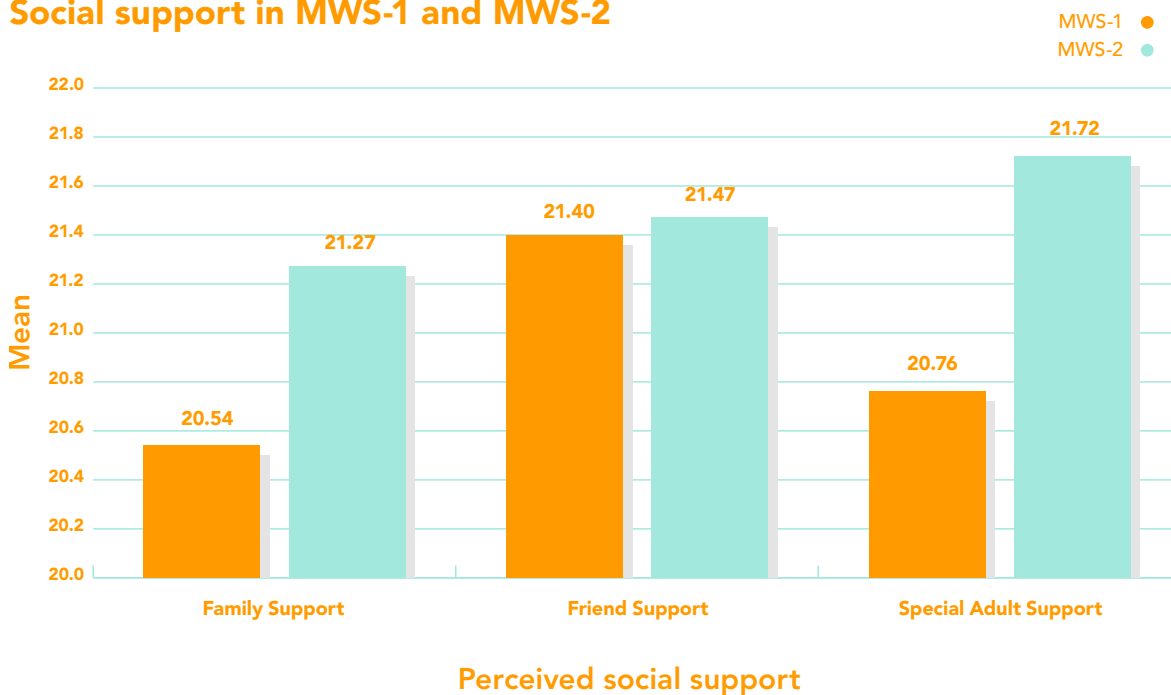
Overall, adolescents in MWS-2 (M=64.5, SD=15.14) displayed significantly higher levels of social support than adolescents in MWS-1 (M=62.29, SD=15.49). As shown in Figure 8.5, adolescents in MWS-2 also reported significantly higher levels of family support (M=21.27, SD=5.78) and adult support (M=21.72, SD=6.06) than adolescents in MWS-1 (family support M=20.54, SD=5.78; adult support M=20.76, SD=5.93).

42%  
coping well in MSW-2

49%  
coping well in MSW-1

Figure 8.4.

## Social support in MWS-1 and MWS-2



**76%**

reported presence of One Good Adult® in MSW-2

Adolescents in MWS-2 (76%) were much more likely to report the presence of One Good Adult® than adolescents in MWS-1 (71%).

### Help-seeking behaviour

In terms of dealing with problems, adolescents in MWS-2 (59%) were less likely to talk about them with anyone compared to adolescents in MWS-1 (66%).

**71%**

reported presence of One Good Adult® in MSW-1

For those who responded that they talk about their problems, adolescents in MWS-2 were more likely to report that they would talk to their family (56%) than adolescents in MWS-1 (44%). Adolescents in MWS-2 were less likely to report that they would talk to their friend (36%) than adolescents in MWS-1 (43%).

# Young Adult Findings

## 8.1.4. Personal wellbeing and lifestyle factors

### Enjoying family life

Young adults in MWS-2 (32%) were much less likely to report that they enjoy family life than young adults in MWS-1 (66%). They were much more likely to report that they sometimes enjoyed family life (62%) than young adults in MWS-1 (31%).

### Bullying

Young adults in MWS-2 (56%) were less likely to report having been bullied than young adults in MWS-1 (62%). They were also less likely to report having seen bullying (81%) than young adults in MWS-1 (88%).

### Stressed by financial situation

Young adults in MWS-2 (48% highly/often stressed) were less likely to report being stressed by their current financial situation than young adults in MWS-1 (60% highly/often stressed). However, young adults in MWS-2 (60%) were more likely to report feeling highly stressed about the pressure to work outside of their college/university course than young adults in MWS-1 (40%).

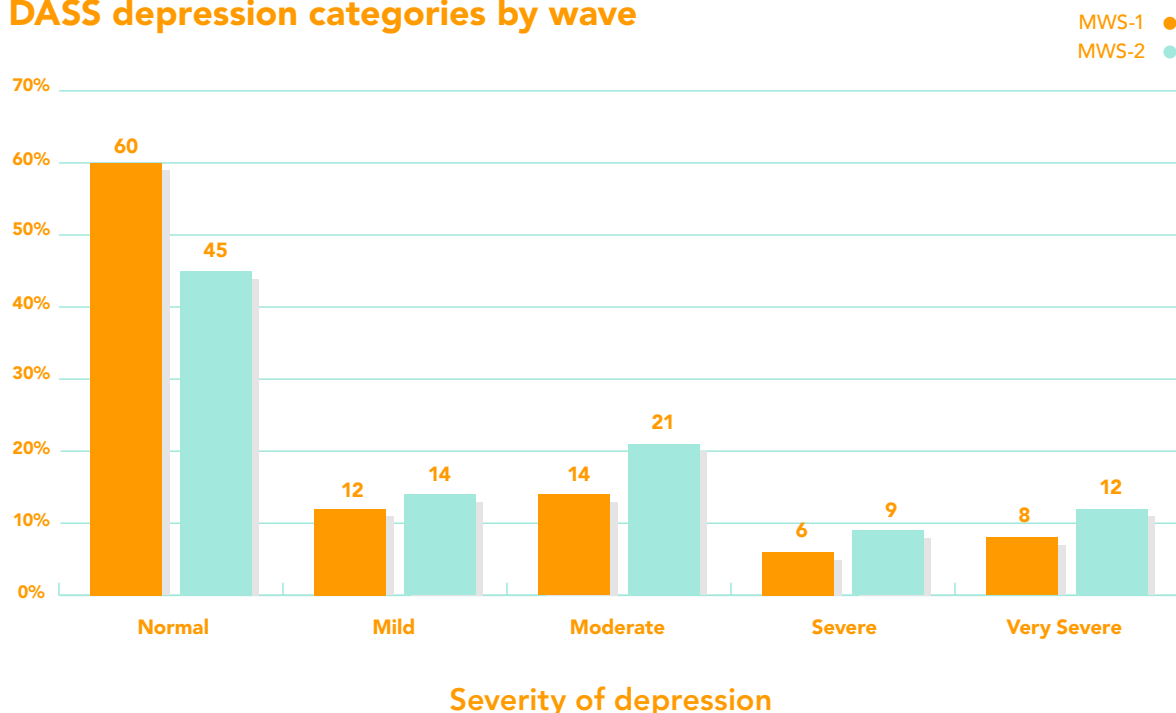
## 8.1.5. Negative domains

### Depression and anxiety

Similar to adolescents, young adults in MWS-2 ( $M=12.83$ ,  $SD=10.57$ ) reported significantly higher levels of depression than young adults in MWS-1 ( $M=9.92$ ,  $SD=9.63$ ). They were less likely to be in the normal range and more likely to be in the moderate, severe or very severe ranges for depression than young adults in MWS-1 (see Figure 8.6).

Figure 8.5.

### DASS depression categories by wave

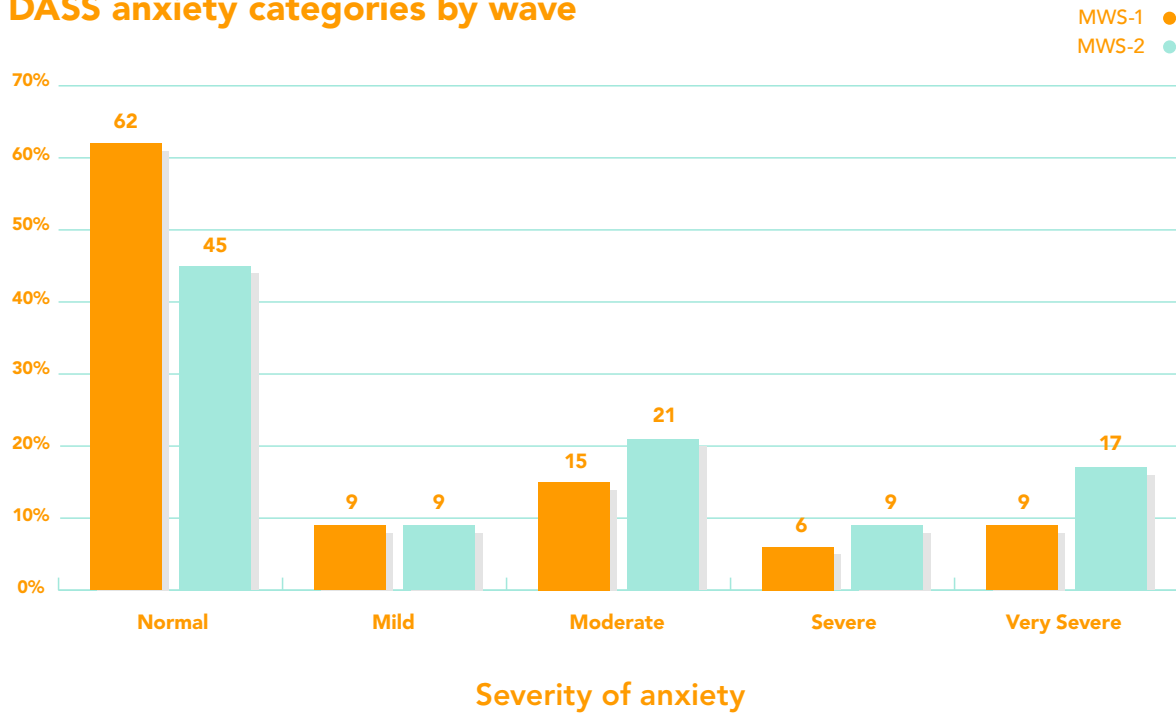




Again, for anxiety, young adults in MWS-2 ( $M=10.3$ ,  $SD=8.78$ ) displayed significantly higher levels of anxiety than young adults in MWS-1 ( $M=7.15$ ,  $SD=7.65$ ). These young adults were less likely to be in the normal range and more likely to be in the moderate, severe or very severe ranges for anxiety (see Figure 8.7).

Figure 8.6.

### DASS anxiety categories by wave



### Suicidality

Young adults in MWS-2 (33%) were much more likely to report having deliberately hurt themselves without wanting to take their own life than young adults in MWS-1 (22%). Over half of the sample in MWS-2 (53%) reported that they had thought that life was not worth living at some point, whereas 43% of adolescents in MWS-1 reported this. More young adults in MWS-2 (60%) reported having thought about taking their own life even though they would not do it with 52% of young adults in MWS-1 reporting this. Finally, young adults in MWS-2 (8%) were more likely to report having made a suicide attempt than young adults in MWS-1 (7%).

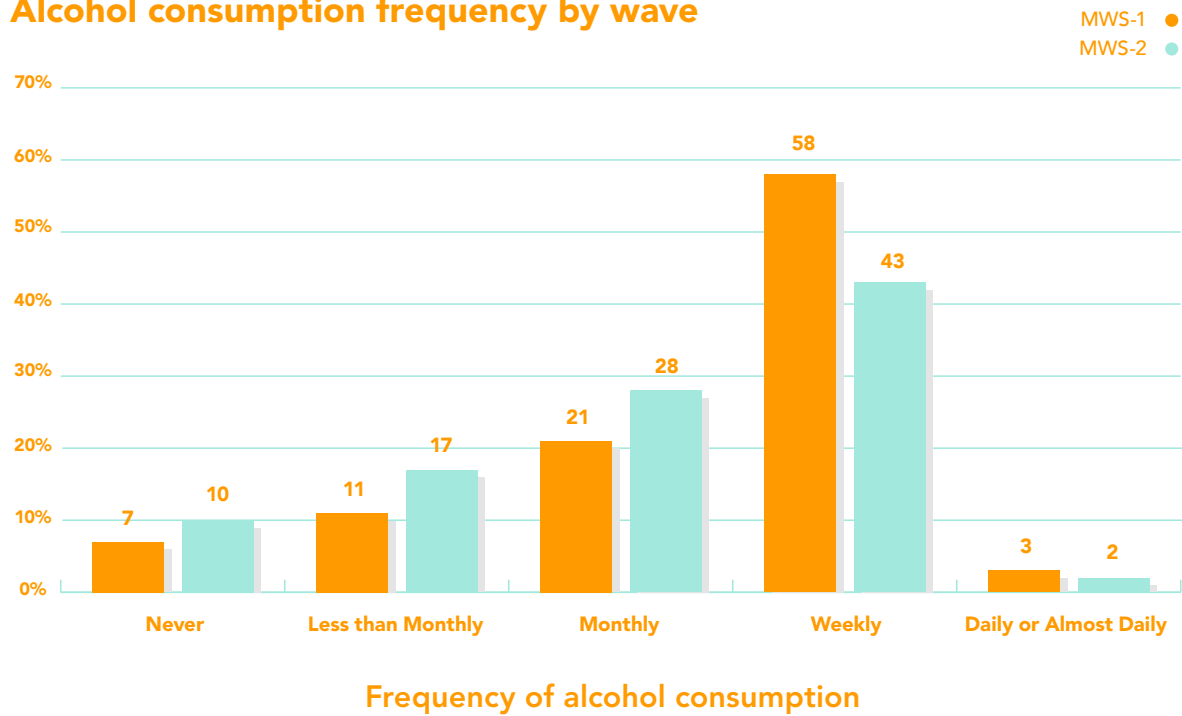
Of those who accessed support for a suicide attempt, those in MWS-2 (18%) were less likely to report that it was easy/very easy to access that support than those in MWS-1 (37%).

### Alcohol behaviour

Similar to adolescents, young adults in MWS-2 (10%) were more likely to report that they never drank alcohol than young adults in MWS-1 (7%). They were also more likely to report drinking less frequently than those in MWS-1 (see Figure 8.8).

Figure 8.7.

### Alcohol consumption frequency by wave



**10%**

never drank alcohol  
in MSW-2

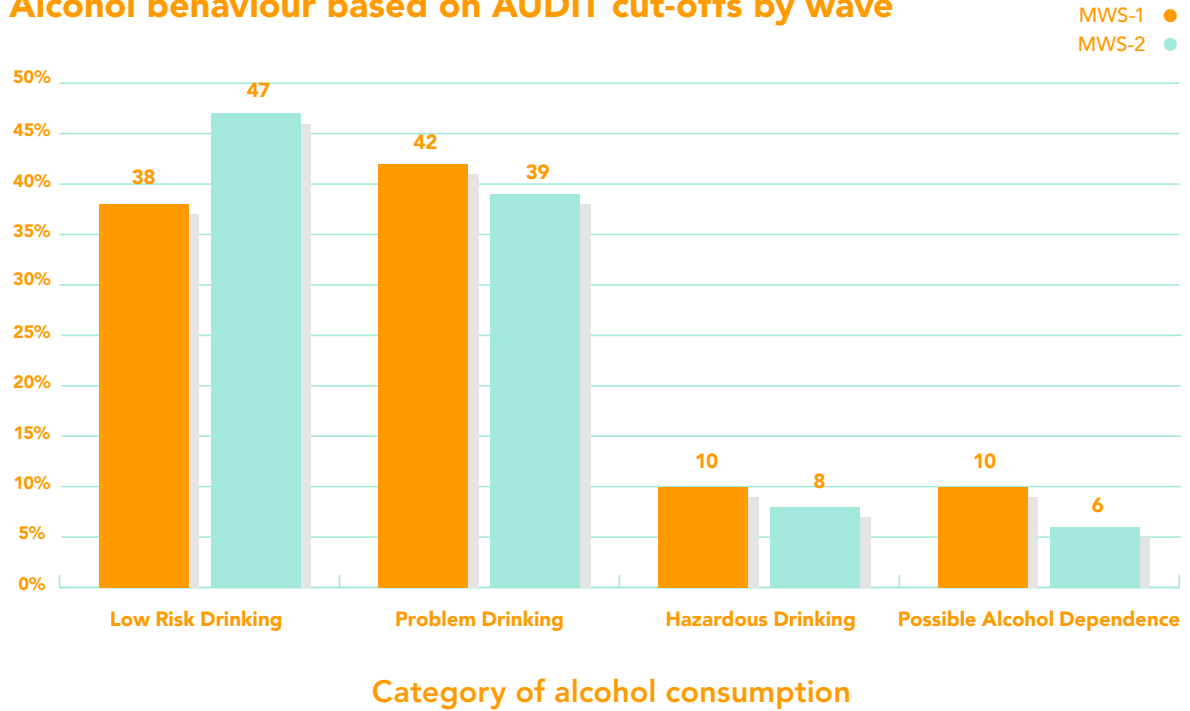
**7%**

never drank alcohol  
in MSW-1

Of those who reported drinking alcohol, young adults in MWS-2 were more likely to be in the low-risk range than young adults in MWS-1. They were also less likely to be in the problem drinking, harmful and hazardous drinking and possible alcohol dependence categories than those in MWS-1 (see Figure 8.9).

Figure 8.8.

### Alcohol behaviour based on AUDIT cut-offs by wave



**47%**  
in low-risk range for  
alcohol use in MSW-2

**38%**  
in low-risk range for  
alcohol use in MSW-1

### 8.1.6. Positive domains

Young adults in MWS-2 reported significantly lower levels of self-esteem, optimism, planned coping, support-focused coping and friend support and significantly higher levels of avoidance-based coping than young adults in MWS-1 (see Table 8.1 for mean scores).

**self-esteem**  
**optimism**  
**coping**  
**friend support**

lower in MWS-2

Table 8.1.  
**Mean scores for positive domains in MWS-1 and MWS-2**

	MWS-1 M (SD)	MWS-2 M (SD)
Self-esteem	28.1 (5.8)	26.21 (6.19)
Optimism	13.56 (5.47)	11.97 (5.18)
Planned coping	17.01 (5.16)	16.63 (4.8)
Support-focused coping	13.75 (4.75)	12.83 (4.65)
Avoidance-based coping	17.37 (6.11)	18.77 (6.11)
Friend support	20.67 (5.66)	20.21 (5.46)

Young adults in MWS-2 (15%) were less likely to report the absence of One Good Adult® than young adults in MWS-1 (18%).

**15%**

absence of  
One Good Adult®  
in MSW-2

**18%**

absence of  
One Good Adult®  
in MSW-1

## Help-seeking behaviour

### Talking about problems

Similar percentages of young people reported that they do not talk about their problems in both waves. In MWS-2, 40% of young adults reported that they do not talk about their problems and 38% of young adults reported this in MWS-1. Where young adults reported that they did talk about their problems, young adults in MWS-2 (42%) were more likely to report talking to their family than young adults in MWS-1 (33%). On the other hand, young adults in MWS-1 (50%) were more likely to talk to their friends than young adults in MWS-2 (42%).

### Sources of help

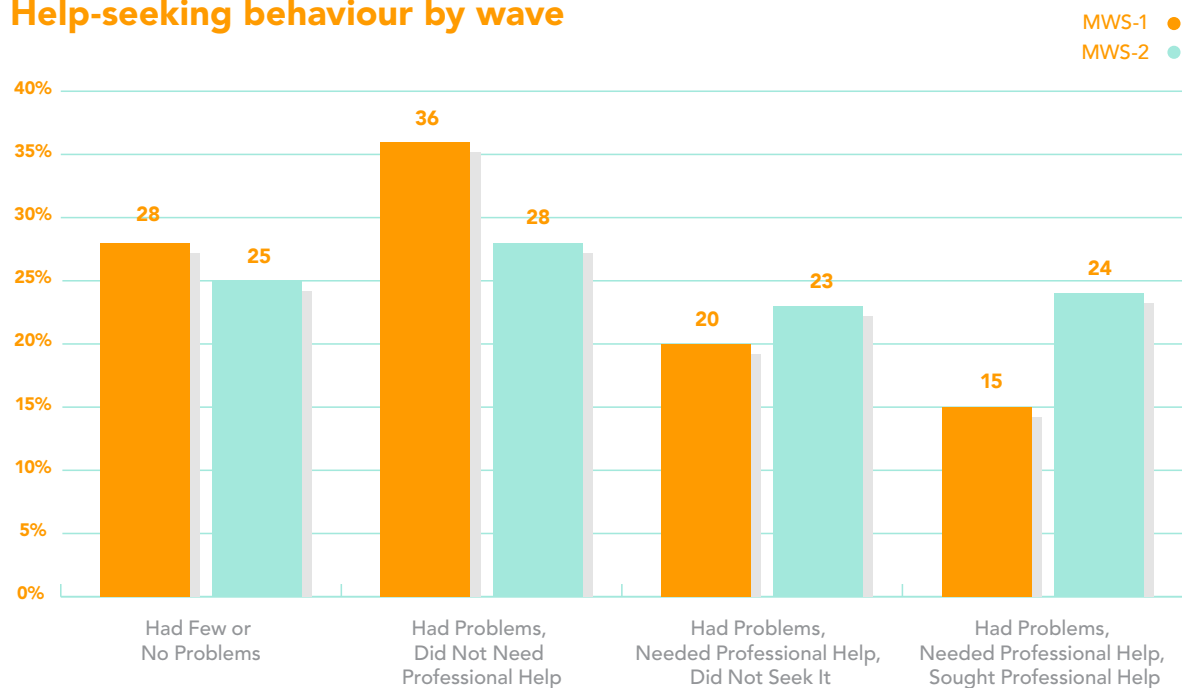
Young people in MWS-2 were more likely to report approaching student counselling (13% vs 10% in MWS-1) and more likely to report approaching a psychologist/counsellor/therapist (30% vs 24% in MWS-1) in relation to support for their mental health. Young people in MWS-1 were more likely to report that they would be very likely to approach their friends (30% vs 24% in MWS-2), parents (28% vs 21% in MWS-2), relatives (30% vs 17% in MWS-2) or their Doctor/GP (14% vs 10% in MWS-2) for support.

### Mental Health Barometer

Young adults in MWS-2 were less likely to report having few problems than young adults in MWS-1; however, if they reported problems, they were more likely to seek professional help (see Figure 8.10).

Figure 8.9.

### Help-seeking behaviour by wave



### Help seeking behaviour

## Summary

This chapter presents comparative data on adolescents in MWS-1 data collected (2010/11) and MWS-2 data collected (2018/19).

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### 8.1.7. Adolescents

Overall, findings indicated significant increases from MWS-1 to MWS-2 in:

- **Depression**
- **Anxiety**
- **Avoidance-based coping**
- **Problem-based coping**
- **Family support**  
(with an increase in proportion who report talking to their families about their problems)
- **Adult support**

Furthermore, there were significant decreases from MWS-1 to MWS-2 in:

- **Self-esteem**
- **Optimism**
- **Life satisfaction**
- **Resilience**
- **School connectedness**
- **Talking about problems**
- **Number of adolescents engaging in alcohol behaviour,**  
however, for those who are consuming alcohol, they are more likely to be engaging in more problematic behaviours

Data on negative and positive domains for adolescents across MWS-1 and MWS-2 are presented in Table 8.2.

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Table 8.2.

## Summary of key findings among adolescents between MWS-1 and MWS-2

Indicator	Summary	MWS-1	MWS-2
Negative Domains			
Bullying	Between MWS-1 and MWS-2, there was a decrease in the proportion of adolescents who reported being bullied.	45%	39%
Depression	There was an increase in the proportion of adolescents who fell into the severe and very severe categories for depression.	8%	15%
Anxiety	There was an increase in the proportion of adolescents who fell into the severe and very severe categories for anxiety.	11%	22%
Ever drank alcohol	There was a decrease in the proportion of adolescents who reported having ever drank alcohol.	51%	42%
Problem or hazardous drinking behaviour	For those adolescents who reported drinking alcohol, there was an increase in the proportion who were in the problem and hazardous drinking categories for alcohol behaviour.	18%	33%
Cannabis use	There was an increase in the proportion of adolescents who reported to have smoked cannabis. However, the age of first trying cannabis remained stable, with 45% reported to have tried it at ages 14 or 15 years in both MWS-2 and MWS-1.	12%	15%
Positive Domains			
Coping well with problems	There was a decrease in the proportion of adolescents reporting that they coped well with problems.	49%	42%
Talking about problems	There was a decrease in the proportion of adolescents who reported talking about their problems.	66%	59%
Talking to family about problems	For those who talked about their problems, there was an increase in the proportion of adolescents who reported talking to their family.	44%	56%
Talking to friends about problems	For those who talked about their problems, there was a decrease in the proportion who reported talking to friends.	43%	36%

### 8.1.8. Young Adults

Overall, findings indicated significant increases from MWS-1 to MWS-2 in:

- **Depression**
- **Anxiety**
- **Non-suicidal deliberate self-harm**
- **Suicidal thoughts**
- **Suicide attempts**
- **Avoidance-based coping**

Furthermore, there were significant decreases from MWS-1 to MWS-2 in:

- **Alcohol behaviour**  
(for those who were consuming alcohol, they were more likely to be in the low-risk category for alcohol behaviour)
- **Self-esteem**
- **Optimism**
- **Problem-based coping**
- **Support-focused coping**
- **Friend support**

Data on negative and positive domains for young adults across MWS-1 and MWS-2 are presented in Table 8.3.

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Table 8.3.

## Summary of key findings among young adults between MWS-1 and MWS-2

Indicator	Summary	MWS-1	MWS-2
<b>Negative Domains</b>			
Bullying	Between MWS-1 and MWS-2, there was a decrease in the proportion of young adults who reported being bullied.	62%	56%
Stressed by financial situation	There was a decrease in the proportion of young adults who reported being stressed by their current financial situation.	60%	48%
Depression	There was an increase in the proportion of young adults who fell into the severe and very severe categories for depression.	14%	21%
Anxiety	There was an increase in the proportion of young adults who fell into the severe and very severe categories for anxiety.	15%	26%
Deliberate self-harm	There was an increase in the proportion of young adults who reported having deliberately hurt themselves without wanting to take their own life.	22%	33%
Thought life was not worth living	There was an increase in the proportion of young adults who reported having thought that life was not worth living.	43%	53%
Suicide attempt	There was an increase in the proportion of young adults who reported having made a suicide attempt.	7%	8%
Ease of accessing support after a suicide attempt	There was a decrease in the proportion of young adults who reported that it was easy/very easy accessing support after a suicide attempt.	37%	18%
Ever drank alcohol	There was a decrease in the proportion of young adults who reported having ever drank alcohol.	93%	90%
Frequency of drinking weekly	For young adults who drank alcohol there was a decrease in the proportion of young adults who reported drinking weekly.	58%	43%
Problem, hazardous or possible alcohol dependence drinking categories	For those who drank alcohol, there was a decrease in the proportion who were in the problem, hazardous and possible alcohol dependence categories for alcohol behaviour.	62%	53%
<b>Positive Domains</b>			
Presence of One Good Adult®	There was a decrease in the proportion of young adults reporting the absence of One Good Adult®.	18%	15%
Talking about problems	The proportion of young adults who reported talking about their problems remained stable.	62%	60%
Talking to family about problems	For those who talked about their problems, there was an increase in the proportion of young adults who talked to their family.	33%	42%
Talking to friends about problems	For those who talked about their problems, there was a decrease in the proportion who talked to their friends.	50%	42%
Formal help-seeking	There was an increase in the proportion of young adults who reported having some problems and seeking professional help for these problems.	15%	24%

All differences reported here were statistically significant at  $p \leq .01$  level.

# Chapter 9:

## Summary and Conclusions

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My World Survey 2 aimed to capture up-to-date information on the mental health of young people in Ireland aged 12-25 years. This study was the second wave of research examining potential risk and protective factors in relation to young people's mental health. The research involved the participation of over 19,000 young people in Ireland; from second-level education, third-level education, employed groups and seldom heard groups.

MWS-2 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 allow us to see how different elements and experiences in the life of a young person are related to their mental health. Two waves of data collection enable us, for the first time, to examine increases, decreases or stability in key risk and protective factors associated with mental health.

The complexity of the data gathered in MWS-2 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 sleep, body image and social media use.

This chapter expands on key mental health indicators outlined in previous chapters. In doing this, we adopted Bronfenbrenner's (1979; 2000) Ecological Model of Human Development which involves studying an individual across multiple contexts; studying the individual, their relationships with family and friends, the context of their education or work and society in general.

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# Key Findings

## 9.1.1. Adolescents

In relation to levels of depression, 60% of adolescents were classified as having normal levels of depression, 11% were in the mild range, 15% in the moderate, 6% in the severe and 9% in the very severe range. Males were more likely to be classified in the normal range and females were much more likely to be in the severe and very severe categories.

Similar to the breakdown for depression, 51% of adolescents were within the normal range for anxiety, 9% were in the mild range, 18% in the moderate range, 7% in the severe range and 15% in the very severe range. Again, males were more likely to fall into the normal range for anxiety than females.

Among the adolescents surveyed, 23% reported that they had deliberately hurt themselves without wanting to take their own life at some point, 41% had thought about taking their own life even though they would not do it and 6% of adolescents reported to have made a suicide attempt, with similar rates across gender and school cycle.

Over half of the adolescent sample (57%) reported that they have never drunk alcohol, 22% reported doing so less than monthly, 16% monthly, 4% weekly and <1% daily. Of those who had drunk alcohol, 65% fell into the low-risk drinking range, 28% were classified as problem drinkers, 4% as harmful and hazardous drinkers, and 3% as potentially alcohol-dependent. Top endorsed stressors for adolescents were related to their education (school, exams and homework).

Overall, adolescents scored above the midpoint on various standardised measures of positive wellbeing, indicating average levels of self-esteem, body esteem, personal competence, social competence, family cohesion, optimism and life satisfaction. Males reported significantly higher self-esteem, optimism and life satisfaction than females.

When adolescents are faced with problems, 60% reported that they talk about them with someone. Females (63%) were more likely than males (56%) to talk to someone about their problems.

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## 9.1.2. Young adults

Approximately 42% of young adults were classified as being in the normal range for depression, 14% in the mild range, 20% in the moderate range, 10% in the severe and 13% in the very severe range. There was no association observed between depression and gender.

Similarly, 42% of young adults were classified as being within the normal range for anxiety, 9% in the mild range, 21% in the moderate range, 9% in the severe and a further 19% in the very severe range. Unlike depression, an association was observed between gender and anxiety where males were more likely to be in the normal range and females were more likely to be in the very severe range for anxiety.

A total of 38% of the sample reported that they had ever deliberately hurt themselves without wanting to take their own life and 12% of young adults reported that they had ever deliberately hurt themselves wanting to take their own life. Nearly two-thirds of the sample (63%) had ever thought about taking their life though they 'would not do it' and 10% of young adults reported a suicide attempt.

One in ten young adults reported that they do not drink alcohol, 17% reported that they drink less than monthly, 29% monthly, 42% weekly and 2% daily or almost daily. Of the young adults who reported drinking alcohol, 49% fell into the range for low risk drinking behaviour, 38% into the problem drinking range, 7% into the harmful and hazardous drinking range and 6% were classified as having a possible alcohol dependence. A total of 53% of young adults reported that they had smoked cannabis in their lifetime and 40% reported using drugs other than those required for medical reasons. Exams, the future and finance were the most salient endorsed stressors for young adults.

Young adults scored slightly below the midpoint in terms of optimism and body esteem. Their scores on the self-esteem and resilience standardised measures centred around the scale midpoint. Young adults scored slightly above the midpoint in terms of life satisfaction. Similar to adolescents, males reported significantly higher levels of resilience, optimism, body esteem and self-esteem than females.

Nearly 40% of young adults reported that they did not talk about their problems. Overall, males (47%) were less likely to talk about their problems than females (36%). Where young adults indicated they do talk about problems, 45% would talk to their friends, 39% would talk to their family and 16% to other sources such as boyfriend, girlfriend or counsellor.

### 9.1.3. Seldom heard

Young people in Youthreach (29%) and in CFE (24%) were more likely to be in the very severe range for anxiety than young people in SL/PSL sample (15%) with no significant differences between these groups in depression.

Young people in Youthreach (32%), young people with physical disabilities (24%) and young people in CFE (20%) were much more likely to report having made an attempt to take their own life (9% in SL/PSL sample).

Young people in Youthreach reported significantly lower levels of family support than the SL/PSL sample while young people in CFE/community training reported significantly lower levels of family and friend support than the SL/PSL sample. There were no significant differences between young people with a physical disability and the SL/PSL sample in terms of social support.

---

**29%**

Youthreach sample and

**24%**

CFE sample were more likely to be in the very severe range for anxiety than young people in SL/PSL sample (**15%**)

---

**24%**

young people with a physical disability were much more likely to report having made an attempt to take their own life than young people in SL/PSL sample (**9%**)

## 9.1.4. Changes between MWS-1 and MWS-2

### Adolescents

Adolescents in MWS-2 reported significantly higher levels of depression and anxiety than adolescents in MWS-1. In MWS-2 they were more likely to report that they never drank alcohol (58%) than adolescents in MWS-1 (49%). However, of the adolescents who reported that they drink alcohol, they were more likely to engage in more problematic drinking than the adolescents who reported drinking in MWS-1.

Adolescents in MWS-2 reported significantly lower levels of self-esteem, optimism, satisfaction with life, personal competence, social competence and family cohesion than adolescents in MWS-1. In relation to problem solving, adolescents in MWS-2 displayed significantly higher levels of planned coping than adolescents in MWS-1, however, they also showed significantly higher levels of avoidance-based coping.

In terms of dealing with problems, adolescents in MWS-2 (59%) were less likely to talk about them with anyone compared to adolescents in MWS-1 (66%).

### Young adults

Young adults in MWS-2 reported significantly higher levels of depression and anxiety than young adults in MWS-1. In MWS-2 (33%) they were much more likely to reporting having deliberately hurt themselves without wanting to take their own life than young adults in MWS-1 (22%). Young adults in MWS-2 (8%) were more likely to reporting having made a suicide attempt than young adults in MWS-1 (7%).

Similar to adolescents, young adults in MWS-2 (10%) were more likely to report that they never drank alcohol than young adults in MWS-1 (7%). They were also more likely to report drinking less frequently than those in MWS-1. Of those who reported drinking alcohol, young adults in MWS-2 were more likely to be in the low-risk range than young adults in MWS-1.

Young adults in MWS-2 reported significantly lower levels of self-esteem, optimism, planned coping, support-focused coping and friend support and significantly higher levels of avoidance-based coping than young adults in MWS-1.

Similar percentages of young people reported that they do not talk about their problems in both waves. In MWS-2, 40% of young adults reported that they do not talk about their problems and 38% of young adults reported this in MWS-1. Where young adults reported that they did talk about their problems, young adults in MWS-2 (42%) were more likely to report talking to their family than young adults in MWS-1 (33%). On the other hand, young adults in MWS-1 (50%) were more likely to talk to their friends than young adults in MWS-2 (42%).



# Conclusions

## 9.1.5. Personal Wellbeing and Lifestyle Factors

### Physical activity and appearance-altering strategies

Both adolescents and young adults who reported getting the recommended amount of physical activity enjoyed better mental health. They were more likely to be in the normal ranges for depression and anxiety. They also indicated higher levels of self-esteem, body esteem, optimism and resilience than their peers. This is in line with international research showing the link between physical activity and mental wellbeing (see Dale, Vanderloo, Moore, & Faulkner, 2019 for review) and indicates a potential point of intervention for young people.

Furthermore, both adolescents and young adults who reported low body esteem indicated higher levels of anxiety and depression than their peers with higher body esteem. Related to body esteem, over two-thirds of adolescents had engaged in appearance-altering strategies. For males, this involved predominantly muscle-building, while for females, this involved strategies to lose weight or to avoid gaining weight, typically through exercise. In the adolescent sample, 63% of males indicated that they had tried to bulk up or maintain muscle mass. A similar proportion of males bulking up was found in the young adult sample. However, there was a marked difference among females, with 31% of adolescent females reporting trying to bulk up compared to 20% of young adult females. Given the mean age of adolescent males in the sample is 14.80 years, this is a high proportion of particularly young males bulking up. Little has been done in Ireland to address appearance-related concerns; to promote greater body acceptance among young people and to ensure adolescents, in particular, avoid engaging in harmful appearance altering strategies. Given the link between mental health and body-altering strategies, the current research highlights the potential value of developing and evaluating body image programmes which may impact not only on body image but also have associated benefits for mental health and wellbeing.

### Sleep hygiene

Good sleep hygiene was linked with better mental health in both adolescents and young adults. Adolescents and young adults who reported good sleep hygiene indicated higher levels of resilience, self-esteem and body esteem compared to those with poor sleep hygiene. These findings support conclusions from various reviews which observe that inadequate sleep results in poor mental health outcomes (Chaput et al., 2016; Shocat, Cohen-Zion, & Tzischinsky, 2014). For both adolescents and young adults, females were also less likely to get the recommended amount of sleep. Females not getting sufficient sleep were likely to experience more severe anxiety and depression compared to males not getting adequate sleep. A further finding showed that there was a decrease in good sleep hygiene across the school year, with only 1 in 3 sixth-years in second-level getting adequate sleep as defined by the National Sleep Foundation. This is an important finding for both school and parents given the significance of the final year in preparing for the terminal exam of second-level education. It should be noted that good sleep hygiene is better among the young adults. Approximately two-thirds of young adults reported good sleep hygiene. Finally, over a third of young adults reported poor sleep hygiene and this group was more likely to report being absent from work or college and to report risky drug and alcohol behaviour.

### Alcohol and drug use

As was reported in MWS-1 and again observed in MWS-2, problematic alcohol use was associated with more severe feelings of anxiety and depression. Although over half of adolescents reported to have never drunk alcohol, there was an increase in levels of problematic drinking across the school year for adolescents who reported to engage in drinking. Building on MWS-1, findings from MWS-2 also showed a significant association between problematic drug use and depression and anxiety. In adolescents, cannabis use increased across the school year, and by the time adolescents

reached sixth year, 1 in 3 had smoked cannabis. Among young adults, over 50% reported smoking cannabis in their lifetime. With regard to drug use, 40% of young adults reported that they had used drugs other than those required for medical reasons. In the young adult sample, polysubstance use was evident, where young adults classified in the moderate-to-severe categories for drug use were more likely to be engaging in very risky alcohol behaviour.

Of note, adolescents and young adults who reported to have made a suicide attempt displayed significantly higher levels of problematic drinking and were more likely to have smoked cannabis (among adolescents) or have used illicit drugs (among young adults) than those who did not attempt suicide. Literature points to the strong association between engaging in illicit drug use and alcohol use. DuPont, Han, Shea and Madras (2018) found evidence in support of multiple drug use among youth, therefore, it is recommended not to look at any one drug in isolation i.e., solely cannabis use or alcohol behaviour, as youth engaging in high risk behaviours are likely to do this across multiple contexts. Given the significant relationship between substance misuse and poorer mental health outcomes and increased suicidal behaviour, it is important to implement policies that specifically address the use of illicit drugs and alcohol misuse among young people in Ireland.

### **Suicidality**

Deliberate self-harm is one of the strongest predictors of suicide (McMahon et al., 2014; Vuagnat, Jollant, Abbar, Hawton, & Quantin, 2019) and continues to be one of the leading causes of death in young people worldwide (WHO, 2016). In this study, almost 1 in 4 adolescents reported to have engaged in non-suicidal deliberate self-harm, while this was 2 in 5 among young adults. In a Swedish study (Landstedt & Gillander Gådin, 2011), a lifetime history of deliberate self-harm was reported by 17% of students and was more common among girls (23%) than among boys. This self-harm rate is lower than the adolescent sample in MWS-2, which is 23% (26% female in MWS-2), however data were collected before 2011. As expected, both adolescents and young adults

who had engaged in deliberate self-harm or who had attempted suicide were significantly higher on all risk factors and lower on protective factors in comparison to their peers who did not engage in these behaviours.

Although many young people who attempt to take their life do not die by suicide (Owens, Horrocks, & House, 2002), our data indicated that these young people who have made a suicide attempt are experiencing a broad spectrum of psychological distress and are in need of support. In addition, our data indicate that many young people whom have made a suicide attempt reported finding it difficult to get the support they needed after an attempt. Among the few who did get support, most reported that the support was at least somewhat helpful. For all of the seldom heard samples in MWS-2, the rates of suicide were significantly higher than their age-matched peers, indicating the vulnerability of these groups. In addition, young adults who identified as LGBAP in MWS-2 were more likely to report that they had deliberately hurt themselves without wanting to take their own life, and to report that they had ever made an attempt to take their own life. In the Connecting for Life Suicide Strategy, some of the priority groups identified include young people aged 15-24 years, young people who identify as LGBT, people with drug or alcohol problems, or people with mental health difficulties, all of which were captured in MWS-2. More needs to be done to improve access (and awareness to access) to support following a suicide attempt. This has been identified as a goal in the Connecting for Life - Ireland's National Strategy to Reduce Suicide 2015-2020 (National Office for Suicide Prevention, 2015).

### **Social media use**

Findings from MWS-2 indicate a significant relationship between time spent online (more than 3 hours) and higher levels of depression and anxiety and lower levels of body esteem. There are several explanations for the potential link between time spent on social media and mental health issues among adolescents and young adults. For example, there is some evidence that time spent engaging with social media might displace other more important activities protective for mental



health such as sleep or face-to-face time with friends (Coyne, Rogers, Zurcher, & Stockdale, 2019; Scott & Woods, 2019). Another explanation is that a major motivating factor for using media in general involves escapism and diversion from everyday life (Kırcaburun & Griffiths, 2018). Indeed, the current research showed that young people who reported spending more than three hours online showed significantly higher levels of avoidant-based coping than their peers who reported spending less time online. It is also important to note that this research does not suggest a causal relationship between time online and poorer mental health. For instance, a young person who is feeling depressed may turn to social media to try to reduce their negative mood/depressed symptoms, to connect virtually with others or to escape from their problems.

Findings from the current research suggests that many adolescents and young adults are using their social media to build on and extend their social connections in real life and there may be some benefits to spending time online. Adolescents and young adults who reported spending less than 2 hours online a day had lower levels of support-focused coping and lower levels of perceived social support from friends than those who spend 2-3 hours online. Further research is needed to examine the context and content surrounding social media use as the data provide evidence for both the potential risk and protective aspects of social media engagement.

### **Pornography**

Significant gender differences were observed in relation to watching pornography where females who reported watching pornography displayed significantly poorer mental health than females who do not watch pornography.

Females who watched pornography regularly were more likely to display elevated levels of depression, while this pattern was not evident for males who watched pornography regularly. This negative association between female pornography use and psychological wellbeing was also shown in a recent Croatian study among adolescents which suggested that the depiction of women in sexually explicit material may affect women's mood (Wright & Štulhofer, 2019). Regular pornography

use among both males and females was associated with lower self-esteem and body esteem. It should be noted that there is research suggesting that young people are differentially susceptible to the influence of the media (Valkenburg & Peter, 2013). Similar exposure to sexually explicit material could have a vastly different impact on young adults with distinct psychosocial profiles, thus further research is required.

### **Relationships**

The number one source of support for adolescents who experience problems was family. There was an increase in the proportion of adolescents who report talking to their friends about problems as they move through second-level school. However, the proportion of adolescents in the Senior Cycle who would talk to their family about problems was higher than friends. This highlights the important role of family even among older adolescents.

Notably, young people in Youthreach and in CFE showed significantly lower levels of family support than their matched peers. Furthermore, they were more likely to provide unpaid help for a family member with a long-term illness. These factors may put these young people at increased vulnerability in terms of their mental health, as evidenced by their higher level of anxiety in relation to their matched peers.

Adolescents who reported higher levels of parental criticism and lower parental approval had significantly higher levels of anxiety and depression, while adolescents who showed good mental health outcomes generally reported lower criticism from parents, a greater sense of shared family values, a stronger social network, and enjoying their family life. International research has indicated that perceived parental criticism may cause devaluing of the self, which in turn contributes to lower mood and increased depression symptoms (Bolton, Barrowclough, & Calam, 2009). Overall, what the data show are that to support and promote a young person's mental health, it is important to support families in understanding their key role in the lives of adolescents.

Similar to MWS-1, over three-quarters of adolescents and young adults reported that they have a special adult in their lives when in need, named as the One Good Adult® (OGA). To progress on what was learnt from MWS-1, in this study, more in-depth analyses were conducted on the importance of OGA among adolescents. Adolescents who reported that this OGA was very regularly or always available to them reported lower anxiety and depression, higher resilience and were less likely to have serious problems over the past year. In other words, adolescents who reported that they have a special adult in their life and that this OGA is very regularly available to them in time of need appear to display better mental health across a range of indicators. The OGA is also important in the lives of young adults. Among young adults, having an OGA was linked with lower levels of depression and anxiety, higher levels of life satisfaction, higher self-esteem, higher resilience and optimism. Furthermore, young adults reported that friends were their top source of support and that they would most likely talk to their friends if they had problems.

### **Stressful life events**

The most common stressful life events for adolescents and young adults centred around relationships, where over half reported to have someone close to them die, and over a third reported parental conflict. In general, both adolescents and young adults who experienced these stressful events had significantly higher levels of depression and anxiety, lower self-esteem, optimism, social support, and personal competence. Again, adolescents and young adults who reported violence in a romantic relationship (although this percentage was low) were more likely to report having experienced elevated levels of depression and anxiety.

Almost half (47%) of young adults reported that they had been touched against their will or without their consent and 20% said they had been forced or pressured to have sex. This is in line with international research which shows that 30% to 47% of female students in Poland, Spain, Germany and UK reporting at least one experience of an unwanted sexual act (European Institute for Gender

Equality, 2016). Young adults who reported sexual harassment were more likely to experience higher levels of depression and anxiety. The current data provide evidence of a link between sexual harassment, violence and mental health which may inform the work of Ending Sexual Harassment and Violence in Third Level Education (ESHTE) to understand the potential effects of sexual harassment and violence on women in the third-level sector in Ireland.

### **Wider Social Context**

Clear differences were observed between younger (first-, second- and third-year students) and older adolescents (fourth-, fifth- and sixth-year students) in relation to the risk and protective factors related to their mental health outcomes. Younger adolescents were significantly more likely to report higher personal competence and self-esteem (individual), greater enjoyment of family life, lower family conflict and greater family cohesion (family) and greater school connectedness including being less likely to be absent from school (school). Younger adolescents were also more likely to report few or no problems in the past year in line with previous research (Dooley, Fitzgerald, & Mac Giollaibhui, 2015). These findings support the aim set out in the National Wellbeing Policy Statement and Framework for Practice (2018-2023) to provide evidence-informed supports to promote wellbeing of all young people in second-level schools in Ireland, irrespective of school cycle.

Young adults who reported to have sought help mostly engaged with informal sources of support. Given the salience of peer relationships in emerging adulthood (Arnett, 2015), it is unsurprising that 74% of young people who accessed support for their mental health turned to their friends for that support. This indicates a potential burden placed on young adults to support each other in times of need and highlights the need to equip young adults with the resources to support their peers reaching out to them for help. This is in line with the recovery model for mental health given that connectedness and supportive relationships are a key element of wellbeing. Given that the majority of young adults in Ireland are in third-level education, there is

potential to offer education in terms of peer-led support for mental health and access to more formal sources of support within this context. Further research is needed to explore this in young adults in Ireland.

### **Relevance to broader society**

As highlighted by a national report on the economic costs of mental illness, the majority of economic costs occur outside the health sector itself and lie mostly in the labour market due to loss of productivity and absenteeism (O'Shea & Kennelly, 2008). MWS-2 findings showed the relative importance of mental health problems with regard to the number of days out-of-role (DOR; number of days for which a person is unable to carry out normal activities such as go to school/college or work because of health problems). Adolescents and young adults who reported a mental health difficulty or those who reported both a dual mental and physical health difficulty were significantly higher in number of days absent from school/college/work in the past month than those who reported a physical health difficulty or no long-term health difficulty. These findings indicate that mental health problems are potentially major contributors to loss of productivity among young people in Ireland. Notably, young people in Youthreach and in CFE were more likely to report having a long-term health difficulty than their matched peers. This further highlights the value of promoting and supporting the mental health of young people in Ireland, particularly among the seldom heard groups, to ensure that each individual reaches their potential.

### **The changing landscape of youth mental health in Ireland**

There was a notable increase in rates of anxiety and depression from MWS-1 to MWS-2 for both adolescents and young adults. There was also an increase in the rates of non-suicidal self-harm and suicide attempt among young adults. This trend is in line with data from the National Self-Harm Registry Ireland 2018 which reported that there was an increase in self-harm among young people aged 10-24 years. Changes in other risk factors from MWS-1 to MWS-2 common to both

adolescents and young adults included increases in avoidant coping behaviour and decreases in self-esteem and optimism. In terms of positive change, adolescents in MWS-2 were less likely to report having been bullied, were less likely to be in trouble with the Gardaí and were more likely to have never drunk alcohol in comparison to adolescents in MWS-1. This reduction in bullying among adolescents may indicate the value of the Department of Education and Skills Anti-Bullying Procedures (2013), which requires all schools to have an anti-bullying policy. For young adults, a positive change was observed with regard to alcohol behaviour, with a higher proportion in the low risk category compared to young adults in MWS-1.

Overall, the findings from MWS-1 to MWS-2 indicate increasing trends in some risk factors and decreasing trends in others making it difficult to draw conclusions about what may explain these trends. Therefore, going forward, there is a need to better understand the complex interrelationship between mental health and factors identified in this study in order to 1) know where and when to best intervene, and to 2) consider how best to prevent further increases in psychological distress among young people in the future.

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# Appendix 1:

## Methodology for Adolescent Sample

### Overview

This appendix provides further detail on the methodology used to conduct the MWS-2-Second Level (MWS-2-SL) study. The characteristics of the schools that took part are presented as well as a description of the survey instruments.

### Characteristics of post-primary schools

This appendix provides further detail on the methodology used to conduct the MWS-Second Level (MWS-SL) study. The characteristics of the schools that took part are presented as well as a description of the survey instruments.

#### DEIS and non-DEIS schools

- 65% of schools in the sample (n=54) were classified as non-DEIS
- 35% of schools in the sample (n=29) were classified as DEIS

#### CHO areas

Table A1.

#### Regions and Counties in nine CHO areas

Area 1	Donegal, Sligo/Leitrim/West Cavan, and Cavan/Monaghan	N=11, 13%
Area 2	Galway, Roscommon, and Mayo	N=8, 10%
Area 3	Clare, Limerick, and North Tipperary/East Limerick	N=8, 10%
Area 4	Kerry, North Cork, North Lee, South Lee, and West Cork	N=11, 13%
Area 5	South Tipperary, Carlow/Kilkenny, Waterford, and Wexford	N=11, 13%
Area 6	Wicklow, Dun Laoghaire, and Dublin South East	N=4, 5%
Area 7	Kildare/West Wicklow, Dublin West, Dublin South City, and Dublin South West	N=9, 11%
Area 8	Laois/Offaly, Longford/Westmeath, Louth, and Meath	N=11, 13%
Area 9	Dublin North, Dublin North Central, and Dublin North West	N=10, 12%

## Gender classification of schools in final sample

- Mixed gender (n=55, 66% of sample of schools)
- Single-sex males (n=11, 13% of sample of schools)
- Single-sex females (n=17, 21% of sample of schools)

## School type

- Secondary (n=45, 54% of schools in sample)
  - Vocational (n=27, 33% of schools in sample)
  - Community (n=11, 13% of schools in sample)
- 

## Description of MWS-2-SL

Paper-based and web-based MWS-2-SL surveys presented the same questions. The MWS-2-SL survey contained four major sections as follows:

1. Demographic characteristics
2. Personal wellbeing and lifestyle factors
3. Negative domains
4. Positive domains

Details of each section are described below. Note that sections with '\*' denote questions which were only presented to those in the Senior Cycle and were not presented to those in the Junior Cycle.

The scales included in the Negative and Positive Domains sections of the survey are standardised and have been shown to have good psychometric properties (reliability and validity).

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## Demographic characteristics

Participants were asked to provide details on:

- Age
  - Gender
  - School year
  - Sexual orientation
  - Family type
  - Marital status of parents
  - Parent education status
  - Parental employment status
  - Living situation
  - Religion
-

# Personal wellbeing and lifestyle factors

Adolescents were asked questions on their wellbeing and lifestyle.

These comprised of questions on:

- **Enjoying family life**  
(i.e., 'Do you enjoy family life?' with responses 'yes', 'no', 'sometimes')
- **Feelings of anger**  
(i.e., 'do you feel angry a lot?' with responses 'yes', 'no' and 'somewhat')
- **Long-term health difficulty**
- **Carer status**
- **School work**  
(‘In my school work, I am...’ with responses ‘at the top of the class’, ‘middle of the class’ and ‘at the bottom’)
- **Days absent from school in previous month**
- **Trouble with Gardaí**
- **Amount of sleep**
- **Level of physical activity**
- **Body image**
  - 'Have you ever tried to 'bulk up' or maintain muscle mass?'
  - 'Have you ever tried to lose weight or tried to avoid gaining weight?'
  - 'How satisfied are you with your body?'
  - 'Have you regularly (at least once a week) played one or more sports in the past six months?'
  - 'Have you regularly (at least once a week) attended the gym in the past six months?'
  - 'Have you regularly (at least once a week) participated in any other hobbies/volunteered in the past six months?'
- **Bullying**
  - Adolescents were asked 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 ('physically', 'verbally', 'emotionally') and where they were most frequently bullied ('in school', 'at home', 'online', 'by text').
- **Social media**
  - Adolescents were asked 'Do you have a social media profile or account on any sites of apps?'.  
Those who responded 'yes' were presented with questions related to how they spend their time online, including what sites they use, how long they spend on social media a day, experiences of cyberbullying and their privacy settings on the apps they use.
- **Pornography\***
  - Adolescents were presented with questions on watching pornography, how they accessed pornography and how often they watch pornography.

- **Relationships**
  - Adolescents were asked about the nature of their relationships with their best friend and boyfriend/girlfriend, if applicable. This included how long they have had the relationship, how they spend time with each other and how satisfied they are with the relationship.
- **Sexual behaviours\***
  - Adolescents were presented with various questions including 'Have you had sex?'. For those who responded 'yes', further questions on safe sex, number of sexual partners and age at which they first had sex were presented.
- **Top stressors**
  - Adolescents were asked to select their top stressors from a list of common problems, including school, parents, family, friends, relationships, exams, homework and money. They were also given the option to write their top stressor.
- **Coping with problems**

(i.e., 'Do you generally cope well with problems?' with responses 'yes', 'no' or 'sometimes')
- **Top coping strategies**
  - Adolescents were asked to select top ways that help them cope when things are tough, including friends, parents, family, talking, music, sleep, sport/exercise and playing video games. They were also given the option to write their top coping method.
- **Parents' mental health status and drug/alcohol addiction status**
- **Relationships with parents**
  - The Network of Relationships Inventory - Relationship Qualities Version (NRI-RQV; Furman & Buhrmester, 2009) 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 and satisfaction) and one negative relationship feature (criticism).
  - Mother and father approval and criticism were asked in MWS-2. Each subscale consists of three items, with responses ranging from 'never or hardly at all (1)' to 'always or extremely (5)'. Scores on each of the subscales range from 3 to 15. The NRI-RQV has previously been used among adolescents in Ireland and the internal consistency of all subscales has been estimated to be good (Kenny, 2011). Higher scores on these subscales indicate higher levels of approval/criticism.



# Negative domains

A number of standardised scales were used to assess negative domains in relation to mental health.

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

The DASS-21 is a self-report measure in which participants rate the frequency and severity of experiencing negative emotions over the previous week (Lovibond & Lovibond, 1995). Two subscales, Depression and Anxiety, were used in MWS-2. Frequency ratings are made on a 4-point scale, which ranges from 'does not apply to me at all (0)' to 'applies to me most of the time (3)'. The scale contains items on depression (e.g., 'I felt that I had nothing to look forward to'), and anxiety (e.g., 'I felt close to panic').

Using recommended cut-off scores (Lovibond & Lovibond, 1995), adolescents are classified as displaying low-risk, mild, moderate, severe, or very severe levels of depression and anxiety (see Table A2). The validity of the DASS-21 has been consistently demonstrated (Crawford & Henry, 2003; Henry & Crawford, 2005; Tully, Zajac, & Venning, 2009).

Table A2.

### Cut-off scores for classification of depression and anxiety

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

## 2. Suicidality

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

- 'Have you ever deliberately hurt yourself without wanting to take your life?'
- '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 6 months', 'within the last month'). 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, 2012), where the process starts with suicidal ideation, progressing towards planning an act and often recurrent suicide attempts, and may end with a fatal suicide.

Adolescents were 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.

### 3. Psychotic-like experiences

A shortened 3-item version of the Adolescent Psychotic-like Symptom Screener (APSS; Kelleher, Harley, Murtagh, & Cannon, 2011) was used to screen for psychotic experiences. These three items were selected as they have the greatest predictive power of psychotic-like experiences in an Irish sample. Response options are 'yes definitely (1)', 'maybe (0.5)', and 'no (0)'.

---

### 4. Alcohol Use Disorders Identification Test (AUDIT)

The AUDIT was developed by the World Health Organisation (WHO; 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 including alcohol consumption, signs of alcohol dependence and alcohol-related harm.

Adolescents were first asked how often they drink alcohol (from 'never' to 'daily or almost daily'). Next, among those who reported drinking alcohol, adolescents were 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'. Responses to these questions ranged from 'never (0)' to 'daily or almost daily (4)'.

The AUDIT has been shown to have good reliability and validity in numerous studies (Reinert & Allen, 2002; Shields, Guttmanova, & Caruso, 2004).

Table A3.

#### Classification categories for AUDIT

Classification	AUDIT cut-off scores
Low-risk drinking	<8
Problem drinking	8-15
Harmful and hazardous drinking	16-19
Possible alcohol dependence	≥20
Very severe	28-40

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### 5. Cannabis use

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

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## 6. Problem Gambling Severity Index (PGSI)

The Problem Gambling Severity Index (PGSI; Ferris & Wynne, 2011) is a 9-item scale of problem gambling, derived from the 31-item Canadian Problem Gambling Index (Ferris & Wynne, 2001). The PGSI uses a 4-point rating scale ranging from 'never (0)' to 'almost always (3)'. Items are summed and the range of scores lie between 0 and 27. Table A4 shows the categories for gambling behaviour in the PGSI. The PGSI has good criterion validity and has been shown to strongly correlate with similar measures such as the South Oaks Gambling Scale (Ferris & Wynne, 2011; Lesieur & Blume, 1987).

Table A4.

### Classification categories for the PGSI

Classification	PGSI cut-off scores
Non-gambler	0
Low-risk gambler	1-2
Moderate-risk gambler	3-7
Problem gambler	≥8

## 7. Stressful life events

A list of stressful life events was presented to adolescents. This list was adapted from items used in the National Longitudinal Study of Children and Youth in Canada (Statistics Canada, 2010). The following adverse life events were listed: 'moving house within Ireland', 'moving country', 'serious illness/injury of a friend', 'their house been broken into', 'conflict with parents', 'violence in a romantic relationship', and 'violence in the home'. Participants were also asked whether their mother, father or other guardian has a long-term problem such as a mental health problem or an alcohol or drug addiction.



# Positive domains

## 1. Rosenberg Self-Esteem Scale (RSE)

Self-esteem was 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 & Simmons, 1971). Scale response options range from 'strongly disagree (1)' to 'strongly agree (4)' 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. The RSE has shown strong psychometrics properties and has been used in several studies.

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## 2. Body Esteem Scale for Adolescents and Adults (BESAA)

The Body Esteem Scale for Adolescents and Adults (BESAA) is a 23-item scale consisting of three subscales measuring general feelings about appearance, weight satisfaction, and attribution; that is, judgements of how others view one's appearance. The Appearance subscale was used in the MWS-2. This subscale contains 10 items assessing participants' attitudes and feelings about their looks. Adolescents indicate their degree of agreement on a 5-point Likert scale ranging from 'never (0)' to 'always (4)', and negative items are reversed scored. Scores range from 0 to 40 and higher scores indicate higher body esteem. The Appearance subscale has shown good internal consistency (Franko et al., 2012).

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## 3. Life Orientation Test Revised (LOT-R)

The LOT-R is a measure of dispositional optimism. Participants are asked to indicate on a 5-point scale the degree to which they agree 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 (Carver & Gaines, 1987; Scheier & Carver, 1985).

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#### **4. Brief Multidimensional Students' Life Satisfaction Scale - Peabody Treatment Progress Battery (BMSLSS-PTPB)**

The Brief Multidimensional Students' Life Satisfaction Scale (BMSLSS-PTPB) has been adapted from the original BMSLSS by Seligson, Huebner, and Valois (2003). The BMSLSS-PTPB measures life satisfaction with six youth appropriate items. Response choices for the BMSLSS-PTPB are presented on a 7-point Likert scale ranging from 'very dissatisfied (1)' to 'very satisfied (7)'. The BMSLSS-PTPB has displayed adequate psychometric properties with high internal consistency, adequate item-total correlations and the originally-proposed single factor model (Athay, Kelley, & Dew-Reeves, 2012)

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#### **5. The Adapted Coping Strategy Indicator**

The Adapted CSI (Amirkhan, 1990) assesses three dimensions of coping strategies: problem-solving, seeking social support and avoidance. Problem-solving and seeking social support are regarded as positive methods of coping, while avoidance-based coping is regarded as a negative method of coping. This scale asks an individual to indicate how they cope when faced with difficulties or problems. Adolescents can respond from 'never (1)' to 'always (6)'. 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).

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#### **6. 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 five response options ranging from 'totally disagree (1)' to 'totally agree (5)' and focuses on how an adolescent relates to family and friends, and the degree to which they are goal-oriented. The scale consists of five factors: Personal Competence (8 items), Social Competence (5 items), Structured Style (4 items), Family Cohesion (6 items), and Social Resources (5 items).

For the purpose of MWS-2, the following factors were presented to adolescents: Personal Competence, Social Competence and Family Cohesion. 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 Family Cohesion factor looks at support within the family and the family's ability to maintain a positive outlook.

Scores for the READ subscales are as follows: Personal Competence: 8-40; Social Competence: 5-25; and Family Cohesion: 6-30. Higher scores indicate higher levels of resilience. The READ was developed using confirmatory factor analysis and has shown adequate psychometric properties and promising validity (Hjemdal et al., 2006). The READ was also validated in a sample of Irish adolescents (Kelly, Fitzgerald, & Dooley, 2017).

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## 7. Hemingway Measure of Adolescent Connectedness (MAC)

Two subscales from the Hemingway Measure of Adolescent Connectedness (MAC; Karcher, 1999) were used to assess adolescents' connectedness with their peers and their school. Each subscale consists of six items designed to measure the degree of caring for and involvement in relationships with peers and involvement in school. Response options range from 'not true at all (1)' to 'very true (5)'. Scores on each of the 6-item peer and school subscales range from 6 to 30. Higher scores indicate higher levels of connectedness. 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).

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## 8. Multidimensional Scale of Perceived Social Support (MSPSS)

The MSPSS (Zimet, Dahlem, Zimet, & Farley, 1988) is a 12-item inventory assessing perceived social support from family (4-items), friends (4-items), and significant others (4-items) yielding an overall score and three subscale scores. Responses are given on a 7-point Likert scale ranging from 'very strongly disagree (1)' to 'very strongly agree (7)'. The measure is scored so that higher scores indicate greater levels of support. The scale has been tested on five non-clinical samples and two clinical samples. Zimet, Powell, Farley, Werkman, and Berkoff (1990) reported the test-retest reliability to be .85, and the internal consistency to have a range from .84 to .92. Construct validity was established in the original sample of college students by revealing a consistent inverse correlation between social support, depression and anxiety (Zimet et al., 1988).

Participants in the MWS-2 were also asked to identify the special adult in their life that they referred to in the MSPSS (e.g., a family member, friend). They were also asked how regularly this person is available to them from 'irregularly' to 'always'.

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## 9. Support about your mental health

Three questions assessed what places young people are likely to use to get information or support about their mental health, what places they have actually used, and if they used these places, whether they found these places helpful. The list of places includes friends, parents, relatives, doctor/GP, online, phone helpline, teacher/guidance counsellor, psychiatrist, psychologist/counsellor/therapist, or other. In addition, participants were asked whether they have ever heard of Jigsaw youth mental health service to capture data on awareness of this service.

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## 10. Formal and Informal Help-Seeking Behaviour (HSB)

Formal help-seeking was assessed using a measure that was slightly adapted from a study by Saunders, Resnick, Hoberman, & Blum (1994) and has been previously used with 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).'
- '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'
- 'I have had some problems and I did seek professional help'

Participants were asked two general questions: 'When you have problems, do you talk about them with anyone?' and 'If yes, who would you most talk to?' with response options being 'family', 'friends' and 'no one'. They were then asked who they would talk to first if they had problems with their family, had a romantic relationship problem or a problem with depression.

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## Consultation

In devising the MWS-2-PSL survey, young people from Jigsaw Youth Advisory Panel (YAP) were consulted on three separate occasions. The YAP was presented with the plan for the survey and was requested to provide feedback.

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## Statistical analyses

A range of statistical tests were employed to understand the data collected. In general, Chi Squares and one-way analyses of variance were used (details below). Note that to reduce the risk of a false positive, particularly with such a large sample size,  $p \leq 0.01$  was considered to be significant.

Chi Square: The Chi Square test indicates what percentage each group on one variable fell into a category on a different variable. The standardised residual values were examined to determine how likely a particular group was to report that they fell into a category on another variable. A standardised residual value less than -2 indicated that a group was less likely to fall into the category in question, while a standardised residual value greater than 2 indicated that a group was more likely to fall into a category on another variable.

Analysis of Variance (ANOVA): One-way ANOVAs were used to determine if there were any statistically significant differences in the group means within a sample whilst considering only one independent variable. Post-hoc analyses were then used to determine where, if any, differences existed between groups.

Two-way ANOVAs examined the effect of two independent variables on a continuous dependent variable. It also determined the inter-relationship between the independent variables influencing the values of the dependent variable, if any. When interactions were significant, tests of simple effects were employed to explore the nature of the interaction.

# Appendix 2:

## Methodology for Young Adult Sample

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### Overview

This Appendix provides further information on the measures used in the MWS-2- Post Second Level (MWS-2-PSL). These groups included 1) young adults in universities, 2) young adults in institutes of technology, 3) young adults who were in employment (including members of Macra na Feirme). All young adults who participated were aged over 18 and based in the Republic of Ireland.

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### Description of MWS-2-PSL study

Similar to the MWS-2-SL, the MWS-2-PSL version contains four sections:

1. Demographic characteristics
2. Personal wellbeing and lifestyle factors
3. Negative domains
4. Positive domains

Scales previously described in Appendix 1, common to both the MWS-SL and MWS-2-PSL, are not reported here. Only questions and scales that are unique to MWS-2-PSL are presented below.

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### Demographic characteristics of sample

Participants were asked:

- Highest level of education to date
  - If they have children
- 

### Personal wellbeing and lifestyle factors

- Experience of bereavement
  - Experience of discrimination
  - Experience of bullying
  - Experience of romantic relationship break-up
-

# Negative domains

## 1. Drug Abuse Screen Test - DAST-10

Drug use was assessed with the Drug Abuse Screen Test (DAST-10; Skinner, 1982). The DAST-10 is a 10-item self-report instrument that assesses drug use in the past 12 months. Each question requires a 'yes' or 'no' response. Scores range from 0 to 10 and higher scores indicate more abusive involvement with drugs (see Table A5 for scoring ranges). Yudko et al. (2007) conducted a comprehensive review of the psychometric properties of the DAST and showed that the DAST-10 has moderate to high levels of validity, sensitivity and specificity.

Table A5.

### Degree of drug use and cut-off scores for DAST-10

Degree of drug use	DAST-10 cut-off scores
No problem reported	0
Low level	1-2
Moderate level	3-5
Substantial level	6-8
Severe level	9-10

# Positive domains

## 1. Satisfaction with Life Scale - SWLS

The Satisfaction with Life Scale (SWLS - Diener, Emmons, Sem, & Griffin, 1985) is a 5-item self-report questionnaire designed to measure global cognitive judgements of ones' life. The scale uses a 7-point Likert scale with responses ranging from 'very strongly disagree (1)' to 'very strongly agree (7)'. 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 in young adults (Arrindell, Heesink, & Feij, 1999; Di Fabio & Gori, 2016; Silva, Taveira, Marques, & Gouveia, 2014). A clear single factor structure has been identified (Diener et al., 1985) and confirmed (Compton, Smith, Cornish, & Qualls, 1996).

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## 2. Brief Resilience Scale

The Brief Resilience Scale (BRS; Smith et al., 2008) was used to measure resilience, defined as the ability to bounce back from adverse situations, in young adults. Items in the BRS all reflect a sense of personal agency. Response options range from 'strongly disagree (1)' to 'strongly agree (5)'. The six-item scale is on a score range of 5-30 and higher scores indicate higher levels of resilience. A methodological review of resilience measures found that the Brief Resilience Scale (BRS; Smith et al., 2008) received one of the best psychometric ratings out of 15 measures of resilience (Windle, Bennett, & Noyes, 2011).

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## Consultation

In devising the MWS-2-PSL survey, young people from Jigsaw Youth Advisory Panel (YAP) were consulted on three separate occasions. The YAP was presented with the plan for the survey and was requested to provide feedback. The research team also consulted with the Psychological Counsellors in Higher Education in Ireland (PCHEI). Members of PCHEI work closely with young people in higher education, particularly young people with mental health difficulties. In relation to gender identity and sexual orientation, the research team consulted with Transgender Equality Network Ireland and BeLonGTo. The National Youth Council of Ireland also provided feedback to the survey.

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# Appendix 3:

## Methodology for Seldom Heard Sample

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### Characteristics of organisations

Youthreach: This is an official education, training and work experience programme provided by the Department of Education for early school leavers aged 15-20.

College of Further Education (CFE)/community training: This group includes young people who are engaged in any further study after post-primary education that is not part of higher education.

Physical disability: This group consisted of wheelchair users, young people living with deafness or hearing loss and young people who are visually impaired.

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### Description of MWS-2-SH

Paper-based and web-based surveys presented the same questions. If paper-based, the survey was presented to young people in a youth-friendly and accessible booklet.

The MWS-SH survey contained four major sections, where a number of items/standardised scales were included under each section. The sections were as follows:

1. Demographic characteristics
  2. Personal wellbeing and lifestyle factors
  3. Negative domains
  4. Positive domains
-



## Demographic characteristics

Participants were asked to provide details on:

- Age
- Gender
- School year (where appropriate)
- Sexual orientation
- Family type
- Marital status of parents
- Parental employment status
- Living situation
- Religion
- Participant's marital status
- Ethnicity
- Educational level achieved to date
- Do you have children

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## Personal wellbeing and lifestyle factors

*Young people were asked questions on their wellbeing and lifestyle.*

*These comprised of questions on:*

- **Enjoying family life**  
(i.e., 'Do you enjoy family life?' with responses 'yes', 'no', 'sometimes')
- **Feelings of anger**  
(i.e., 'do you feel angry a lot?' with responses 'yes', 'no' and 'somewhat')
- **Long-term health difficulty**
- **Carer status**
- **Days absent from school/college/university/work in previous month**
- **Trouble with Gardaí**
- **Bullying**
  - Young people were asked 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 ('physically', 'verbally', 'emotionally') and where they were most frequently bullied ('in school', 'at home', 'online', 'by text').
- **Social media**
  - Young people were asked 'Do you have a social media profile or account on any sites of apps?'. Those who responded 'yes' were presented with questions related to how they spend their time online, including what sites they use, how long they spend on social media a day, experiences of cyberbullying and their privacy settings on the apps they use.
- **Pornography\***
  - Young people were presented with questions on watching pornography, how they accessed pornography and how often they watch pornography.

- **Top stressors**
  - Young people were asked to select their top stressors from a list of common problems, including college work, finance, family, exams, relationships, friends, future and job. They were also given the option to write their top stressor.
- **Coping with problems**
  - (i.e., 'Do you generally cope well with problems?' with responses 'yes', 'no' or 'sometimes')
- **Top coping strategies**
  - Young people were asked to select top ways that help them cope when things are tough, including friends, family, talking, music, sleep, exercise, walking and taking time out. They were also given the option to write their top coping method.
- **Parents' mental health status and drug/alcohol addiction**
- **Stressful life event**
- **To what extent do you currently feel stressed by the following factors?**
- **How safe do you feel in your neighbourhood?**
- **Support for my mental health**
- **Use cannabis**
- **Alcohol behaviour**
- **Drug question**
- **HSB**
- **Self-esteem**
- **MSPSS**
- **DASS (depression, anxiety and stress scale) only anxiety and depression subscales used.**
- **Brief Resilience Scale**
- **Self-harm and suicide questions**
- **CSI**
- **Discrimination questions**
- **LOT-R**

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## Negative domains

A number of standardised scales were used to assess negative domains in relation to mental health. They are described in more detail in Appendix 1 and 2.

- **Depression, Anxiety and Stress Scale (DASS-21) - Depression and Anxiety Subscales**
  - **Suicidality**
  - **Psychotic-like Experiences**
  - **Alcohol Use Disorders Identification Test (AUDIT)**
  - **Cannabis Use**
  - **Drug use**
  - **Problem Gambling Severity Index (PGSI)**
  - **Stressful Life Events**
-

## Positive domains

A number of standardised scales were used to assess positive domains in relation to mental health. They are described in more detail in Appendix 1 and 2.

- Rosenberg Self-Esteem Scale (RSE)
- Body Esteem Scale for Adolescents and Adults (BESAA)
- Life Orientation Test Revised (LOT-R)
- Brief Multidimensional Students' Life Satisfaction Scale - Peabody Treatment Progress Battery (BMSLSS-PTPB)
- The Adapted Coping Strategy Indicator
- Resilience Scale for Adolescents (READ)
- Hemingway Measure of Adolescent Connectedness (MAC)
- Multidimensional Scale of Perceived Social Support (MSPSS)
- Support About Your Mental Health
- Formal and Informal Help-Seeking Behaviour (HSB)

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## Consultation

The research team consulted with the National Youth Council of Ireland who work closely with various seldom heard groups. Feedback from the Council was taken on board when conducting this research.

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# Appendix 4:

## MWS-1 vs MWS-2

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### Overview

This chapter outlines the items and measures that were asked in MWS-1 and MWS-2.

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### Adolescent

Participants were asked to provide details on:

- Age
  - Gender
  - School year
- 

### Personal wellbeing and lifestyle factors

*Adolescents were asked questions on their wellbeing and lifestyle. These comprised of questions on:*

- **Enjoying family life** (i.e., 'Do you enjoy family life?' with responses 'yes', 'no', 'sometimes')
  - **Feelings of anger** (i.e., 'do you feel angry a lot?' with responses 'yes', 'no' and 'somewhat')
  - **Trouble with Gardaí**
  - **Bullying**
    - Adolescents were asked 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 ('physically', 'verbally', 'emotionally').
  - **Relationships**
    - Adolescents were asked about the nature of their relationship with their boyfriend/girlfriend, if applicable. They were also asked about their experience with break-ups.
  - **Coping with problems** (i.e., 'Do you generally cope well with problems?' with responses 'yes', 'no' or 'sometimes')
  - **Relationships with parents**

The Network of Relationships Inventory - Relationship Qualities Version (NRI-RQV; Furman & Buhrmester, 2009) assesses the quality of relationships with mothers, fathers, Three subscales from the NRI-RQV assess two positive relationship features (approval and satisfaction) and one negative relationship feature (criticism).
  - **Mother and father approval and criticism** were asked in MWS-2. Each subscale consists of three items, with responses ranging from 'never or hardly at all (1)' to 'always or extremely (5)'. Scores on each of the subscales range from 3 to 15. The NRI-RQV has previously been used among adolescents in Ireland and the internal consistency of all subscales has been estimated to be good (Kenny, 2011). Higher scores on these subscales indicate higher levels of approval/criticism.
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## Negative domains

- Depression, Anxiety and Stress Scale (DASS-21) - Depression and Anxiety Subscales
  - Psychotic-like Experiences
  - Alcohol Use Disorders Identification Test (AUDIT)
  - Cannabis Use
- 

## Positive domains

- Rosenberg Self-Esteem Scale (RSE)
  - Life Orientation Test Revised (LOT-R)
  - Brief Multidimensional Students' Life Satisfaction Scale - Peabody Treatment Progress Battery (BMSLSS-PTPB)
  - The Adapted Coping Strategy Indicator
  - Resilience Scale for Adolescents (READ)
  - Hemingway Measure of Adolescent Connectedness (MAC; School- and Peer-Connectedness)
  - Multidimensional Scale of Perceived Social Support (MSPSS)
  - Support About Your Mental Health
  - Formal and Informal Help-Seeking Behaviour (HSB)
- 

The following items/measures were added to the above for the adult sample analyses

## Young Adult

### Personal wellbeing and lifestyle factors

- Experience of discrimination
- Experience of bullying

### Negative domains

- Suicidality

### Positive domains

- Satisfaction with Life Scale - SWLS
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