





# HRB National Psychological Wellbeing and Distress Survey: Baseline Results

Report by the Mental Health Research Unit, Health Research Board

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# About the HRB

The Health Research Board (HRB) is the lead agency supporting and funding health research in Ireland. We also have a core role in maintaining health information systems and conducting research linked to national health priorities. Our aim is to improve people's health, build health research capacity, underpin developments in service delivery and make a significant contribution to Ireland's knowledge economy.

## Our information systems

The HRB is responsible for managing five national information systems. These systems ensure that valid and reliable data are available for analysis, dissemination and service planning. Data from these systems are used to inform policy and practice in the areas of alcohol and drug use, disability and mental health.

## Our research activity

The main subjects of HRB in-house research are alcohol and drug use, child health, disability and mental health. The research that we do provides evidence for changes in the approach to service delivery. It also identifies additional resources required to support people who need services for problem alcohol and drug use, mental health conditions and intellectual, physical and sensory disabilities.

The **Mental Health Research Unit** gathers data on patient admissions, treatment and discharges from psychiatric hospitals and units throughout Ireland. The data collected have been reported in the Activities of Irish Psychiatric Services since 1965 and continue to play a central role in the planning of service delivery. The unit is extending its service to include information about activity in community care settings in order to reflect the changing patterns of care for patients with a mental illness. Multi-disciplinary experts in the unit carry out national and international research and disseminate findings on mental health and mental illness in Ireland. These findings inform national policy, health service management, clinical practice and international academic research.

The **HRB Research Series** reports original research material on problem alcohol and drug use, child health, disability and mental health.



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# Executive summary

There is little information available on the level of psychological distress in the Irish population or on the use of health care services and professionals by individuals experiencing mental health problems. The Health Research Board (HRB) National Psychological Wellbeing and Distress Survey (NPWDS) sought to address this gap in information. It is envisaged that the survey will be completed every two years to identify trends and monitor changes and to assist national planning and evaluation of mental health in the Irish population. In addition, the survey will be used to carry out research on the determinants and correlates of psychological distress and service use and to explore the relationship with underlying psychological theoretical concepts. This is the first report from the series. It is important to stress that this report details descriptive baseline data only and focuses on age and gender differences. Future work will exploit the data to address a range of research questions relating to psychological wellbeing and distress in the Irish population and will explore in greater detail how other socio-demographic factors such as education, income and free medical care impact on the levels of psychological distress.

The NPWDS was a telephone survey of a nationally representative random sample of 2,711 adults aged 18 years and over and living in private households. The data were collected by the Economic and Social Research Institute (ESRI) between the period December 2005 and April 2006 over three two-week intervals. Telephone numbers were drawn on a random, probability basis. In order to ensure geographical coverage, an initial set of sampling areas was selected from the GeoDirectory. This initial sample of areas was then employed to generate a random telephone sample using random digit dialling. The survey received ethical approval from the HRB Research Ethics Committee. In line with best practice the completed sample was re-weighted to ensure that it was representative of the population from which it had been selected. Comparisons with relevant census data showed that the profile of the sample was comparable to that of the general population aged 18 years and over.

Of the 2,711 participants, 50% were female. Two-thirds of the respondents were under the age of 50 and 14% were over the age of 65. Almost half of the respondents were married (49%), 36% were never married, 4% were living with a partner, 7% were widowed and 3% were separated or divorced. The majority of the respondents had received a secondary level of education (60%), while 20% had completed primary level education and 19% had completed a third level education. Over one-quarter of the respondents reported non-manual occupations (26%), with 20% reporting professional/managerial occupation and 19% reporting manual skilled occupations. Regarding weekly household income, the highest proportion of the respondents reported income of 500 – 749 Euro per week (17%) and over 1,249 Euro per week (15%). Approximately

10% of the respondents fell into the other five household income categories. A total of 23% of the respondents had access to free medical care, while 46% had private health insurance. Almost a quarter of respondents had no free medical care or private insurance while 8% had access to free medical care and had private health insurance.

The main aims of the present report are to:

- provide much-needed data in relation to mental health issues from a representative sample of the population
- determine the proportion of the Irish population who are experiencing psychological distress or had experienced psychological distress in the previous year
- determine the proportion of the sample who had experienced limitations in physical or social activities due to mental health problems
- describe the willingness of the respondents to discuss emotional distress with others
- describe the help-seeking behaviour of the Irish population when experiencing mental health problems, including use of primary care, use of secondary mental health services and use of other professionals/support persons
- investigate the perceived effectiveness of the support used for mental health problems in the previous year
- describe the willingness to use professionals/support persons for mental health problems in the future
- describe the use of the Internet as a source of information on health
- describe the extent of use of antidepressants and tranquillisers in the previous year and the perceived effectiveness of the medication.

A summary of the main findings from the HRB NPWDS are presented below.

## Health status, quality of life and willingness to disclose distressing information

The majority of the respondents reported 'good or very good' mental health in the past year, with 15% reporting 'less than good' mental health. Those aged 50–64 years were most likely to report less than good mental health. A total of 14% (one in seven) of respondents reported experiencing mental health problems in the previous year, with females more likely to report mental health problems and the youngest and oldest age groups least likely to report such problems. A total of 66% of the respondents had a score of zero on the GHQ12 indicating high levels of wellbeing while current psychological distress was evident in a total of 12% of the sample (one in eight). Again, females were more likely to exhibit signs of distress on the GHQ12 as opposed to males, and the youngest and oldest age groups were least likely to exhibit distress.

Regarding limitations in social and physical activities due to mental health or emotional problems, a total of 13% of respondents reported limitations in physical activities and 12% reported limitations in social activities. There were little differences across the age groups in self-reported limitations in physical or social activities until the 65+ age group; a greater proportion of this age group reported limitations in physical activities than in social activities.

Approximately 21% of the respondents reported 'less than good' physical health. A greater proportion of females reported less than good physical health compared to males. There was a steady increase in the proportion reporting less than good physical health across the age groups.

Of all respondents, 19% reported 'less than good' quality of life, with females more likely to do so than males. As in the self-reports of physical health status, the proportion reporting less than good quality of life increased over the age groups.

Females reported that they were more willing to disclose distressing information to others than males. Furthermore, the willingness to discuss distressing information decreased over the age groups.

## Use of health care services and willingness to seek help

The majority of the respondents (71%) had attended a general practitioner (GP) in the previous year for physical health problems, while only 9% reported that they had spoken to a GP about mental health problems. However, those who had spoken to a GP about mental health problems had, on average, a greater number of visits (4.4 visits) than those attending with physical health problems (3.9 visits). Females were more likely than males to report general practice use for physical or mental health problems. As expected, the older age group was more likely to attend a GP for physical health problems, while the 50–64 year age group was more likely to discuss mental health problems with a GP.

A total of 16% of the sample reported that there were barriers that prevented them from attending a GP in the previous 12 months. The most frequently reported barriers were cost of visits, the length of time involved in visits and embarrassment/feeling awkward. However, in the 65+ age group the most frequently reported barriers preventing respondents from attending a GP were length of time involved in the visit followed by difficulties in transportation. It is not unexpected that cost was not an issue for the 65+ age group as the majority of these individuals had free medical care.

Not surprisingly, the proportions of respondents reporting attending secondary mental health services were much less than the proportion reporting attending general practice for mental health problems. For example, nine per cent reported attending a GP, five per cent reported attending outpatient clinics, while less than one per cent reported attending inpatient services.

A total of 6% of the sample reported attending other professionals/support persons for mental health problems in the previous year and the most frequently attended were psychiatrist, nurse or counsellor. Alternative practitioners were reported as the least likely to be contacted for mental health problems. Most of the respondents reported that the professionals/support persons they contacted had been effective or very effective in the treatment of their problems.

In line with previous findings from Europe (Ohayon et al. 2002),<sup>1</sup> approximately 6% of the adult population surveyed reported having been prescribed medication for mental health problems in the previous year. The reported use of prescribed medication for

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1 A previous telephone survey carried out in France, Germany, Italy and UK found that 6.3% of those surveyed reported currently using psychotropic medication. See Ohayon et al. (2002) Use of psychotropic medication in the general population of France, Germany, Italy and the United Kingdom. *Journal of Clinical Psychiatry*, 63(9): 817–825.

mental health problems increased for females over the age groups with those aged 65 years and over the most likely to report using prescribed medication. For males the highest proportion reporting use of prescribed medication for mental health problems was in the age group 30 – 39 years. Few males aged 65 years and over reported using prescribed medication. Antidepressants were more frequently prescribed than tranquillisers. The majority of respondents reported that they had been prescribed the medication by a GP. The medication was reported as 'very effective' or 'moderately effective' in the majority of cases. However, results showed that over one-quarter of respondents (27%) rated antidepressants as 'slightly effective' or 'not at all effective'. Given the small numbers in this analysis, further research into the effectiveness of various medications for the treatment of mental health problems is required. Only 1–2% of the respondents reported having taken non-prescribed or alternative medication for mental health problems in the previous 12 months.

A total of 93% of the respondents were willing to seek help for mental health problems if required and a GP was the preferred source of help followed by a psychiatrist, counsellor or psychologist. While almost 90% were willing to contact a GP, only 31% to 48% were willing to contact a psychiatrist, counsellor or psychologist. Of the respondents who reported that they would use other professionals or support persons than those listed, the majority reported that they would seek help from family and/or friends.

Over one-half of the respondents had used the Internet in the past for general purposes, with males more likely to do so than females. Of those who reported using the Internet, almost one-half reported using it as a source of information on health, with more females than males reporting that they had done so for this purpose. However, of those who reported that they had never used the Internet for any purposes or had not previously used it as a source of information on health, almost one-half reported that they would be willing to do so in the future. A greater proportion of the younger age group compared to the older age group were more likely to report that they were willing to use the Internet as a source of information on health in the future.

These findings showed that of the total sample, only 28% are currently using the Internet as a source of information on health. However, combining this with the proportion that were willing to use the Internet for health information in the future suggested a total of 63% of the population are, or would be, willing to use the Internet for this purpose. This highlights the potential for the use of the Internet as a source of health information in the Irish population.

## Conclusion

This is the first national survey of the extent of psychological wellbeing and distress within the Irish population. It is important to highlight that many adults within the Irish population report 'good' or 'very good' mental health, physical health and quality of life. Yet a significant number of adults will experience psychological distress at some point in their lives that will, for the most part, require some form of support or intervention, whether formal or informal. While the majority of these will experience short-term mental health problems, others may require the help of specialised mental health services. Thus, as is in other European countries, psychological distress is an under-acknowledged feature of Irish society and the findings have implications for policy and service planning in a range of sectors.

The failure of individuals and civic society to acknowledge psychological distress has a number of important and fundamental consequences, from the philosophical to the political, which require detailed exploration. For present purposes, individual and civic reluctance to 'own' psychological distress can result in psychological problems going unrecognised yet wreaking personal, familial and societal trauma. The issue of stigma and deficit in ownership is clearly interrelated. A consequence of the deficit in ownership and stigma is that formal and informal supports which could provide healing, support and hope go undeveloped or underused, with inevitable social and economic costs for individuals, families and society.

The NPWDS found that approximately 12% of the Irish adult population were currently experiencing psychological distress – a figure which is similar to that found in other countries (ESEMED/MHEDEA 2000 Investigators, 2004). It is evident that formal services as currently provided cannot respond to the demand for support and it may not be appropriate that they do so in all cases. The decision to seek help can depend on a number of health beliefs such as the perceived need for help, the perceived efficacy of treatment and the barriers and facilitators to seeking help.

There is an evident need to develop new models of support for persons experiencing psychological distress – many of these could be informal and inexpensive, operating at individual (recognition and ownership of stress/distress), interpersonal (seeking informal support from family, friends) and societal (mental health promotion programmes, development of social capital in communities) levels in a wide range of situational contexts (schools, homes, resident associations). Individuals and communities need to be provided with strategies aimed at reducing or coping with psychological distress so as to reduce the chances of symptoms reaching diagnostic criteria. This would, of course, reduce the chances of the symptoms requiring formal health care services.



With regard to formal supports, this survey has highlighted the important role the GP plays in the assessment and treatment of mental health problems. GPs are often the first and only port of call for those seeking help and are also the primary gatekeepers to specialised mental health services. These findings raise a number of important issues relating to the assessment and treatment of both short-term mental health problems to more enduring mental health problems within the primary care setting. There is a need for training in mental health care for GPs and those working within the primary care setting. Importantly, there is a need for mental health professionals within the primary care network who can provide a range of psychological therapies. And finally, the interface between primary care and secondary mental health services needs to be developed so there is a continuity of care for those who require specialised mental health services.

The survey has highlighted a number of important issues in relation to psychological distress. As in other European countries, the extent of psychological distress needs to be acknowledged, not only at the societal level but also at the individual and interpersonal level. The acknowledgement that psychological distress is a part of Irish life will reduce the stigma surrounding mental health problems. The National Office for Suicide Prevention is currently in the process of developing a national mental health awareness and attitudes campaign. This campaign should help to reduce the stigma surrounding mental health problems by highlighting the extent of mental health problems.

There is a need for individuals and communities to be provided with strategies that can help recognise, alleviate or reduce psychological distress. These strategies can be provided within a range of situational contexts, such as schools, community groups and employment settings, ensuring that a variety of audiences is reached. Mental health care policy and service planners should acknowledge the need for early detection and treatment, ensuring that as many individuals are treated as soon as possible to prevent the symptoms from escalating unnecessarily.

The important roles of the GP and the primary care network in the assessment and treatment of mental health problems need recognition. The development of primary care networks should provide a range of mental health professionals who can be accessed by the GP. The most recent mental health policy document, A Vision for Change 2006, highlights many of these issues.

The present survey has taken the first step of capturing and describing the reality of psychological distress in the Irish adult population, exploring its gender and age correlates, the formal and informal supports used and their perceived effectiveness. To date, population-based information on the prevalence and correlates of psychological distress has been limited, as has information relating to the use of formal and informal supports. Successful policies and service planning need to be based on reliable and valid information. It is anticipated that the findings from this and future surveys will provide this important information. Further reports from this survey will focus on specific aspects of the survey data and will investigate the important correlates of psychological distress and service use. It is important that the findings are debated within an inter-sectoral arena so that appropriate responses for mental health care delivery can be developed.

# Introduction and methods

The HRB National Psychological Wellbeing and Distress Survey (NPWDS) 2006 is the first in a biennial series. It provides reliable information on the psychological wellbeing and distress of the adult population living in private households in Ireland. It also provides information on help-seeking behaviour and service use, primarily for psychological problems. The primary purpose of this survey is to add to the knowledge of mental health status in the Irish population and to explore its determinants and correlates. Such information is very important for the planning of services, *inter alia*; its absence was noted in A Vision for Change (Department of Health and Children, 2006), the most recent Irish mental health policy document. The importance of a population approach to health and mental health has been highlighted in the Irish context (National Economic and Social Forum, 2006). The Mental Health Research Unit (MHRU) of the HRB has for some time sought to interest public bodies in the provision of funding to conduct a study on psychological morbidity in the Irish context. Such studies are extremely expensive to carry out and the cost of allowing many other equally valid research areas to go unexplored must be built into the overall cost-benefit equation. Against this background, the MHRU decided to review existing information relating to the prevalence of psychological distress and to conduct the current survey with a view, *inter alia*, to estimating the extent of mental distress in the Irish population.

The HRB has an unbroken 35-year record of monitoring inpatient activity (National Psychiatric Inpatient Reporting System – NPIRS) in the Irish context; census information on inpatients has been collected decennially until recently and is now being reported on more regularly (Daly & Walsh, 2006). For some years, the HRB also gathered information regarding contact with outpatients services in the mental health area (e.g. case registers); it also reported on annual returns relating to use of community services, for example, staffing levels in the mental health services for the Department of Health and Children (aggregate data). Thus, the HRB databases provide a unique record of the use of inpatient mental health services and, to date, a less comprehensive, albeit informative picture of outpatient use of mental health services. The HRB is currently planning the implementation of WISDOM (formally known as NPIRS/COMCAR) which will collect individualised information regarding usage of community mental health services and inpatient services. This database will be the most comprehensive database to date and will cover all components of the mental health services. One further piece of the national psychological distress jigsaw was provided by a recently completed MHRU research paper (Walsh, 2007); this captured data on patients whose primary diagnosis was psychiatric and who were discharged from the general hospital services. Thus, we have an indication of mental health problems in inpatient services, in outpatient services and in general hospitals. The HRB NPWDS is a major innovation aimed at addressing the extent of psychological distress and mental health problems in

the adult general population in Ireland. The survey will be carried out every two years and is designed to monitor changes in mental health status in the Irish population and the use and willingness to use services and professionals if experiencing mental health problems. The survey will also be used to carry out research on the determinants and correlates of psychological distress and service use and explore the relationship of psychological concepts such as distress disclosure, coping and social support to psychological wellbeing and distress.

## **Aims**

The main aim of the surveys is to provide a reliable estimate of the prevalence of psychological distress in a representative cross section of the Irish population aged 18 years and over, and to report on the extent of service use for psychological problems. As the database expands comparisons will be made with previous years to identify trends and monitor changes in psychological wellbeing and in service use over time. It is anticipated that each survey will also include psychological measures on a one-off basis to evaluate their impact, either negative or positive, on psychological distress within the Irish population. The current study incorporated a measure of the willingness to disclose distressing information (Distress Disclosure Index). Descriptive analyses on this measure are presented here, while the relationship between the Distress Disclosure Index and psychological distress is presented in a forthcoming paper 'It's good to talk' (Ward et al. 2007).

The aim of this report is to provide a descriptive account and summary of the data from the first survey carried out in 2005–2006. The data will be presented in three sections. The first section will focus on health status, quality of life and willingness to disclose distressing information. The second section will explore the use of care and treatment services and help-seeking, while discussion and conclusions will be presented in the final section. The analysis presented in this report focus exclusively on age and gender differences. A future report from this survey will explore the influence of other socio-demographic factors such as education, income and access to free medical care on the mental health status of the sample (Tedstone Doherty et al. 2007).

## **Method**

The survey was administered by telephone to a total of 2,711 participants. The data was collected by the Economic and Social Research Institute (ESRI) on behalf of the HRB and formed part of the EU Consumer Survey which is carried out every month by the ESRI. The EU Consumer Survey measures attitudes to, opinions about, and recent and future trends in the Irish economy, on behalf of the European Commission. The study received ethical approval from the HRB Research Ethics Committee (REC).

Fieldwork for the survey was carried out over two-week intervals in December 2005, January 2006 and April 2006. The time delay between data collection periods was considered short enough to validly combine the samples into a single sample. Duplication was ruled out since the ESRI Survey Unit ensures that phone numbers cannot be re-used within a two-year period (see Procedure below).

## **Respondents**

The samples from the three data collection periods detailed above were merged to create a final sample of 2,711 participants. Of all those who were contacted successfully and were eligible to participate ( $n = 5,678$ ), 2,905 people (51%) agreed to participate and 2,711 people (48%) completed the survey. The response rate of 51% is similar to the response rate for the EU Consumer Survey, with over 90% of those completing the EU Consumer Survey also completing the module on psychological distress.

## **Procedure**

Prior to the HRB carrying out the survey, the proposed questionnaire was piloted by the ESRI. No changes were made to the questionnaire, which was administered by telephone. The target population was all persons aged 18 years and over living in private households. Telephone numbers were drawn on a random, probability basis. In order to ensure geographic coverage, an initial set of random clusters (or sampling areas) was selected from the GeoDirectory. This is a comprehensive list of private households in the Republic of Ireland; it is compiled jointly by the Ordnance Survey and An Post (the national postal service). The initial sample of areas was then employed to generate a random telephone sample using random digit dialling (RDD). Using this system, different phone numbers for each month are selected. The matching stem of each phone number is marked up on a file thus ensuring that phone numbers cannot be used again for at least another two years. As a result, there are no duplicates in the HRB's dataset for this survey.

In line with normal survey protocol, the ESRI interviewers stressed to respondents that any information obtained during the interview would be confidential, that it would be used for research purposes only and that the respondent could terminate the telephone interview at any time. In addition, interviewers were provided with protocols in the unlikely event that the respondent became distressed during the interview.

## Re-weightings

In line with best practice, the completed sample was re-weighted or statistically adjusted to ensure that it was representative of the population from which it had been selected. (The re-weighting procedure involves adjusting the results to compensate for over-representation or under-representation of subgroups within the sample.) The completed sample was weighted using a minimum information loss algorithm; this has been used previously in Irish surveys (e.g. McGee et al. 2005). The weighting scheme was designed to adjust the sample distributions for a number of key variables. Thus, it was weighted by age (five age categories); by gender; marital status by age group; region; number of adults in the household; gender by principal economic status; level of education by two age categories. Weightings were applied according to the corresponding population distributions. The population distribution was derived from the Quarterly National Household Survey carried out by the Central Statistics Office; it was based on a sample of approximately 30,000. This re-weighting procedure resulted in a nationally representative sample of persons aged 18 years and over living in private households in the Republic of Ireland.

## Measures

Comprehensive socio-demographic information was recorded on the core instrument of the ESRI EU Consumer Survey and was available for analysis by the MHRU. Included were household size (number of adults and minors); age of respondent; gender; highest level of educational attainment; occupation (used for generating a social class scale); marital status; household income and principal economic status. In addition, geographical region of residence of respondents was recorded by the ESRI, to include such broad regions of Ireland as Border (counties Cavan, Donegal, Leitrim, Louth, Monaghan, Sligo), Mid-East (counties Kildare, Meath, Wicklow), Midland (counties Laois, Longford, Offaly, Westmeath), Mid-West (counties Clare, Limerick and Tipperary North), South-East (counties Carlow, Kilkenny, Tipperary South, Wexford and Waterford), South-West (counties Cork and Kerry) and West (counties Galway, Mayo, Roscommon). The MHRU added other items to this list, including a question on 'size of location'; this related to the size of the location in which the respondent resided and health care coverage (whether covered by free medical care/private health care insurance). The following sections detail the items included in the MHRU questionnaire. See Appendix 1 for a copy of the MHRU questionnaire.

## **General Health Questionnaire**

The short version of the General Health Questionnaire (GHQ12) was used as a measure of psychological distress. This questionnaire has been widely used as a screening measure to assess psychological distress in community samples (e.g. Shaw et al. 1999). Previous research has shown the validity of the questionnaire to be high, with issues such as age, gender and educational level having no significant effect on the validity of the GHQ (Goldberg et al. 1997).

Two methods are used for scoring the GHQ12. The bimodal method, commonly referred to as the GHQ scoring method, scores items on a scale of 0-0-1-1 with a score range of 0–12, while the Likert scoring system scores items on a scale of 0-1-2-3 with a score range of 0–36. It has been argued that if the GHQ12 is to be used as a case detector (i.e. to identify individuals who have probable mental disorders), then the shorter version scored in the simplest manner (i.e. GHQ12 using GHQ scoring) should be used (Goldberg and Williams 1988). It is preferable to use the Likert scoring system when comparing the severity of distress between groups as it gives a less skewed distribution of scores (Goldberg et al. 1997). For the purposes of this report, the GHQ12 scores were classified using the bimodal method for the calculation of point prevalence with a score of four and above used as the cut-off score to indicate probable psychological distress; this is in line with previous research in the UK (Scottish Health Survey 2003; Health Survey for England 2003; Northern Ireland Health and Social Wellbeing Survey 2002). The highest level of wellbeing was defined as those with a score of zero (Scottish Health Survey, 2003).

## **Self-perceived health status and quality of life in the last year**

In addition, a subjective measure of mental health problems in the previous year was included in the questionnaire. Respondents were asked if they had suffered from mental, nervous or emotional problems in the previous year; they were also asked to rate their mental health during the previous year on a five-point scale from 'very poor' to 'very good'. The other two self-reported measures included respondents' ratings of their physical health in the last 12 months, and their quality of life in the last 12 months on a five-point scale from 'very poor' to 'very good.'

## **Distress Disclosure Index**

In order to measure an individual's level of distress disclosure a 12-item Likert scale, the Distress Disclosure Index (DDI; Kahn and Hessling 2001) was used. This scale is a self-reporting measure of one's tendency to conceal versus disclose distressing personal information, which has been shown to be related to an individual's psychological well-being and a predictor of an individual's help-seeking behaviour (see Kahn and Hessling 2001). Respondents were asked to rate 12 DDI statements (six positive and six negative) on a five-point scale from 'strongly disagree' to 'strongly agree'. After data collection, scores of the six negative statements were reversed and the total DDI score was calculated for all respondents.

## **Use of general practice services over the last year**

In order to measure the level of help sought for both physical and mental health problems, respondents were asked how many times (if any) they had seen a general practitioner (GP) for physical problems in the last 12 months. They were also asked how many times (if any) they had spoken to a GP about being anxious or depressed, or about mental, nervous or emotional problems.

It was considered useful to explore possible barriers to seeking help from GPs. To do so, respondents were asked if any of the following prevented them from seeing a GP in the past 12 months: transportation; cost of visit; it takes too much time; embarrassment/feeling awkward; it's not helpful; too ill; anything else; nothing prevented me.

## **Use of mental health services over the last year**

In order to measure the level of use of professional mental health services, respondents were asked whether (yes/no question) they had been in contact with any outpatient clinic, day centre, day hospital or inpatient psychiatric hospital or unit in the last 12 months.

## **Use of professionals/support persons in the last year and perceived effectiveness**

In order to assess the level of use of professionals/support persons and their perceived effectiveness, respondents were asked if they had been in contact with any of the following in the previous 12 months; psychiatrist, nurse, psychologist, social worker, counsellor, psychotherapist, clergy, alternative practitioner and other. If the answer to any of these was positive, respondents were asked to rate how effective each professional/support person had been for them on a four-item scale from 'very effective' to 'not at all effective'.



## **Use of prescribed and non-prescribed medication in last year and perceived effectiveness**

To explore the patterns of use of prescribed medication for mental or emotional problems and its perceived effectiveness, respondents were asked if they had taken any prescribed medication for a mental, nervous, or emotional problem in the last 12 months. If the answer was positive, respondents were asked who prescribed this medication: psychiatrist, GP, medical doctor in hospital or clinic and other. Respondents were also asked to indicate whether the medication was a tranquilliser, antidepressant or other type of medication. Those who were able to identify one of the three types of medication were asked to rate the effectiveness of each type of medication used on a four-item scale from 'very effective' to 'not at all effective'. An option of 'don't know' was also available.

In addition, in order to explore the possible use of non-prescribed medication for mental health problems, respondents were asked if they had taken any non-prescribed or alternative medication for a mental, nervous or emotional problem in the last 12 months.

## **Preference for services if required in the future**

As one of the aims of the study was to explore the patterns of help-seeking for mental health problems in the general population and the willingness to use various services, respondents were asked if they would contact any of the following professionals if they were experiencing mental, nervous or emotional problems: GP, psychiatrist, nurse, psychologist, social worker, counsellor, psychotherapist, clergy, alternative practitioner and other.

## **Internet use for health matters**

In order to explore patterns of Internet use as a source of information on health, respondents were asked three questions regarding their use of the Internet. The first yes/no question asked whether respondents had ever used the Internet for any purpose. In the case of a positive response, they were asked if they had ever used the Internet as a source of information on health. If respondents replied that they had not used the Internet as a source of information on health in the past, they were asked if they would be willing to use the Internet as a source of information on health matters in the future.

## Interpretation of results

In line with best practice, the completed sample was re-weighted or statistically adjusted to ensure that it was representative of the population from which it had been selected. Weighted percentages are reported in all tables.<sup>2</sup> Data are rounded to the nearest percentage in the text and are presented in the graphs and tables to the nearest one decimal place. The valid response for each question has been used (i.e. includes only those who answered the question). Throughout the report all questions are cross-tabulated by gender and age only. A number of forthcoming reports will analyse the data in greater detail. For example, other socio-demographic factors will be examined such as employment and income and whether, or to what extent, these variables influence the mental health status of the sample.

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<sup>2</sup> In line with survey protocol, n's have not been routinely reported in tables as data have been weighted.

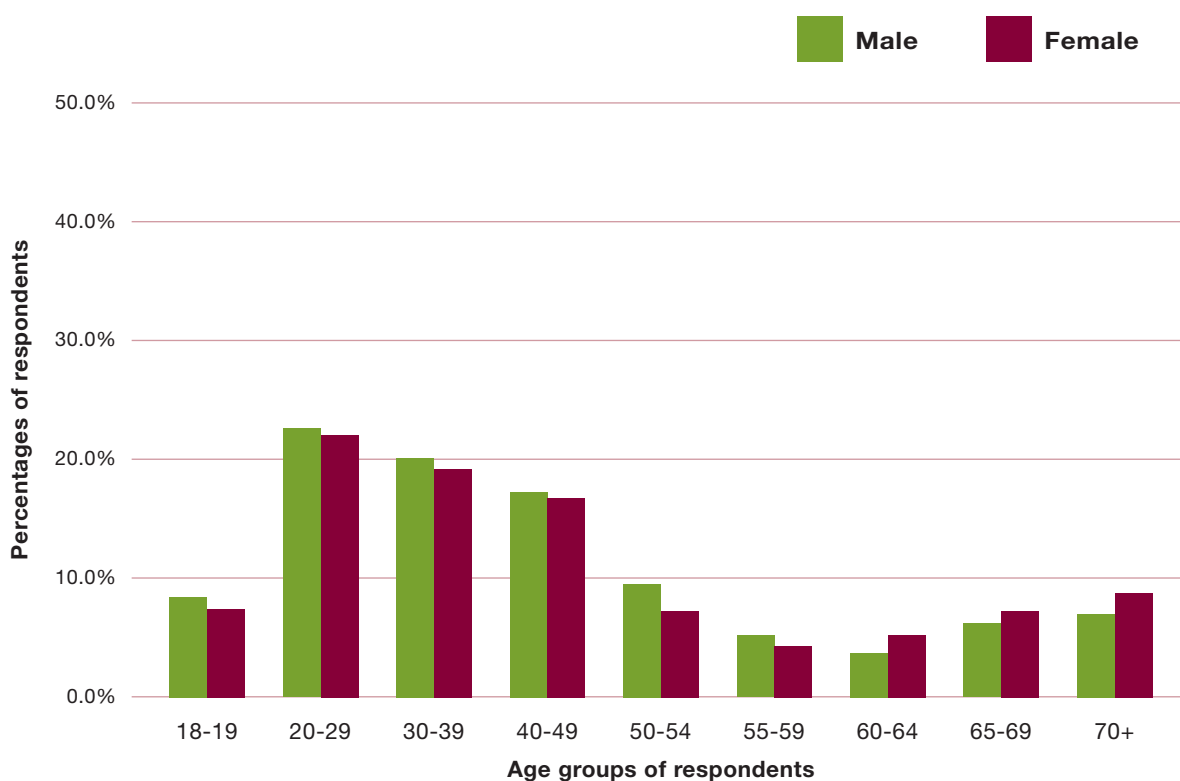
# Socio-demographic background information of sample

A total of 2,711 people participated in the survey, 51% female. Table 1 shows the age profile of the sample.

**Table 2.1** Weighted percentages of respondents' age groups

Age group	Percentage
18–19	7.6
20–29	21.7
30–39	19.7
40–49	17.3
50–54	8.6
55–59	5.4
60–64	5.3
65–69	6.6
70+	7.8
<b>Total</b>	<b>100.0</b>

Figure 2.1 presents the distribution of respondents' age groups by gender. As can be seen from the graph, percentages of male and female respondents in all age groups of the sample were similar.



**Figure 2.1** Age groups of respondents by gender – weighted percentages

Table 2.2 presents the major demographic characteristics of respondents including their marital and employment status, level of education, socio-economic group, household income per week, size of household location, geographical location and medical card or private medical insurance coverage.

**Table 2.2** Weighted percentages of socio-demographic characteristics of respondents in HRB NPWDS

Marital status	%	Household income per week	%
Never married	36.3	Under 300	10.9
Married	49.2	300–399	10.9
Living with partner	3.9	400–499	10.8
Separated	2.5	500–749	17.3
Divorced	0.9	750–899	10.3
Widowed	7.2	900–1,249	9.2
		Over 1,249	15.3
		Don't know	1.9
		Missing/don't know	13.4

<b>Employment status</b>	<b>%</b>	<b>Size of location</b>	<b>%</b>
Employed	53.8	Small town – population < 5,000	43.5
Unemployed	6.4	Town – population > 5,000	20.7
Retired	11.3	City – Waterford, Limerick, Cork, Galway	10.3
Long-term sickness/disability	4.0	Dublin city and county	23.1
Full-time training or education	9.6	Don't know	2.6
Domestic duties		14.5	
Other		0.4	
<b>Occupation</b>	<b>%</b>	<b>Geographical location<sup>3</sup></b>	<b>%</b>
Self-employed	6.6	Border	10.8
Farmer	4.1	Dublin	29.4
Professional/Manager	20.2	Mid-East	10.2
Other non-manual	25.7	Midland	5.6
Manual skilled	19.1	Mid-West	8.7
Manual unskilled	14.0	South-East	10.7
Never worked	7.6	South-West	14.9
Other	2.7	West	9.6
<b>Education</b>	<b>%</b>	<b>Medical card<sup>4</sup> and medical insurance</b>	<b>%</b>
Primary	20.2	GMS	22.6
Secondary	60.4	Private insurance	46.5
Third	19.4	No GMS or private insurance	23.2
		Both	7.8

As can be seen from Table 2.2, nearly one-half of the sample was married (49%), whereas more than one-third was never married (36%). Other marital status categories such as separated, divorced and widowed were represented by much lower proportions of respondents.

More than one-half of the sample was employed (54%). Other employment groups were represented by those involved in domestic duties (14%), retired (11%) and those in full-time training or education (10%). Smaller proportions of respondents were unemployed (6%), had a long-term sickness or disability (4%) or were of unspecified employment status (0.4%).

3 Border: Cavan, Donegal, Leitrim, Louth, Monaghan, Sligo; Mid-East: Kildare, Meath, Wicklow; Midland: Laois, Longford, Offaly, Westmeath; Mid-West: Clare, Limerick City, Limerick Co., Tipperary NR; South-East: Carlow, Kilkenny, Tipperary SR, Waterford City, Waterford Co., Wexford; South-West: Cork City, Cork Co., Kerry; West: Galway City, Galway Co., Mayo, Roscommon.

4 The medical card is provided by the Health Service Executive. It is means tested and provides free medical care to card holders and their dependents.

The occupation of more than one-quarter of respondents was in the non-manual category (26%). The next most frequently reported occupation was professional/managerial (20%), followed by manual skilled (19%). The smallest proportion of respondents was farmers (4%), and 8% of the sample never worked.

The majority of the respondents reported attaining second-level education (60%). Approximately one-fifth of the respondents had attained primary level education only (20%), while almost one-fifth of the respondents had attended third-level education (19%).

Among those who specified the range of their weekly income (85%), the two highest proportions of the sample were in the 500–749 and over 1,249 euro per week income groups. Proportions of those in other income groups were roughly equal. A small number of respondents (2%) could not specify their weekly income, and 13% preferred not to specify how much they earned. More than one-half of the sample was in the category main earners (52%).

Nearly one-half of the respondents resided in a small town with a population of 5,000 people or less (43%). Less than one-quarter (23%) lived in Dublin city or country, and the smallest proportion resided in such cities as Waterford, Limerick, Cork or Galway (10%). For a minor proportion, information about the size of their location was not available (3%). The largest proportion of respondents (29%) resided in the city and county of Dublin, and the smallest proportion lived in the Midlands (5%).

Nearly one-half of the sample (46%) had private medical insurance either in their own name or through another family member. Nearly one-quarter of respondents had no private or public health coverage at all (23%). Of all respondents, 23% were patients of General Medical Service (GMS), either in their own name or through someone else's card. A total of 8% reported that they had both private medical insurance and medical cards.

The majority of respondents reported that they had no dependent children living with them at the time of the survey (67%). As can be seen from Table 2.3, out of 877 respondents who reported the number of children living in their household (32%), the majority had one or two dependent children (76%). About one-quarter of respondents (24%) had from three to five children living with them, and two respondents had six dependent children.

**Table 2.3** Weighted percentages of dependent children living with respondents

Number of children	Percentage
1	36.6
2	39.5
3	15.4
4	6.7
5	1.7
6	0.2
<b>Total</b>	<b>100.0</b>

## Summary

To summarise, the age distribution of the sample mirrored that of the national adult population, with 86% of the sample between the ages of 18 years and 64 years and 14% of the sample aged 65 years or over. Nearly one-half of the sample was married, more than one-half was employed, one-fifth was professionals/managers, while over one-quarter reported other non-manual occupations. The majority of respondents had attained second-level education; more than one-half was in the category main earners; and one-half was in paid employment. The reported weekly household income of one-half of the respondents was in the range of 500–749 Euro.

Nearly one-half of respondents lived in a small town with a population less than 5,000 people, with about one-third being from the city and county of Dublin. Nearly one-half had private medical insurance, and the majority did not have any dependent children living with them. The majority of those who had children had one or two dependent children living in their household.

# Health status, quality of life and willingness to disclose distressing information

## Health status and quality of life

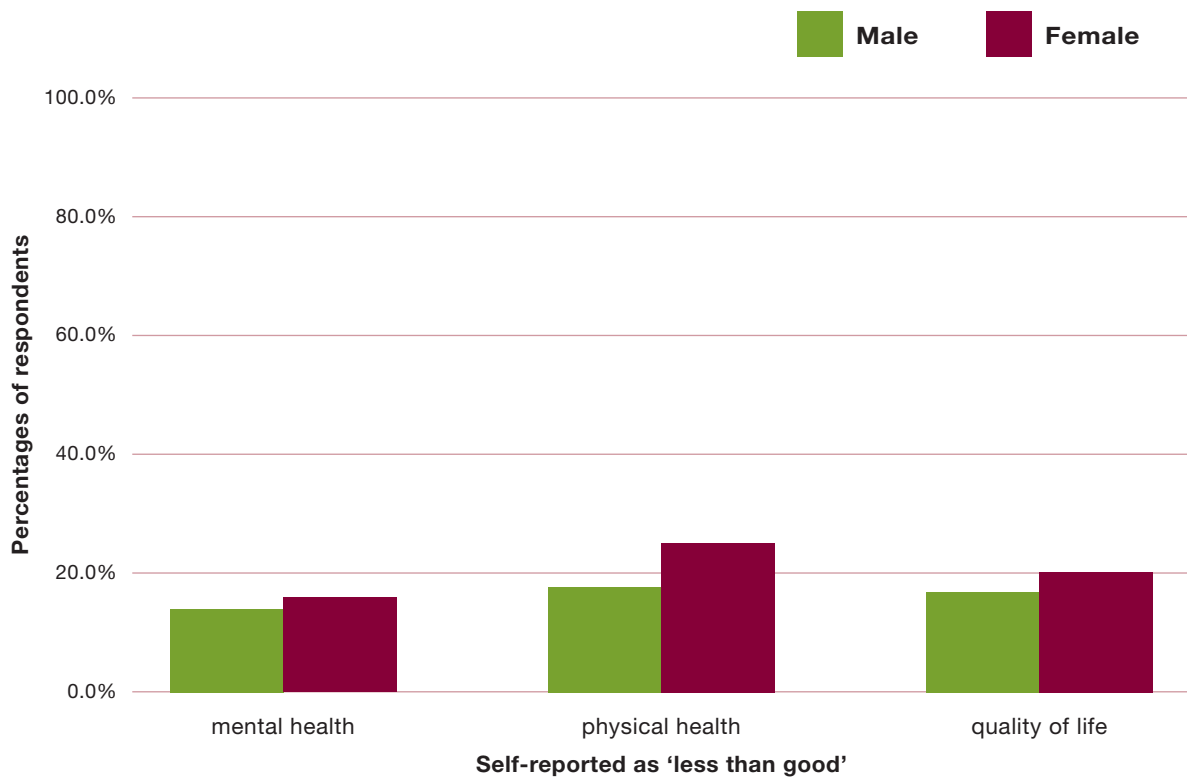
Table 3.1 shows respondents' self-reported health and quality of life over the previous 12 months. The majority of the respondents reported their mental (85%) and physical (79%) health as good or very good in the last 12 months. Likewise, the majority of the respondents rated their quality of life (81%) as good or very good in the last 12 months. Good or very good mental health was reported by equal proportions of men (86%) and women (84%), while more males than females tended to report good to very good physical health (83% vs 75%) and quality of life (83% vs 80%).

**Table 3.1** Weighted percentages of respondents' self-reported mental and physical health and quality of life in the last 12 months

	Mental health	Physical health	Quality of life
Very poor	0.8	1.2	1.2
Poor	3.1	4.7	2.9
Fair	10.9	15.1	14.6
Good	35.8	38.6	46.2
Very good	49.4	40.5	35.1
<b>Total</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>

Proportions of respondents self-reporting 'less than good' ('very poor', 'poor', or 'fair') mental and physical health status and quality of life were compared across gender and age groups of participants. Figure 3.1 shows the proportions of self-reported ill health and quality of life among male and female respondents.

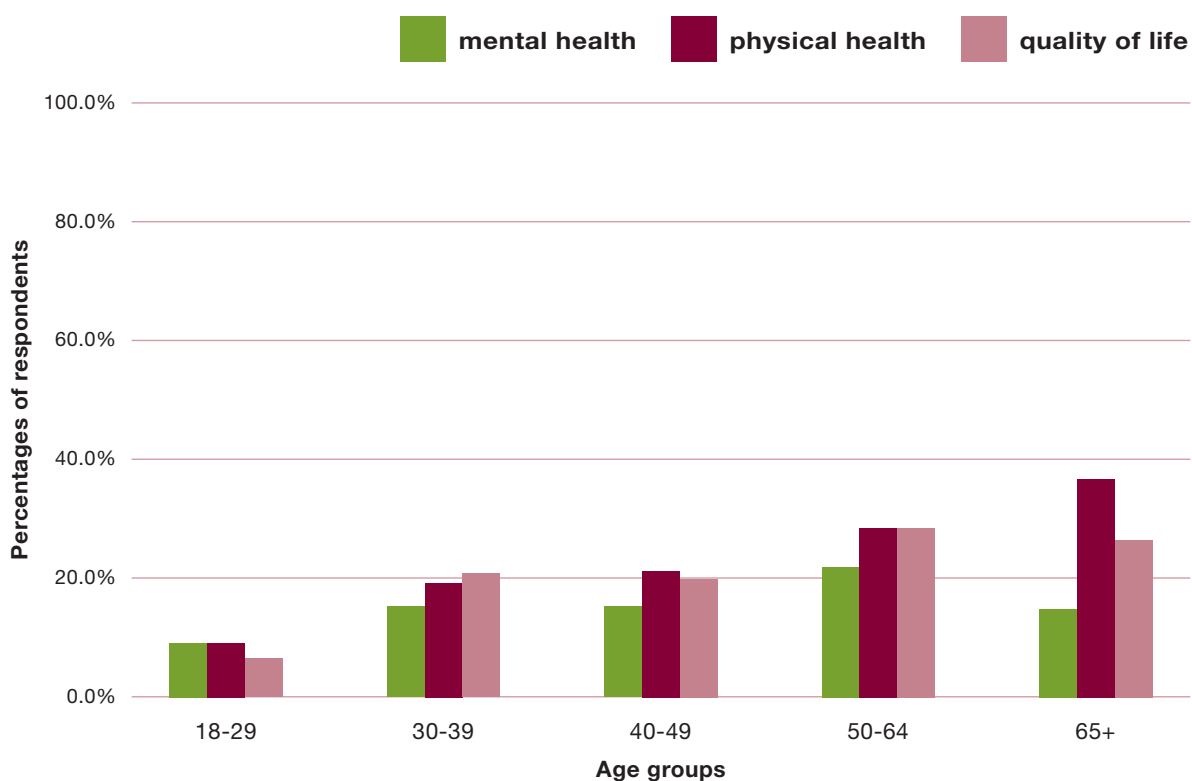




**Figure 3.1** Weighted percentages of respondents self-reporting less than good mental health, physical health and quality of life, by gender

A slightly but not significantly higher percentage of female (16%) than male (14%) respondents reported that their mental health was less than good. A significantly higher percentage of female (25%) than male (17%) respondents reported that their physical health was less than good [ $\chi^2 (1) = 22.21, p < 0.000$ ]. Similarly, a small but significantly higher proportion of female ( $n = 277/1,369, 20.2\%$ ) as compared to male (17%) respondents self-reported that their quality of life was less than good in the last 12 months [ $\chi^2 (1) = 4.31, p = 0.038$ ].

Figure 3.2 shows comparisons of percentages of self-reported less than good mental health, physical health and quality of life, by age group of respondents.



**Figure 3.2** Weighted percentages of respondents self-reporting less than good mental health, physical health and quality of life, by age groups

There were significant age group differences in self-reported mental health [ $X^2(4) = 36.01, p < 0.000$ ]. As can be seen from Figure 3.2, the highest proportion of respondents reporting less than good mental health in the previous 12 months was among those aged between 50 and 64, with the lowest percentage of self-reported less than good mental health among those aged 18–29 years (9%). These age group differences in reporting less than good mental health in the past 12 months were statistically significant.

There was also a significant age group difference in self-reported physical health [ $X^2(4) = 137.20, p < 0.000$ ]. Proportions of respondents reporting that their physical health had been less than good in the past 12 months showed a steady increase over the age groups. The lowest proportion was among the youngest age group of 18–29 (9%), whereas the highest was among those aged 65 years and over (37%).

The proportion of those reporting less than good quality of life also increased over the age groups, with the lowest proportion in the youngest age group. The proportion of those reporting less than good quality of life showed an increase in the 30–49 year age group, with a further increase in the proportion of those reporting less than good quality of life in the 50–64 and over 65 year age groups. These age group differences in self-reported good quality of life of respondents were statistically significant [ $\chi^2(4) = 117.02, p < 0.000$ ].

## **General Health Questionnaire (GHQ12)**

The average total GHQ score of 2,607 respondents (96%) was 9.8 (median = 9.0), ranging from 0.0 to 35.0. Half of the respondents had GHQ total scores of 9.0 or lower. Females reported significantly higher levels of psychological distress than males. The average total GHQ score of female respondents (mean = 10.2, median = 9.0, standard deviation = 4.7) was significantly higher than that of male respondents (mean = 9.4, median = 9.0, standard deviation = 4.0) [ $t(2545.7) = -4.9, p < 0.000$ ].

GHQ 12 scores were transformed using the GHQ bimodal scoring method (Goldberg & Williams, 1988), and those with a score of four or above were classified as a 'probable case' (i.e. those having a probable psychiatric illness). A total of 66% of the respondents had a score of zero, which could be considered an indicator of psychological wellbeing (Scottish Health Survey 2003). A total of 12% with a score of four and above were classified as 'probable cases' (having potential psychiatric problems).

Table 3.2 presents a socio-demographic profile of respondents by GHQ12 score. A later report will investigate in greater detail the impact of the socio-demographic factors on psychological wellbeing and distress. Percentages in the table are row percentages.

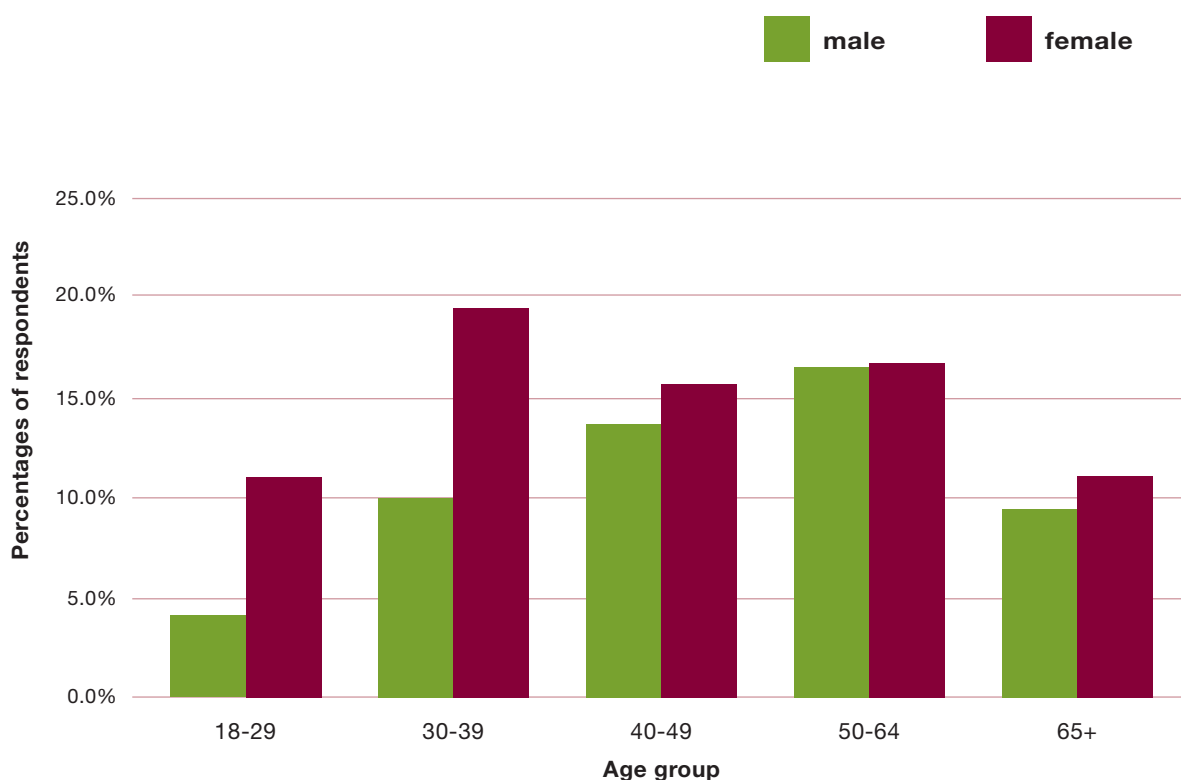
**Table 3.2** Profile of respondents across socio-demographic variables by GHQ12 score in the HRB NPWDS

	<b>% scoring zero on GHQ12</b>	<b>% scoring 1 – 3 on GHQ12</b>	<b>% scoring four or above on GHQ12</b>
<b>Gender</b>			
Female	64.1	21.5	14.4
Male	68.4	21.5	10.1
<b>Age</b>			
18 – 29 years	70.4	22.1	7.5
30 – 39 years	66.3	19.0	14.7
40 – 49 years	63.4	22.0	14.6
50 – 64 years	60.7	22.8	16.6
65+ years	68.1	21.6	10.2
<b>Marital status</b>			
Married/cohabitating	66.2	21.4	12.4
Separated/divorced/widowed	59.1	24.9	16.0
Never married	68.2	20.7	11.1
<b>Level of education</b>			
Primary	64.3	21.4	14.4
Secondary	66.7	20.4	12.9
Higher	66.6	25.1	8.3
<b>Employment status</b>			
Employees	71.1	20.6	8.2
Unemployed	50.0	18.5	31.5
Self-employed	67.9	22.5	9.6
Retired	71.8	21.1	7.1
Full-time education/training	68.4	24.4	7.2
Other/unable to work – e.g. sick	29.1	25.5	45.5
Domestic duties	62.9	21.9	15.1
<b>Household income (£ per week)</b>			
Under 300	53.3	27.1	19.6
300–399	57.6	23.6	18.8
400–499	65.5	19.4	15.1
500–749	61.7	24.1	14.2
750–899	73.1	20.5	6.4
900–1,249	69.2	21.1	9.7
Over 1,249	73.4	20.3	6.2
<b>Size of location</b>			
Open countryside	70.6	18.5	10.9
Village/small town (200–4,999)	71.9	20.2	7.9
Large town (5,000–10,000)	63.0	20.6	16.4
City (Waterford, Limerick, Galway, Cork, Dublin)	66.3	22.5	11.2
Dublin county (outside Dublin city)	51.6	32.7	15.7
<b>Medical cover</b>			
GMS card	54.3	22.8	22.8
Private insurance	70.5	22.2	7.3
No GMS card or private insurance	71.9	17.5	10.6
Both	57.9	25.7	16.3

A higher percentage of male respondents (68%) had a score of zero compared to the female respondents (64%). Of the total sample (n = 2,607) a significantly higher percentage of females (14%) than males (10%) were classified as 'probable cases' [ $\chi^2(1) = 11.55, p = 0.001$ ] and is in keeping with previous UK and European findings (e.g. European Opinion Research Group, 2003; European Commission, 2006; Scottish Health Survey, 2003; Northern Ireland Health and Social Wellbeing Survey, 2002). Females tended to report higher levels of distress while males reported higher levels of wellbeing.

In terms of age, Table 3.2 shows the percentage of respondents with a GHQ12 score of zero was greatest in the lowest and highest age groups. An opposite pattern of results was found in those showing a score of four or more whereby those in the youngest and oldest age groups were the least likely to exhibit signs of distress. Psychological distress was most common in those who fell into the age category of 50 – 64 years and was relatively common in the age groups 30 – 39 years and 40 – 49 years.

In order to examine in more detail the relationship of age and gender in those who exhibited psychological distress, percentages of respondents with GHQ scores of four and above were compared across age and gender. Figure 3.3 shows the distribution of 'probable cases' within the total sample of respondents (n=2,607) across these two socio-demographic categories.



**Figure 3.3** Weighted percentages of respondents with a GHQ score of four and above, by age groups and gender

As can be seen from Figure 3.3, the highest percentage of 'probable cases' among female respondents was among those aged between 30 and 39 years (19%), whereas the lowest percentage was among those in the 18–29 and 65+ age groups. These age differences among females were statistically significant [ $\chi^2(4) = 12.41, p = 0.015$ ]. Whereas percentages of 'probable cases' among males were generally lower than those among females for all age groups, the pattern of distribution of 'probable cases' among males of various age groups was somewhat different from those of females. The highest percentage of 'probable cases' among males was in the age group 50–64 (16%), whereas the lowest percentage was among those aged between 18 and 29 (4%). These GHQ differences by age among males were statistically significant [ $\chi^2(4) = 30.08, p < 0.000$ ].

Within marital status those in the separated/married/divorced group (16%) showed the highest levels of distress. The highest levels of psychological wellbeing was evident in the never married group (68%), although there was little difference between the proportion in the never married group and the proportion in married/cohabiting group (66%) scoring zero on the GHQ12.

There was little difference across the educational groups in the proportions scoring zero. The proportion of those experiencing psychological distress decreased across the educational groups with the highest proportion of those with a score of four or more evident in those with a primary level education (14%) while the lowest proportion of 'probable cases' was evident in those with a third level education (8.3%).

Regarding employment, over two-thirds of the respondents in each employment category were scoring zero on the GHQ12 apart from those who were unemployed and those who were unable to work (e.g. due to sickness). Only half of those unemployed (50%) had scored zero and only just over a quarter (29%) of those who were unable to work did so. Within the 'probable cases', the unemployed and those unable to work were the most vulnerable with 31% of the unemployed being categorised as 'probable cases' and 45% of those unable to work being categories as such.

Wellbeing was generally highest in those with greater weekly incomes. However the greatest difference in psychological distress was between those who earned under €750 per week and those earning over €750 per week. Over 14% or more of those with weekly incomes of less than €750 were categorised as 'probable cases' while less than 10% of those with a weekly income of more than €750 were categorised as such.

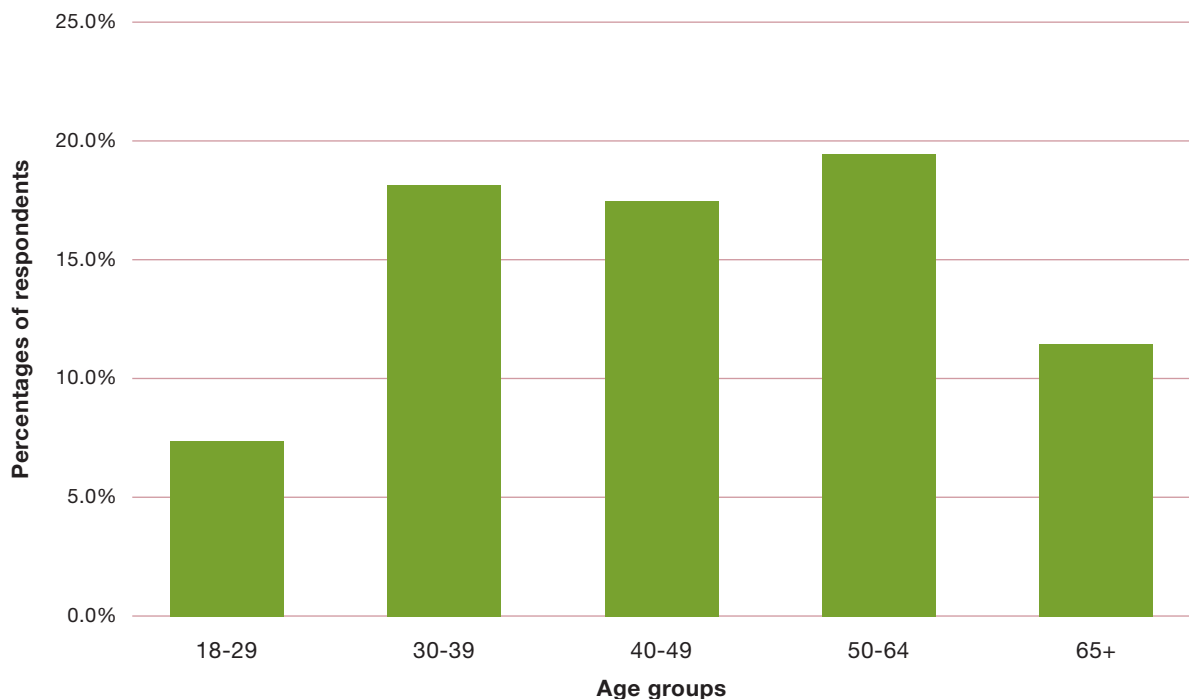
There was little difference in psychological wellbeing across the size of the locations in which the respondents lived; however psychological distress seemed most evident in those who lived in large towns with populations of 5,000 – 10,000 (16%) and those who lived in Dublin county (16%; outside Dublin city).

The highest levels of distress were evident in those who had access to free medical care (23%) and those who had both free medical care and private health insurance (16%). The highest levels of wellbeing were evident in those with private insurance (70%) or those who had neither private insurance or free medical care (72%).

### Self-reported mental health problems

A total of 14% of 2,678 respondents reported that they had experienced some mental, nervous or emotional problems, such as anxiety or depression, in the last 12 months. Gender comparisons ( $\chi^2 (1) = 12.5, p = 0.000$ ) showed that a greater proportion of females (17%) reported experiencing mental health problems in the last year than males (12%).

Figure 3.4 presents percentages of respondents with self-reported mental, nervous or emotional problems by age groups.



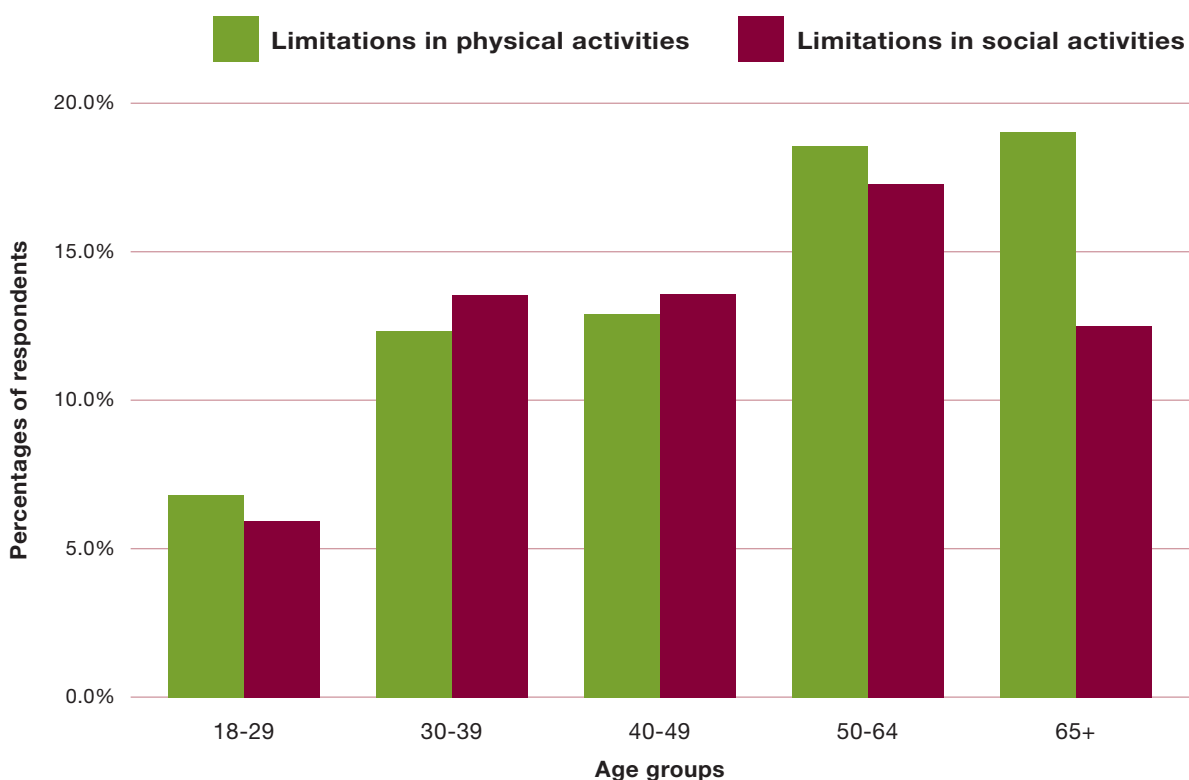
**Figure 3.4** Weighted percentages of respondents with self-reported mental or emotional problems in the last 12 months, by age groups

As can be seen from Figure 3.4, the highest percentage of respondents with self-reported mental, nervous and emotional problems in the last year was in the age group of 50–64 (20%), whereas the lowest was among those aged 18–29 (7%; [ $\chi^2(4) = 55.85, p < 0.000$ ]). As with the GHQ12 scores, the self-reported mental health problems seemed to peak among those aged 50–64 and then decrease among those aged 65 or over.

## Self-reported limitations in physical and social activities

Limitations in physical or social activities in the last year due to mental health problems were reported by over 10% of the respondents, which is a significant indicator of disability. A total of 13% of respondents reported that they had experienced limitations in physical activities and 12% reported that they had experienced limitations in social activities. There were no significant differences in the reported limitations in physical or social activities due to mental or emotional problems between male and female participants.

Figure 3.5 presents self-reported limitations in physical and social activities by age groups.



**Figure 3.5** Weighted percentages of respondents with self-reported limitations in physical and social activities in the last 12 months, by age groups



As can be seen from Figure 3.5, the lowest percentage of respondents reporting that they had experienced some limitations in physical activities (6%), not surprisingly, was in the age group 18–29 years. The highest percentage was among those aged 65 and over (19%). The percentages of respondents reporting some limitations in physical activities seemed to increase among older age groups. Age group differences among respondents reporting limitations in physical activities due to mental or emotional problems were statistically significant [ $\chi^2 (4) = 55.30, p < 0.000$ ].

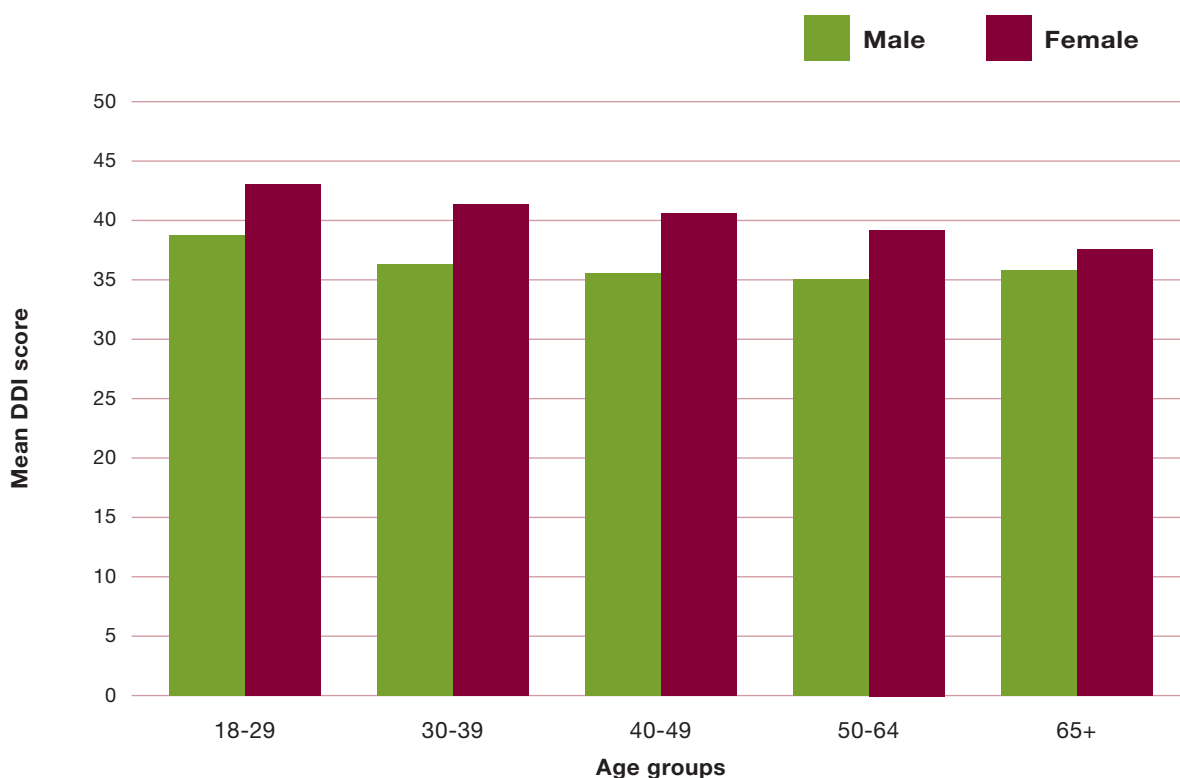
Similar to self-reported limitations in physical activities, significant age group differences were observed for self-reported limitations in social activities [ $\chi^2 (4) = 40.48, p < 0.000$ ]. The lowest percentage of those reporting limitations in social activities were aged between 18 and 29 (6%). However, the highest percentage of respondents with self-reported limitations in social activities was among those aged between 50 and 64 (17%) and not in the 65 years and over age group as was the case with limitations in physical activities.

## **Willingness to disclose distressing information to others**

The Distress Disclosure Index measures the willingness to disclose distressing information to others. The average total score of Distress Disclosure Inventory (DDI) was 38.60 (median = 41.0, standard deviation = 8.7, range 12.0 to 60.0). The average DDI score for females (mean = 40.60) was significantly higher than that for male respondents (mean = 36.5) [ $t (2691.10) = -12.44, p < 0.000$ ], indicating that female respondents reported a greater willingness to disclose psychological distress than males (Figure 3.6).

In general, respondents from younger groups tended to report higher average scores of DDI than those from older groups. For example, those aged 18–29 had the highest average DDI score of 40.72 (SD = 8.29) and those aged 65 and over had the lowest DDI score of 36.60 (SD = 8.79). Kruskal-Wallis non-parametric test for equality of mean ranks showed that these age differences between average scores of emotional disclosure were statistically significant [ $\chi^2 (4) = 107.46, p < .000$ ], whereby respondents who were older were less willing to disclose emotional distress.

Overall, younger female respondents seemed to be most willing to disclose their emotional distress, with the oldest male and female respondents least willing (Figure 3.6). Further analysis of the DDI can be found in Ward et al. (2007).



**Figure 3.6** Mean DDI score of males and females, by age group

## Summary

In summary, the majority of the respondents rated their mental health, physical health and quality of life as good or very good in the previous year. There were no gender differences in self-rated mental health, but a greater proportion of males reported good or very good physical health and quality of life than females. Those reporting less than good physical health increased over the age groups, as did the proportion reporting less than good quality of life. However, the greatest proportion of those reporting less than good mental health occurred in the 50–64 year age group.

Approximately two-thirds of the respondents had scores of zero on the GHQ12, indicating high levels of psychological wellbeing. Those showing high the highest mental health and wellbeing scores were male, aged 18 – 29 years, married or cohabiting, employed and have private health insurance. Regarding current psychological distress, a total of 12% of the respondents were classified as ‘probable cases’, with significantly more females being classified as such. The majority of these individuals were classified as married or cohabiting, employed and have access to free medical care. The lowest proportion of ‘probable cases’ was in the 18–29 age group and 65 and over age group. The distribution pattern of ‘probable cases’ was different across gender. For males the highest proportion of probable cases was in the 50–64 year age group, while for females it was in the 30–39 year age group.

In terms of self-reported mental health problems in the previous year, 14% of the respondents reported that they had experienced some mental, nervous or emotional problems, such as anxiety or depression. Again, there were significant gender differences, with a greater proportion of females than males reporting such problems. Similar to the findings of current psychological distress (GHQ12), the lowest proportion of those reporting mental health problems in the previous year was in the youngest (18–29 years) and oldest (65 and over) age groups.

A number of the respondents reported experiencing limitations in social or physical activities in the previous year due to mental health problems. A total of 13% of the respondents reported limitations in physical activities, while 12% reported limitations in social activities. These figures correspond to those reporting mental health problems in the previous year and to the proportion reporting current mental health problems. This adds validity to the findings that approximately 12% to 14% of individuals within the population are experiencing significant mental health problems that may interfere with their daily activities. The proportion of people reporting limitations in physical activities showed an increase over the age groups, but within social activities, the greatest proportion reporting limitations was in the 50–64 year age group. Furthermore, across the age groups, until 65 years and over, the pattern of reported limitations in social and physical activities appear relatively similar, with very little difference between the proportion reporting limitations in physical activities compared to social activities. Within the 65 years and over age group, a greater proportion reported limitations in physical activities than in social activities, suggesting that mental health problems have a greater impact on this group's physical activity than social activities.

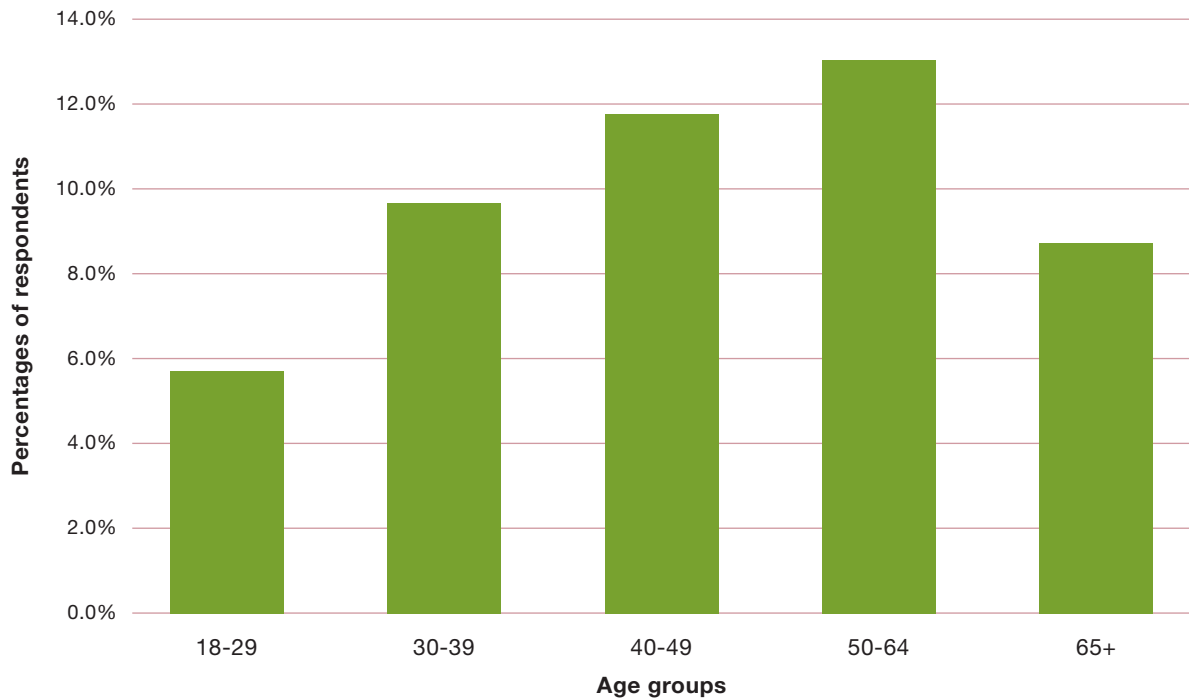
Regarding the willingness to report distressing information to others, females reported a greater willingness to disclose distressing information to others than males, and the youngest age groups were more willing to disclose distressing information than were the older age groups.

# Use of health care and treatment services and willingness to seek help

## Primary health care use

Respondents were asked if they had seen a GP for physical health problems in the last 12 months. Almost 71% of the respondents reported that they had seen a GP for physical problems. Of the 1,912 respondents who reported having seen a GP, 29% had been to see a GP once, while 71% had attended their GP more than once. Regarding those who visited a GP for physical health problems, the 1,912 respondents accounted for a total of 7,544 visits, resulting in an average of 3.9 visits per person who attended. Out of 1,912 respondents who visited their GPs at least once for physical problems, a higher percentage of female (77%) than male (64%) respondents did so [ $\chi^2 (1) = 50.84, p < 0.000$ ]. In addition, the reported average number of times respondents spoke to GPs about physical problems was significantly higher for female (mean = 4.4) than for male (mean = 3.4) respondents [ $t (1903.03) = -4.67, p < 0.000$ ]. Within age groups, over two-thirds of all age groups had reported attending a GP for physical health problems. As expected, the greatest proportion of attendees were within the older age groups, with 92.2% of those over the age 65 years reporting that they attended a GP at least once in the previous year and 78% of the 50–64 year age group doing so [ $\chi^2 (1) = 141.9, p < 0.001$ ].

Respondents were asked if they had spoken to a GP in the previous 12 months about being anxious or depressed, or about mental, nervous or emotional problems. A total of 9% of the sample reported speaking at least once to a GP about mental health problems in the last year. A special Eurobarometer report on mental wellbeing reported that 14% of the Irish sample had sought help for psychological problems in the previous year and of those that had sought help, 91% had contacted the GP (European Commission, 2006). In this survey, the respondents ( $n = 255$ ) reported a total of 1,132 GP consultations, resulting in an average of approximately 4.4 visits per person specifically for mental health problems within the year. As expected, the number of respondents reporting that they had attended a GP for physical health problems was much greater than the number reporting that they had spoken to a GP about mental health problems, yet the latter group had more visits on average (4.4) than those reporting physical health problems (3.9). Of the 255 respondents who reported having spoken to a GP about mental health problems in the last year, a greater proportion of these were female (61%; [ $\chi^2 (1) = 12.35, p < 0.000$ ]). Regarding the age of those who reported having discussed mental health problems with a GP in the last year (Figure 4.1), only 9% of the over 65 year age group and 6% of the 18–29 year age group did so.

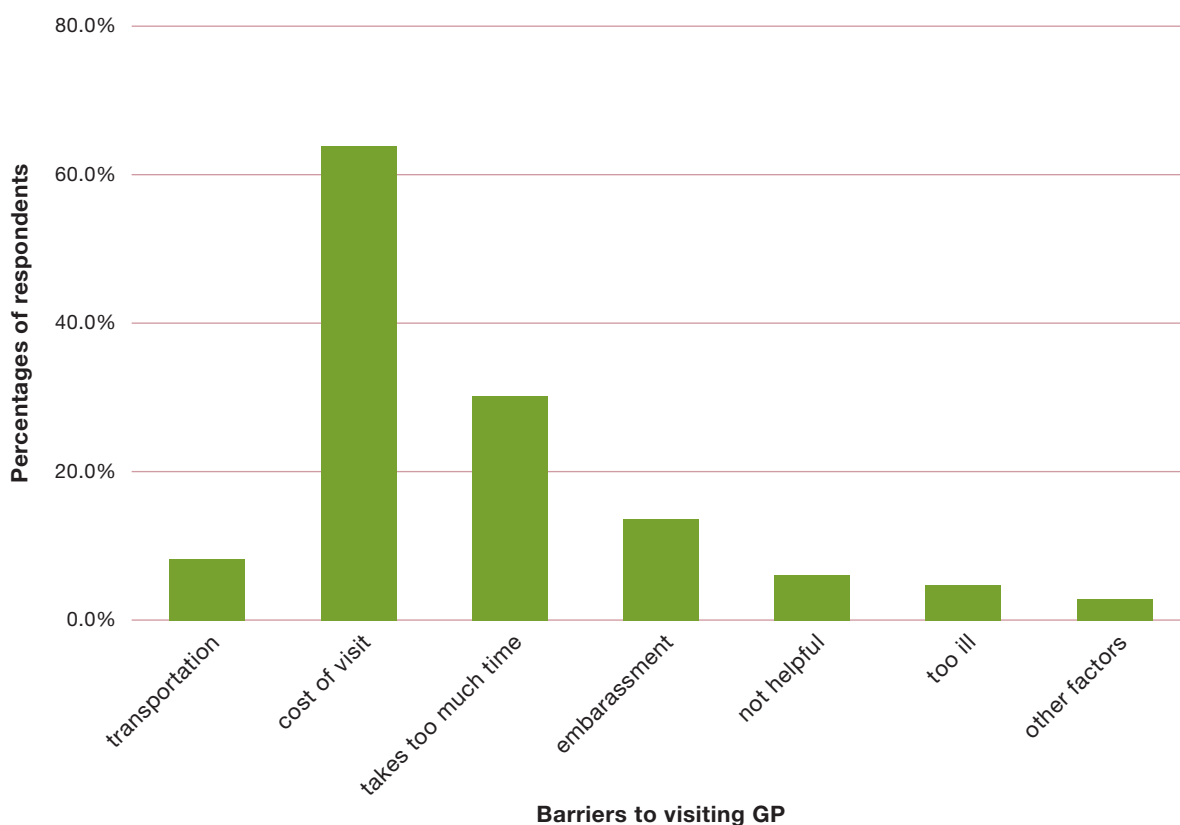


**Figure 4.1** Weighted percentages of respondents reporting that they had spoken to a GP about mental health problems in the last 12 months, by age group

## Barriers to seeing a GP

Out of the total 2,711 respondents, 16% provided information on the barriers that prevented them from visiting their GP in the previous 12 months. A total of 84% of respondents reported that nothing prevented them from seeing a GP. As can be seen from Figure 4.2, the most frequently quoted barrier (63%) was the cost of the visit. Not surprisingly, 95% of this group did not have free medical cover. The next two most frequently reported barriers were that it took too much time (30%) and embarrassment/feeling awkward (13%). Few respondents reported that they were too ill to see the doctor (4%) or reported that there were other factors that prevented them from seeing their GP (3%).

Regarding gender comparisons, the pattern of responses was similar across males and females, with both groups reporting cost as the most frequent barrier preventing attendance at a GP. This pattern was also evident across the age groups until the age of 65 years and over. For those aged 65 years and over, however, the pattern of responses changed, with those in this age group reporting time as the most frequent barrier, followed by transportation. Cost was the third most frequent barrier reported by this group. Only 23% of the responses from this age group viewed cost as a barrier, while for the other age groups cost was reported as a barrier in over 60% of responses. Unlike the other age groups the majority of respondents in the 65 year or over age group had access to free medical care from a GP, thus cost of visit was not an issue.



**Figure 4.2** Weighted percentages of respondents reporting barriers preventing them from visiting a GP

## Use of mental health services

Respondents were asked if they had been in contact with any of the following mental health services in the last 12 months: outpatient clinic, day centre, day hospital and inpatient psychiatric hospital/unit. Of all respondents, 6% of respondents reported using some form of mental health services. A total of 5% had contact with an outpatient clinic, 1% with a day centre, 2% with a day hospital and 0.6% with an inpatient service. As expected, a much lower proportion of individuals had contacted specific mental health services than had contacted a GP.

## Use of services of professionals/support persons and perceived effectiveness

Nine types of mental health professionals and support persons, such as nurse, psychiatrist, clergy, were read out to respondents (Table 4.1) and they were asked if they had been in contact with any of these in the last 12 months for help with a mental, nervous or emotional problem. If the answer was positive, respondents were asked to evaluate the effectiveness of each professional/support person, ranging from 1 'very effective' to 4 'not at all effective', with an additional option 5 of 'don't know'.

A very small percentage of respondents reported seeking help, other than from a GP, for mental health problems in the previous year. Percentages of those who reported seeking help ranged from 0.4% to 2%, with the majority of respondents reporting contact with a psychiatrist, followed by a nurse and a counsellor (Table 4.1).

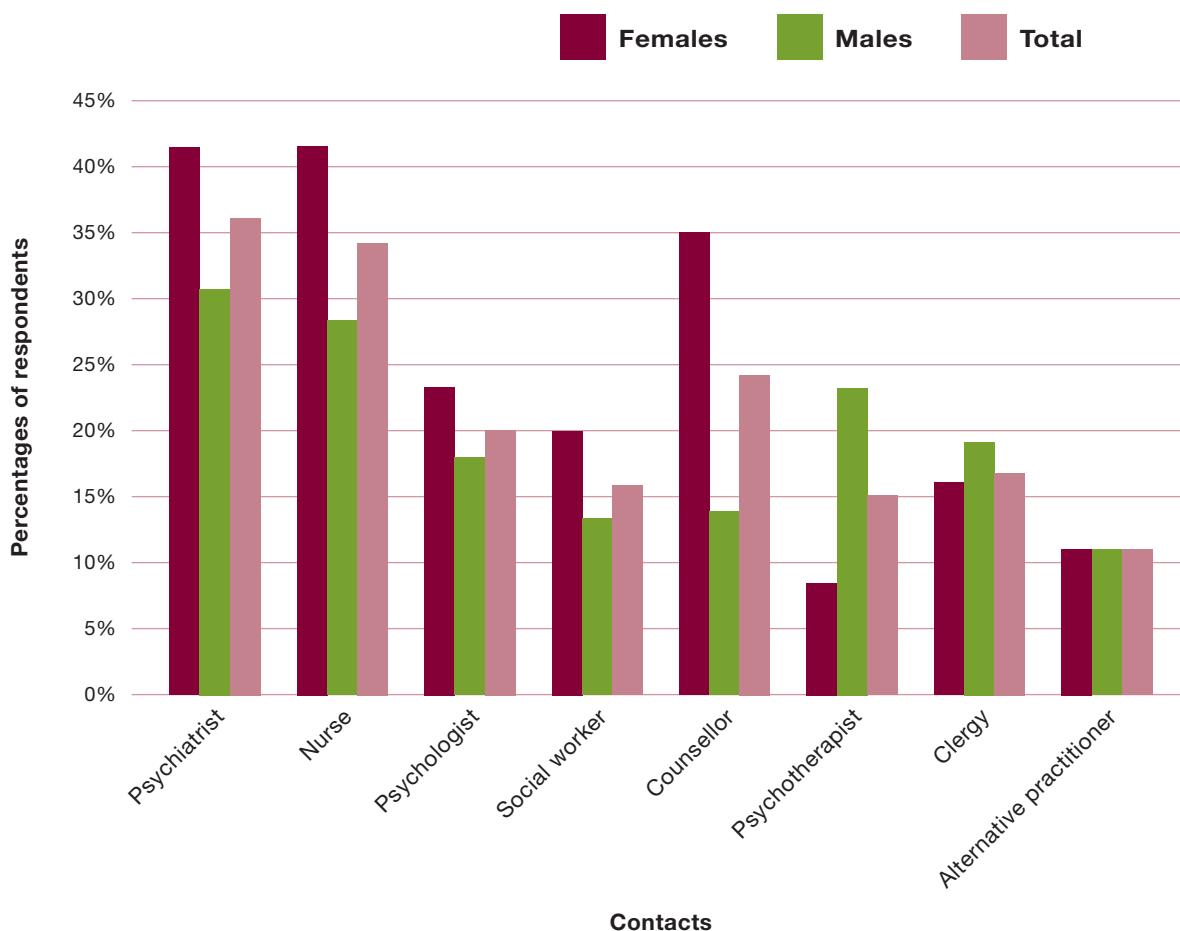
It is important to reiterate here that the number of respondents reporting contact with a GP was 255, which resulted in a total of 1,132 reported visits per year. Thus the GP is still the most widely used source of help for those experiencing mental health problems. The only significant gender differences in the current findings were for contact with counsellor and contact with psychotherapist. Females were more likely to contact a counsellor than males, while males were more likely to contact a psychotherapist than females.

**Table 4.1** Weighted percentages of respondents who sought help for mental health problems from professionals/support persons in the past 12 months

Source of help	Female	Male	Total
Psychiatrist	2.6	1.9	2.2
Nurse	2.6	1.7	2.1
Counsellor	2.2	0.8	1.5
Psychologist	1.5	1.1	1.3
Clergy	1.0	1.1	1.1
Social worker	1.2	0.8	1.0
Psychotherapist	0.5	1.4	0.9
Alternative practitioner	0.7	0.7	0.7
<b>Other</b>	<b>0.6</b>	<b>0.2</b>	<b>0.4</b>

A total of 165 respondents (6%) reported that they had been in contact with one or more of the named professionals/support persons in the past 12 months for help with a mental health or emotional problem. As can be seen from Figure 4.3, the highest percentage of reported contacts for help with mental health problems of the 165 respondents was with psychiatrists (36%), followed by contacts with a nurse (34%)

and a counsellor (24%). The lowest number of reported contacts was with alternative practitioners (11%). Of the 165 respondents, 48% were female and 52% were male. Figure 4.3 shows the percentage of male and female responses to the use of contacts for mental health problems in the previous year. The pattern is relatively similar across gender, with both males and females reporting contact with a psychiatrist most frequently, followed by contact with a nurse.



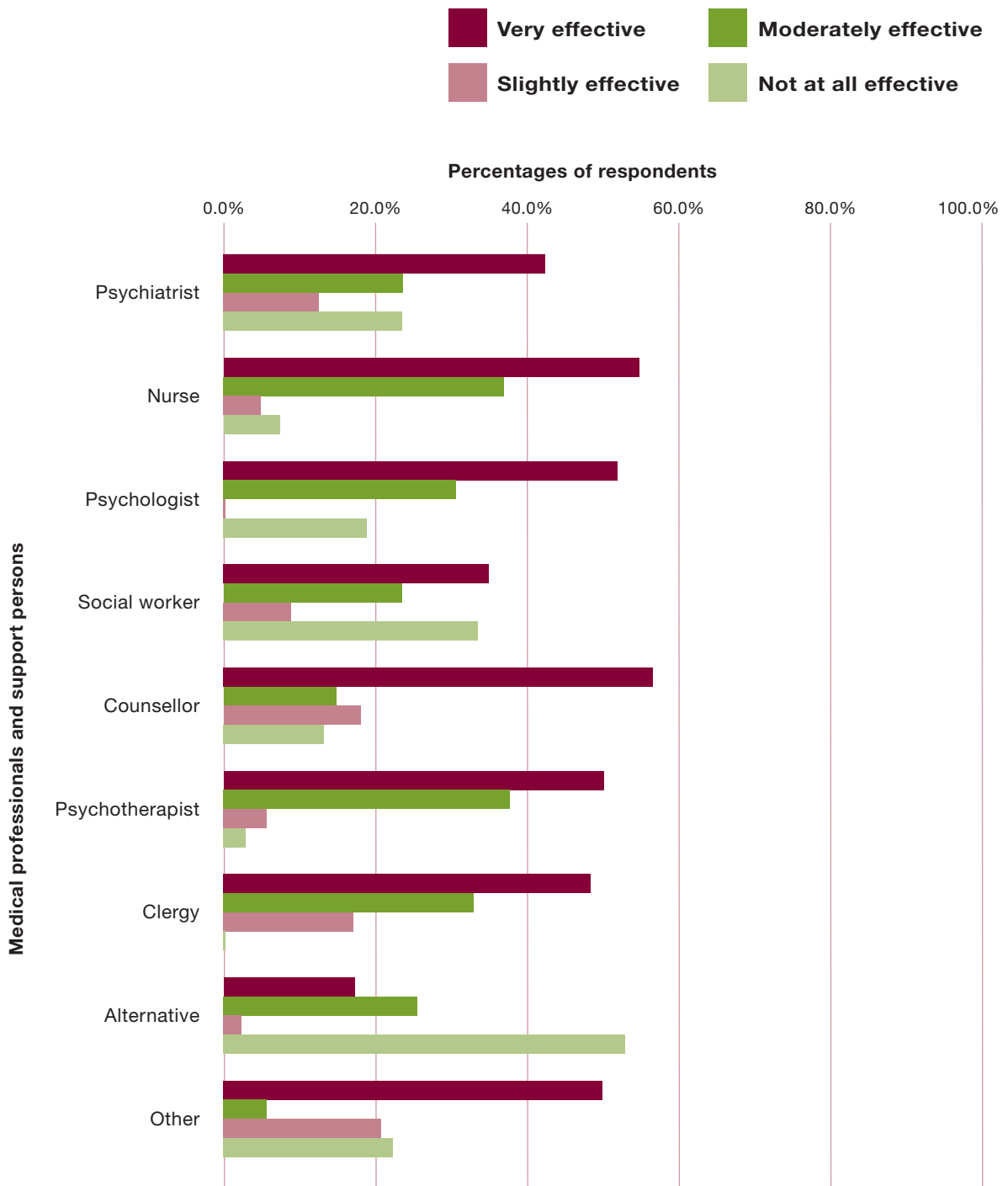
**Figure 4.3** Weighted percentages of contacts for help with mental or emotional problems in the last 12 months, by gender

The majority of the 165 respondents who contacted such professionals/support persons (96%) rated the effectiveness of each on a scale from 1 'Very effective' to 4 'Not at all effective'. The perceived effectiveness is presented in Figure 4.4.

Nearly one-half of the 60 persons who contacted psychiatrists in the previous 12 months (42%) rated them as 'very effective'. However, about one-quarter of the respondents (23%) rated psychiatrists as 'not at all effective'. More than one-half of the 54 respondents who rated the effectiveness of their contact with nurses (54%) considered such contacts as 'very effective'. Only three of those who contacted nurses (6%) rated contacts with nurse as 'not at all effective'. More than one-half of the 39



respondents who rated the effectiveness of their contacts with counsellors (56%) viewed such contacts as 'very effective', with five respondents (13%) considering them 'not at all effective'. One-half of the 26 respondents who rated the effectiveness of their contacts with members of the clergy (50%) considered these contacts as very effective. No respondents rated contacts with the clergy as 'not at all effective'.



**Figure 4.4** Perceived effectiveness of contacts for help with a mental or emotional problem, by weighted percentages of respondents

In order to facilitate comparison of the perceived overall effectiveness of various professionals/support persons, the scores of four items ranging from 1 'Very effective' to 4 'Not at all effective' were reversed and recalculated to four items ranging from 0 'Not at all effective' to 3 'Very effective'. Table 4.2 presents the average 'effectiveness' score of each health professional in a descending order of means.

**Table 4.2** Average scores of perceived effectiveness of contacts for help with a mental, nervous or emotional problem in the past 12 months<sup>5</sup>

Overall effectiveness scores		
Contacts	Mean	Standard deviation
Nurse	2.38	0.83
Psychotherapist	2.37	0.80
Clergy	2.33	0.76
Counsellor	2.14	1.12
Psychologist	2.13	1.14
Other contacts	1.86	1.32
Psychiatrist	1.84	1.21
Social worker	1.59	1.29
Alternative practitioner	1.07	1.26

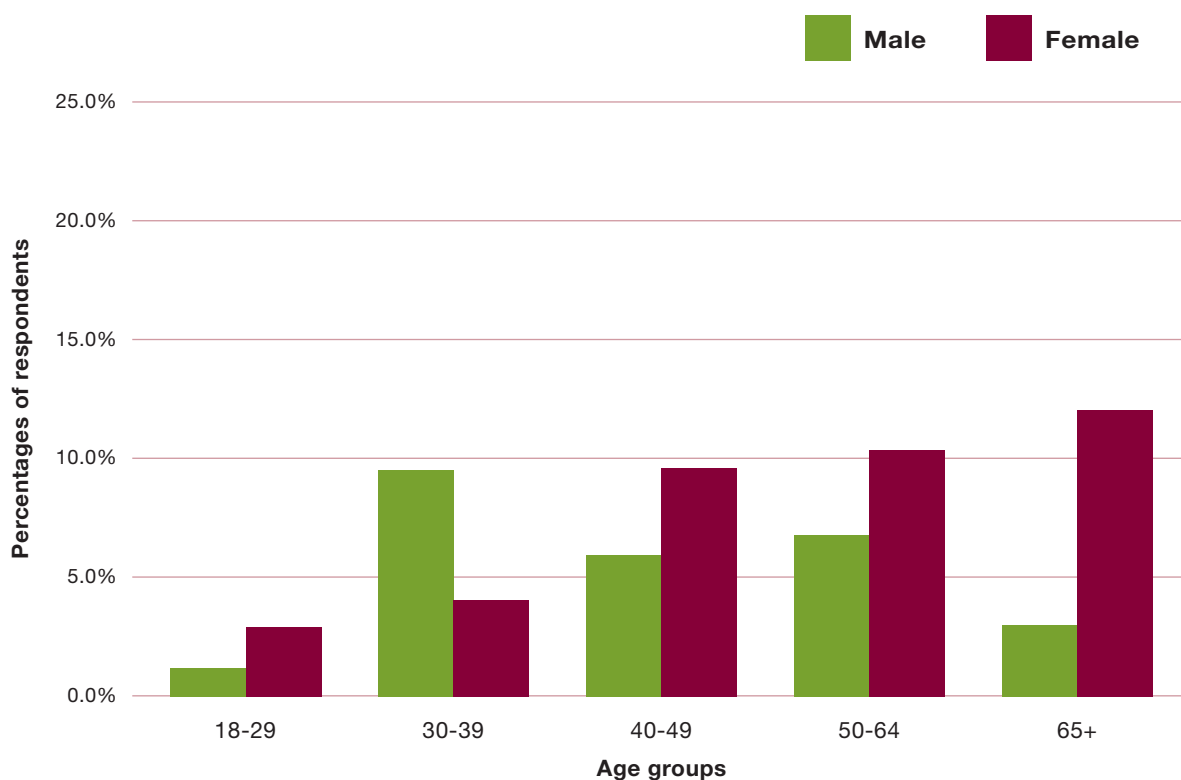
As can be seen from Table 4.2, contacts with nurses had the highest average effectiveness score (mean = 2.38), with half of the 54 respondents rating these contacts as 'very effective' (median = 3.0). The second highest average effectiveness score (mean = 2.37) was reported for contacts with psychotherapists, with half of the 25 respondents considering these contacts as 'very effective' (median = 3.0). The lowest average effectiveness score (mean = 1.07) was reported for contacts with alternative practitioners, with approximately half of the 15 contacts considered to be between 'slightly' or 'moderately effective'.

5 Four-item scale: 0 'Not at all effective', 1 'Slightly effective', 2 'Moderately effective', 3 'Very effective'

## Use and perceived effectiveness of medication for mental health problems

Respondents were asked if they had taken any prescribed medication for a mental, nervous or emotional problem in the last 12 months. The majority of respondents who answered this question (94%) reported that they had not, whereas 6% stated that they had used prescribed medication for mental or emotional problems. A significantly higher percentage of female (7%) than male respondents (5%) reported that they had taken some prescribed medication in the last 12 months for mental or emotional problems [ $\chi^2 (1) = 5.69, p = 0.017$ ].

Figure 4.5 presents the distribution of percentages of respondents (n = 162) who reported that they had taken any prescribed medication for a mental, nervous or emotional problem in the last 12 months by age and gender groups.



**Figure 4.5** Weighted percentages of respondents who reported that they had taken any prescribed medication for a mental, nervous or emotional problem in the last 12 months, by age and gender

As can be seen from Figure 4.5, there were also age by gender differences in the reported use of prescribed medication. The highest percentage of male respondents reporting use of prescribed medication for a mental or emotional problem in the past year were those aged between 30 and 39 years (10%), followed by those in the age

group of 50–64 years (6%). The smallest percentage of male respondents reporting use of prescribed medication was aged between 18 and 29 (1%). These age differences in the percentages of males reporting use of prescribed medication were statistically significant [ $\chi^2 (4) = 29.25, p < 0.000$ ].

The percentages of females reporting use of prescribed medication for mental, nervous and emotional problems were the lowest among those aged between 18 and 29 (3%) and increased among older age groups. The highest percentage of reported use of prescribed medication for mental or emotional problems was among females aged 65 and over (12%). These age differences in the percentage of female respondents reporting use of prescribed medication for emotional problems in the last year were statistically significant [ $\chi^2 (4) = 28.91, p < 0.000$ ].

In general, reported use of prescribed medication was the lowest among the youngest group of respondents aged between 18 and 29. The percentages of those reporting use of prescribed medication tended to increase by age for female respondents. As for the male respondents, the percentage of reported use reached its highest point among those aged 30–39, slightly decreased among the 40–49 age group, reached the second highest point among those aged between 50 and 64 and then decreased again among male respondents aged 65 or over.

In total, 98% of the 162 respondents who reported that they had used prescribed medication in the last 12 months for mental or emotional problems responded to the question about who prescribed such medication. Table 4.3 shows reported numbers and percentages of professionals who had prescribed medication.

**Table 4.3** Weighted percentages of reported professionals who prescribed medication for a mental, nervous or emotional problem in the last 12 months

Who prescribed medication	%
Psychiatrist	26.2
GP	78.4
Doctor/Hospital/Clinic	12.0
Other	1.4

As can be seen from Table 4.3, in the majority of probable cases (78%) medication was prescribed to respondents by GPs. In slightly over one-quarter of the 148 probable cases (26%) medication was prescribed by a psychiatrist.

Respondents were asked to indicate whether the medication had been a tranquilliser, antidepressant or other type of medication. A total of 99% could specify what kind of medication they had been prescribed. The majority of those who reported what kind of medication they had been prescribed stated that they had been prescribed antidepressants (72%). Less than one-quarter reported to have been prescribed tranquillisers (23%), with one-fifth of the respondents reporting that they had been prescribed some other type of medication (20%).

### **Effectiveness of prescribed medication**

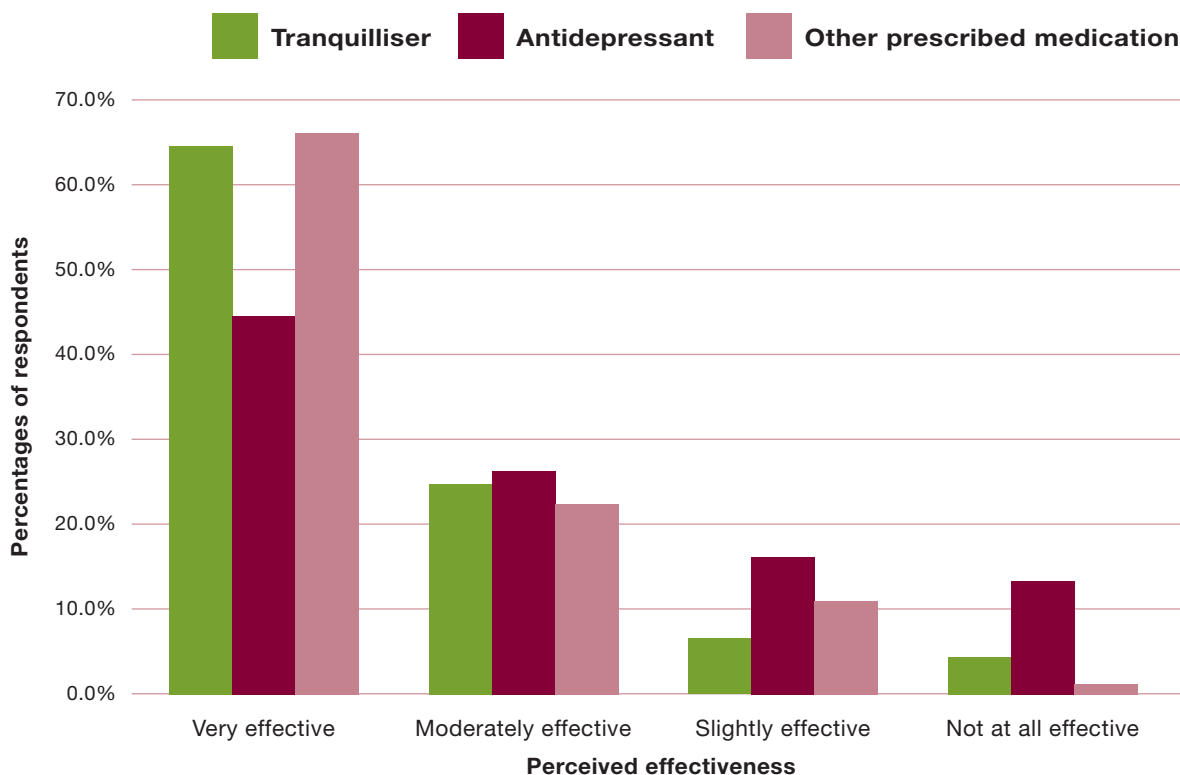
Those 157 respondents who reported what kind of medication they had been prescribed were asked to evaluate the effectiveness of the prescribed tranquillisers, antidepressants or other medication on a 4-item scale from 1 'Very effective' to 4 'Not at all effective'. Most of the 157 respondents (96%) commented on the effectiveness of one or two types of their prescribed medication. There were a total of 172 comments from 151 respondents on the effectiveness of the medication. A total of 21% were on the effectiveness of tranquillisers, 62% on the effectiveness of antidepressants and 17% on the effectiveness of other prescribed medication.

Most of the 151 respondents who reported how effective other medication had been to them considered such medication 'very effective' (60%). Over one-quarter of respondents thought that their prescribed medication was 'moderately effective' (29%), 15% reported that their medication was 'slightly effective', and 10% reported that it was 'not at all effective'.

Weighted percentages of responses are presented in Figure 4.6.

As can be seen from Figure 4.6, the majority of respondents who provided their comments about the effectiveness of each type of medication considered tranquillisers (65%) and other prescribed medication (66%) very effective. About one-quarter of those who evaluated tranquillisers (25%) considered them moderately effective, and only two respondents (4%) considered them not at all effective for their mental or emotional problem.

Nearly one-half of those who provided information about the effectiveness of antidepressants considered them very effective (45%). More than one-quarter (26%) considered them moderately effective, and 13% reported them as 'not at all effective'. The majority of the 29 respondents who evaluated effectiveness of other prescribed medication considered it 'very effective'.



**Figure 4.6** Weighted percentages of responses regarding the effectiveness of prescribed medication

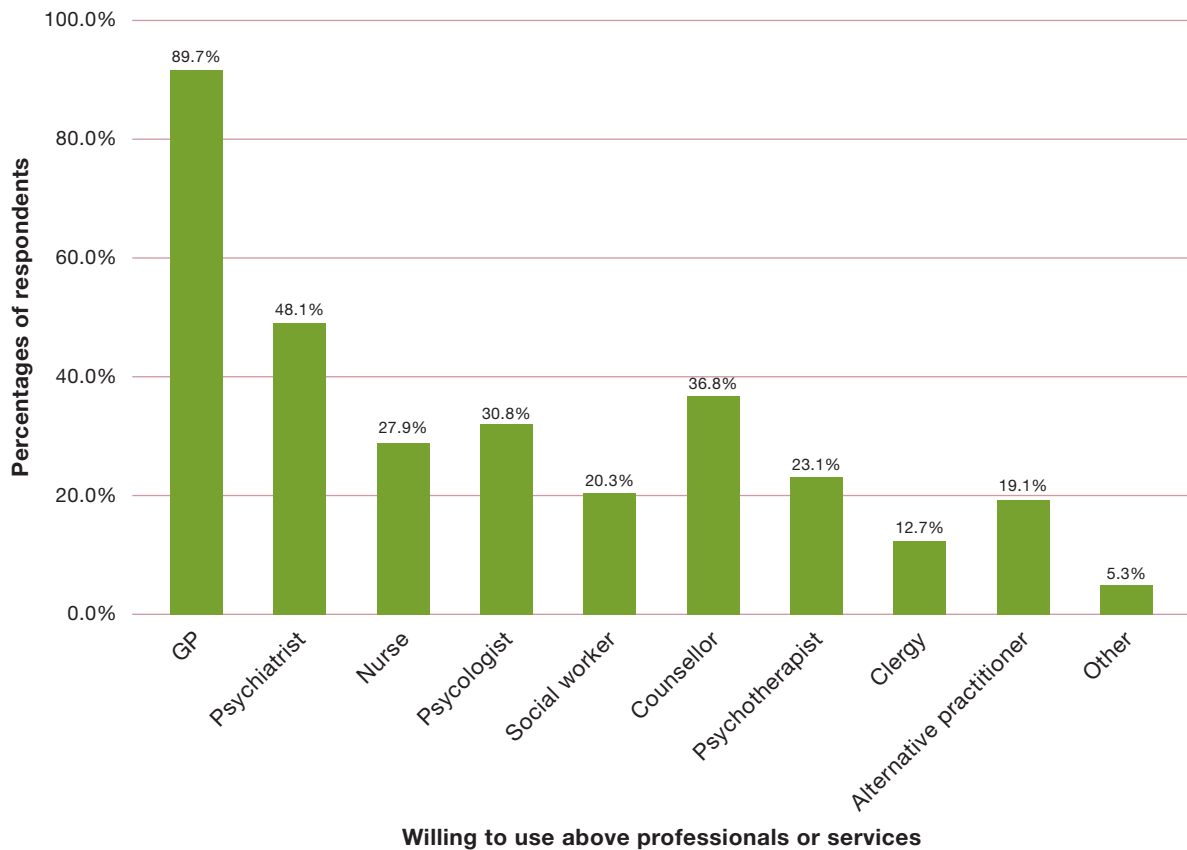
### Use of non-prescribed and alternative medication

Regarding non-prescribed and alternative medication, of the 2,711 respondents, 1% reported that they had taken some non-prescribed medication and 2% some alternative medication for a nervous, mental or emotional problem in the last 12 months.

### Willingness to contact health professionals/support persons for mental, nervous or emotional problems

Respondents were asked if they would be willing to contact a range of professionals/support persons in the future if they were suffering from significant mental, nervous or emotional problems. The majority of respondents (93%) were willing to use at least one of the professionals/support persons in the future and 4% were unwilling to contact any of the listed professionals/supports persons.

Respondents were willing to use multiple professionals/support persons in the future, which resulted in a total of 8,048 positive responses from the 2,521 participants. Figure 4.7 shows the weighted percentages of those willing to use professionals or support persons for mental or emotional problems in the future out of the total numbers of positive and negative responses.



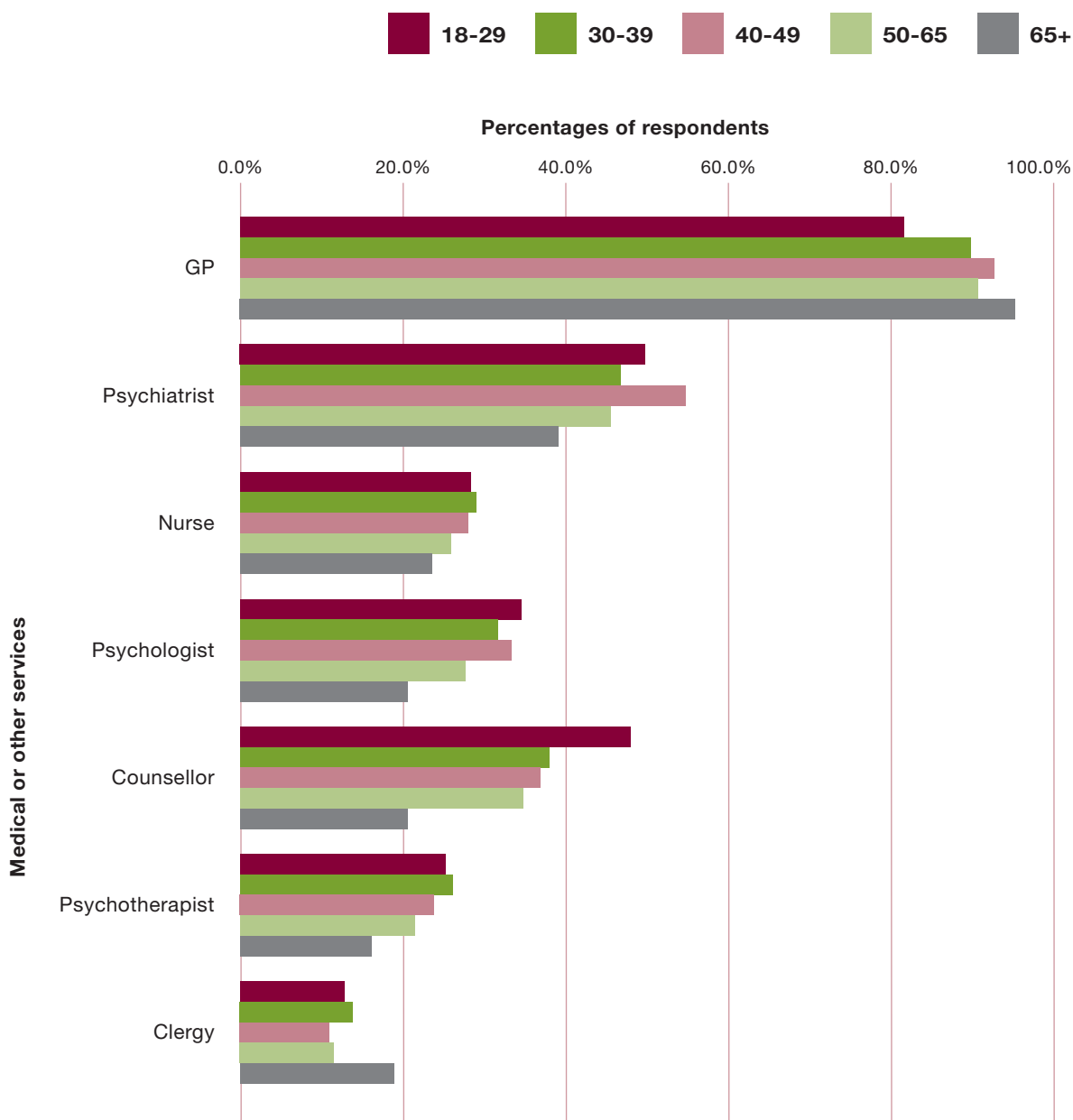
**Figure 4.7** Weighted percentages of respondents willing to contact professionals/support persons for mental or emotional problems

As can be seen from Figure 4.7, the majority of respondents reported that they would be willing to contact a GP in the future for mental or emotional problems (90%). Psychiatrists were the next most frequent choice of future contact (48%), followed by counsellors (37%) and psychologists (31%). Much lower proportions of respondents were willing to contact alternative practitioners (19%), members of the clergy (13%) or other (5%).

Out of 137 respondents who mentioned that they would contact others not listed in the questionnaire for help with mental or emotional problems, the majority were willing to contact family and/or friends (97%), and four respondents (3%) mentioned other contacts such as voluntary or charity organisations.

There was no gender difference in the four most frequently reported professionals/support persons that respondents were willing to contact for help. However, a significantly higher percentage of female respondents than male respondents were willing to contact a GP (91% vs 88%; [ $\chi^2$  (1) = 5.86,  $p = 0.015$ ], counsellor (39% vs 34%; [ $\chi^2$  (1) = 9.31,  $p = 0.002$ ] and alternative practitioner (23% vs 15%; [ $\chi^2$  (1) = 29.5,  $p < 0.000$ ]).

Significant differences in reported willingness to contact professionals or support persons for mental or emotional problems were found among different age groups. Figure 4.8 shows the weighted percentages of respondents who were willing to use these contacts, by age groups.



**Figure 4.8** Weighted percentages of respondents willing to contact professionals/support persons for mental or emotional problems, by age groups

As can be seen from Figure 4.8, the lowest proportion of respondents willing to contact GPs in the future for mental or emotional problems was among those aged between 18 and 29 years (82%). The highest percentage of respondents willing to contact GPs was found among those aged 65 and over (95%). The age group differences were statistically significant [ $\chi^2 (4) = 74.81, p < 0.000$ ].

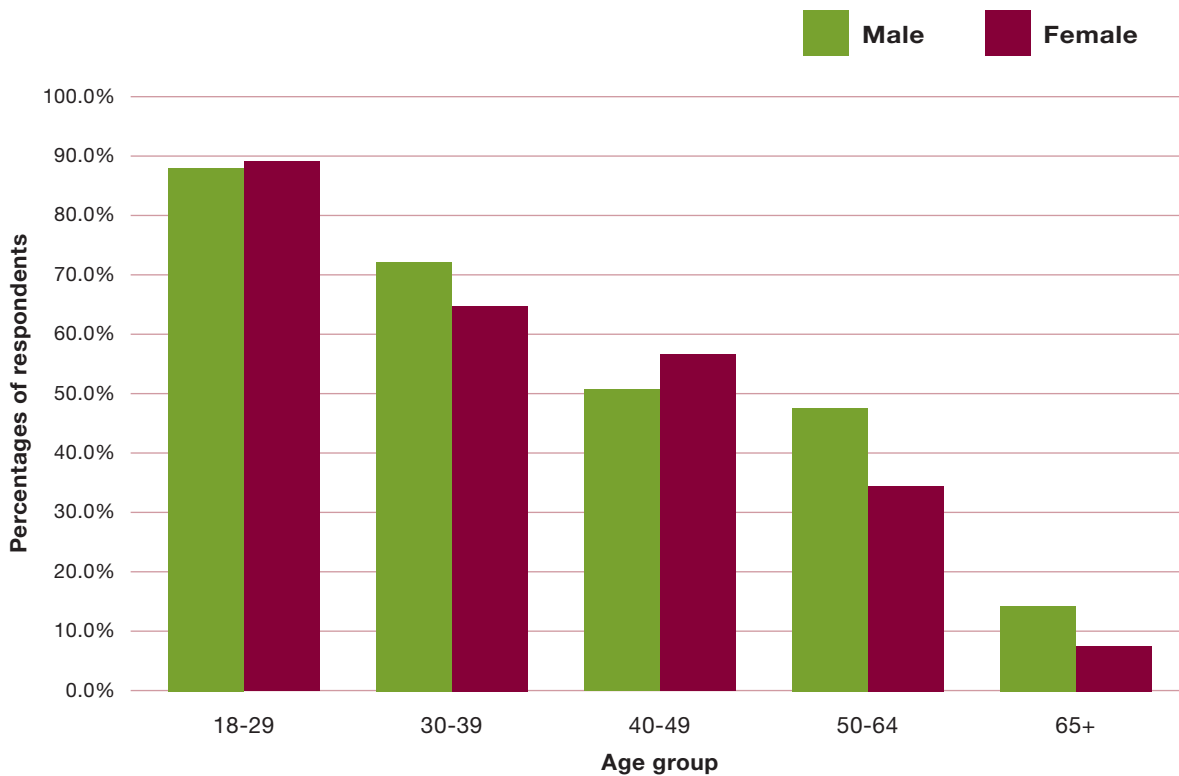


The highest proportion of those willing to contact psychiatrists for emotional problems was among those aged between 40 and 49 (55%), followed by those aged 18 and 29 years (50%), and the lowest proportion was among respondents aged 65 and over (39.1%; [ $\chi^2$  (4) = 22.47,  $p < 0.000$ ]). The percentages of those willing to contact counsellors tended to decrease from 47% among those aged between 18 and 29 to 21% of those aged 65 or over [ $\chi^2$  (4) = 69.30,  $p < 0.000$ ]. The percentage of respondents reporting that they would contact psychologists was the highest among those aged between 18 and 29 (35%), the second highest among those aged between 40 and 49 (34%) and the lowest among those aged 65 and over (20%) ([ $\chi^2$  (4) = 27.75,  $p < 0.000$ ]). The percentage of those who were willing to contact members of the clergy for mental or emotional problems was the highest among the oldest age group of respondents (19%), with the lowest being among respondents aged 40–49 years (11%; [ $\chi^2$  (4) = 16.58,  $p = 0.002$ ]).

## Use of the Internet as a source of health information

Out of the total of 2,688 respondents more than one-half (58%) had used the Internet at least once for any purpose. Figure 4.9 shows the percentage of respondents who used the Internet for general purposes by age group and gender. Overall, significantly more males (61%) than females (56%) had used the Internet for general purposes [ $\chi^2$  (1) = 6.42,  $p = 0.011$ ]. There was a decrease in the proportion of respondents who had used the Internet for any purpose by age groups [ $\chi^2$  (4) = 758.9,  $p = 0.000$ ], with 89% of those in the youngest age group and just 10% in the 65+ age group reporting that they had done so.

Those who reported that they had used the Internet for any purpose were asked if they had used it as a source of information on health. Approximately 49% (767/1557) of those who were asked reported that they used the Internet as a source of information on health. A greater proportion of females reported that they had used the Internet as a source of information on health than males (58% vs 41%; [ $\chi^2$  (1) = 46.61,  $p = 0.000$ ]). There were also significant age group differences [ $\chi^2$  (4) = 28.12,  $p = 0.000$ ]. As expected, the proportion of respondents reporting that they used the Internet for health information decreased across the age groups, with 45% of those in the youngest age group reporting that they had done so and 36% of those in the over 65 year age group reporting so.



**Figure 4.9** Percentage of respondents who have used the Internet for general purposes by age group and gender

Those who had reported that they had never used the Internet as a source of information on health and those who reported that they had never used the Internet for any purpose, were asked if they would be willing to do so in the future (n = 1886; see Appendix 1, items 15a–15c). Of these, 48.9% reported that they would be willing to do so. There were no significant gender differences in the willingness to use the Internet for health matters (females 49.3%; males 48.6% [ $\chi^2 (1) = 0.093, p = 0.760$ ]), but there were significant age group differences [ $\chi^2 (4) = 294.09, p = 0.000$ ]. The pattern of the age differences was the same as previously reported, with higher proportions in the younger age groups reporting that they would be willing to use the Internet for health matters. A total of 15% of the over 65 year age group reported that they would be willing to do so, compared to 71% of the 18–29 year age group.

## Summary

Almost 71% of the respondents reported that they had seen a GP in the previous year for physical health problems, while almost 10% of the respondents reported that they had spoken to a GP about a mental, nervous or emotional problem such as anxiety or depression. Interestingly, those who had spoken to a GP about mental health problems had done so, on average, more times than those who had seen a GP for physical health problems. In both instances females were more likely to report attending or speaking to a GP for physical or mental health problems. As expected, the older age groups more often reported attending a GP for physical health problems. The respondents most likely to speak to a GP about mental health problems were in the age group 30–64 years, while few of the 18–29 year age group and 65 years and over group had spoken to a GP.

Of the total respondents, 16% reported factors that prevented them from seeing a GP in the previous year. The two most common barriers were cost (63%) and that it took too much time (30%). A total of 13% reported that feeling awkward or embarrassed was a barrier to seeing a GP. Within the age group 65 years and over, the most common barrier preventing attendance at a GP was that it took too much time, followed by transportation.

As expected, much fewer of the respondents reported attending the dedicated mental health services such as outpatient clinics, day hospitals and centres and inpatient facilities. Of all respondents, a total of 6% reported attending one or more of these facilities. The most frequently reported attendance was at the outpatient clinic, while approximately 1.5% reported attending day hospitals or centres and less than 1% reported attending inpatient facilities.

As with the mental health services, a total of 6% of the respondents reported that they had been in contact with one or more of the named professionals/support persons in the previous year for help with mental or emotional problems. Interestingly, of those who had reported seeking help from one or more of the professionals/support persons, males were more likely to do so than females. Of the total sample, a very small number of respondents reported that they had contacted professionals or support persons in the previous year, ranging from 0.4% to 2.2%. Respondents reported most frequently that they sought help from psychiatrists, followed by nurses and then counsellors. It is likely that those who reported contact with the psychiatrist are the most severe and are most likely to be referred to a psychiatrist through the GP. Alternative practitioners were the least frequently contacted professionals. Gender differences showed that females were more likely than males to contact a counsellor, while males were more likely than females to contact a psychotherapist. These findings suggest that there may be gender differences in the type of preferred talking therapy.

In terms of the effectiveness of the professionals or support persons who were contacted, there was little difference in the average effectiveness scores. Psychotherapists, nurses and members of clergy were rated as most effective, followed closely by counsellors and psychologists. The effectiveness scores of the psychiatrists may be affected by the fact that those attending psychiatrists may be the most severe and thus have more difficult to treat problems. The respondents perceived that the least effective professionals or support persons were alternative practitioners, with a large percentage of respondents who used these professionals rating them as not at all effective. However, these findings must be interpreted with caution given the small numbers in each subgroup.

Regarding the use of prescribed medication for a mental, nervous or emotional problem in the previous year, a total of 6% of respondents reported medication use, with a higher proportion of females reporting that they had taken prescribed medication. There were also age by gender differences in the use of prescribed medication. Previous surveys in Europe have found that from 6% to 15% of the population have used psychotropic medication and that females and older adults report a higher pattern of usage (ESEMED 2000 Investigators, 2004). For females in this survey the proportion that reported using prescribed medication increased over the age groups, with the highest reported use in those aged 65 years and over. For males, the highest reported use occurred in the 30–39 year age group followed by the 50–64 year age group and the 40–49 year age group. Very few of the males in the 18–29 year age group and 65 years and over age group reported using prescribed medication for mental health problems. The majority of the respondents who used prescribed medication were prescribed the medication by their GP (78%), with just over one-quarter reporting that they were prescribed the medication by a psychiatrist. Again, this highlights the important role that GPs play in the treatment of mental health problems. The type of medication that was prescribed to the respondents was, in the majority of cases, reported to be antidepressants (72%), while just less than one-quarter were prescribed tranquillisers. Almost 20% of the respondents reported that they were prescribed some other type of medication for mental health problems. A total of 172 comments were made regarding the effectiveness of the prescribed medication. The majority of the respondents reported that their medication was very effective, although it appeared that antidepressants were rated as very effective less often than tranquillisers or other medication. Approximately one-quarter of the respondents rated the three types of prescribed medication as moderately effective. While less than 10% of the respondents rated tranquillisers and other medication as slightly effective or not at all effective, slightly more respondents rated antidepressants as less than effective. Very few respondents reported taking non-prescribed (1%) or alternative medication (2%) for mental health problems in the previous year.

In terms of the willingness to use professional or support persons in the future for mental health problems, a total of 93% of respondents were willing to use one or more of the services. As expected, the majority of the respondents were willing to contact a GP, followed by a psychiatrist, counsellor and psychologist. The proportion of responses regarding the willingness to contact alternative practitioners and members of the clergy were the lowest, at 19% and 13%, respectively. A total of 137 respondents reported that they would use other services. Of these, 97% reported that they would be willing to contact family and/or friends, while the other 3% reported that they would contact a voluntary agency or charity organisation. This highlights the importance of family and friends in mental health and wellbeing and also suggests that programmes aimed at awareness and stigma may help individuals provide support to others faced with mental health problems. Although there were no gender differences in the four most frequently reported professionals and support persons that respondents would contact, females were more willing than males to contact GPs, counsellors and alternative practitioners. Likewise with age, there were no overall differences in terms of the professionals most likely to be contacted, however, the younger age groups were more willing to contact a counsellor and psychotherapist than the older age groups, while the older age groups were more willing to contact the clergy than the younger age groups.

Over one-half of the respondents had used the Internet in the past for any purpose. Of these, almost one-half had used it as a source of information on health, while 48.9% of those who had not used the Internet or had never used it as a source of information on health were willing to do so in the future. Of the total sample then, only approximately 28% are currently using the Internet as a source of information on health. However, if we add this to the proportion that are willing to use the Internet for health information (34%), then approximately 62.8% of respondents could potentially use the Internet as a source of information on health. Overall, more males were more likely to use the Internet in general, but females were more likely to use it as a source of information on health. Furthermore, the younger age groups were more likely to use the Internet than the older age groups.

# Discussion and conclusions

This is the first national survey of psychological wellbeing and distress in the Irish population carried out by the MHRU of the HRB. The survey provides information on the extent of psychological distress in a representative sample of the Irish adult population and the use of formal health care services and informal supports for psychological distress by the sample. The findings provide important information for policymakers and service planners and call for debate within a multi-sectoral arena so that appropriate responses can be developed and implemented.

It is important to reiterate at the outset that the NPWDS results showed that the majority of respondents reported 'good' or 'very good' mental health, physical health and quality of life with two in every three respondents (66%) reporting very good mental health and wellbeing. A recent European report stated that "the majority of EU citizens have experienced positive and balanced feelings rather than negative emotions such as feeling depressed" (European Commission, 2006). Nonetheless, findings showed that one in eight adults (12%) was currently experiencing significant symptoms of psychological distress and one in seven (14%) had experienced mental health problems in the previous year. The findings are in line with findings from the World Health Organisation (WHO, 2001) of a point prevalence of 10% and showed similar patterns, in terms of gender and age, to health surveys carried out in the UK (Scottish Health Survey, 2003; Health Survey for England, 2003; Northern Ireland Health and Social wellbeing Survey, 2002). Extrapolating the survey findings to the Irish population would suggest that 348,500 adults aged 18 years and over are experiencing symptoms of psychological distress. The extent of psychological distress in the general population has gone unrecognised in society. The failure to recognise and acknowledge the extent of psychological distress has a number of important and fundamental consequences. Of importance here is the individual and civic reluctance to 'own' psychological distress, resulting in many problems going unrecognised, with consequent negative implications, not just at the individual level but also the familial and societal levels. The stigma associated with mental health problems may lead to this deficit in ownership and reluctance to acknowledge the extent of the mental health problems. This has the further consequence of many informal and formal supports, which could provide healing, support and hope, remaining undeveloped or underused, with inevitable social and economic costs for individuals, families and society. The World Health Organization (2001; 2002) highlights the stigma surrounding mental health problems and advocates the need for an integrated public health approach to reduce the burden of mental and behavioural disorders worldwide. A Vision for Change (Department of Health and Children, 2006) highlights the need for mental health promotion programmes to enhance mental wellbeing and for the early intervention and prevention of mental health problems. On a national level, the Office for Suicide

Prevention (2007) has completed a survey detailing the attitudes to mental health in the Irish population. The survey findings will be used to inform the development of a national mental health awareness campaign.

In terms of help-seeking, the findings from this report illustrated that the Irish population utilised a number of formal and informal supports for psychological distress. The decision to seek help can depend on a number of health beliefs, such as the need for treatment and the efficacy of treatment *inter alia*. Given the stigma surrounding mental health problems it is likely that many individuals have employed various coping strategies, such as behavioural or cognitive strategies, to alleviate the symptoms of distress, prior to seeking support. There is an evident need to develop new models of support for persons undergoing psychological distress – many of these could be informal and inexpensive and operate at the individual (the recognition and ownership of stress/distress), interpersonal (seeking informal help from family and friends) and societal (mental health promotion programmes, development of social capital in communities) level and be offered in a range of situational contexts (e.g. schools, homes, resident associations).

In line with European surveys (European Commission, 2006, European Opinion Research Group, 2003), the majority of people who had sought help for mental health problems in the previous year had done so from a GP. Furthermore, the majority of respondents reported that they would be willing to contact a GP if they were experiencing mental health problems. The findings highlight the important role of the GP in the assessment, diagnosis and treatment of mental health problems. This raises important issues regarding the provision of health care for mental health problems in primary care, such as the importance of training for GPs and the availability of appropriate mental health professionals within the primary care network. The current mental health policy document, *A Vision for Change*, suggests that there is an over-reliance on medication for the treatment of mental health problems (Department of Health and Children, 2006). While lack of training may account for some of the over-reliance on medication, the most likely cause is the lack of alternative mental health professionals whom GPs could access. So, while training in evidence-based practice for the assessment and treatment of mental health problems is essential, the GP must also have access to other mental health professionals and voluntary and community resources and supports that provide a range of psychological therapies and services that do not require specialised mental health services.

In addition and as expected, a smaller number of adults reported contact with specialised mental health services. For those who do require specialised mental health services and who experience enduring mental health problems it is important that care pathways to secondary mental health services are evaluated and developed, especially in terms of the interface between primary care and mental health services. Furthermore there is a need to expand the accessibility and availability of psychological services within the mental health services. The need for psychological therapies within mental health services has been highlighted in numerous documents including the most recent policy document – A Vision for Change (Department of Health and Children, 2006). Thus for those who can not afford to pay for private psychological therapies, the access to services is limited or non-existent.

In conclusion, the results have highlighted a number of important issues. The extent of psychological distress within the Irish population is comparable to that in other European countries, such that a significant number of adults will experience psychological distress at some point in their lives. While the majority of these will experience short-term mental health problems, others may require the help of specialised mental health services. There is a need for acknowledgement and recognition of the extent of psychological distress in the Irish population so that appropriate inter-sectoral responses can be developed. Appropriate responses refer not only to the use of formal health services and supports, but also to the use of informal resources such as family and friends and the development of social capital to strengthen the potential supportive roles of communities. The acknowledgement of psychological distress by the general population as well as by health service planners and policymakers will ensure earlier recognition, detection, assessment and treatment of distress and avoid the unnecessary escalation of symptoms that may require more intensive and prolonged formal treatment. GPs play an important role in the patient's recognition of psychological distress, in addition to the assessment and treatment of mental health problems as they are often the first and only port of call for those seeking help. They are also the primary gatekeepers to specialised mental health services. Training specifically aimed at GPs and those who work within a primary care setting is required. There is also a need to provide mental health professionals who can offer a range of psychological therapies within primary care and triage to a range of informal and semi-formal supports.



A number of limitations with the current report must be highlighted. Firstly, this was a telephone survey of private households and consequently, those who may be most at risk of psychological distress may not have been included; these would include the homeless, people who live in sheltered accommodation, refugees and non-nationals who may not yet have a home of their own and whose first language may not be English. Thus, the estimates presented here are likely to be conservative. There is a need for future research to address the extent of psychological distress in these vulnerable populations. In addition, the analysis presented in this report are limited to age and gender differences in order to provide a descriptive report that details all measures that were included in the HRB NPWDS. However more sophisticated and comprehensive analysis of the data will be presented in later reports. These reports will concentrate on specific issues addressed in the survey (e.g. the socio-demographic characteristics of those most susceptible to psychological distress (Tedstone Doherty et al. in preparation); the relationship of distress disclosure and mental health (Ward et al. 2007); the key demographic and self-reported mental health characteristics of those who use the Internet as a source of information on health (Gallagher et al. 2007)).

This survey has taken the first step in capturing and describing the reality of psychological distress in the Irish population, exploring its gender and age correlates and the formal and informal supports used and their perceived effectiveness. To date, population-based information on the prevalence and correlates of psychological distress has been limited within the Irish context, as has information relating to service use and informal supports and the effectiveness of these supports. Reliable and valid information such as this is crucial for effective policies and service planning and for the development of age and gender appropriate services. It is anticipated that this and further similar surveys that will be carried out on a two-year basis will provide the necessary information for service planning and effective inter-sectoral policy formulation and evaluation.

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# Appendix 1

## Module for Mental Health Research Unit Health Research Board

### Supplement on Health, EU Consumer Survey, December 2005

Area  Resp.  Stem  Int. Number

*[Int. Make sure to transfer Area and Respondent Codes from EU Consumer Survey]*

**I would now like to ask you some different types of questions about your physical and psychological health and your use of health services. I will be asking you some questions about how you have been feeling over the last while. For example, if you have experienced anxiety or depression or any other mental, nervous or emotional problems. I will also be asking you about services that you may or may not have used in the last year (e.g. GP, counsellor, psychologist, psychiatrist) and if you are currently taking any medication for mental, nervous or emotional problems. I would like to remind you that all the information you provide is confidential. The information will be used for research purposes only and you are free to stop the interview at any time, etc.**

**Time interview began \_\_\_\_\_ : \_\_\_\_\_ (24hr clock)**

MH1 Are you covered by a medical card, either in your own name or through someone else's card?

Yes, holder of medical card <sub>1</sub> Yes, on someone else's card <sub>2</sub> Not covered <sub>3</sub>

MH2 Are you (also) covered by private health insurance (through VHI, BUPA or any other health insurance company/occupational scheme), either in your own name or through another family member?

Yes, in own name <sub>1</sub> Yes, through family member <sub>2</sub> Not medically insured <sub>3</sub>

MH3a How would you rate your mental health in the last 12 months?

Very poor <sub>1</sub> Poor <sub>2</sub> Fair <sub>3</sub> Good <sub>4</sub> Very good <sub>5</sub>

MH3b How would you rate your physical health in the last 12 months?

Very poor <sub>1</sub>      Poor <sub>2</sub>      Fair <sub>3</sub>      Good <sub>4</sub>      Very good <sub>5</sub>

MH3c How would you rate your quality of life in the last 12 months?

Very poor <sub>1</sub>      Poor <sub>2</sub>      Fair <sub>3</sub>      Good <sub>4</sub>      Very good <sub>5</sub>

MH4 General Health Questionnaire – GHQ12

[Objective Measure of Psychological Wellbeing]

Over the last few weeks, have you:

1. been able to concentrate on what you're doing?

Better than usual <sub>1</sub>      Same as usual <sub>2</sub>  
Less than usual <sub>3</sub>      Much less than usual <sub>4</sub>

2. lost much sleep over worry?

Not at all <sub>1</sub>      No more than usual <sub>2</sub>  
Rather more than usual <sub>3</sub>      Much more than usual <sub>4</sub>

3. felt that you are playing a useful part in things?

More so than usual <sub>1</sub>      Same as usual <sub>2</sub>  
Less so than usual <sub>3</sub>      Much less than usual <sub>4</sub>

4. felt capable of making decisions over things?

More so than usual <sub>1</sub>      Same as usual <sub>2</sub>  
Less so than usual <sub>3</sub>      Much less than usual <sub>4</sub>

5. felt constantly under strain?

Not at all <sub>1</sub>      No more than usual <sub>2</sub>  
Rather more than usual <sub>3</sub>      Much more than usual <sub>4</sub>

6. felt you couldn't overcome your difficulties?

Not at all <sub>1</sub>      No more than usual <sub>2</sub>  
Rather more than usual <sub>3</sub>      Much more than usual <sub>4</sub>

7. been able to enjoy your normal day-to-day activities?

More so than usual <sub>1</sub>      Same as usual <sub>2</sub>  
Less so than usual <sub>3</sub>      Much less than usual <sub>4</sub>

8. been able to face up to your problems?

More so than usual <sub>1</sub>      Same as usual <sub>2</sub>  
Less so than usual <sub>3</sub>      Much less than usual <sub>4</sub>

9. been feeling unhappy or depressed?

Not at all <sub>1</sub>      No more than usual <sub>2</sub>  
Rather more than usual <sub>3</sub>      Much more than usual <sub>4</sub>

10. been losing confidence in yourself?

Not at all <sub>1</sub>      No more than usual <sub>2</sub>  
Rather more than usual <sub>3</sub>      Much more than usual <sub>4</sub>

11. been thinking of yourself as a worthless person?

Not at all <sub>1</sub>      No more than usual <sub>2</sub>  
Rather more than usual <sub>3</sub>      Much more than usual <sub>4</sub>

12. been feeling reasonably happy, all things considered?

More so than usual <sub>1</sub>      Same as usual <sub>2</sub>  
Less so than usual <sub>3</sub>      Much less than usual <sub>4</sub>

MH5 Have you experienced limitations in physical activities in the last year because of mental, nervous or emotional problems?

None <sub>1</sub>      Mild <sub>2</sub>      Moderate <sub>3</sub>      Severe <sub>4</sub>      Extreme <sub>5</sub>

MH6 Have you experienced limitations in social activities in the last year because of mental, nervous or emotional problems? By this I mean activities involving friends, family or others.

None  1 Mild  2 Moderate  3 Severe  4 Extreme  5

MH7 Measure of Emotional Disclosure – 12-item measure

**I am going to read 12 statements. Please tell me how strongly you agree or disagree with each.**

1. When I feel upset I usually confide in my friends. Do you:

Strongly disagree  1 Disagree  2  
Neither agree nor disagree  3 Agree  4  
Strongly agree  5

2. I prefer not to talk about my problems. Do you:

Strongly disagree  1 Disagree  2  
Neither agree nor disagree  3 Agree  4  
Strongly agree  5

3. When something unpleasant happens to me, I often look for someone to talk to. Do you:

Strongly disagree  1 Disagree  2  
Neither agree nor disagree  3 Agree  4  
Strongly agree  5

4. I typically don't discuss things that upset me. Do you:

Strongly disagree  1 Disagree  2  
Neither agree nor disagree  3 Agree  4  
Strongly agree  5

5. When I feel depressed or sad, I tend to keep those feelings to myself. Do you:

Strongly disagree	<input type="checkbox"/>	1	Disagree	<input type="checkbox"/>	2
Neither agree nor disagree	<input type="checkbox"/>	3	Agree	<input type="checkbox"/>	4
Strongly agree	<input type="checkbox"/>	5			

6. I try to find people to talk with about my problems. Do you:

Strongly disagree	<input type="checkbox"/>	1	Disagree	<input type="checkbox"/>	2
Neither agree nor disagree	<input type="checkbox"/>	3	Agree	<input type="checkbox"/>	4
Strongly agree	<input type="checkbox"/>	5			

7. When I am in a bad mood, I talk about it to my friends. Do you:

Strongly disagree	<input type="checkbox"/>	1	Disagree	<input type="checkbox"/>	2
Neither agree nor disagree	<input type="checkbox"/>	3	Agree	<input type="checkbox"/>	4
Strongly agree	<input type="checkbox"/>	5			

8. If I have a bad day, the last thing I want to do is talk about it. Do you:

Strongly disagree	<input type="checkbox"/>	1	Disagree	<input type="checkbox"/>	2
Neither agree nor disagree	<input type="checkbox"/>	3	Agree	<input type="checkbox"/>	4
Strongly agree	<input type="checkbox"/>	5			

9. I rarely look for people to talk to when I am having problems. Do you:

Strongly disagree	<input type="checkbox"/>	1	Disagree	<input type="checkbox"/>	2
Neither agree nor disagree	<input type="checkbox"/>	3	Agree	<input type="checkbox"/>	4
Strongly agree	<input type="checkbox"/>	5			

10. When I am distressed I don't tell anyone. Do you:

Strongly disagree	<input type="checkbox"/>	1	Disagree	<input type="checkbox"/>	2
Neither agree nor disagree	<input type="checkbox"/>	3	Agree	<input type="checkbox"/>	4
Strongly agree	<input type="checkbox"/>	5			



11. I usually seek out someone to talk to when I am in a bad mood. Do you:

Strongly disagree	<input type="checkbox"/> 1	Disagree	<input type="checkbox"/> 2
Neither agree nor disagree	<input type="checkbox"/> 3	Agree	<input type="checkbox"/> 4
Strongly agree	<input type="checkbox"/> 5		

12. I am willing to tell others my distressing thoughts. Do you:

Strongly disagree	<input type="checkbox"/> 1	Disagree	<input type="checkbox"/> 2
Neither agree nor disagree	<input type="checkbox"/> 3	Agree	<input type="checkbox"/> 4
Strongly agree	<input type="checkbox"/> 5		

MH8 In the last 12 months, how many times have you seen a GP for physical problems? \_\_\_\_\_ times.

MH9a In the last 12 months, (approximately) how many times have you spoken with a GP about being anxious or depressed, or about mental, nervous or emotional problems? \_\_\_\_\_ times.

MH9b In the last 12 months have you experienced any mental, nervous or emotional problems (e.g. anxiety or depression)?

Yes	<input type="checkbox"/> 1	No	<input type="checkbox"/> 2
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MH10 In the past 12 months have any of the following factors prevented you from seeing a GP? Please tick all that apply.

Transportation	<input type="checkbox"/> 1	It's not helpful	<input type="checkbox"/> 5
Cost of visiting doctor	<input type="checkbox"/> 2	Too ill	<input type="checkbox"/> 6
It takes too much time	<input type="checkbox"/> 3	Anything else	<input type="checkbox"/> 7
Embarrassment/feeling awkward	<input type="checkbox"/> 4	Nothing prevented me	<input type="checkbox"/> 8

MH11 Have you at any time in the last 12 months been in contact with any of the following mental health services?

Outpatient Clinic	Yes <input type="checkbox"/> 1	No <input type="checkbox"/> 2
Day Centre	Yes <input type="checkbox"/> 1	No <input type="checkbox"/> 2
Day Hospital	Yes <input type="checkbox"/> 1	No <input type="checkbox"/> 2
Inpatient psychiatric hospital/unit	Yes <input type="checkbox"/> 1	No <input type="checkbox"/> 2

MH12 (a) I am going to read out 9 types of medical professionals. Could you tell me if you have been in contact with any of these in the last 12 months for help with a mental, nervous or emotional problem?  
 (b) If yes, how effective was each to you?

	(a) Contact with?		(b) If yes, how effective?				
	Yes	No	Very effective	Moderately effective	Slightly effective	Not at all effective	Don't Know
1 Psychiatrist	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
2 Nurse	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
3 Psychologist	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
4 Social worker	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
5 Counsellor	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
6 Psychotherapist	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
7 Clergy	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
8 Alternative practitioner	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
9 Other	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

MH13 (a) Did you take any prescribed medication for a mental, nervous or emotional problem in the last 12 months?

Yes  1      No  2      ► Go to MH14a.

(b) If yes, who prescribed this medication for you?

Psychiatrist      Yes  1      No  2  
 GP      Yes  1      No  2  
 Medical doctor in hospital or clinic      Yes  1      No  2  
 Other      Yes  1      No  2

(c) Was the medication a tranquiliser, antidepressant or other type of medication?

(d) How effective was it?

	(c) Type			(d) How effective was it?				
	Yes	No	DK	Very Effective	Moderately Effective	Slightly Effective	Not at all effective	Don't Know
Tranquiliser	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
Antidepressant	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
Other	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>

MH14a Did you take any non-prescribed or alternative medication for a mental, nervous or emotional problem in the last 12 months?

Yes <sub>1</sub>      No <sub>2</sub>

MH14b Suppose you were suffering from significant mental, nervous or emotional problems, would you contact any of the following?

- |                            |   |  |
|----------------------------|---|--|
| 1 General practitioner     | Yes <input type="checkbox"/> <sub>1</sub> | No <input type="checkbox"/> <sub>2</sub> |
| 2 Psychiatrist             | Yes <input type="checkbox"/> <sub>1</sub> | No <input type="checkbox"/> <sub>2</sub> |
| 3 Nurse                    | Yes <input type="checkbox"/> <sub>1</sub> | No <input type="checkbox"/> <sub>2</sub> |
| 4 Psychologist             | Yes <input type="checkbox"/> <sub>1</sub> | No <input type="checkbox"/> <sub>2</sub> |
| 5 Social worker            | Yes <input type="checkbox"/> <sub>1</sub> | No <input type="checkbox"/> <sub>2</sub> |
| 6 Counsellor               | Yes <input type="checkbox"/> <sub>1</sub> | No <input type="checkbox"/> <sub>2</sub> |
| 7 Psychotherapist          | Yes <input type="checkbox"/> <sub>1</sub> | No <input type="checkbox"/> <sub>2</sub> |
| 8 Clergy                   | Yes <input type="checkbox"/> <sub>1</sub> | No <input type="checkbox"/> <sub>2</sub> |
| 9 Alternative practitioner | Yes <input type="checkbox"/> <sub>1</sub> | No <input type="checkbox"/> <sub>2</sub> |
| 10 Other (please specify)  | Yes <input type="checkbox"/> <sub>1</sub> | No <input type="checkbox"/> <sub>2</sub> |

MH15a Have you ever used the Internet for any purpose?

Yes <sub>1</sub>      No <sub>2</sub>

MH15b Have you ever used the Internet as a source of information on health?

Yes <sub>1</sub>      ► Go to MH16      No <sub>2</sub>

MH15c Would you be willing to use the Internet for health matters?

Yes <sub>1</sub>      No <sub>2</sub>

MH16 Do you have any dependent children living with you?

Yes  1 How Many? \_\_\_\_\_ No  2

(dependent child is one aged less than 16 or 17/18 years if still in education)

MH17 Size of location in which household is situated:

Open country	<input type="checkbox"/> 1	Waterford City	<input type="checkbox"/> 7
Village (200–1,499)	<input type="checkbox"/> 2	Galway City	<input type="checkbox"/> 8
Town (1,500–2,999)	<input type="checkbox"/> 3	Limerick City	<input type="checkbox"/> 9
Town (3,000–4,999)	<input type="checkbox"/> 4	Cork City	<input type="checkbox"/> 10
Town (5,000–9,999)	<input type="checkbox"/> 5	Dublin City (incl. Dún Laoghaire)	<input type="checkbox"/> 11
Town (10,000 or more)	<input type="checkbox"/> 6	Dublin County (outside Dublin city)	<input type="checkbox"/> 12

**Time interview ended** \_\_\_\_\_ : \_\_\_\_\_ **(24hr clock)**

**Date** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Gender of respondent: Male  1 Female  2

Socio-demographic profile of individual respondents will be provided as part of the data set, e.g. education, age, marital status, etc., and will be used to analyse the data.







