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Patient and Client Council

The mental and emotional health of 16-year olds in Northern Ireland

Evidence from the Young Life and Times survey

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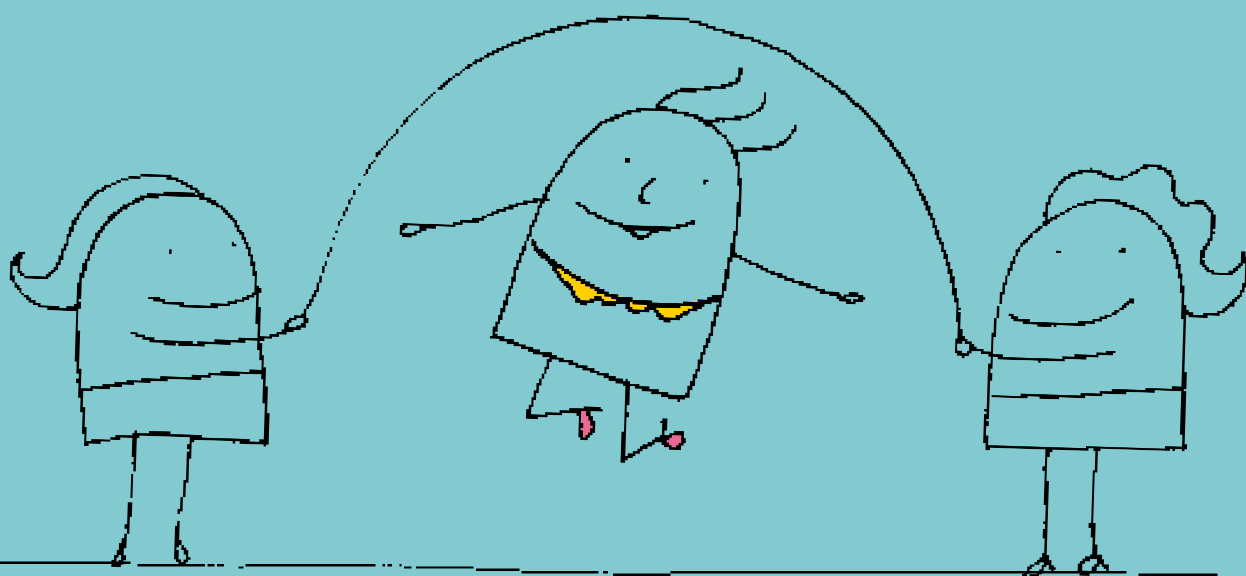
June 2010



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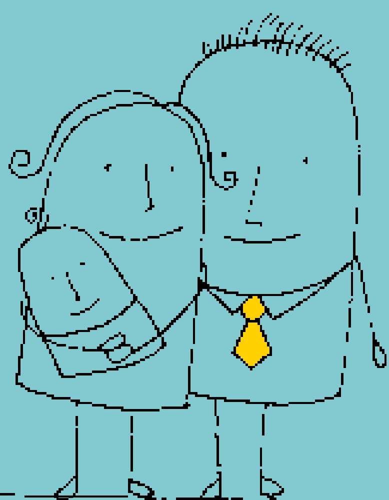

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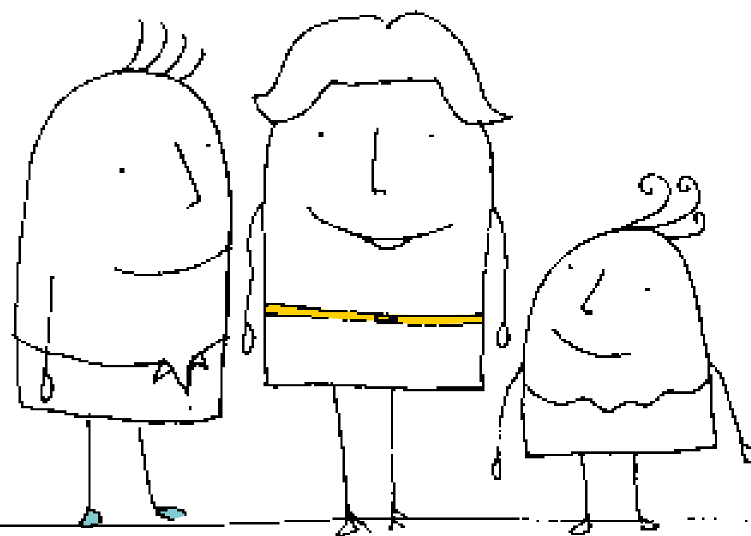


1.0 Introduction

1.1 Young Life and Times

The Young Life and Times (YLT) survey has monitored the mental and emotional health of 16-year olds in Northern Ireland since 2004. ARK reported about 'Stress at 16' (Cairns and Lloyd, 2005), the extent of school bullying (Burns, 2006) and more recently about the issue of self-harm (Schubotz, 2009). A brief review of the YLT research on mental health was provided by Lloyd et al. (2008) in a book chapter within an edited volume on young people in post-conflict Northern Ireland.

It had become clear from the YLT research on mental health that there were substantial barriers among young people to accessing mental health services. Many of these barriers exist due to the stigmatisation of mental ill-health which, despite growing numbers of young people facing, and being diagnosed with, mental and emotional health problems, is often seen as a taboo subject.

In 2009, the Patient and Client Council (PCC) worked in partnership with ARK to ask 16-year olds a range of questions on their emotional and mental health and their attitudes towards, and experiences of, mental health services for young people.

A Research Update with key findings of this research was published in April 2010 (Schubotz and McMullan, 2010).

This report is a more comprehensive review of findings of the YLT surveys with regard to the mental and emotional well-being of young people. In each section of the report the YLT findings are being contextualised with other publications on the topic. This review hopes to inform the further work of Patient and Client Council in this area.

1.2 The Patient and Client Council

The Patient and Client Council is a relatively young organisation established on 1st April 2009 to provide a **powerful, independent voice** for patients, clients, carers, and communities on health and social care issues.

The role of the Patient and Client Council is to:

- Engage with the public to obtain their views on any part of health and social care;
- Promote the involvement of patients, clients, carers and the public in the design, planning, commissioning and delivery of health and social care;
- Provide assistance to people making a complaint relating to health and social care;
- Provide advice and information to the public about health and social care services.

For the first year of its existence, the Patient and Client Council established seven priorities for action. One of these priorities is to improve understanding of the experiences of young people accessing mental health services.

YLT is a research project encouraging participation. Each year five questions or question areas identified by previous YLT respondents are included in the survey. Beyond that, YLT encourages respondents to voice their opinions about issues that affect them. Similarly, the Patient and Client Council aims to consult young people directly about health and social care.

The input of the Patient and Client Council in the 2009 YLT survey has given 16-year olds the opportunity to share their opinions and experiences of mental health and emotional health care services.

1.3 About this report

This report summarises findings from the YLT surveys of 16-year olds on mental and emotional health issues and related topics.

The report is divided into sections discussing mental health issues individually with regard to background variables that allow for an identification of health inequalities between different groups of 16-year olds, for example males and females, people with disabilities, people of different sexual orientations etc. Within these sections the YLT findings are related to other publications relevant to these issues that have emerged from Northern Ireland. At the end of each section key findings are summarised in a box.

The second part of the analysis reveals relations and correlations between different mental health indicators as revealed by YLT surveys. Again, this section is completed with a summary of key findings before the report is then brought to a conclusion.

2.0 Background

Mental health among young people has been a concern for policy makers for some time. Research undertaken on this subject area has pointed to the links between poor mental health and stress, substance abuse and bullying. High rates of suicide, especially among young men and increasing numbers in hospital admissions on grounds of self-harm, especially among young females in Northern Ireland, have resulted in policy initiatives to address and tackle poor mental health. Above all, poor mental health has been shown to be linked to social deprivation. A review of children's rights in Northern Ireland undertaken relatively recently on behalf of the Northern Ireland Commissioner for Children and Young People (NICCY, 2008) clearly pointed to some of these health inequalities suffered by young people.

In 2002 the Department of Health Social Services and Public Safety (DHSSPS) initiated a comprehensive review of the law, policy and provision affecting people with mental health needs or a learning disability in Northern Ireland. This review, known as the *Bamford Review of Mental Health and Learning Disability (Bamford Review),* took four years to complete, and between June 2005 and August 2007 new policies, good practice guidelines and the strategic principles were published with the aim to improve mental health and learning disability service provision in Northern Ireland. One outcome of this review process was a report titled '*A Vision of a Comprehensive Child and Adolescent Mental Health Service'* (CAMHS) (2006) which made 51 recommendations to improve the mental health service provision for young people. Teggart and Linden (2006) investigated service users' views of CAMHS and found that whilst service users were generally positive about services provided, a more in-depth investigation in focus groups found a lack of information provision and understanding about the role of CAMH services. It concludes that this should be addressed by an involvement of service users in the development of CAMHS.

One of the recommendations from the CAMHS review was that a study of mental health needs of children in Northern Ireland should be commissioned. Whilst this study is still outstanding, the present report will provide a snapshot of the mental and emotional health of young people in Northern Ireland, based on the research findings of the annual Young Life and Times (YLT) survey undertaken by ARK.

Niwa (2007) was complementary about the Bamford review and called the new policy framework a 'comprehensive and encouraging vision of mental health legislation.' (p. 348). However, she also left no doubt that the current mental health service provision for young people was 'inadequate', which is echoed by Fulton and Cassidy (2007) who analysed admissions to Child and Family Centres for three years and found histories of untreated mental ill-health among those admitted.

Prior to the Bamford Review, in 1999 four *Health Action Zones* (HAZ) had been set up in Northern Ireland in order to tackle health inequalities in areas most affected by social deprivation. The work of these HAZs in North and West Belfast and in Dungannon and Armagh, amongst other issues, focussed on an improvement of mental health and the prevention of self-harm and suicide.

Further policy documents are directly relevant to the research findings presented in this report. In 2006, a consultation document, The Northern Ireland Suicide Prevention Strategy *'Protect Life - a Shared Vision'* was published by the Minister for Health, Social Services and Public Safety and followed up by regional implementation processes and action plans. Again, the main objective of these initiatives was to create a better joint-up approach of service providers with the ultimate goal to decrease the incidents of suicide and self-harm within the five-year period of the action plan.

More generically *'Our Children - Our Pledge - A Ten Year Strategy for Children and Young People in Northern Ireland, 2006 - 2016'*, published by the Office of the First Minister and Deputy First Minister (OFMDFM) in Northern Ireland in 2006, has the aim to work towards a society in which all children and young people can fulfil their potential. The first of the *'super six'* priorities highlighted in this Strategy is that children and young people should be healthy, which puts the onus on the Northern Irish Government to work towards an improvement of health for young people, which of course includes their mental health. OFMDFM's Children and Young People's Unit was set-up to support the implementation of this Strategy.

3.0 Methodology

3.1 The Young Life and Times (YLT) Survey

The YLT survey has been in existence since 1998. In its first three years the survey ran alongside the Northern Ireland Life and Times (NILT) survey, with all 12-17 year olds living in the household of an adult NILT respondent completing the YLT survey, which took the form of a paper questionnaire consisting of a subset of questions from the adult survey. One of the main aims was to be able to compare the attitudes of young people to those of their parents; however, this initial methodology also raised some serious questions. For example, questions suitable for a 17-year old were not necessarily also suitable for a 12-year old (and vice-versa). Interviewing young people in their own homes, often in front of their parents, was ethically problematic and may have caused young people to give dishonest responses. Further, young people were not involved in the survey design at all. Thus, following a methodological review with policy makers and academics in 2001, the YLT survey was redesigned as an independent survey of 16-year olds. In this new format, the YLT survey has been undertaken annually since 2003.

YLT uses the Child Benefit Register as a sample frame. Child Benefit is paid to all parents and carers bringing up children in the UK, for each child. Using the Child Benefit Register has some advantages over school-based samples, namely the fact that young people not attending, or excluded from, school are not per se excluded from the survey. Furthermore, completion of sensitive questions is best done in a safe and private environment.

Since 2003, all 16-year olds born in February who received Child Benefit and were residents in Northern Ireland were invited to take part in the YLT survey; and from 2008, respondents born in March of the survey year were also invited to take part, in order to address a falling birth rate as well as a decreasing response rate over the years. Respondents can choose to return the paper questionnaire in a Freepost envelope that is provided or else to complete the survey online or over the phone. One reminder letter is sent out after approximately two weeks of the fieldwork period containing another paper questionnaire and Freepost envelope.

The YLT survey contains a number of questions that are repeated each year. These are some key background variables and a time series on attitudes to community relations in Northern Ireland. Aside from these, the content

of the YLT survey varies each year and depends on the timeliness of the questions and on what YLT respondents themselves think should be asked.

The results presented in the next section consequently relate to different survey years - some questions may have been asked just once, some a few times and others each year. Full technical reports for each survey year are freely available from the YLT website (www.ark.ac.uk/ylt/datasets/techinfo.html).

If data from different survey years are available, the most recent results are discussed. Provided this is meaningful, a comparison of results from different survey years is presented.

The response rate to the YLT surveys varied from year to year. Overall, approximately one third of 16-year olds invited to take part in the YLT survey responded. Similar to other surveys, despite annual prize draws and an increase of money spent on incentives to take part, YLT has not escaped the general trend of falling response rates, and the two most recent surveys (2008 and 2009) have only achieved a response rate of 23 percent. This is still a very respectable result for postal surveys and this decreasing response rate has not affected particular subgroups of respondents or caused concerns about the representativeness of the survey results.

Overall, 5,741 16-year olds took part in YLT surveys since 2003. The number of exact responses and response rate can be found in Table 1 below:

Table 1: YLT survey sample sizes and response rates

Survey Year	Eligible sample	Responses	%
2003	1,971	902	**46**
2004	1,983	824	**42**
2005	2,049	819	**40**
2006	1,973	772	**39**
2007	1,925	627	**33**
2008*	4,088	941	**23**
2009	3,798	856	**23**

* From 2008 onwards 16-year olds in March of the survey year were also invited to take part in the YLT survey.

3.2 Measures and categories

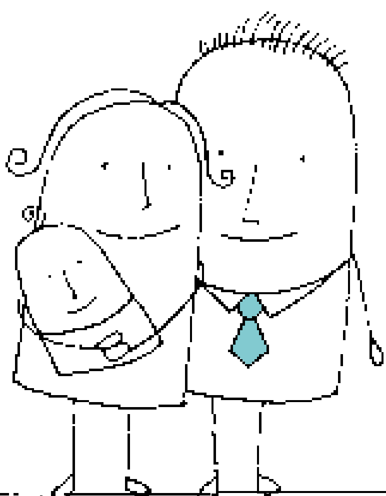
The YLT survey routinely collects a range of background variables that directly, or by proxy, refer to Northern Ireland equality legislation, namely the categories in Section 75 of the 1998 Northern Ireland Act. These background variables collected by YLT are:

- **Gender**
  whether respondents are male or female;
- **Ethnicity**
  What ethnic group respondents belong to and whether they think they are part of a minority ethnic group;
- **Religion**
  The religious background of respondents;
- **Disability**
  Whether respondents have a longstanding illness and whether this is limiting them;
- **Sexual orientation**
  Whether respondents have been sexually attracted to anyone and what gender this other person/these other persons were.

YLT also collects the following information:

- **Educational background**
  What type of school respondents attend and whether they intend to attend a university or other third-level education institution;
- **Rurality**
  Whether respondents live in rural or urban environments;
- **Caring responsibility**
  Whether respondents care for somebody in their home or for somebody who lives somewhere else;
- **Financial background**
  How well-off respondents think their family is financially.

Throughout the Findings section of this report we refer to background variables when presenting findings of the YLT surveys in order to highlight particular mental and emotional health issues among particular respondent groups.



In terms of recording the sexual orientation of respondents, YLT does not ask directly whether or not respondents identify as gay or bi-sexual, but rather uses a question format utilised by sexual attitude surveys (NATSAL, Johnson et al., 1994; Schubotz et al., 2003) which asks respondents to say whether or not they have been sexually attracted to anyone and whether this was never, at least once, mostly, or always to someone of the same sex. This question format has considerable advantages, in particular in a survey of 16-year olds as some of the respondents may not have come to terms yet with their sexual orientation. Models of gay identity formation (Cass, 1979; Troiden, 1989) show that coming out happens approximately between the ages of 11 and 17 years, and a Rainbow Project's study (McNamee, 2006) gave evidence that many gay men in Northern Ireland do not come out publicly until they have left school because of fear of bullying and psychological torment.

For this report, the responses were re-coded into a dichotomous variable which allows a comparison of respondents who had never been sexually attracted to someone of the same sex ('**opposite-sex attracted**') with those who had at least once been sexually attracted to someone of the same sex ('**same-sex attracted**').

The few respondents who said they had never been sexually attracted to anyone are excluded from the analysis. Whilst acknowledging that this differentiation may not be an accurate capture of sexual orientation (heterosexual, homosexuality, bisexuality), as the results below show, this is the most useful way of capturing sexuality-related mental and emotional health issues. Respondents in the 'same-sex attracted' category have arguably at some point been in conflict with prevailing hetero-normative views in Northern Ireland, and the results show clearly that this may lead to additional emotional health problems. Each year between eight and ten percent of YLT respondents say that they had been sexually attracted to someone of the same sex at least once. This figure corresponds well with estimations about the proportion of gay, lesbian or bisexual people in society.

With regard to the perception of their family-financial background, responses were also grouped into a three-point scale of **'well-off', 'average well-off'** and **'not well-off'** with those saying they don't know how well-off their family is financially being excluded from the analysis. Self-reporting is regarded as an appropriate and reliable way of measuring socio-economic status among young people.

4.0 Findings

4.1 Mental and emotional health problems

4.1.1 General Health Questionnaire (GHQ12)

Whilst the 2003 survey exclusively focussed on community relations and cross-community contact, YLT has recorded issues related to mental and emotional health problems since 2004. From 2004-2008 YLT monitored the mental health of respondents through the 12-item version of the General Health Questionnaire (GHQ12) developed by Goldberg and Williams (1988). The GHQ is used to detect the potential of psychiatric disorders in the general population or in particular patient groups. There are different versions of the GHQ (12, 28, 30 or 60 questions). Due to its briefness and simplicity the 12-item version of the GHQ is suitable for incorporation into a longer survey, such as YLT and ideal for self-administration to young people.

The GHQ12 has been used widely in Northern Ireland (Cairns, 2003; McNamee, 2006; Murphy and Lloyd; 2007) - including the Northern Ireland Health and Social Wellbeing studies (Miller et al., 2003). It has been shown to be both reliable and valid amongst community samples in Northern Ireland (Cairns et al., 1986; Curran, 1990).

When completing a survey, respondents are asked to rate their general well-being in the period of a few weeks before the interview (Figure 1).

Based on the responses a total score is calculated, where a higher score indicates poorer mental health.

There are different ways of analysing the GHQ12. For this report the caseness method was used, in which the total score (based on the scoring system of 0,0,1,1 for answers to questions in Figure 2) is used to calculate a dichotomous variable which indicates good or poor mental health. The caseness method is useful to highlight clearly the differences in mental health between particular groups of respondents. Although there is no complete consensus on the threshold which should be used to identify a mental health problem (O'Reilly & Stephenson, 2003), most researchers use a cut-off point of four items, which is the threshold above which respondents are deemed to have a potential psychiatric disorder and are classified as 'cases'. This principle is followed here.

Figure 2 shows a summary of GHQ12 scores by YLT survey year and respondents' gender and family-financial background. The figure shows that females are much more likely than males to be GHQ12 cases. The same is true for 16-year olds from not well-off families compared to those from average well-off and well-off backgrounds. Those from not-well-off backgrounds are most likely to have a GHQ12 score of 4 or more, which suggests that they are potentially most likely to suffer from mental ill-health.

Figure 1: Twelve-item version of the General Health Questionnaire (GHQ12)[1] Caseness Scoring Method.

1. Have you recently been able to concentrate on whatever you're doing?

Better than usual	☐	0
Same as usual	☐	0
Less than usual	☐	1
Much less than usual	☐	1

2. Have you recently lost much sleep over worry?

Not at all	☐	0
No more than usual	☐	0
Rather more than usual	☐	1
Much more than usual	☐	1

3. Have you recently felt you were playing a useful part in things?

More so than usual	☐	0
Same as usual	☐	0
Less useful than usual	☐	1
Much less useful	☐	1

4. Have you recently felt capable of making decisions about things?

More so than usual	☐	0
Same as usual	☐	0
Less so than usual	☐	1
Much less capable	☐	1

5. Have you recently felt constantly under strain?

Not at all	☐	0
No more than usual	☐	0
Rather more than usual	☐	1
Much more than usual	☐	1

6. Have you recently felt you couldn't overcome your difficulties?

Not at all	☐	0
No more than usual	☐	0
Rather more than usual	☐	1
Much more than usual	☐	1

[1]Adapted from Goldberg and Williams (1988) who hold the copyright for the GHQ questionnaire.

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

More so than usual	☐	0
Same as usual	☐	0
Less so than usual	☐	1
Much less than usual	☐	1

8. Have you recently been able to face up to your problems?

More so than usual	☐	0
Same as usual	☐	0
Less able than usual	☐	1
Much less able	☐	1

9. Have you recently been feeling unhappy and depressed?

Not at all	☐	0
No more than usual	☐	0
Rather more than usual	☐	1
Much more than usual	☐	1

10. Have you recently been losing confidence in yourself?

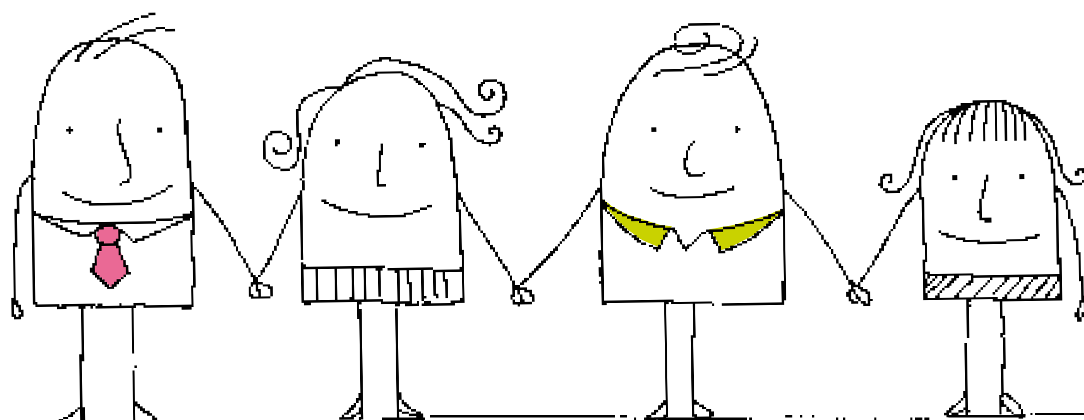
Not at all	☐	0
No more than usual	☐	0
Rather more than usual	☐	1
Much more than usual	☐	1

11. Have you recently been thinking of yourself as a worthless person?

Not at all	☐	0
No more than usual	☐	0
Rather more than usual	☐	1
Much more than usual	☐	1

12. Have you recently been feeling reasonably happy, all things considered?

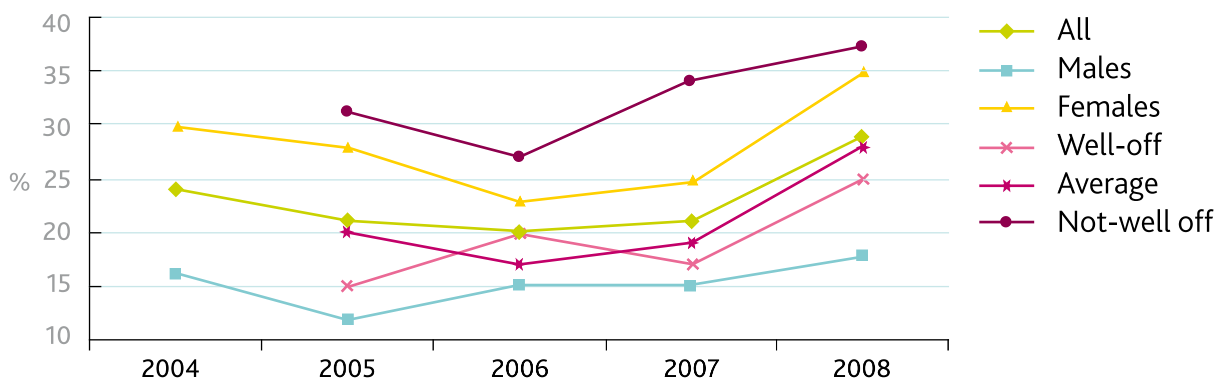
More so than usual	☐	0
About the same as usual	☐	0
Less so than usual	☐	1
Much less than usual	☐	1



In the most recent YLT survey in which this question was asked (2008), 37 percent of respondents from not well-off backgrounds and 35 percent of females were GHQ 'cases'. This compares with one quarter (25%) of respondents from well-off backgrounds and 18 percent of males. Thus, females from not-well-off backgrounds were more than twice as likely as males from well-off backgrounds to be GHQ 'cases' (40% and 17% respectively).

Another group which is particularly vulnerable in terms of their mental health are same-sex attracted 16-year olds. Of all YLT respondents from 2005-2008, 44 percent of same-sex attracted females and one quarter (25%) of same-sex attracted males were GHQ12 'cases'.

Figure 2: GHQ12 scores by survey year and respondents' gender and family financial background (%)



Source: 2004-2008 YLT surveys

In McNamee's (2006) 'Out on Your Own' report, which was produced on behalf of the Rainbow project, the GHQ12 caseness among young non-heterosexual men was even higher (32.4%). McNamee reported that 37.9 percent of her 190 male respondents had received professional help for mental health problems, which two thirds said were related to their sexual attraction. The extent of prejudice, homophobia and harassment experienced by non-heterosexual people in Northern Ireland was reported by Jarman and Tennant (2003), O'Doherty (2009) and recently again by Jarman (2010). Along with McNamee's report, other publications, for example Carolan and Redmond (2003), McNamee, Lloyd and Schubotz (2008) and Schubotz and McNamee (2009) have all highlighted the link between homophobia and poor mental health in Northern Ireland.

The secondary analysis of the 1997 and 2002 Northern Ireland Health and Social Wellbeing surveys, which both included the GHQ12 questionnaire, young age and stress were two main determining factors of GHQ12 caseness (Miller et al., 2003). In the group of 16 to 24-year olds, 19 percent of respondents were GHQ12 cases in 1997. This had risen to 21 percent in 2001, which supports the YLT survey findings. The number of 16-year olds in NISRA's Health and Social Wellbeing surveys were quite small. In 2001, only 92 16-year olds were included. Only 75 completed the GHQ12 and 18 percent were found to be 'cases' (Lloyd et al., 2008). With regard to a comparison with the other parts of the UK, Northern Ireland's results are similar (Murphy and Lloyd, 2007).

Key Findings

In 2008, 29% of YLT respondents were potential sufferers of a psychiatric disorder, measured by the General Health Questionnaire (GHQ12). Previously around 20% of respondents had been recorded has having a risk of psychiatric disorder.

Females (35%), those from not well-off backgrounds (37%) and respondents who were same-sex attracted (males 25%, females 44%) were disproportionately likely to be GHQ12 cases.

4.1.2 Perception of prevalence of emotional and mental health problems

In 2008 and 2009 YLT respondents were asked whether they had experienced serious mental or emotional health problems in the past year for which they felt they needed professional support.

The results in both survey years were nearly identical. In 2009, nearly three quarters of respondents (74%) reported that they had not had such problems. Of the 26 percent of 16-year olds who had experienced serious personal, emotional or mental health problems, only nine percent had sought professional help for these problems. Males were less likely than females to report emotional or mental health problems (79% and 71% respectively saying they had no such problems).

Whilst the differences between males and females are interesting, they were not statistically significant. This cannot be said about the differences in mental and emotional health problems between 16-year olds who come from well-off financial backgrounds and those who do not. As Table 2

shows, whilst over three quarters of YLT respondents from well-off backgrounds (78%) and average well-off backgrounds (77%) said they had had no or few emotional and mental health problems over the past year, only 57 percent of those from not well-off backgrounds said the same. In other words, more than four in ten 16-year olds from financially not well-off backgrounds (43%) reported that they had suffered from emotional or mental health problems in the past year.

The finding that there is an association between financial well-being and mental and emotional health was confirmed by the result that 52 percent of respondents who reported they had been affected 'a lot' by the recent economic crisis reported serious mental and emotional health problems compared to just one quarter (25%) of respondents who said they had 'not at all' been affected by this crisis.

Respondents living in rural areas - those who lived either in a country village or on a farm/in the country - were least likely to report mental or emotional health problems (80% saying they had none), whereas respondents who lived in large cities reported the most (only 62% saying they had none). There was no statistical difference by respondents' school type, but 16-year olds who lived with both their parents were significantly more likely than their counterparts to say that they had no or few of these problems (79%). Furthermore, respondents who had no caring responsibility at home or outside their home were much more likely to report no such emotional problems (76% and 77% respectively) than respondents who looked after someone who was sick or disabled who lived in their home (45%) or outside of their home (66%). Respondents with longstanding illnesses and those who considered they belonged to a minority ethnic group (regardless of what they said this group was) were also proportionately more likely to report emotional and mental health problems.

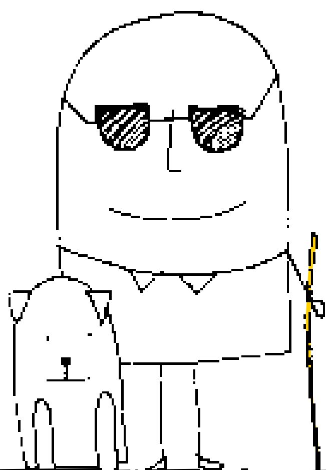


Table 2: Prevalence of serious emotional and mental health problems, by family-financial background (%)

	%			
	Not well-off	Average	All Well-off	All
Have you in the past year had any serious personal, emotional, behavioural or mental health problem for which you felt you needed professional help?				
Yes, but I did not try to get professional help	14	10	12	**11**
Yes, and I did ask for professional help	18	9	5	**9**
No, I have had few or no problems	57	77	78	**74**
I have had, or now have, serious problems, but have never felt the need for professional help	11	4	6	**6**

Source: 2009 YLT survey

Whilst this question hadn't been asked in that format in Northern Ireland before, other available research would support these findings. Back in 2001 the Health Promotion Agency for Northern Ireland (HPANI) found that around one in five young people will experience mental health problems during the formative years of adolescence. In the same year, HPANI released findings of the Health Behaviour of School Children study, which found that girls viewed themselves as being less happy and less healthy than boys. Again, one in four young people were found to 'feel low' on a weekly basis. This was true for twice as many Year 12 girls as boys. HPANI reported that older pupils were more likely to feel irritable or bad tempered sometimes.

Key Findings

Around one quarter (26%) of respondents said they had suffered from a serious mental or emotional problem in the past 12 months. This proportion is much higher among those from not well-off background (43%).

Respondents from rural areas (20%) were much less likely to report emotional and mental health problems than those who lived in cities (38%).

Those with caring responsibility and those with a longstanding illness or disability were also more likely to report emotional or mental health problems.

4.1.3 Stress

In 2004, 2005 and 2008, YLT asked respondents about the level of stress they experienced and about the nature of these stressors. Cairns and Lloyd had discussed findings from early surveys in the Research Update 'Stress at 16' (2005) and in a book chapter in 2008 (Lloyd et al., 2008).

In the 2004 and 2005 YLT surveys 29 and 27 percent of respondents respectively said that they were often or very often stressed. This figure was much higher in 2008 when 39 percent responded in this way. Again, females were much more likely than males to say that they were stressed often or very often (36% and 20% respectively in 2004; 35 and 15% respectively in 2005 and 51 and 20% respectively in 2008).

Schoolwork and exams were identified by most respondents as the main cause of their stress. This is confirmed by the cross-departmental biannual Young Person's Behaviour and Attitude survey which found that 84 percent of respondents felt a certain amount of stress due to school work with almost two in five saying that they sometimes had difficulty falling asleep because they were thinking about school (Sweeney et al., 2008).

Seven out of ten respondents in the 2004 and 2005 YLT surveys identified school as the main source of their stress. This had risen to eight out of ten respondents in 2008. This was followed by family problems which were identified by around one quarter of respondents (26%) in 2004 and 2005 and by one fifth of respondents (21%) in 2008. Financial problems, being under pressure and problems with friends were the next most common stressors. Females were again more likely than males to mention these problems, but the difference was most significant in relation to school work which females experienced as much more stressful than males.

Equally, respondents from less well-off backgrounds and same-sex attracted respondents experienced higher levels of stress, as Table 3 shows. Respondents with caring responsibility at home, those with longstanding illnesses or disabilities and those who said they belonged to a minority ethnic group (regardless of the group they said they belonged to) also reported higher levels of stress, whereas there was no difference between respondents who attended different school types.

Table 3: How often do you get stressed? By gender, financial background and sexual orientation of respondents (%)

	%							
	Gender		Family-financial background			Sexual Orientation		All
	Males	Females	Not Well-Off	Average	Well-Off	Opposite -Sex Attracted	Same -Sex Attracted	
Very often	5	15	19	10	8	10	25	**11**
Often	15	36	29	28	27	28	35	**28**
Sometimes	40	33	32	36	39	36	29	**36**
Rarely	27	12	12	19	19	19	8	**18**
Never	13	4	9	7	7	8	2	**8**

Source: 2008 YLT survey

Key Findings

Nearly four in ten (39%) 16-year olds get stressed often or very often.

Stress levels are much higher among females than males (51% and 20% saying they got stressed often or very often respectively).

Those from not well-off backgrounds (48%) and same-sex attracted people (60%) were also much more likely to report high stress levels than their better-off and heterosexual counterparts.

Stress was by far most often connected to school, but problems in the family, with friends and at work were also main causes for high stress levels.

4.1.4 Social pressures

Social pressures to engage in health-adverse behaviours have also been highlighted as having negative consequences for the general health, but particularly the mental and emotional health of young people. The pressure for young people to engage in sexual intercourse was highlighted by research undertaken by fpaNI and the University of Ulster which found that 32 percent of 14-25 year olds said that their first sexual intercourse came too early (Schubotz, Simpson and Rolston, 2003). Pressures to engage in drinking and drug taking and consequences of doing so for young people are probably one of the widest-researched areas with regard to young people's health in Northern Ireland. Numerous studies using both quantitative and qualitative methodologies and investigating particular target groups have been published. Some notable studies are the longitudinal Belfast Youth and Development study (BYDS) undertaken by the Institute of Childcare Research at Queen's University, (McCrystal and Percy, 2009; McCrystal, Percy and Higgins, 2006, and 2007), Miller and Plant's 2001 study published by DHSSPS, as well as the secondary data analyses conducted by HPANI (2005) and by Miller and Dowds (2002), also published by DHSSPS. Hannaford (2005) had summarised early findings from the YLT survey on social pressures.

Each year YLT asks respondents what questions should be asked to next year's respondents. Questions related to the consumption of illegal drugs and the effect of this, smoking, early sexual intercourse and alcohol consumption top the list of suggestions for inclusion in next year's survey. This is evidence of the importance that these issues have to 16 year-olds.

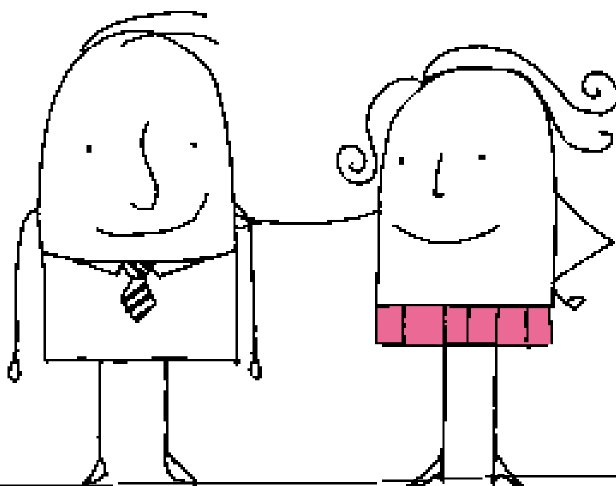


Table 4: Proportion of respondents who said they felt pressurised to do the following (by gender, family-financial background and sexual orientation) (%)

	%							
	Gender		Family-financial background			Sexual Orientation		All
	Males	Females	Not Well-Off	Average	Well-Off	Opposite-Sex Attracted	Same-Sex Attracted	
Drink alcohol	72	79	86	76	71	77	82	**76**
Smoke tobacco	33	43	59	38	30	38	61	**39**
Lose weight	10	46	37	31	33	30	57	**32**
Have sexual intercourse	19	24	40	21	15	22	37	**22**
Take illegal drugs	17	13	23	15	10	14	22	**15**

Source: 2008 YLT survey

Table 4 shows that over three quarters (76%) of 2008 YLT respondents said they felt under pressure to drink alcohol. The second most likely pressure respondents felt was the pressure to smoke tobacco (39%), followed by the social pressures to lose weight (32%), to have sexual intercourse (22%) and to take illegal drugs (15%). As the Table shows, females were significantly more likely to feel pressurised to engage in these behaviours than males, except for the pressure to take illegal drugs. Notable is that females were almost five times as likely as males to feel under pressure to lose weight.

There is also a correlation between family-financial background and social pressures with not well-off respondents significantly more likely to experience all of these pressures than respondents who said they were financially well-off. Finally, same-sex-attracted respondents were much more likely to say that they felt social pressures to engage

in behaviours listed in Table 4 than opposite-sex attracted respondents. Again, McNamee's report (2006) about the mental health of gay men highlights in more detail and depth the pressures that young non-heterosexual men experience to engage in risky behaviours. In their study of young women, McAllister, Gray and Neill (2007) found that most women were knowledgeable about health-related advice but still blamed peer pressure as the cause why they engaged into health-adverse such as drinking alcohol extensively. The particular pressures for young women and perceptions of 'self' arising from this were highlighted in an article by McAlister and Neill in 2008. Blake (2008) concluded that the pressures that young people experience to engage in health-adverse behaviours should be addressed by their involvement in service provision and education about these issues.

Key Findings

High proportions of 16-year olds experienced social pressures to engage in health-adverse behaviours. 76% felt pressurised to drink alcohol, 39% felt pressurised to smoke, 32% felt pressured to lose weight, 22% experienced the pressure to have sexual intercourse and 15% felt pressurised to take illegal drugs.

Apart from the pressure to take illegal drugs, females felt more pressure to engage in the other health-adverse behaviours listed in Table 4. The pressure among females to lose weight was almost 5 times higher than among males (46% and 10% respectively).

Social pressures were also much more experienced by same-sex attracted and not well-off respondents.

4.1.5 School bullying

YLT regularly monitors the prevalence of school bullying. On behalf of NICCY, a mixed-methods study on school bullying involving peer researchers was jointly undertaken with the National Children's Bureau (NCB) in 2005/06 (Schubotz et al., 2006; Burns, 2007; Sinclair, 2008). However, school bullying is also regularly monitored by the Department of Education (Collins, McAleavy and Adamson, 2002), CAMH (Dyer and Teggart, 2007) users and Childline (1998).

The most recent data available on school bullying in YLT are from the 2008 YLT survey. In that survey, 37 percent of all respondent said they had been bullied in school. This figure was lower among females (32%) than males (40%). Eight percent of respondents (10% of males and 7% of females) said they had taken part in bullying other students in their school.

There was no significant difference between respondents attending different types of school with regard to school bullying - that is whether they attended a grammar school, a secondary school or a planned integrated school.[1] Similarly, the religious composition of schools was not related to the extent of bullying experienced by respondents.

The relationship between school bullying and same-sex attraction and its consequences for the mental health of same-sex attracted young people was explored extensively elsewhere (McNamee, Lloyd and Schubotz, 2008). Table 5 gives evidence for the significantly higher levels of school bullying experienced among same-sex attracted YLT respondents.

[1]There were too few respondents attending Irish language schools, special schools or other types of schools to include these in the analysis.

Table 5: Respondents saying they have been bullied in school. By sexual attraction and survey year (%)

		%
	2005	2008
All Males	27	32
Opposite-sex attracted males	25	28
Same-sex attracted males	67	70
All Females	32	40
Opposite-sex attracted females	32	37
Same-sex attracted females	40	62
All respondents	30	37

Source: 2005 and 2008 YLT surveys

The Attitudes to Difference report published in 2010 by the National Children's Bureau (NCB) and ARK (YLT) revealed that 16-year olds from minority ethnic backgrounds were significantly more likely to experience racially motivated school bullying as well as other levels of xenophobia both inside and outside the school environment, as Table 6 highlights. However, with regard to their life-time experience of school bullying, respondents from minority ethnic backgrounds did not differ from their counterparts, although they were more likely to report bullying in the recent two months.

Table 6: Experience of xenophobia. By ethnic group (%)

	%			
	Member of minority ethnic group		Self-identifies as belonging to a minority ethnic group	
	Yes	No	Yes	No
Have any of your friends called someone names to their face because of their colour or ethnic origin?				
Often	4	3	3	3
Sometimes	18	9	15	9
Only once or twice	22	18	24	19
Never	56	68	57	67
And how about you? Have you ever called someone names to their face because of their colour or ethnic origin?				
Often	0	<1	1	<1
Sometimes	0	1	1	1
Only once or twice	17	7	13	7
Never	83	90	83	90
Respondents saying they…				
Have witnessed racist bullying or harassment in their school	59	33	40	34
Have themselves been a victim of racist bullying or harassment in their school	29	4	10	4
Know someone personally who has been the victim of racist harassment or assault outside of school	41	18	21	18
Have themselves been a victim of racist harassment or assault outside of school	17	2	8	3

Source: 2008 YLT survey

Key Findings

Over one third (37%) of respondents had experienced school bullying.

Experience of bullying among same-sex attracted respondents is much more common with seven out of ten same-sex attracted young men and over six out of ten (62%) same-sex attracted young women reporting school bullying.

Respondents from minority ethnic backgrounds had significant experiences of xenophobic name-calling, bullying and harassment.

4.1.6 Causes of mental and emotional health problems

In 2009 YLT asked respondents on behalf of the Patient and Client Council what sort of things would cause them emotional problems. 'Appearance or body shape' was identified by the highest proportion of respondents (50%), as Table 7 shows. This was followed by the pressure they experience from 'having too much homework' (45%) and by 'having to cope with criticism from family and teachers' (37%). With regard to this pressure from school, the 2003 Young Person's Behaviour and Attitude survey (NISRA, 2004) found that 82 percent of 11 to 16-year old respondents felt a certain amount of pressure due to the school work they had to do. Thirty-four percent also felt that their parents expected too much of them.

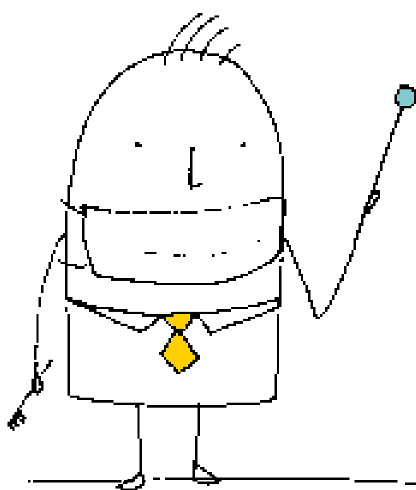


Table 7: Which of the following things cause you emotional problems? By gender (%)

	%		
	Male	Female	All
My appearance or body shape	28	64	**50**
Having too much homework	34	53	**45**
Having to cope with criticism from family and teachers	31	41	**37**
Not being confident with opposite sex	17	21	**20**
Being in debt	11	16	**14**
Thinking about suicide	9	15	**12**
Being concerned that I drink too much	9	7	**8**
Thinking I may be gay	5	5	**5**
Being pressurised to take drugs	6	4	**5**
Something else	13	15	**14**
None of the above	30	12	**19**

Source: 2009 YLT survey

In YLT, there were some significant differences between males and females in relation to these pressures. For nearly every issue, apart from 'drinking too much', 'being pressurised to take drugs' and 'thinking I may be gay', 16-year old females were more likely than males to say that it caused them emotional problems - sometimes significantly more so. For example, nearly two thirds (64%) of females said that their 'appearance and body shape' caused them emotional problems compared to just over one quarter of males (28%). Over half (53%) of females compared to one third of males (34%) said that 'having too much homework' caused them emotional problems. 'Having to cope with criticism from family and teachers' was also identified as causing emotional problems by 41 percent of females but only 31 percent of males. Nearly three times as many males as females said that none of the listed issues would cause them emotional problems.

Other interesting findings in relation to perceived causes of emotional problems emerged. As could be expected, same-sex attracted respondents were much more likely than their opposite-sex attracted counterparts to say that a lack of confidence with the opposite sex or thinking that they may be gay caused them emotional problems, as Table 8

shows. However, same-sex attracted respondents were also much more likely (54%) to say that criticism from teachers and parents caused them emotional problems. Worryingly over one quarter (27%) of respondents who said they were sexually attracted to people of the same sex said that thinking about suicide caused them emotional problems. This compares with 11 percent of opposite-sex attracted YLT respondents who said the same. Worry about appearance and body shape was also a much bigger issue for same-sex attracted respondents as Table 8 shows.

Table 8: Which of the following things cause you emotional problems? By sexual orientation (%)

	%	
	Same-Sex Attracted	Opposite-Sex Attracted
My appearance or body shape	68	49
Having too much homework	52	45
Having to cope with criticism from family and teachers	54	36
Not being confident with opposite sex	32	19
Being in debt	21	14
Thinking about suicide	27	11
Being concerned that I drink too much	14	7
Thinking I may be gay	26	3
Being pressurised to take drugs	5	5
Something else	17	14
None of the above	6	19

Source: 2009 YLT survey

Respondents' family-financial background also made a difference to the extent to which these issues caused emotional problems. As could be expected, well-off respondents were much less likely to say that being in debt caused them emotional problems (8%) than respondents who said they came from average well-off backgrounds (15%) or from not well-off backgrounds (20%). However, well-off respondents were also much less likely to say that thinking about suicide caused them emotional problems (8%)

than respondents from not-well off backgrounds (23%). Their appearance or body shape caused emotional problems for a smaller proportion of well-off respondents (45%) than average well-off (50%) and not well-off respondents (57%).

Key Findings

Appearance and body shape (50%), too much homework (45%) and criticism from parents and teachers (37%) were identified by YLT respondents as the three main reasons why young people suffer from mental or emotional health problems.

Females were more likely to identify any of the problems listed, except for the pressure to take drugs (6% males, 4% females).

Same-sex attracted respondents were also significantly more likely to experience any of these problems as causes for their emotional health problems.

4.1.7 Attitudes to mental and emotional health issues

In 2009, YLT respondents were asked how much they agreed or disagreed with twelve statements focusing on emotional and mental health issues and services. Some of these statements were directly related to the provision of mental health services for young people. A 5-point response scale was used, from 1 (strong agreement) to 5 (strong disagreement). In order to be able to calculate and compare the extent to which young people agreed with each statement, the mean scores of the responses were calculated. Those who said they did not know how to respond to the statements were excluded from the analysis along with those who failed to respond to these questions.

Table 9 shows the responses to these statements and compares the respondents who said they had suffered from mental or emotional health problems over the past 12 months with those who did not. It shows that those 16-year olds who had reported serious mental or emotional health problems over the past 12 months had more negative attitudes and experiences of mental health services than their counterparts. Most of these differences were statistically significant. For example, the majority of respondents who had experienced serious emotional or mental health problems disagreed that there were 'suitable activities and facilities in the local community that they can attend to help them'. On the other hand, most 16-year olds who had not reported such mental health problems agreed that there were suitable activities and facilities available. Furthermore, 16-year olds who had reported mental or emotional health problems were less likely to agree that there were lots of organisations that can help them if they experienced such problems than 16-year olds who had no such problems.

Table 9: Level of agreement or disagreement with statements.
By reported mental or emotional health problems in past 12 months (Mean score)

	Mean Score		
	Emotional or mental health problems in past 12 months	No reported emotional or mental health problem	All
I believe that doctors and nurses understand and respect my right to confidentiality when it comes to my emotional or mental health problems.	2.18	1.84	**1.93**
There are very few services for young people who have emotional or mental health problems.	2.66	3.02	**2.90**
When you have emotional or mental health problems it is easy to trust and talk to school nurses and health visitors.	3.90	3.55	**3.64**
The voice of young people who have emotional or mental health problems is not heard by health professionals.	2.63	2.88	**2.81**
I feel that I could get help from services in an emergency if I had emotional or mental health problems.	2.83	2.46	**2.57**
Young people are able to influence the delivery of health care that relates to their emotional or mental health needs.	3.04	3.01	**3.02**
There is no support in the health service for families who have a young person with emotional or mental health problems.	3.21	3.43	**3.35**
When young people have emotional or mental health problems there are suitable activities and facilities in the community that they can attend to help them.	3.44	3.02	**3.15**
Young people like me have difficulty talking to anyone about their own emotional or mental health issues.	2.16	2.66	**2.51**
There are lots of organisations that can help me if I have emotional or mental health problems.	2.98	2.67	**2.77**

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

Source: 2009 YLT survey

Respondents with emotional or mental health problems were also more likely to agree than those without such problems that the voice of young people who have emotional or mental health problems is not heard by health professionals.

The views of respondents were most similar in relation to the statement that 'young people are able to influence the delivery of health care that relates to their emotional or mental health needs with the majority neither agreeing nor disagreeing. A positive finding of the YLT survey is that 16-year olds were most likely to agree that 'doctors and nurses understand and respect their right to confidentiality'. On the other hand, disagreement was strongest with the statement that 'it is easy to trust and talk to school nurses and health visitors when they have emotional or mental health problems'.

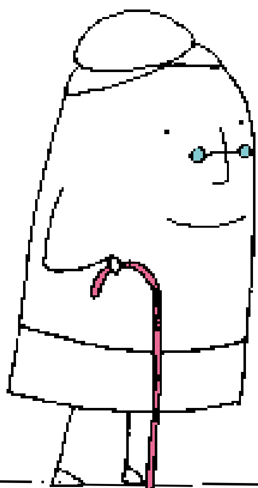


Table 10 compares the views of females and males as well as opposite-sex attracted and same-sex attracted respondents to on these statements on mental emotional health issues and gives the levels of statistical significance for these differences. Females were much less likely than males to agree that they could get help in an emergency if they had emotional or mental health problems. They were on the other hand more likely to disagree that there are few mental health services. Males, on the other hand, were much less likely to agree that young people have difficulties talking to anyone if they have mental or emotional health problems.

Same-sex attracted 16-year olds also held more negative views towards emotional and mental health services. They were less likely than their opposite-sex attracted counterparts to agree that health professionals understood and respected their rights of confidentiality. They were also more likely to agree that people like them had difficulty talking to anyone about their own emotional or mental health issues. Finally, they were more likely to agree with the statement that 'the voice of young people is not heard by health professionals'.

As reported earlier, financially not well-off respondents were much more likely to report mental and emotional health problems. Similar to females and same-sex attracted respondents they also hold more negative views towards respective health services. Their attitudes varied significantly from those of better-off respondents with regard to the agreement that there 'is no support in the health service for families who have a young person with emotional or mental health problems', their agreement with the view that young people's voices are not heard by health professionals and the agreement that there are very few services for young people with emotional health problems.

McAllister, Gray and Neill (2007) as well as McNamee (2006) provide more in-depth information about young women's and gay men's views on mental health service provision on the groups of young people they researched respectively.

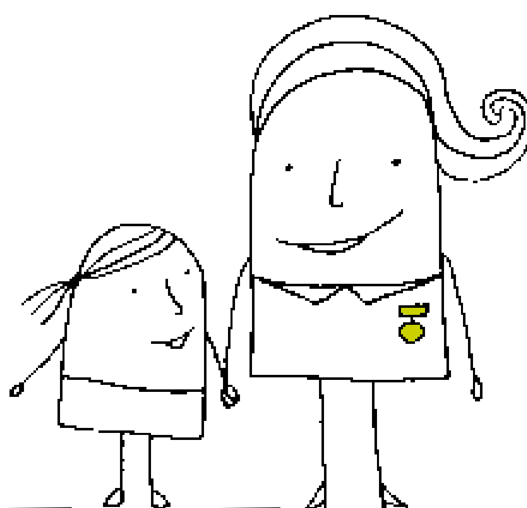


Table 10: Level of agreement or disagreement with statements. By gender and sexual orientation (Mean score)

	Mean Score			
	Males	Females	Opposite-sex attracted	Same-sex attracted
I believe that doctors and nurses understand and respect my right to confidentiality when it comes to my emotional or mental health problems.	1.91	1.94	1.90	2.24
There are very few services for young people who have emotional or mental health problems.	3.06	3.82	2.92	2.73
When you have emotional or mental health problems it is easy to trust and talk to school nurses and health visitors.	3.50	3.72	3.65	3.79
The voice of young people who have emotional or mental health problems is not heard by health professionals.	2.83	2.79	2.83	2.56
I feel that I could get help from services in an emergency if I had emotional or mental health problems.	2.40	2.67	2.54	2.80
Young people are able to influence the delivery of health care that relates to their emotional or mental health needs.	3.02	3.02	3.01	3.10
There is no support in the health service for families who have a young person with emotional or mental health problems.	3.33	3.36	3.37	3.15
When young people have emotional or mental health problems there are suitable activities and facilities in the community that they can attend to help them.	3.10	3.19	3.15	3.28
Young people like me have difficulty talking to anyone about their own emotional or mental health issues.	2.66	2.42	2.56	2.10
There are lots of organisations that can help me if I have emotional or mental health problems.	2.76	2.78	2.75	3.00

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

Key Findings

The attitudes towards mental health issues differed significantly between those who had experiences serious emotional and mental health problems and those who hadn't.

The groups of YLT respondents who hadn't experienced serious emotional and mental health problems reported overall significantly more positive views than the young people affected by mental health issues.

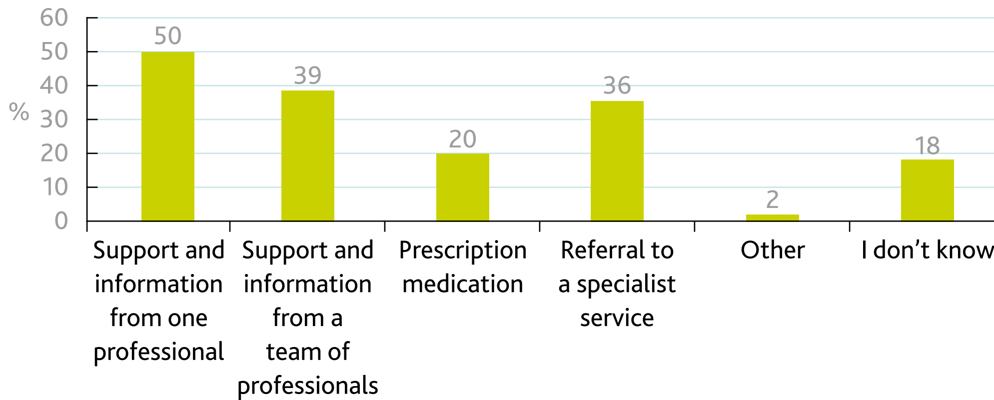
Females held more negative views than males and same-sex attracted respondents held more negative views than those who were only sexually attracted to people of the opposite sex.

4.1.8 Sources of support

When asked by YLT what type of professional support would be helpful for a young person with emotional or mental health problems, 50% of respondents felt that support and information from one understanding professional would be most appropriate, as Figure 3 shows. The least popular option among respondents was that prescription medication should be given, with one in five respondents (20%) giving this response.

Females were slightly more likely than males to prefer support from a team of health professionals (42% and 35% respectively). Females were also more likely than males to favour the idea of prescription medication (23% and 16% respectively).

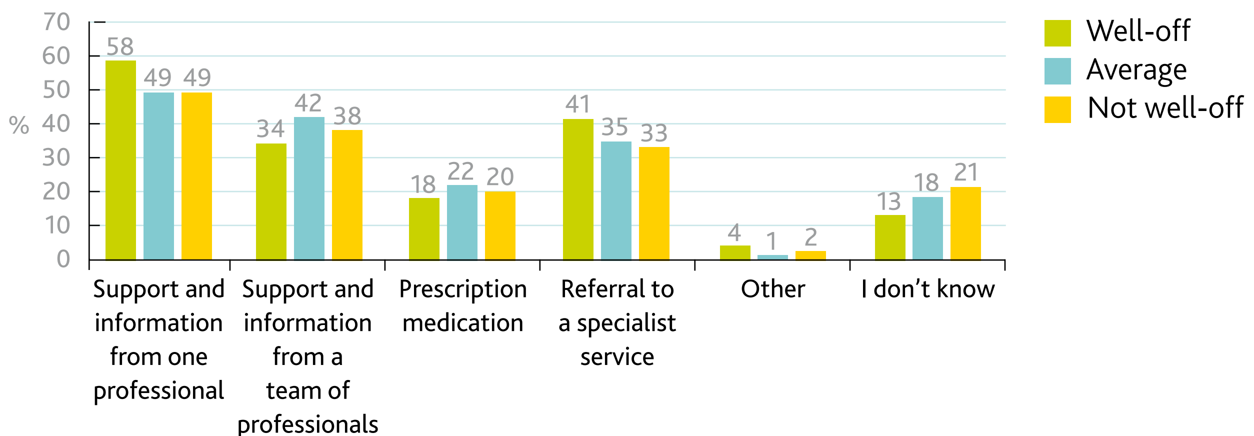
Figure 3: What kind of professional response would be helpful to a young person who has emotional/mental health problems?* (%)



* Respondents were allowed to choose more than one response option.
Source: 2009 YLT survey

Figure 4 shows the different responses to this question by 16-year olds from different financial backgrounds. The Figure shows that the support for a one-professional approach is much stronger among well-off respondents, who were also most likely to favour a referral to a specialist service.

Figure 4: What kind of professional response would be helpful to a young person who has emotional/mental health problems?* By financial background of respondents (%)



* Respondents were allowed to choose more than one response option.
Source: 2009 YLT survey

A substantial difference in preferred professional responses to mental and emotional health problems was also found between respondents who were same-sex and opposite-sex attracted (Figure 5). Same-sex attracted respondents were more likely to favour a one-professional-only approach and equally more likely to prefer a referral to a specialist clinic. It could be speculated that sensitivities about mental health issues that may be related to their sexuality could cause these respondents to prefer approaches that involve fewer rather than more health professionals.

Respondents were given a list of potential sources of support that young people with emotional or mental health problems may consider contacting and were asked to rate on a 4-point scale how helpful they felt these sources would be to them. Figure 6 shows the level of helpfulness anticipated by respondents expressed as a mean or average score. The higher this score, the more helpful respondents felt this source of support would be to them.

As Figure 6 shows, respondents' friends and mothers were identified as the most helpful sources of support. The mean score for friends was 3.4 and that for respondents' mothers was 3.34. The sources identified as least helpful were a school nurse (mean score: 2.05) or a minister, priest or religious leader (means score: 2.08). Teachers were not included in the list of answer options to this question, but respondents could also name other helpful sources of support. Thirteen respondents did identify 'teachers', which was by far the most common response among all 'other' answers.

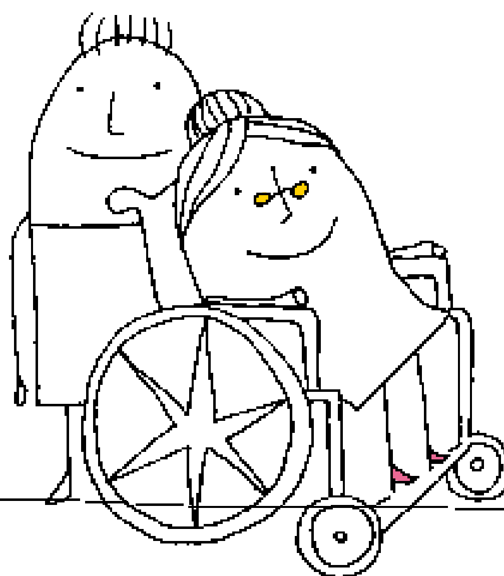
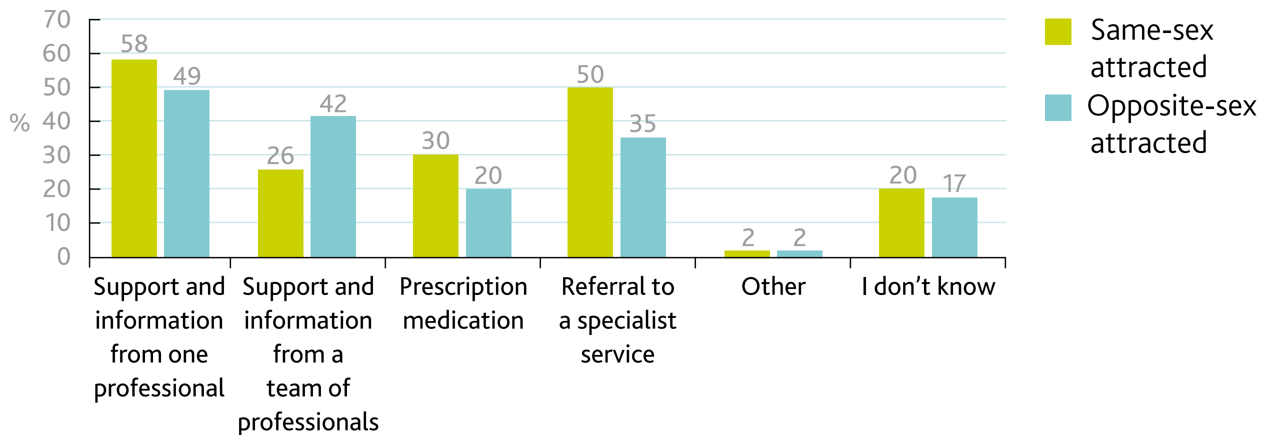
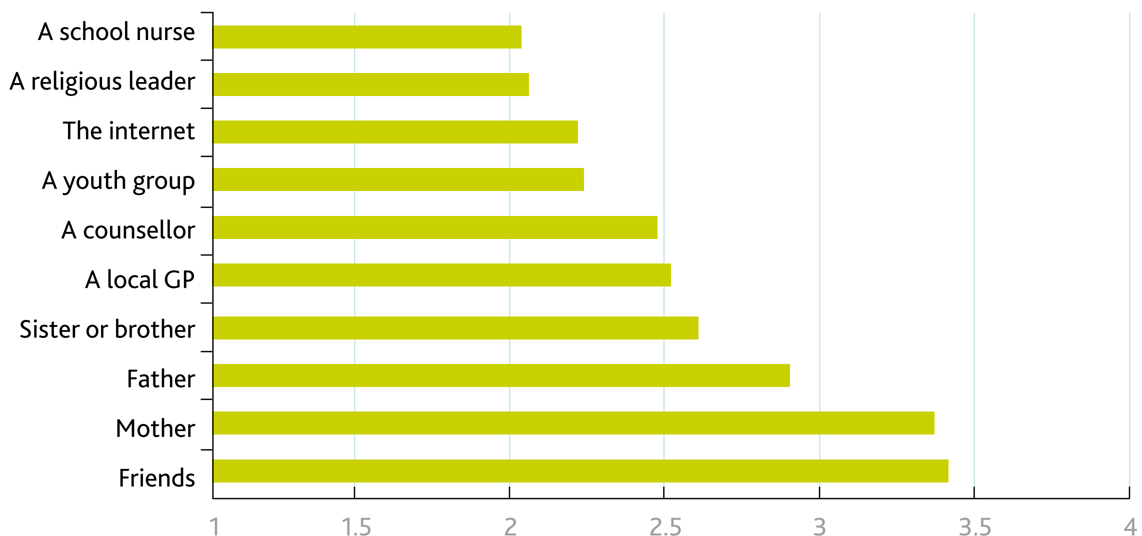


Figure 5: What kind of professional response would be helpful to a young person who has emotional/mental health problems?* By sexual orientation of respondents (%)



* Respondents were allowed to choose more than one response option.
Source: 2009 YLT survey

Figure 6: How helpful do you think these sources would be to you if you had emotional or mental health problems? (Mean score)



Mean of score helpfulness: 1 = Not at all helpful 4 = Very helpful
Source: 2009 YLT survey

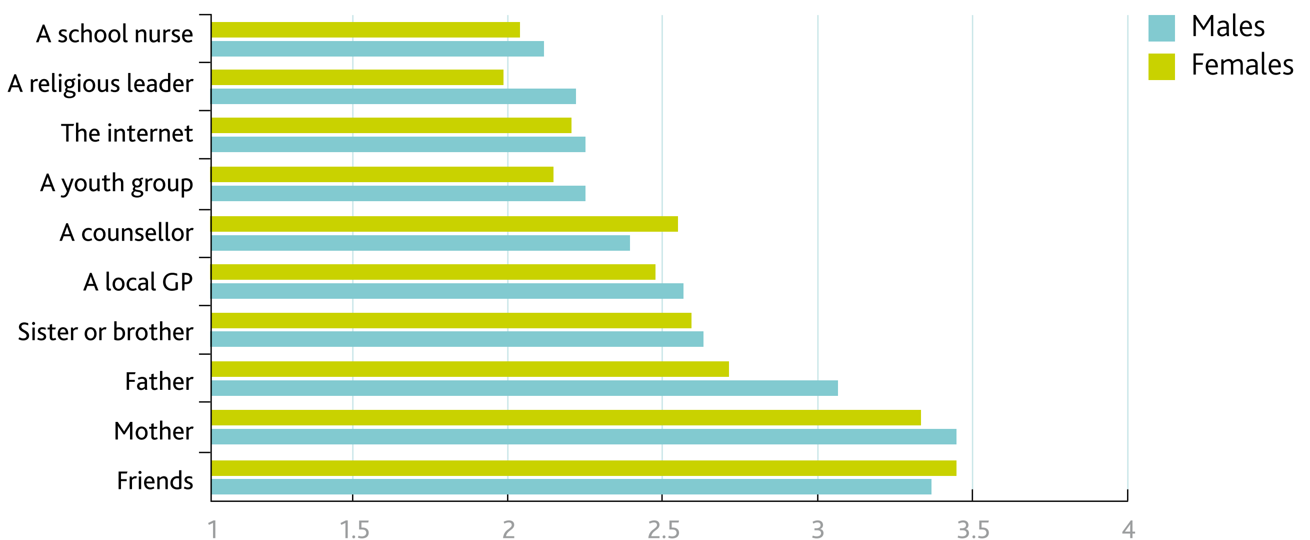
Those groups of YLT respondents who were more likely to report emotional and mental health problems in the past 12 months (females, same-sex attracted respondents and respondents from financially not well-off backgrounds) were less likely to find the sources of support helpful. However there were some notable exceptions.

Females found friends and counsellors more helpful than their male counterparts, whereas all other sources were considered more helpful by males (Figure 7).

Other interesting findings were that same-sex attracted YLT respondents found the Internet and youth groups more helpful, but otherwise all other sources much less useful than their opposite-sex attracted counterparts, some significantly so - notably friends, both mother and father, and a GP. Youth groups were also found more helpful by respondents from financially not well-off backgrounds than by respondents who came from better-off backgrounds. However, mother and father were found significantly less helpful by not-well off respondents with all other sources found a little less helpful.

Respondents with a longstanding illness or disability were significantly less likely to say that friends were a helpful resource for them if they had an emotional or mental health problem. This maybe a reflection of the finding that 16-year olds with longstanding illnesses and disabilities generally had fewer friends than respondents without such conditions.

Figure 7: How helpful do you think these sources would be to you if you had emotional or mental health problems? (Mean score, by gender)

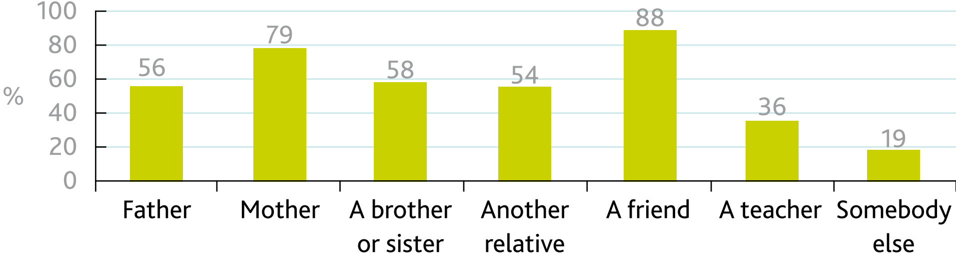


Mean of score helpfulness: 1 = Not at all helpful 4 = Very helpful

Source: 2009 YLT survey

These findings are comparable with the 2008 YLT survey, where again friends were the most likely source of support respondents felt they could talk to about things that really bothered them, as Figure 8 shows. However, those with emotional and mental health problems were less likely to say they could talk to their friends than their counterparts (86% and 91%). Similarly, 63 percent of respondents with mental and emotional health problems said they could talk to their mother, compared to 83 percent of respondents who did not report any mental or emotional health problems.

Figure 8: Respondents who say they can talk to the following people about things that really bother them (%)



Source: 2008 YLT survey

Sixty percent of respondents who had considered taking an overdose or trying to harm themselves said they had tried to get help from their friends. This was by far the most likely source of support they would turn to. One third (34%) said they had sought support from their boyfriend or girlfriend, followed by 22 percent who sought help from their mother. The same proportion said they had sought help from a psychologist or psychiatrist. Interestingly, fathers were the least likely source of support with only five percent of respondents saying they would seek support from their father.

16-year olds who had reported episodes of self-harm sought support from the same sources. Nearly two thirds (64%) of these respondents said they tried to get help from their friends before they injured themselves. Again, boyfriends and girlfriends were the second most likely source from which they sought support (27%), followed by their mother (19%) and a psychologist/psychiatrist (15%).

Table 11: Help-seeking and sources of support of respondents who self-harmed or thought about self-injury (%)

	%			
	Provided support when respondent thought about self-harm	Help sought from these BEFORE self-harm episode	Knew about self-harm	Provided help AFTER self-harm episode
Mother	22	19	40	44
Father	5	6	27	20
Sibling	16	8	25	17
Other relative	9	4	16	12
Partner or girlfriend/boyfriend	34	27	29	27
A friend	60	64	70	52
A teacher	11	6	11	20
A GP	14	4	10	21
A social worker	8	6	10	11
Psychologist/ Psychiatrist	22	15	4	18
Telephone helpline	8	10	6	8
Drop-in or advice centre	5	15	14	3
Other	18	n.a	n.a.	14

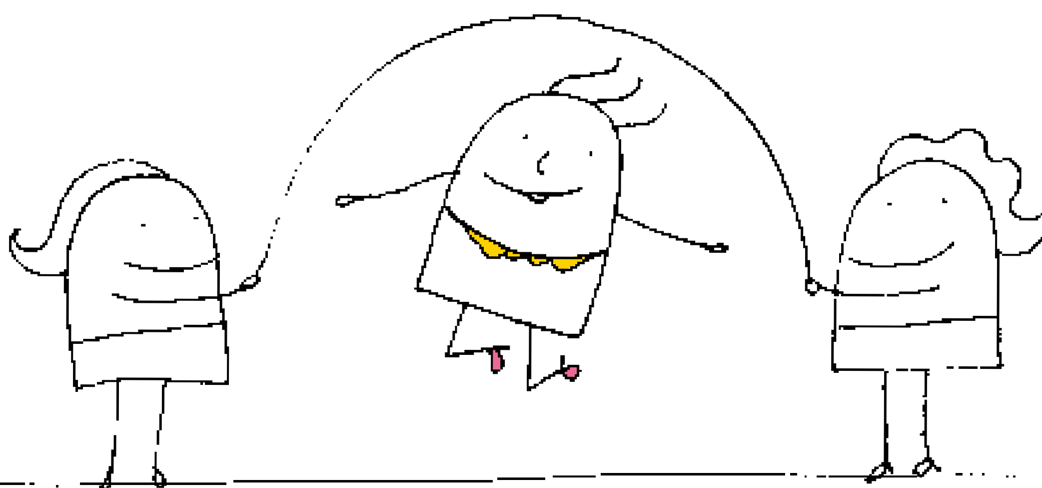
Source: 2008 YLT survey

Table 11 compares the sources of support used by respondents who had thought of injuring themselves and those who had done so, before and after the incident. Self-harm is often seen as a phenomenon that occurs unnoticed. The YLT data would certainly suggest that, at least from the position of the young people who did injure themselves, a relatively high proportion of significant others were aware of the episode of self-harm. Seventy percent of those who had self-harmed said a friend was aware of this. The mother of four out of ten respondents who had self-harmed also knew about this. Over one quarter (27%) of fathers also knew.

The different levels of support provided, in particular by parents to respondents at a stage when they seriously think about self-harm and after the episode of self-injury is particularly note-worthy. As Table 11 shows, mothers were twice as likely to provide support after a self-harm episode than before (22% and 44% respectively). Fathers were even four times as likely to provide support after self-injury than before (5% and 20%). The results suggest that parents may lack the ability to recognise the seriousness of mental health issues that precede episodes of self-injury. A greater support for parents in recognising such serious mental and emotional stress situations may help to prevent many cases of self-injury from occurring.

Overall, the 2008 YLT survey shows that respondents with mental and emotional health problems were much less resourceful in dealing with worry or stress. YLT identified four main barriers in seeking support:

1. Some 16-year olds affected by self-injury didn't feel they needed support in this situation and wanted to sort out the problems themselves.
2. Some respondents said they were too embarrassed, ashamed or afraid to talk about this.
3. Some 16-year olds said they were afraid that people would think they were attention seeking, or they did not want to burden others with their problems.
4. Some respondents said they were unable to discuss these problems with others.



Key Findings

Friends and parents were identified as the main sources of support if young people suffer from emotional or mental health problems. Apart from friends, females were less likely than males to think that any other source was helpful for them when they were experiencing an emotional health problem.

The highest proportion of respondents (50%) preferred support from one professional only when they were experiencing an emotional health problem. The least popular option was prescription medication as a way to help young people (20% supporting this option). Support from one professional only was much more likely to be chosen by young people who were same-sex attracted.

Friends and parents were the most likely source of support for those who self-injured.

A relatively high proportion of friends (70%) and parents (40%) knew about the self-harm episode of the respondents affected.

The findings suggest that support from parents was much stronger after the episode of self-harm than before, which indicates that parents may not be able to identify early signs of serious mental and emotional distress among their children.

4.1.9 Self injury

Until the results of the 2008 YLT survey were published (Schubotz 2009), large-scale survey data on the prevalence of self-injury among young people and their attitudes to self-harm and suicide had been available in England (Hawton, 2006) and Scotland (O'Connor et al., 2009), but not in Northern Ireland. Information about these subject areas were mainly restricted to the analysis of publically available death records and hospital admissions (Tomlinson, 2007) and small-scale studies in particular fields, such as young people in care setting (Cousins, McGowan and Milner, 2008). Teggart (2006) had also published a response by young people on the Northern Ireland Suicide Prevention Strategy, which was undertaken on behalf of the Health Promotion Agency and the Youth Council for Northern Ireland. Anecdotal evidence on experience of self-harm were also revealed by qualitative studies such as McNamee's (2006) and McAlister, Gray and Neill's (2007).

The 2009 YLT survey duplicated many of the questions asked in the international CASE study on self-harm (Hawton, 2006) and, for the first time in Northern Ireland made comparisons possible on a large scale with self-harm rates in other parts of the UK and Europe.

YLT found that 14 percent of respondents said they had in the past seriously thought about taking an overdose or harming themselves, and ten percent of YLT respondents said that they had actually taken an overdose or tried to harm themselves - half of those had done so once and half more than once (5% of YLT sample each). Females were about two and a half times more likely than males to say that they had thought about self-harm (18% and 7% respectively) and to have actually self-harmed (13% and 5% respectively, Table 12).

According to the YLT results, prevalence of self-injury in Northern Ireland is similar to this of England (11%) and the Republic of Ireland (9%) found in the CASE study (Hawton, 206), but lower than this reported by O'Connor et al. (2009) for Scotland (14%).

Table 12: Ideation and experience of self-harm, by gender (%)

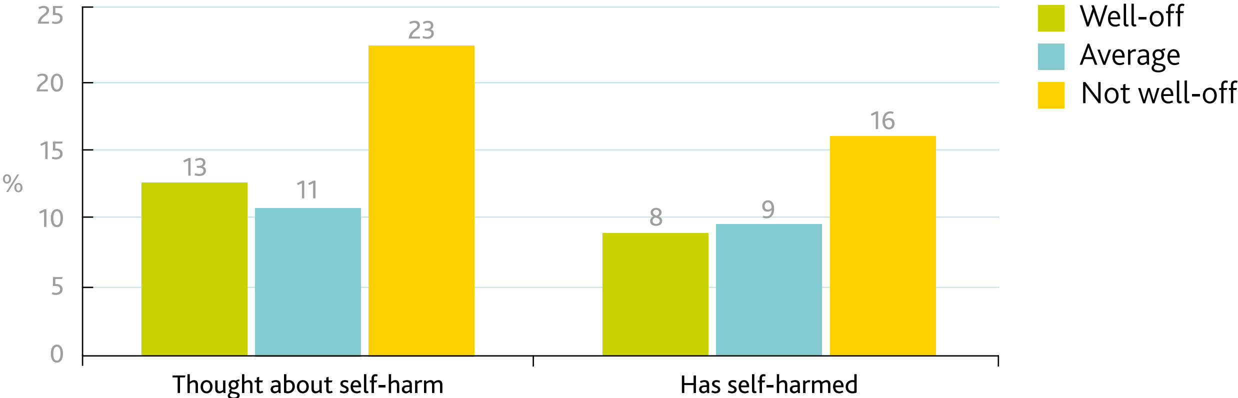
	%		
	Male	**Female**	**All**
Have you during the past month or past year seriously thought about taking an overdose or trying to harm yourself, but not actually done so?			
No	93	82	**86**
Yes, the last time was in the past month	3	5	**4**
Yes, the last time was over a month ago, but less than a year ago.	4	13	**10**
Have you ever deliberately taken an overdose? (For example of pills or other medication, or tried to harm yourself in some other way, such as cut yourself)			
No	95	87	**90**
Yes, once	3	6	**5**
Yes, more than once	2	7	**5**

Source: 2008 YLT survey

Respondents from financially not-well off family backgrounds were more likely to have thought about self-harm and twice as likely to have taken an overdose or tried to harm themselves as respondents who came from well-off backgrounds (16% and 8% respectively; Figure 9). Females from not-well off backgrounds were particularly affected by emotional and mental health problems. Over four in ten (42%) of these females said that they had suffered from emotional and mental health problems for which they thought they needed professional help. This compares with just 19 percent of males from well-off backgrounds who were the group least likely to report such problems. Nearly one in five females from not well-off backgrounds (18%) had tried to harm themselves, six times the proportion of well-off males (3%).

Same-sex-attracted respondents were also disproportionately affected by self-injury. The life-time prevalence of self-harm among same-sex attracted YLT respondents was 37 percent - one fifth (20%) had injured themselves more than once. This compares with a life-time prevalence of eight percent among opposite-sex attracted YLT respondents - only four percent had self-harmed more than once.

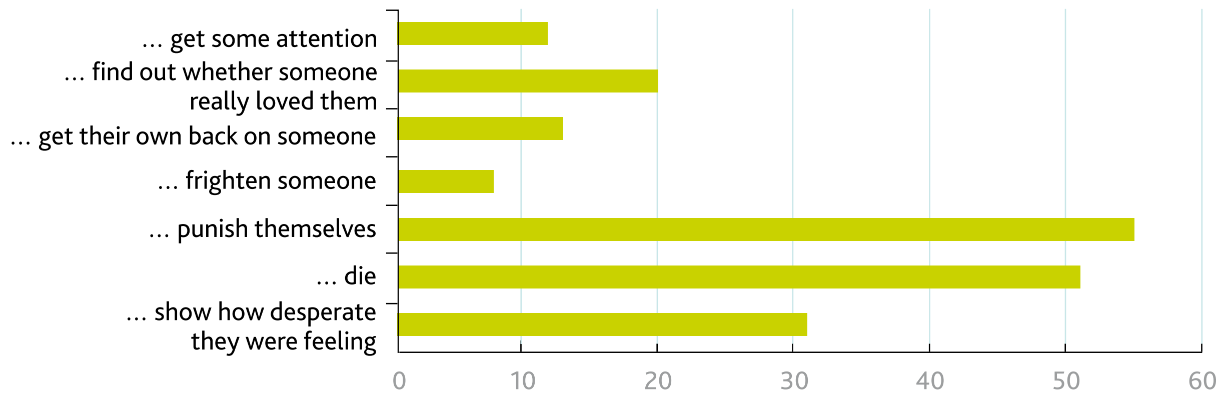
Figure 9: Ideation and experience of self-injury, by family-financial background (%)



Source: 2008 YLT survey

Figure 10 shows that the most likely reason why 16-year olds said they harmed themselves was that they wanted to punish themselves (55%). This was followed by the wish to die (51%) and the desire to show how desperate they were feeling (31%).

Figure 10: Respondents who self-injured saying that they wanted to (%)



Source: 2008 YLT survey

Respondents were asked what strategies they applied when they were worried or upset. Table 13 shows that 16-year olds with mental and emotional health problems tend to use more destructive and non-communicative coping mechanisms in such situations.

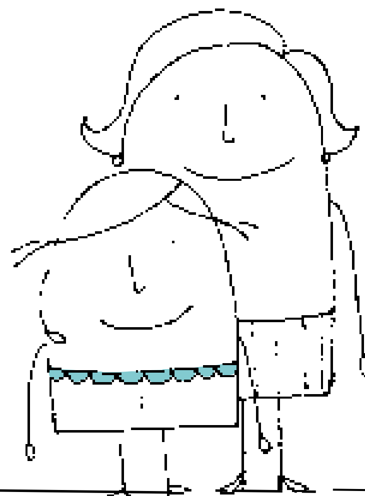


Table 13: When you are worried or upset how often do you do any of the following things? (%)

		%					
		Emotional and mental health problems?		Ever thought about self injury but not done?		Ever self-harmed?	
		No	Yes	No	Yes	No	Yes
Talk to someone	Never	6	12	7	13	7	10
	Sometimes	53	63	54	66	54	66
	Often	41	25	40	21	39	25
Blame myself for getting into the mess	Never	19	9	18	4	18	5
	Sometimes	60	53	60	48	60	47
	Often	21	37	21	48	22	47
Get angry	Never	12	7	12	3	11	6
	Sometimes	54	41	53	36	53	37
	Often	34	52	35	61	36	57
Stay in my room	Never	38	20	37	10	35	13
	Sometimes	42	40	42	42	41	43
	Often	20	40	22	47	23	44
Think about how I have dealt with similar situations	Never	22	25	21	30	22	30
	Sometimes	58	55	58	54	58	55
	Often	20	19	21	15	20	15
Have an alcoholic drink	Never	78	60	77	51	76	54
	Sometimes	18	29	18	37	20	33
	Often	3	11	4	12	4	13
Try not to think about what is worrying me	Never	17	24	16	34	17	34
	Sometimes	62	56	63	46	62	51
	Often	21	21	21	19	22	15
Try to sort things out	Never	1	3	1	3	2	1
	Sometimes	30	50	31	62	32	65
	Often	69	47	68	35	67	34

Source: 2008 YLT survey.

For example, respondents who had thought about harming themselves, or had done so, were twice as likely as their counterparts to say that they 'often blamed themselves' or 'stayed in their room'. They were more than three times as likely to 'often have an alcoholic drink' and they were significantly more likely to say that they often 'get angry'. On the other hand, they were much less likely to say that they 'talked to someone', or tried to 'sort things out'.

Key Findings

15% of YLT respondents had seriously thought about self-harm.

10% had self-injured - 5% once and another 5% more than once.

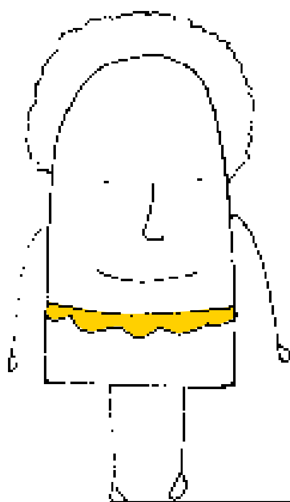
Females (13%) were much more likely to have self-injured than males (5%).

Respondents from not well-off backgrounds were twice as likely to have self-injured than those from better-off backgrounds (16% and 8% respectively).

The life-time prevalence of self-harm among same-sex attracted YLT respondents was 37 percent.

The main reason for self-harm given by those who had injured themselves was that they wanted to punish themselves.

Those who self-injured had more negative coping mechanisms for emotional health problems than those who had not.



4.1.10 Attitudes to self-injury

In 2008, YLT asked a range of questions to elicit 16-year olds' attitudes to self-injury.

Table 14 shows that whilst nearly two thirds of respondents (63%) agreed that most young people who harm themselves are lonely and depressed, fewer than one in five respondents (19%) felt that people who self-injure are mentally ill. There was a strong sense that self-injury could be prevented (64% agreeing), but an even stronger sense that people who harm themselves feel hurt inside (83%). This feeling of 'hurt' also occurred frequently in the comments of those describing the reasons why they self-injured.

Table 14: Proportion of respondents agreeing with the following statements on self-harm (%)

	%		
	I agree	I don't know	I disagree
Most young people who harm themselves are lonely and depressed.	63	20	16
Most young people who harm themselves do it on the spur of the moment.	31	37	32
Most young people who harm themselves are feeling suicidal.	34	32	34
Most young people who harm themselves are trying to get attention.	39	31	30
Most young people who harm themselves could have been prevented from doing so.	64	26	10
Most young people who harm themselves are mentally ill.	19	29	52
Most young people who harm themselves feel hurt inside.	83	14	3

Source: 2008 YLT survey

A sizable minority of respondents (39%) agreed that young people who self-harm try to get attention. However, comments received by YLT also illustrated that many disagreed with this notion of attention-seeking and argued that self-injury is a coping mechanism for more serious problems. The predominant tenor of the comments received from 16-year olds was that young people are under a lot of pressure and stress that adults underestimate or fail to understand this - even contribute to a stigmatisation of the subject.

Key Findings

The attitudes to self-injury collected from YLT respondents show that the majority of young people recognise that young people who self-harm suffer from serious emotional health problems and do not self-harm for attention seeking.

64% of respondents agree that self-injury can be prevented.

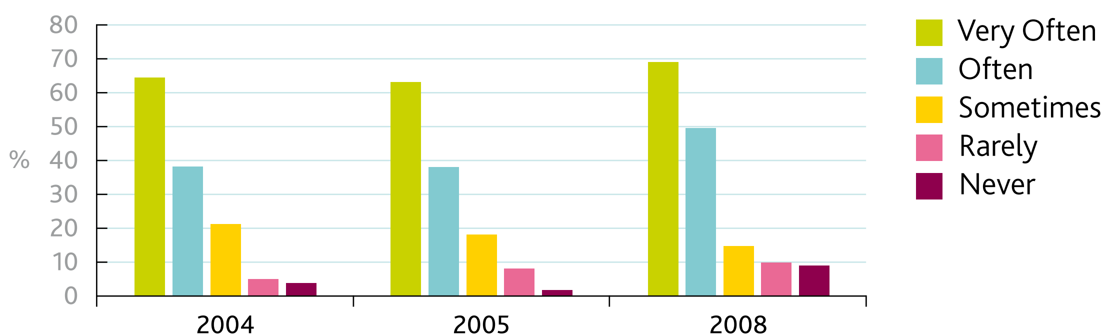
4.2 Relationship between mental health indicators

This section of this report presents evidence for relationships between mental health indicators discussed so far. As stated in the Methodology section, not all questions were asked each year, so there are some limitations with regard to connections that can be made between the variables. However, regardless, this section provides some evidence for the complexity of mental and emotional health issues of young people. Many of those most affected by poor mental health experience multiple stressors and pressures as the data shows.

4.2.1 Stress and mental health

It is not difficult to predict that increased stress levels and poor mental health are closely related. YLT findings show that the more stress 16-year olds experience the more likely they are to be GHQ12 cases. This relationship is very strong as Figure 11 shows. Whilst over six in ten respondents who said they were stressed very often were GHQ 'cases', this is true for less than one in ten respondents who said they were never or rarely stressed. However, Figure 11 also shows that the overall level of GHQ caseness was higher in 2008 than in the two previous survey years, reflecting the overall higher level of stress recorded by 16-year olds in the 2008 YLT survey.

Figure 11: Proportion of respondents who are GHQ12 'cases'. By survey year and frequency of stress reported (%)



Source: 2004, 2005 and 2008 YLT surveys

The high levels of stress reported by respondents who were affected by mental and emotional health problems are remarkable, in particular considering the level of stress experienced by 16-year olds that self-harm or have thought about self-harm. As Table 15 shows, 60 percent of those who said they had recently suffered from emotional and mental health problems reported high stress levels. Furthermore, seven in ten 16-year olds who thought about self-harm and two thirds of respondents who had self-harmed also reported high or very high stress levels.

Table 15: Respondents' stress levels by reported emotional and mental health problems and reported self-injury (%)

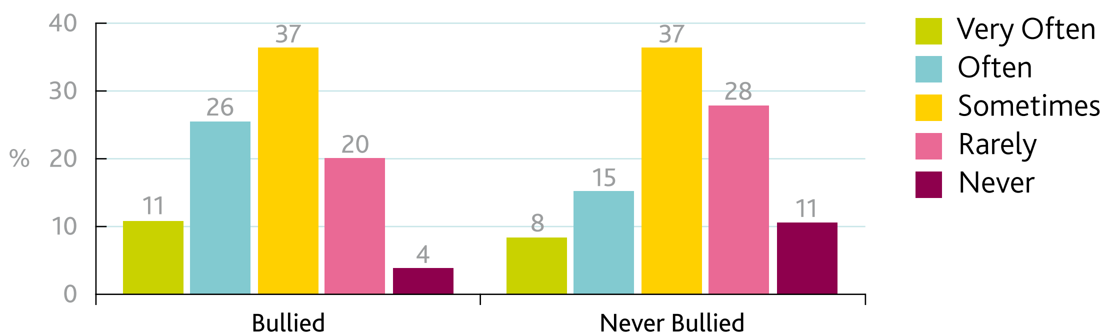
	%					
	Emotional and mental health problems?		Ever thought about self injury but not done?		Ever self-harmed?	
	No	Yes	No	Yes	No	Yes
Respondents saying they get stressed:						
Very often or often	31	60	33	70	35	66
Sometimes	39	29	38	23	37	29
Rarely or never	30	10	28	7	28	5

Source: 2008 YLT survey

4.2.2 Stress and school bullying

Higher stress levels were also recorded for respondents who had experienced school bullying. Those who said they were never bullied were much less likely to say that they got stressed very often or often (23%) than those who had been bullied (37%), as Figure 12 shows.

Figure 12: How often do you get stressed? By experience of school bullying (%)

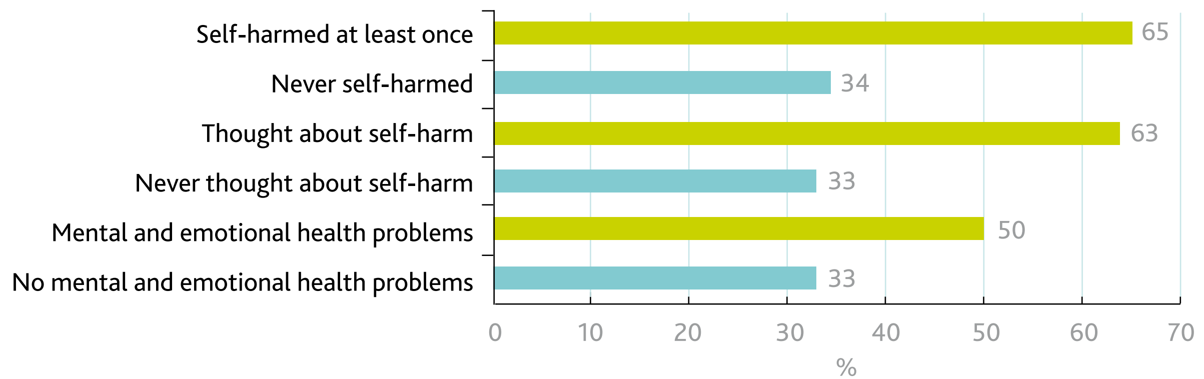


Source: 2005 YLT survey

4.2.3 School bullying, mental health and self-harm

School bullying is not only related to stress, but also to mental and emotional health problems and self-harm. One third (33%) of respondents who did not report mental and emotional health problems had been bullied in school compared with half (50%) of respondents who did. Nearly two thirds (65%) of 16-year olds who had self-harmed had also been bullied in school (Figure 13).

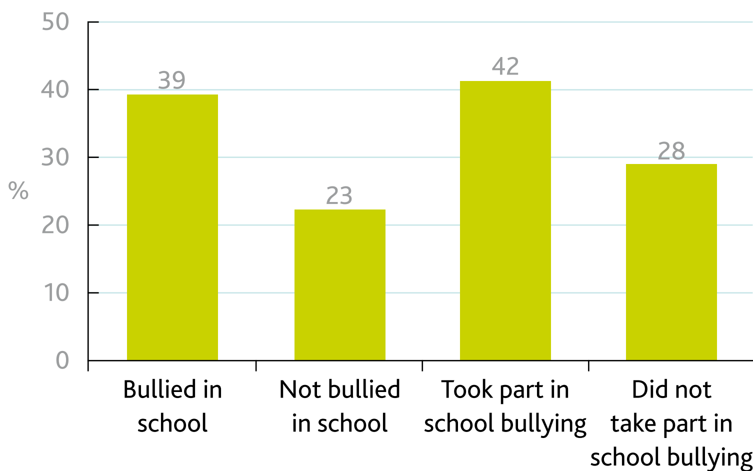
Figure 13: Proportion of respondents who experienced school bullying, by reported emotional and mental health problems and self-harm (%)



Source: 2008 YLT survey

Figure 14 shows that school bullying was also directly related to GHQ caseness. Nearly four in ten (39%) respondents who had been bullied in school were GHQ cases compared to less than one quarter (23%) of respondents who had not been bullied.

Figure 14: GHQ caseness by school bullying (%)

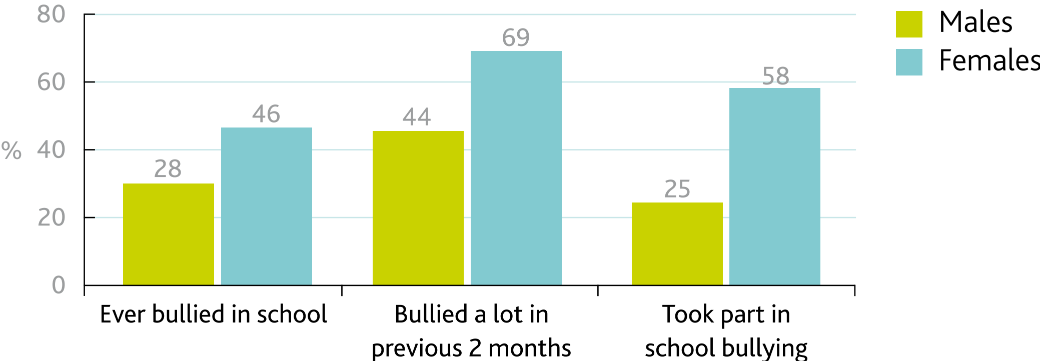


Source: 2008 YLT survey

Figure 14 also shows that both victims and perpetrators of school bullying were more likely to be GHQ12 cases, i.e. more likely to suffer from mental health problems. Interestingly it is those who took part in school bullying who were most likely to be GHQ12 cases (42%), although it is important to note that 63 percent of those who took part in school bullying had also been victims of bullying themselves. This would suggest that school bullying is often a complex issue in which the majority of young people involved can be victims and perpetrators at the same time. It is this particular group of young people that is most affected by emotional and mental health problems.

The proportion of respondents who were GHQ12 cases rose even more among those YLT respondents who said they had been bullied a lot in the previous two months (59%). This compares with 37 percent of respondents who had been bullied, but said that this had not at all happened in the previous two months. Again, a breakdown of these findings by gender confirms that females are particularly affected by mental health issues. Although females overall were less likely than their male counterparts to be victims or perpetrators of school bullying, it was among female victims of bullying where YLT found the highest proportion of GHQ12 cases, as Figure 15 shows.

Figure 15: GHQ caseness by school bullying and gender (%)



Source: 2008 YLT survey

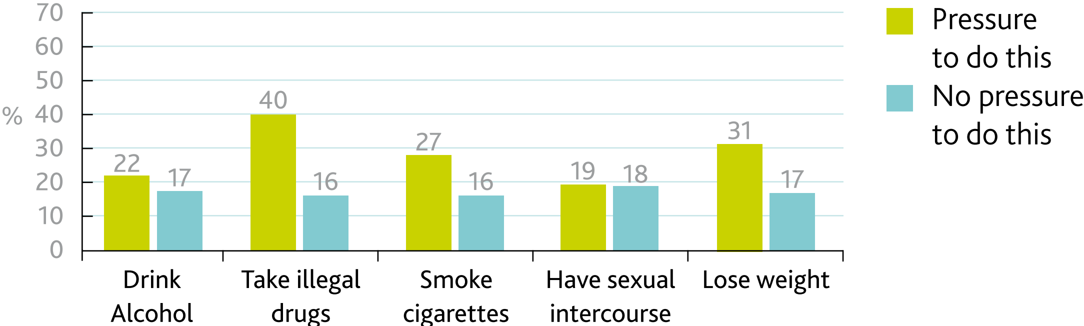
Similar findings emerged again in relation to same-sex attracted YLT respondents and respondents from not well-off backgrounds. Fifty-one percent of respondents who had come from not well-off background and who had experienced school bullying were GHQ12 cases compared to 30 percent of financially well-off victims of school bullying. Fifty-six percent of same-sex attracted victims of school bullying were also GHQ12 cases compared to 37 percent of their opposite-sex attracted counterparts.

4.2.4 Social pressures, health adverse behaviour and mental health

It comes as no surprise that the relations between health-adverse activities such as drinking alcohol excessively, taking illegal drugs, and smoking as well as the perceived pressures to engage in such activities is very closely related to mental and emotional ill-health. Figures 16a and 16b show this relationship for male and female respondents respectively. Firstly, a much higher proportion of females who said they were exposed to these social pressures were likely to be GHQ12 cases. For example six out of ten (60%) females who said they felt under pressure to take illegal drugs were GHQ12 cases. This compares to four out of ten (40%) male respondents who experienced the same pressure. It is also noteworthy that the difference between females who did and those who did not experiences these pressures was much larger than among male YLT respondents, which would suggest that vulnerable female 16-year olds find it much harder to cope with these pressures.

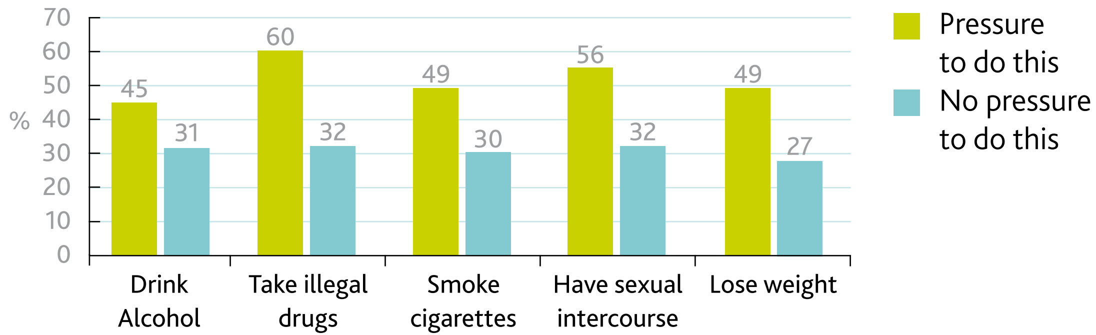
The statistics in Figure 16a and 16b are based on the 2008 YLT survey, which is the most recent survey when these questions were asked.

Figure 16a: Proportion of male YLT respondents who are GHQ12 cases by social pressures experienced (%)



Source: 2008 YLT survey

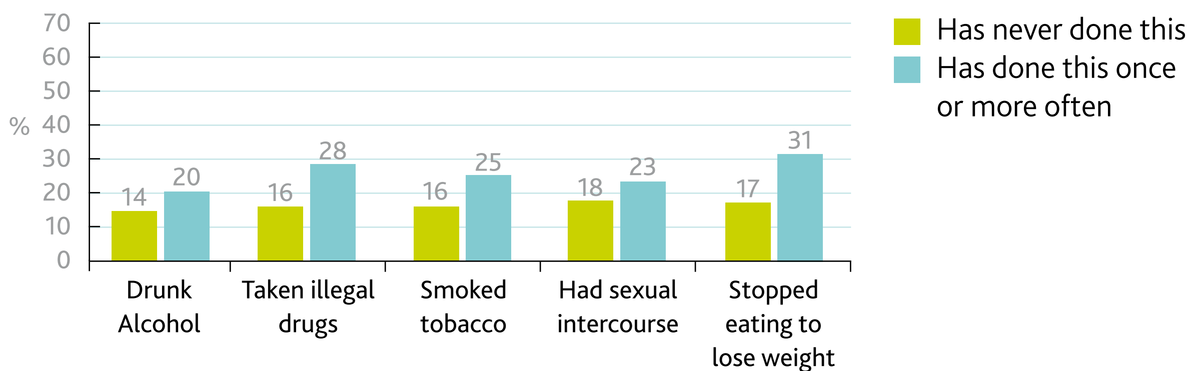
Figure 16b: Proportion of female YLT respondents who are GHQ12 cases by social pressures experienced (%)



Source: 2008 YLT survey

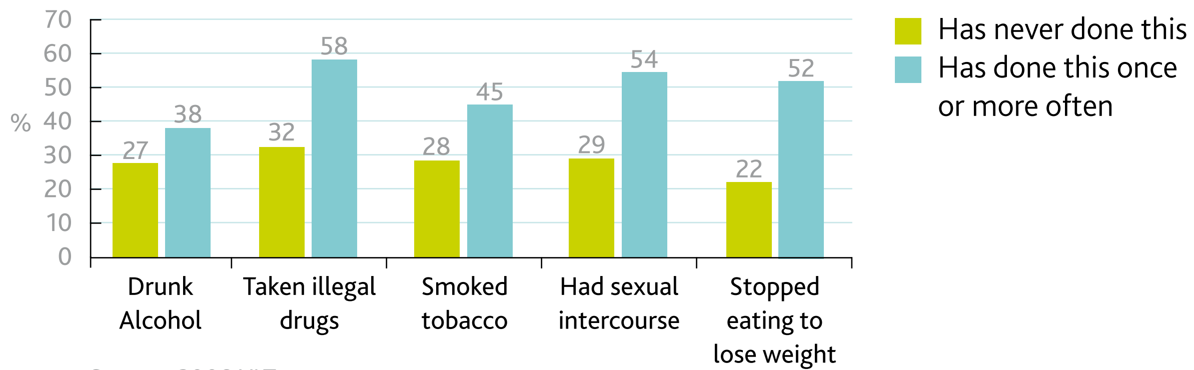
Figures 17a and 17b give evidence that there is also a significant difference in GHQ12 caseness between respondents who had drunk alcohol, taken illegal drugs, smoked tobacco, had sexual intercourse or stopped eating to lose weight even if they were hungry and respondents who had not. Again, these figures show the substantially higher proportion of females who were GHQ12 cases, but they also confirm the strong relationship between health-adverse behaviours and GHQ12 caseness.

Figure 17a: Proportion of male YLT respondents who are GHQ12 cases by health-adverse behaviour (%)



Source: 2008 YLT survey

Figure 17b: Proportion of female YLT respondents who are GHQ12 cases by health-adverse behaviour (%)



Source: 2008 YLT survey

4.2.5 Self-injury and social pressures

Self-injury was not only associated with high levels of stress and school bullying, but also with experience of social pressures (Table 16). Respondents who had self-harmed were over three times more likely than respondents who had not self-harmed to say that they felt pressurised to take illegal drugs (26% and 8%) and to have sexual intercourse (31% and 9%). Respondents who had reported emotional and mental health problems and episodes of self-harm were also significantly less likely to have abstained from health-adverse behaviour (such as drinking alcohol, smoking, taking illegal drugs) as the second half of Table 16 shows. Similarly, there was a significant relationship between the pressure to lose weight and the actual experience of weight loss and emotional and mental health problems, self-harm ideation and self-harm.

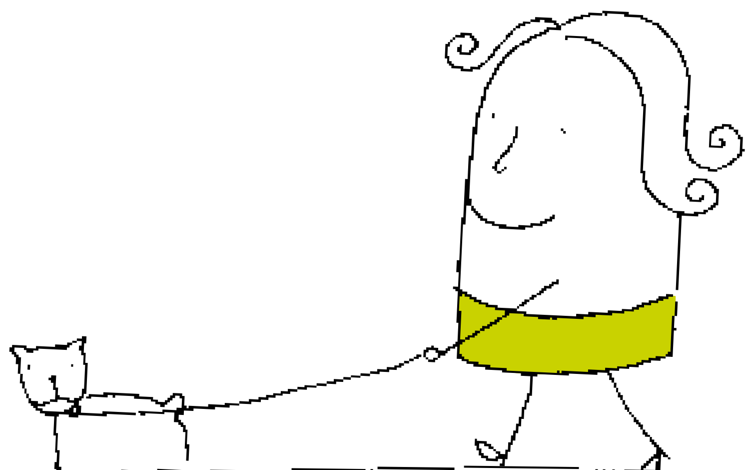


Table 16: Social pressures and health-adverse behaviour of YLT respondents by emotional and mental health problems and reported self-injury (%)

	%					
	Emotional and mental health problems?		Ever thought about self injury but not done?		Ever self-harmed?	
	No	Yes	No	Yes	No	Yes
Respondents who felt pressurised to do the following:						
Take illegal drugs	8	16	7	28	8	26
Smoke tobacco	20	34	20	46	21	46
Drink alcohol	30	41	29	53	30	52
Use solvents	3	12	3	19	4	20
Have sexual intercourse	8	19	8	27	9	31
Lose weight	25	38	26	44	26	45
Respondents who have NEVER done the following:						
Used illegal drugs	89	74	87	71	87	66
Smoked tobacco	67	42	65	34	64	30
Drunk alcohol	28	12	26	12	26	5
Used solvents	98	89	97	85	97	81
Had sexual intercourse	83	62	82	49	81	42
Stopped eating to lose weight	75	48	74	33	72	29

Source: 2008 YLT survey

Key Findings

Mental health indicators are strongly connected.

Young people who experience bullying, social pressures and stress are much more likely to be vulnerable and to be prone to suffer from psychiatric disorder, measured by the GHQ12 questionnaire.

Self-injury is related to school bullying, high levels of stress and social pressures experienced by young people.

Mental health issues among young people are complex and require a multi-agency approach.

5.0 Conclusion

The findings in this report point to a general vulnerability of particular groups of young people with regard to poor mental health. Across almost all factors that impact on the mental health of young people, young females, young people who are attracted sexually to someone of the same sex and particularly those who come from socially deprived backgrounds suffer from poorer mental health. Although a statistical multivariate analysis of mental health indicators by various background variables is not always feasible due to the moderate sample size of YLT surveys, whenever this is possible, the data clearly reveal that the mental health of young people who have multiple disadvantageous background characteristics (for example, being female and coming from a poor background) is of particular concern. One example of this is that over four in ten females from not well-off social backgrounds had suffered from serious mental or emotional health problems over the past twelve months.

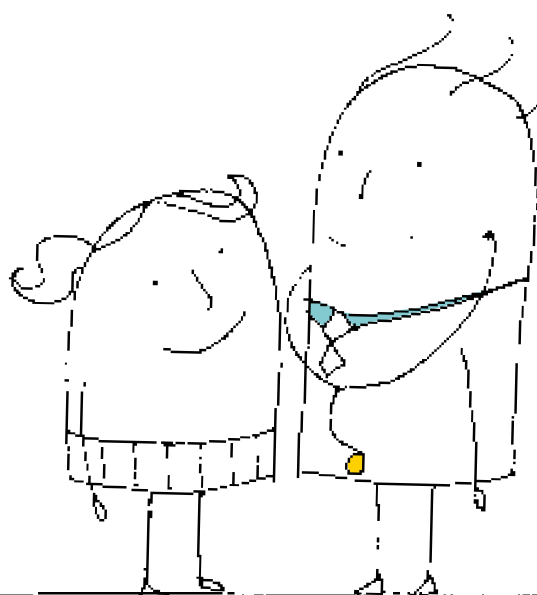
Whilst legislation in Northern Ireland recognises the need to provide equality among people of different gender and sexual orientations, equality legislation does not provide a similar legal framework for people who come from socially deprived backgrounds. Despite the fact that the issue of poverty in Northern Ireland has recently been a focus of significant and comprehensive publications which have all revealed the devastating effects, including the effects on mental health, on young people affected by poverty (Horgan and Monteith, 2009, McAlister, Scraton and Haydon, 2009;) so far there is slow progress towards addressing the gap between the poor and the rich in Northern Ireland and the UK as a whole. However, any efforts made on the improvement of mental health services that fall short of acknowledging and addressing the link between poverty and poor (mental) health are likely to fail. Without a doubt, the YLT findings point to the need to substantially invest into areas of social deprivation in order to create opportunities and raise aspirations rather than to subsidise social disadvantage.

The greater recognition and willingness to involve service users, including young people in the further development of health services, is clearly evidenced in the establishment of the Patient and Client Council as an independent voice for all in health and social care, and will be an important factor for an actual improvement of services.

The second key finding of this report is the fact that mental health issues can only be understood in their complexity. As the second part of this report clearly shows, those young people affected by poor mental health often suffer multiple problems, such as high levels of stress, school bullying, social pressures and the absence of positive coping mechanisms for these problems. Thus, mental and emotional health problems are often connected to multiple factors. This would suggest that one-dimensional approaches to dealing with mental health issues are likely to fail. A multi-agency approach appears to be most suitable to deal with these issues. Again, the fact that friends and parents are by far the most common and preferred sources of support for young people who suffer from mental ill-health would suggest that efforts should be made to equip these people to recognise mental health problems at an early stage.

Finally, whilst the attitudes to mental health services by young people (both by YLT respondents and those questioned by other research referred to in this report) is generally quite positive, it must be a cause for concern that those who do suffer from mental or emotional health problems are more likely to regard the services as inadequate than those young people who have used the services.

There can be no doubt that attitudes towards mental ill-health among young people and to mental health services can be improved. Again, it seems that a participatory approach taking into account young people's views and experiences seems most promising in this respect.



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