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YOUTH MENTAL HEALTH

in Ireland and Northern Ireland

Access Evidence is a series of evidence reviews for frontline practitioners working with children and young people.

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ACCESS EVIDENCE

Youth Mental Health in Ireland and Northern Ireland

An AcCESs Evidence Report

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INTRODUCTION

1.Introduction

Adolescence is a critical time for the development of positive mental health. Most young people across the island of Ireland are doing well and are generally happy with their lives. As they grow up, young people may experience short-term changes in their mental health – temporary dips where they need more support and care from the adults in their lives, from their families and from their friends. Some young people experience changes in their mental health which are acute and can cause them, and their friends and families, considerable pain, distress and harm.

Research shows that 75% of all mental health illnesses emerge between the ages of 15 and 25 years.[1] Mental health difficulties may include behavioural or developmental disorders, periods of anxiety or depression, eating disorders, substance abuse, self-harm, or more acute disorders such as psychiatric illness. They can involve single episodes or more prolonged periods of difficulty. Some young people may struggle with mental health difficulties throughout their lives. Difficulties may emerge during times of physical or emotional stress, or for no apparent reason. There is a strong link between poor mental health and suicide. When mental health problems deteriorate and young people experience considerable distress and suffering, there is a significant risk of self-harm and suicide.

Research shows that 75% of all mental health illnesses emerge between the ages of 15 and 25 years.

Statutory and community services aim to support young people experiencing mental health difficulties. As is the case with other public health challenges, prevention and early intervention approaches are key to recognising and tackling problems early on. Front-line practitioners, such as teachers, social workers, youth workers and other professionals who come into regular contact with young people, play an important role in recognising the signs and symptoms of distress among young people in their field of contact, identifying those at risk, and making appropriate referrals.

Front-line practitioners can also support young people in developing protective factors, i.e. tools that can help them during difficult periods of their lives. Many of the risk factors identified in this report, such as gender, the home environment, and the influence of friends and peers, can also act as protective factors. Developing and maintaining friendships, having supportive parents, taking part in hobbies and sports, and doing well at school are just some of the ways young people can develop self- esteem, confidence and, ultimately, good mental health.

If we are aware that young people are vulnerable to poor mental health from their early

1 Kendall and Kessler, 2002

teens, there is an opportunity to encourage adults in the young person's life to look out for warning signs and support their mental health.

1.1 About this report and how to use it

This report focuses on the mental health of young people between the ages of 12 and 18 years. We look at some of the more common mental health problems experienced by young people, what influences them and what support young people can draw on if they have a mental health difficulty.

This evidence review and the accompanying summary have been produced for front-line practitioners working with young people in different settings – at home, in school or in the community. It is a resource for front-line professionals who come into regular contact with young people as part of their work and who want to have a greater understanding of what some of the risk factors are, to recognise the warning signs, and to determine what they can do to support young people.

We include some key facts and figures on youth mental health in Ireland and Northern Ireland and, in some instances, how they compare with other jurisdictions. We look at some of the factors that influence youth mental health, the risks faced and the opportunities they provide.

We consider how best to support positive mental health in young people, and we look at some learning outcomes from research that may be useful for practice. Some key messages are included, based on findings from research, together with some suggestions from experienced practitioners. We also list a number of agencies and organisations which provide specialist training and resources. These are included at the end of this review and are recommended for further reading and follow-up by practitioners.

It is not the intention of this review and summary to equip front-line practitioners with the specialist skills and knowledge they need to deal with the issue of youth mental health. Youth mental health is a complex matter and is subject to influence by a range of factors, from individual personality characteristics through to more structural factors such as poverty. Practitioners should also have good knowledge of local agencies, services and useful networks so that young people can be referred to the support and services they need wherever possible.

Not all mental health disorders are discussed within this report; instead, we focus on mental health issues which are emerging as recurring issues for young people in Ireland and Northern Ireland.

Front-line practitioners can also play a role in supporting young people who may be struggling with a bereavement as a result of a mental health issue or suicide, and in referring them

to appropriate services as required.

1.2 About the AcCESs Evidence series

This is the third report in the CES AcCESs Evidence series, which includes evidence-informed resources designed to support front-line practitioners working with children, young people and families. This resource has been co-produced with front-line practitioners who have been involved in both designing and producing the material.

The AcCESs Evidence series of evidence reviews aims to contribute to the creation of a common understanding and a common language for practitioners across a range of services dealing with children and young people.

1.3 Key messages from research about youth mental health

Mental health problems are increasing around the world. The majority of **mental health problems emerge in adolescence** and early adulthood. Studies indicate that approximately 1 in 10 adolescents will suffer from mental disorders severe enough to cause impairment.

Boys and girls may cope with poor mental health differently and behave in different ways when they are experiencing setbacks. Girls are more likely to seek out support from services than boys are. In general, girls are more likely to report self-harm than boys, particularly as they get older.

According to the World Health Organization (WHO), suicide was the second leading cause of death among 15–29-year-olds in 2015.[2] While the number of young people taking their own lives in Ireland has been decreasing gradually since the early 2000s, Ireland still has a high rate of youth suicide in comparison to European and OECD counterpart countries.

Self-harm is the most important risk factor for suicide.

Northern Ireland has the highest suicide rate per 100,000 of the population across the UK regions.[3]

Men with poor mental health are particularly at risk of suicide, **with three times as many men** taking their own lives as women in high income countries in recent years.

Self-harm, which includes behaviours such as cutting, hair pulling or overdose, is **the most**

2 World Health Organization, 2017

3 The Samaritans, 2017

important risk factor for suicide. Many young people who self-harm report that it is used as a coping mechanism when they encounter significant stress in their lives. The highest rates of self-harm occur in young people between the ages of 15 and 24. Not all young people who self-harm present to health services and in reality, the incidence of self-harm may be much higher than data suggests.

The reasons for poor mental health, self-harm and suicide are complex. Poor mental health can be associated with structural adversity, such as poverty or homelessness, or from individual behaviours, such as lack of physical activity, or alcohol or substance abuse.

Some groups and communities are particularly at risk of poor mental health, such as members of ethnic minority groups or of the lesbian, gay, bisexual and transgender (LGBT) community, or people with disabilities. Adolescence can be a time when these groups are even more vulnerable to poor mental health outcomes. Over time, the experience of stress, poverty or stigma can contribute to poor mental health lasting well into adulthood.

The signs and symptoms of poor mental health are varied and can be difficult to recognise as young people go through intense physical and emotional changes during adolescence.

The severity, impact and duration of a mental health disorder depends on the individual, the nature of the disorder and the individual's capacity to seek and avail of support. Services at all levels – universal, targeted and specialist – are critical to supporting young people into recovery. In addition, these services have a role to play in promoting positive mental health and reducing stigma. This has included early intervention to support young people going through difficult experiences, assisting them with coping strategies and providing awareness on how and where they can access support if needed.

CHAPTER 2

2. Youth mental health – background

Youth is defined in many different ways across the literature. Some of the research defines youth as the period from 12 to 18 years, while other studies take a broader approach to include all young people up to the age of 24.

This AcCESs Evidence report has a focus on youth mental health during adolescence, i.e. between 12 and 18 years. This age range has been adopted for this report as it is a critical period of transition that coincides with enormous physical, intellectual and emotional growth. It is also a time when practitioners come into regular contact with young people in school, at youth and sports clubs, and in their home and care settings.

2.1 What do we mean by youth mental health?

The term mental health is very broad, covering a spectrum that extends from enjoying positive mental health through to severe and disabling mental illness. The WHO[4] states that mental health can be conceptualised as:

> *'a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community'*

Mental health is more than just the absence of a mental disorder. Mental health is a critical aspect of our development.[5]

The WHO also states:[6]

> *'Positive mental health is cultivated gradually through the development of social, emotional, cognitive and other skills which help build up a young person's self-efficacy, self-esteem and feelings of belonging.'*

4 World Health Organization, 2004

5 The National Academies, 2010

6 ibid

There are many different terms associated with mental health, such as happiness and well-being. The concept of well-being has emerged as increasingly important both within the academic literature and in aspects of public policy concerning children and young people. In a comparative study of European countries in 2011, young people's well-being was conceptualised as having three core components – personal well-being, relational well-being[7] and school well-being. In Ireland, the Aistear early years curriculum defines well-being as 'children being confident, happy and healthy'.[8] Studies and reports such as Growing Up in Ireland (GUI) and State of the Nation's Children (SONC) also use more subjective measures to examine well-being. These include how children and young people report their own life satisfaction and the quality of their interpersonal relationships.[9]

2.2 Adolescence–a time of transition

Adolescence is the transition from childhood to adulthood and a period of huge change for everyone. Changes are physical, psychological and social. Increased hormonal activity during the teenage years brings about physical and behavioural changes. Physical changes include increased growth, changes to the body, and the development of secondary sexual characteristics. For some young people, physical changes are visible early on, even before the onset of teenage years. Others experience physical changes at a later stage. Physical changes, and how and when they occur in comparison to others, can be a source of anxiety and stress for young people.

Adolescence is a time of establishing identity and autonomy, and it is a time of intense learning. Establishing autonomy and independence can involve experimenting with self-expression and identity, but also with risky behaviours.

Developing friendships and romantic relationships is an important aspect of adolescence. Relationships may develop and break up, and emotions can be intense during this period. The nature of relationships with family members, particularly parents, can change and can involve disagreement and conflict.

Technology is an intimate part of life for young people growing up. It is the means by which a great many young people choose to communicate. Online platforms, networks and social media channels provide opportunities to develop and experiment with self-identity and image, to cultivate friendships and relationships both real and virtual, to learn, and to explore questions about personal interests, health, sexuality and relationships.

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7 Relational well-being refers to the concept of well-being concerned with relationships.

8 National Council for Curriculum and Assessment, 2009

9 Smyth, 2015

2.3 The cost of youth mental health

Positive mental health is at the very heart of normal growth and development. It allows us to engage purposefully in our environment and to form meaningful and fulfilling relationships with the people around us. Having good mental health helps children and young people to reach their potential in all aspects of their lives. It is fundamental to good relationships at home; it facilitates the development of healthy friendships and the pursuit of educational and long-term employment opportunities.
Studies now recognise that good mental health is as important as good physical health and that the two are strongly linked.

If positive youth mental health is not cultivated, the costs to the individual, to the community and to society are significant. At a personal level, young people may experience isolation and stigma as a consequence of a mental health difficulty. The friendships and relationships that are a valuable source of social support can be difficult to cultivate and maintain. Substance abuse, school dropout and delinquency rates are all behaviours associated with poor mental health. Other behaviours, such as eating disorders and self-harm, may be less visible, but have serious emotional, social and physical consequences that may last well into adulthood.

If positive youth mental health is not cultivated, the costs to the individual, to the community and to society are significant

When mental health problems persist into adulthood, they deteriorate and continue to affect all aspects of an individual's life – from their physical health and personal relationships to their ability to access employment and to do well at work. Dealing with financial stress, unemployment, marital strain and other adversities that are likely to occur in adulthood can be more challenging. Individuals may require acute health services, counselling, and/or prescription drugs, along with a range of services in justice, education, employment and social services, all of which require significant investment from the State. The long-term consequences of untreated childhood disorders are costly for the individual, as well as in broader economic terms. A World Economic Forum report compares the economic impact of of non-communicable diseases (NCDs) and concludes that mental health costs are the single largest source, greater than cardiovascular disease, chronic respiratory disease, cancer or diabetes.[10] It is estimated that mental illness alone will make up more than half of the projected total economic burden from non-communicable diseases over the next two decades, and approximately 35% of lost global output. The human and social costs are too urgent to overlook.

Suicide may also be an outcome, when poor mental health is not addressed. For every

10 Bloom et al, 2011

life lost to suicide there are families, friends, communities, schools, sports clubs and youth groups who experience intense grief, emotional pain and loss.

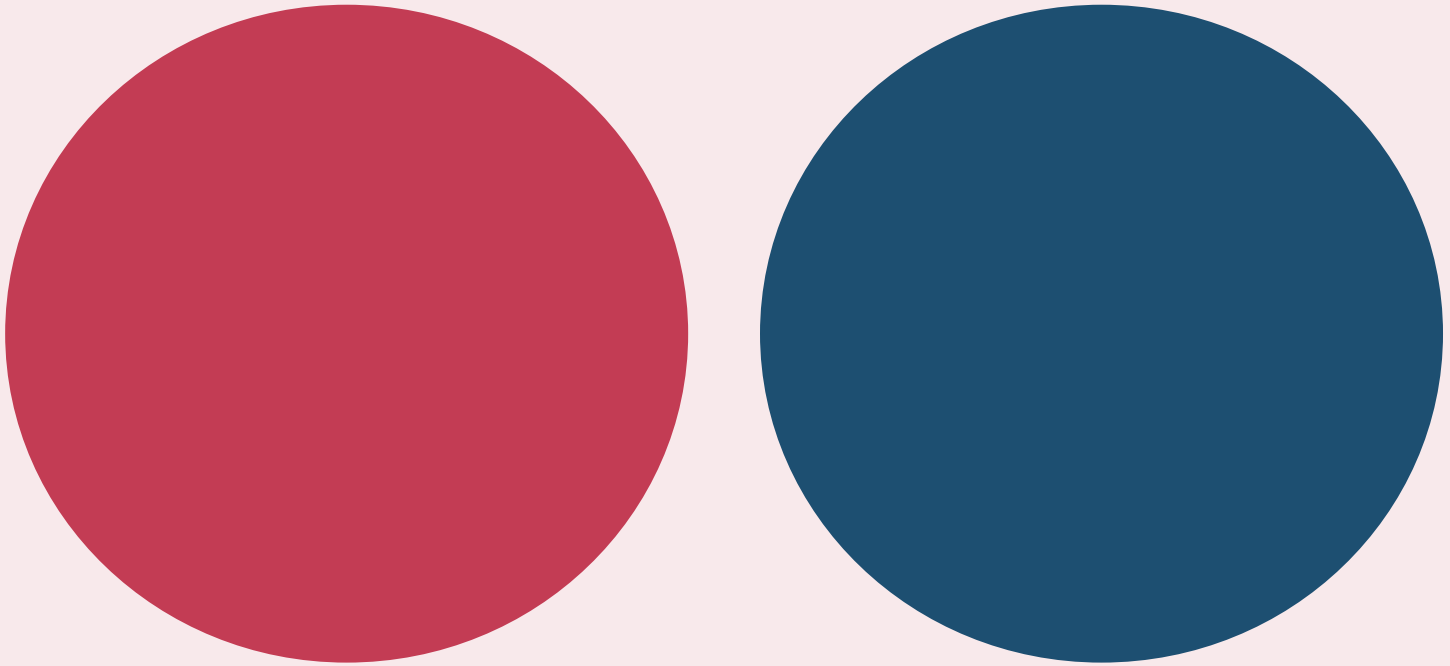
Youth mental health is a priority for all of us, as research suggests that mental health difficulties are on the rise in many countries around the world. A great number of mental health difficulties experienced by adults first emerge in adolescence. While adolescence can be a challenging time to experience difficulties with mental health, it also provides opportunities to intervene early and prevent the problem from escalating.

2.4 What can data tell us?

A wealth of data has already been collected on youth mental health. One of the objectives of this report is to present and synthesise the excellent work being done by researchers, agencies, educational institutions, national offices and other organisations in both Ireland and Northern Ireland. Numerous studies are referenced in this report; they include national, European and international studies on youth mental health and suicide, data from mental health services, along with national and international statistics. This report also draws on the perspectives and views of young people themselves, through qualitative findings from consultations and reports from non- governmental organisations (NGOs) working with young people. The Growing Up in Ireland study, a national longitudinal study which began to follow a cohort of children in 2006, provides valuable insights into the mental health of a group of young people now aged 17 years. Data gathered from services in Ireland and Northern Ireland include information on the types of mental health difficulties recorded by services and how factors such as age and gender influence their development.

The way that countries collect data on mental health and suicide can vary in terms of accuracy, frequency and classification. Differences emerge depending on the time period selected, as well as on the methods of classification and recording employed in different jurisdictions. For example, a recent UNICEF report[11] indicated that from 2010 to 2012 Ireland had the fourth-highest average suicide rate among high income countries for 15–19-year-olds. The data was based on averages covering a three-year period around 2011. For international comparisons in this report we draw on data from Eurostat, because this includes the latest total figures available from 2013 for 15–19-year- olds in Ireland, allowing for comparisons to be made with all of the other 28 EU member states.
This data will be discussed later in the report. Some of the data gathered from services may not provide the full picture about a particular issue, as there may be fear or stigma associated with seeking out support from services. For example,the real incidence of self-harm is thought to be far higher than data from service suggest.

11 UNICEF, 2017



CHAPTER 3

3. Youth mental health – facts, figures and disorders

This part of the report describes some of the mental health issues and disorders experienced by young people in Ireland and Northern Ireland, according to data recorded by national statistics authorities in both Ireland and Northern Ireland (i.e. by the Central Statistics Office and the Northern Ireland Statistics and Research Agency, respectively), as well as data recorded by various services and published research studies. A mental health disorder may include anything ranging from depression to behavioural or developmental disorders to self-harm or a specific psychiatric illness.

International data show that the prevalence of mental health disorders is increasing over time. Adolescence is the peak period for the onset of mental health difficulties, with the majority of disorders emerging during this time.[12] Between 10% and 20% of children and adolescents worldwide suffer from mental health problems.[13]

Suicide is a serious public health challenge across the world, with almost 800,000 people losing their lives to suicide each year.[14] Suicide rates globally have increased by 60% over the past 45 years,[15] with suicide being the second leading cause of death among 15–29-year-olds in 2015.[16] Men are particularly at risk, with three times as many men taking their own lives as women in high income countries.

3.1 Mental health problems are on the increase

The data from Ireland and Northern Ireland reflects international trends, where the numbers and range of mental health problems experienced by young people are on the increase. The 2016 Healthy Ireland annual survey reported that, amongst those surveyed, negative mental health was most prevalent among 15–24-year-olds.[17] Studies show that young females are particularly vulnerable to mental health problems. Sixteen per cent of young women in the Healthy Ireland study were seen to have mental health problems. Similarly, data trends observed in the Health Survey Northern Ireland show that that indicators of mental health problems are most prevalent among young females aged 16–24 years.[18]

12 Carr, 2009

13 Kieling et al, 2011

14 World Health Organization, 2017

15 Scott and Guo, 2012

16 World Health Organization, 2017

17 Department of Health, 2017

18 NISRA, 2017

The latest findings from the child cohort of Growing Up in Ireland,[19] who are now in the 17–18 years age range, found that the majority are reasonably satisfied with their lives. The mean score for 'General life satisfaction' was 7.2 out of 10, with just 15% rating their life satisfaction as 5 out of 10 or lower.[20] More recently, ReachOut's What's wrecking your head? study of 13–19-year-olds found that, when measured using a short version of the Warwick-Edinburgh Mental Well-being Scale, most respondents clustered towards the middle of the well-being scale. Self-reported well-being, similarly to self-reported mental health, decreased with age and female respondents scored lower on both measures than male respondents.[21] Some studies report girls as having poorer well-being, particularly in adolescence, with just 3 out of 10 girls aged 15–17 years saying they felt happy with the way they were in a 2014 HSBC survey.[22]

There is a strong link between **deprivation** and mental health. Data from the Health Survey Northern Ireland and the Healthy Ireland survey in the Republic of Ireland show that people living in the most deprived areas are twice as likely to have mental health issues as those living in the least deprived areas.[23]

In Ireland, the Challenging Times study on youth mental health reported the prevalence of anxiety and depression at 3.7% and 4.5%, respectively.[24] Comparable rates for Northern Ireland are not available for young people. However, it is estimated that the prevalence rates are higher than seen in the rest of the UK, due to higher rates of prescriptions for anxiety and depression, higher levels of socioeconomic deprivation, higher suicide rates and the legacy of the conflict/Troubles in Northern Ireland.[25]

3.2 Mental health difficulties and disorders

Data on young people presenting to Child and Adolescent Mental Health Services (CAMHS) in Ireland is collected by the Health Service Executive (HSE). CAMHS is the statutory mental health service for children and young people in Ireland up to the age of 18. Young people aged 15 years are the most likely to use community CAMHS services in Ireland, followed by 16–17-year-olds and then by children in the 10–14 years age group. While the primary diagnosis for younger children presenting to acute services was hyperkinetic problems (e.g.

19 Growing Up in Ireland is the national longitudinal study of children in Ireland.

20 Growing Up in Ireland Study Team, 2016

21 Chambers et al, 2017

22 Martin et al, 2016

23 Scarlett and Denvir, 2016; Department of Health, 2015

24 Lynch et al, 2006

25 Mental Health Foundation, 2016

Attention Deficit Hyperactivity Disorder), data show an increase in depressive disorders as children grow older, along with an increase in eating disorders and self-harm.[26]

Table 1 shows trends in acute mental health disorders among children and young people in Ireland. It is important to note that this reflects primary presentations to CAMHS in 2012, as that is the most recent year for which there is data publicly available.

Table 1. Primary Presentations to HSE CAMHS services in 2012[27]

Primary Presentation	Percentage
Hyperkinetic disorders (including ADHD)	31.60%
Autism Spectrum Disorders	10.30%
Conduct disorders/problems	6.20%
Substance abuse	0.50%
Gender role/identity disorders/problems	0.10%
More than one disorder/problem	5.40%
Developmental disorders	1.80%
Habit problems (including tics, soiling, sleeping)	1.50%
Not possible to define	2.80%
Other	1.90%
Psychotic disorders	1.50%
Emotional disorders (including anxiety)	18.30%
Depressive disorders	10.40%
Self-harm	5.10%

Source: Health Service Executive, 2014

3.3 Does gender make a difference?

Data indicates a higher number of boys in the under 14 years age bracket accessing services. Hyperkinetic disorders were the most common for this age group, with Autism Spectrum Disorder (ASD) being the most frequent diagnosis in boys under four years of age.

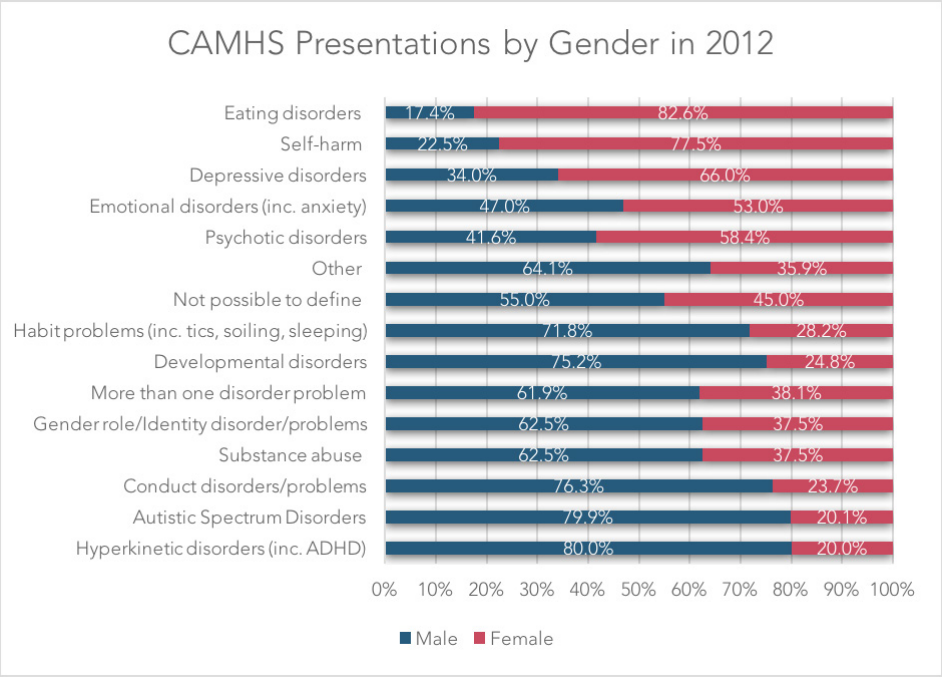
26 Health Service Executive, 2014

27 The Royal College of Psychiatrists (2017) in the UK defines 'attention deficit (ADD)', 'attention-deficit hyperactivity disorder (ADHD)', 'hyperkinetic disorder' and 'hyperactivity' as a behavioural disorder which often arises in childhood and is associated with hyperactivity and a difficulty in concentrating.

From 10–14 years onwards, anxiety and depressive presentations begin to increase in frequency across both boys and girls. It is only at age 15 years that more girls present to CAMHS than boys (54.9% versus 45.1%), with emotional disorders being the most common reason, followed by depression, self-harm and eating disorders. At this age, boys are still most likely to present with ADHD/attentional problems, but depression and anxiety presentations also begin to increase.

Boys were in the majority for every presentation category, apart from psychotic disorders, emotional disorders, depression, self-harm and eating disorders, where more girls than boys presented. The following summary from CAMHS in 2012–2013 shows some key trends in how boys and girls experience mental health disorders.

Figure 1: Primary presentations to CAMHS by gender (2012)



Source: Health Service Executive, 2014

The influence of gender as both a risk factor and a protective factor for mental health is discussed in greater detail later in this report.

3.4 Self-harm – a hidden issue

Self-harm is when a person intentionally causes harm to themselves. It can take many forms, including deliberately overdosing on alcohol or drugs, cutting or picking the skin, pulling-

hair and self-strangulation.[28] Self-harm can happen on a regular basis or less frequently. Having a history of self-harm is significantly associated with risk of suicide.[29] Young people may self-harm as a way of coping with pressures and stresses in their lives. The highest rate of self-harm for both males and females is found among young people. The majority of self-harm does not come to the attention of the health services.[30]

The National Self-Harm Registry Ireland allows for the examination of hospital-treated self-harm at both the national and regional level. It is the world's first national registry of intentional self-harm cases which present to emergency departments. The latest available data on a full year are for 2016, and trends indicate a stabilisation of self-harm rates in recent years.[31] In 2016, there were 11,485 hospital presentations arising from self-harm, involving 8,909 individual cases. The age-standardised rate of individuals presenting to hospitals with self-harm was 206 per 100,000 of the population.

As highlighted in previous reports from the National Self-Harm Registry, the rate of self-harm among females was higher than among males, but the difference between the two groups has reduced to 24% (the gender difference in 2004–2005 was 37%). The only significant increase in self-harm rates from the previous year was among females aged 25–29 years, which increased by 17%.

In Ireland, the peak rate of self-harm for females was among 15–19-year-olds (763 per 100,000) and the peak rate for males was among 20–24-year-olds (516 per 100,000). This indicates that 1 in every 131 girls in the age group 15–19 years and 1 in every 194 men in the age group 20–24 years presented to hospital in 2016 as a result of self-harm.

In Northern Ireland, the overall self-harm rates are higher, but the trends are broadly similar.[32] According to the Northern Ireland Registry of Self-Harm, the overall rate of self-harm in 2014–2015 for Northern Ireland was 373 per 100,000 between 2012 and 2015.[33] Similarly to Ireland, the peak rate of self-harm for females was among 15–19-year-olds, and the peak rate for males was among 20–24-year-olds. In contrast to Ireland, the male rate was slightly higher than the female rate. However, similarly to Ireland, females make up more of the self-harm presentations in the under 18 years cohort (70%).

28 Scott et al, 2001

29 Arensman et al, 2012

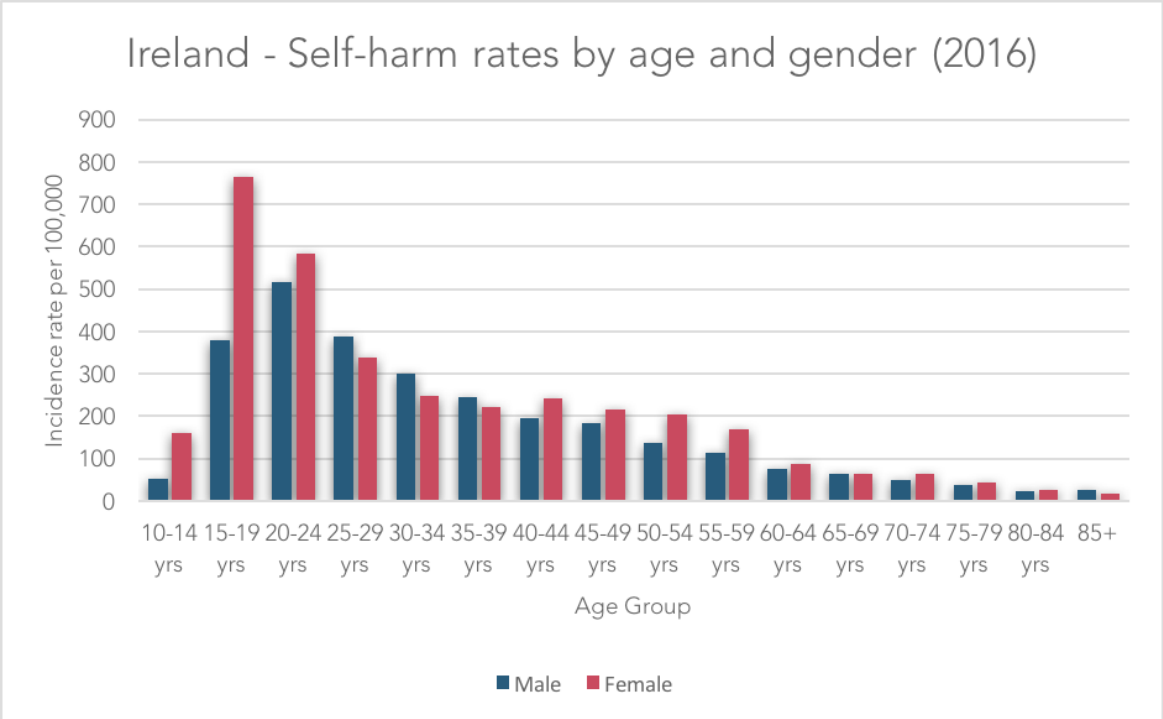
30 McMahon et al, 2014

31 Griffin et al, 2017

32 National Suicide Research Foundation, 2016; Public Health Agency, 2016

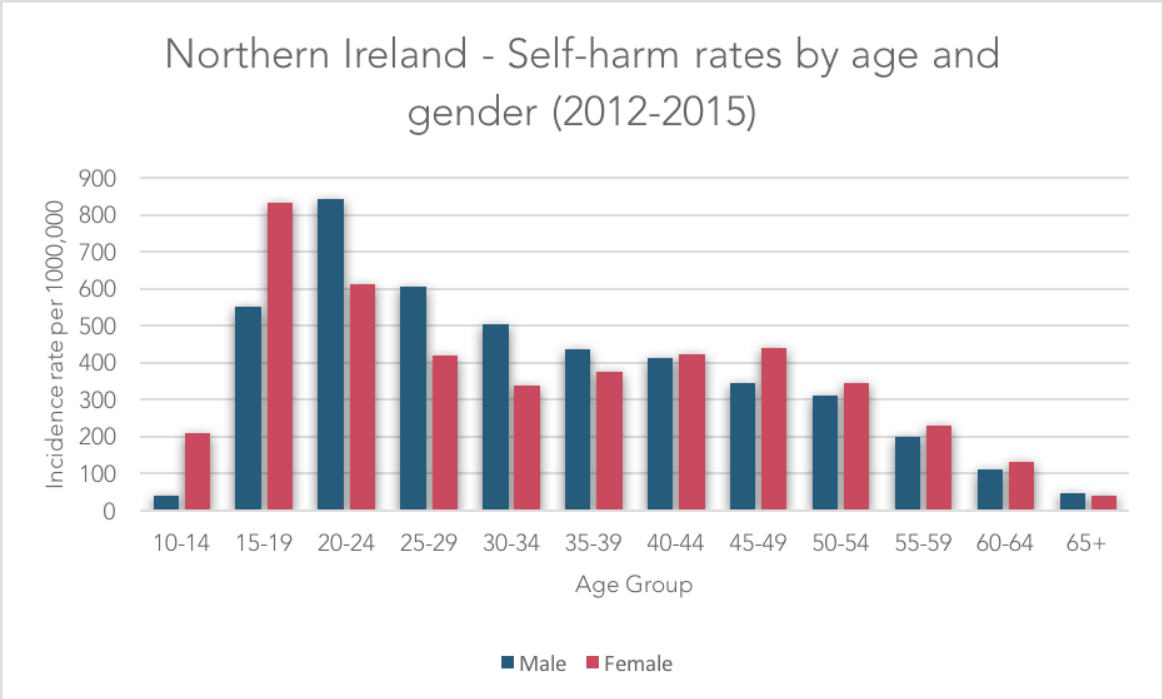
33 National Suicide Research Foundation, 2016

Figure 2: Rates of self-harm by age and gender in Ireland



Source: Griffin et al, 2017

Figure 3: Rates of self-harm by age and gender in Northern Ireland



Source: Public Health Agency, 2016

There may also be an urban/rural dimension to self-harm. The National Suicide Research Foundation found that the incidence of individuals presenting to hospital with self-harm in urban areas was much higher than the rate in rural areas. A similar analysis has not been conducted on the Northern Ireland data. However, according to the 2016 report from the Public Health Agency, rates of self- harm in urban areas, particularly Belfast, are also higher than in rural areas of Northern Ireland.

Nevertheless, it is important to note that these figures are based on hospital presentations. People in urban areas may live closer to a hospital and may be more likely to present for treatment.

Not all young people who self-harm present to the health services, and there are cases of hidden self-harm in the community. As a result, the rate of self-harm may be much higher in reality. A population-based study[34] on a sample of 15–17-year-olds conducted in Ireland reported that for every boy who dies by suicide, 16 presented to hospital for self-harm and 146 reported self-harming in the community. For every girl who died by suicide, 162 presented to hospital with self-harm and 3,296 reported self-harm in the community. The study also reported large gender differences in relative rates of suicide and self-harm. Therefore, only 6% of those who reported episodes of self- harm presented to hospital. The relatively lower rate of self-harm among boys, combined with their high rates of suicide, suggests that boys who self-harm are a particularly high-risk group.

3.5 Mental illness and in-patient admissions

In Ireland, over the period 2008–2015, there was an increase in the provision of acute inpatient beds for children under the age of 18 years. The number of beds available increased from 12 in 2007 to 74 in 2015.

According to HSE inpatient admissions data, of those aged under 18 years, approximately 73.3% were admitted to child and adolescent units and 26.7% to adult units. The majority of these admissions were for depression (37%).[35]

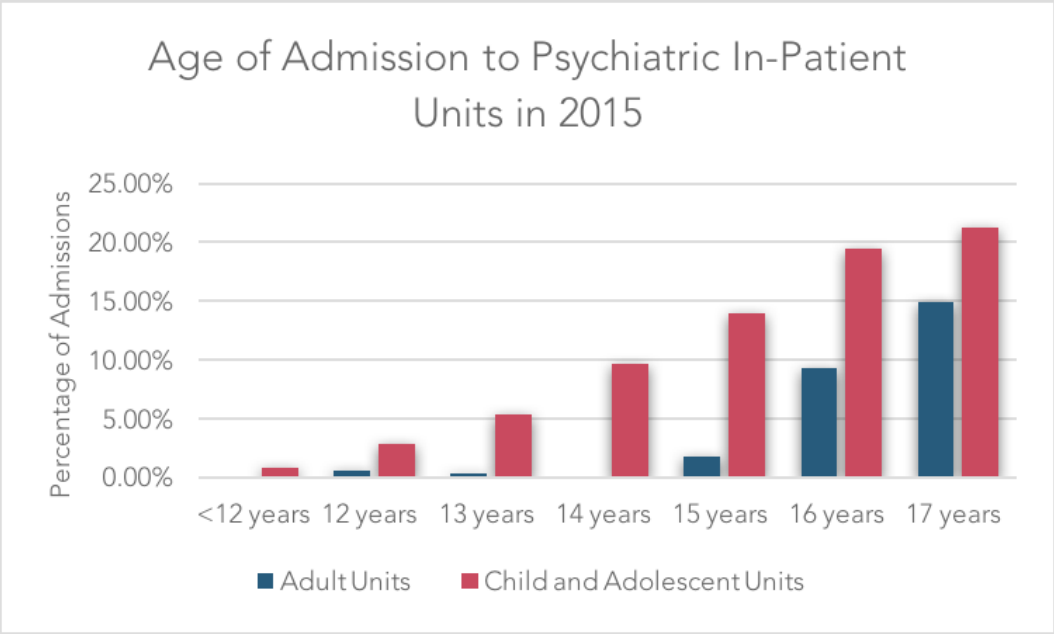
HSE Mental Health Division (MHD)[36] data on children aged 0–17 years show that the numbers admitted increase with age.

34 McMahon et al, 2017

35 Health Service Executive, 2014

36 HSE Mental Health Division, 2016

Figure 4: Age of admission to psychiatric inpatient units in 2015



Source: HSE Mental Health Division, 2016

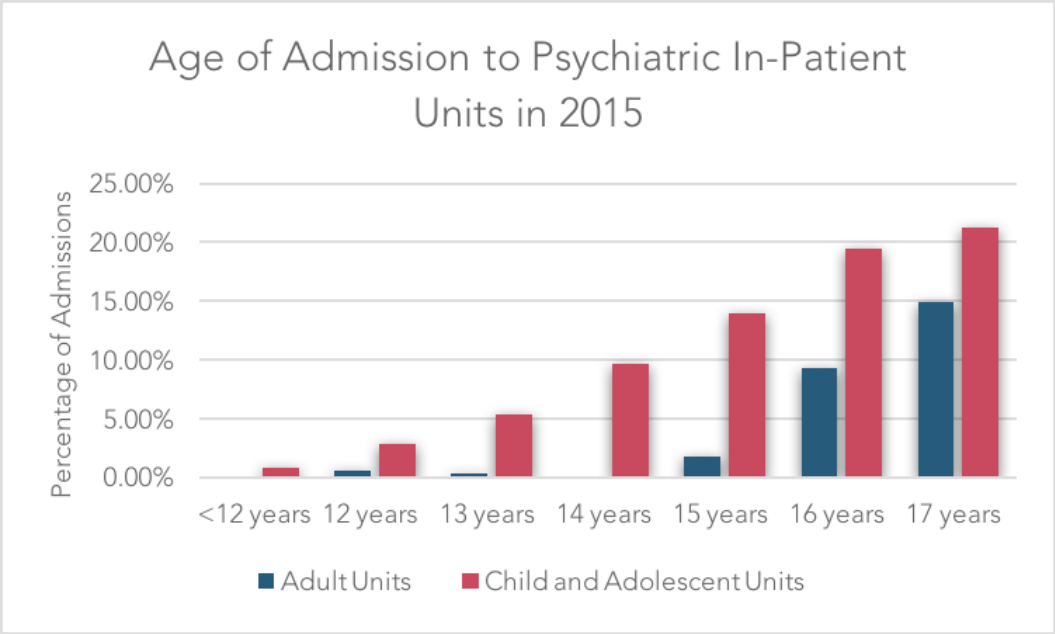
Data on young people aged 17–18 years and over, and inpatient admissions, can be obtained from the National Psychiatric In-patient Reporting System (NPIRS) run by the Health Research Board (HRB). The latest data from 2016 reports that young people are again an at-risk group for inpatient psychiatric admissions. National data on admissions indicate that the 20–24 years age group had the highest rate of all admissions, at 549.4 per 100,000, followed by the 65–74 years age group, at 547.2 per 100,000 and the 55–64 years age group, at 541.8 per 100,000. The 25–34 years age group had the lowest rate of all admissions, at 434.9 per 100,000.[37]

Figure 5 presents data from the Mental Illness and Learning Disability Census conducted in Northern Ireland in 2016.[38] Data on inpatient admissions at the time of the Census show that young people make up a small proportion of psychiatric admissions, with 16–18-year-olds making up the majority of paediatric admissions.

37 Health Research Board, 2017

38 Northern Ireland Statistics and Research Agency, 2016

Figure 5: Psychiatric inpatient admissions in Northern Ireland (2016)



Source: NISRA

3.6 Suicide rates – a global concern

According to *World Health Statistics 2016*, suicide now accounts for 8.5% of all deaths in the world. In high income countries, **three times as many men die by suicide as women**, while globally the corresponding figure is 1.8 times as many.[39] Self-poisoning, hanging and firearms are among the most common methods of suicide globally.[40]

Overall, Ireland and the UK have some of the lowest rates of suicide among OECD member countries. Generally, suicide rates are falling in Ireland, following a peak in the early 2000s and again at the onset of the recession (circa 2008). The figures below compare suicide rates in Ireland and Northern Ireland. While the number of suicides in Ireland appears to be decreasing, there was an increase in the number of suicides in Northern Ireland between 2014 and 2015.

While the suicide rate in Ireland appears to be decreasing, the data show a slight increase in the male rate of suicide and a decrease in the female rate. Looking at finalised data for 2014, 459 deaths were registered as suicide, an approximate 5% decrease on the number of suicides recorded in the previous year. The rate of male suicide was four times higher than the female rate. Provisional data for 2015 and 2016 indicate further small reductions in the suicide rate. However, these figures are subject to change and are often lower than the final reported

39 World Health Organization, 2016

40 World Health Organization, 2017

figures.[41]

In Northern Ireland, 318 suicides were registered during 2015, a 19% increase on the number recorded in 2014 (268). Male suicide represented 77% of these deaths, or approximately three times the number of female suicides.[42] Figures 6 and 7 show the rates of suicide in Ireland and Northern Ireland from 2009 to 2015. **Numerous studies indicate that Northern Ireland has the highest suicide rate in the UK.[43]**

When looking at the graphs below, it is important to keep in mind that the rates in Ireland and Northern Ireland are not necessarily comparable, since the two jurisdictions use different definitions of suicide.[44] The definition used in Northern Ireland, like the rest of the UK, includes deaths of undetermined intent. These are not included in suicide rates in Ireland, which counts only deaths of determined intent. For this reason, rates and trends for each region will be presented separately, and direct comparisons should be made with caution.

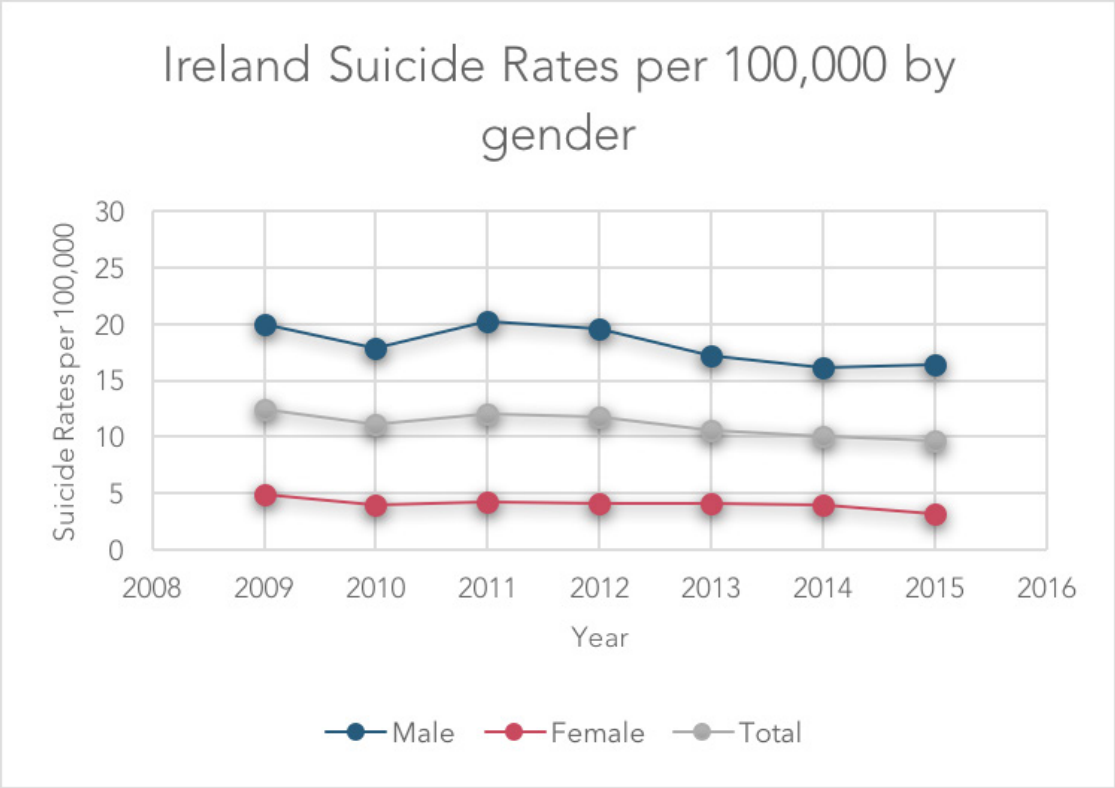
Source: NISRA

41 Suicide figures in Ireland and Northern Ireland represent the year a death was registered, which may be different than the year of occurrence.

42 Betts and Thompson, 2017

43 Mental Health Foundation, 2016

44 The Samaritans, 2017



Source: Central Statistics Office

Figures 6 and 7: Suicide rates in Ireland and Northern Ireland[45]

From Figures 6 and 7 it is clear that the rate of suicide is considerably higher among men. However, it is important to pay attention to the risk of suicide in both males and females. The graphs above indicate that there has been an increase in female suicide rates in Northern Ireland and a decrease among females in Ireland. According to the recent Samaritans annual report, it is too early to tell whether these changes in rates of female suicide are indicative of a more long-term trend.[46]

3.6.1 The rate of youth suicide

Youth suicide is ranked as the second leading cause of death among young adults aged 15–29 years around the world, after road traffic injuries. It is important to note that young people are statistically less likely to die anyway, so the causes of death are more likely to be associated with particular behaviours, as opposed to health issues which tend to increase with age. While suicide rates in Ireland have decreased gradually since 2000, rates in young people aged 15– 24 years continue to be troubling and relatively high by comparison with

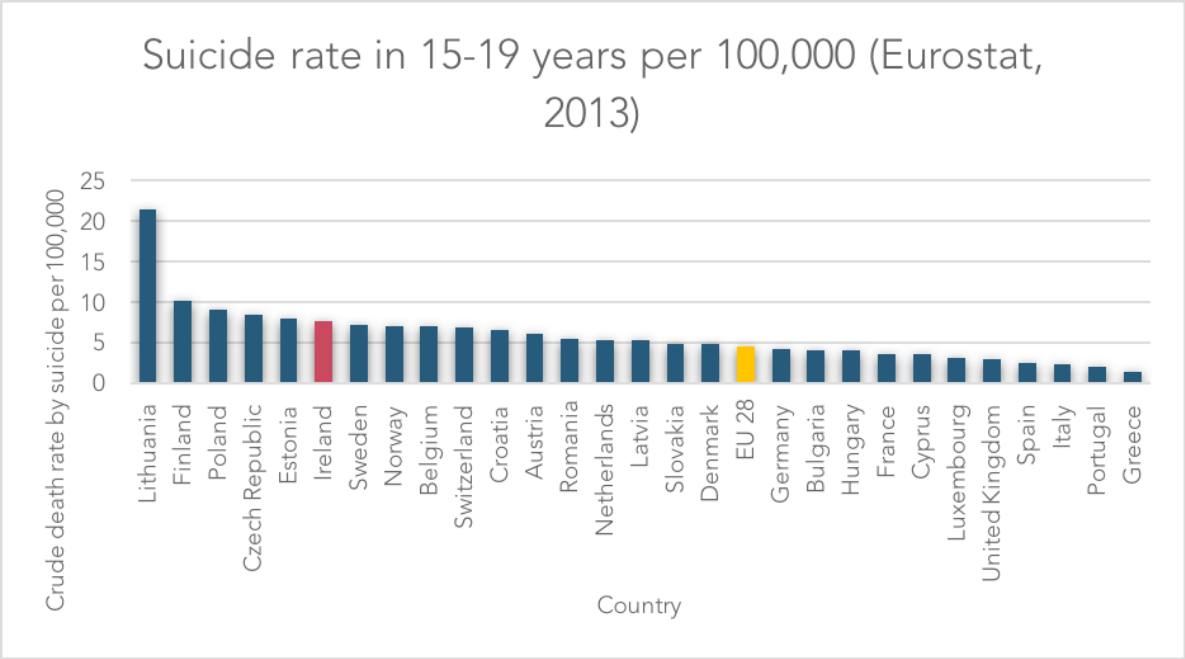
45 Please note that data for 2015 are provisional and subject to change.

46 The Samaritans, 2017

other jurisdictions, including Northern Ireland.

While the suicide rate for young people in Ireland is comparatively lower than some older age groups, it is relatively high by international standards (7.6 per 100,000). The latest available data from Eurostat (2013) show that **Ireland has the sixth-highest rate of suicide among EU countries in young people aged 15–19 years**. This is a decrease from being the fourth-highest in 2010, but it is still high by comparison with other countries, including the UK. It is not possible to disaggregate Northern Ireland rates from this data set. It is important to note that these are crude death rates, and not age-standardised death rates, so comparisons between countries should be made with caution. There are also differences in how suicide is defined and recorded in different countries, which can impact on the reliability and validity of the figures. In other words, the differences in suicide rates across countries can indicate actual differences in population trends, or reflect differences in the recording and classification of suicide.

Figure 8: Crude standardised suicide rates among young people aged 15–19 years



Source: Eurostat

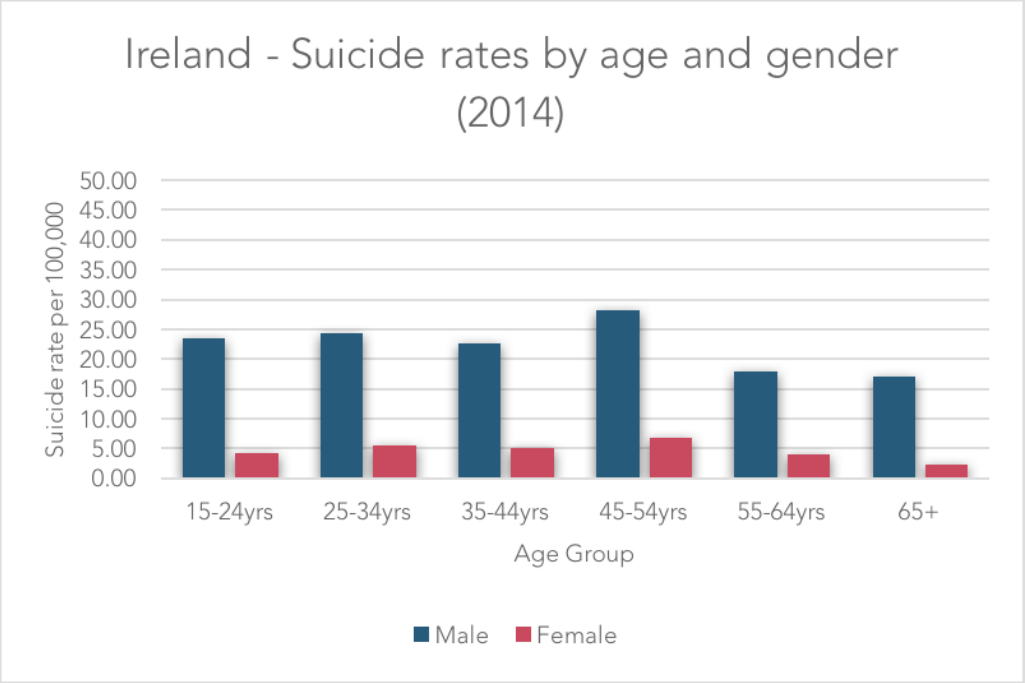
The total standardised population rate[47] is the ninth-lowest of the same group of countries, and below the average in the 28 EU member states of 11.67 per 100,000.

Figures 9 and 10 present data from the Central Statistics Office in Ireland and the Northern Ireland Statistics and Research Agency. The data show a higher rate of suicide among

47 Eurostat, 2013 – This indicator is defined as the crude death rate from suicide and intentional self-harm per 100,000 people, by age group. Figures should be interpreted with care, as suicide registration methods vary between countries and over time. Moreover, the figures do not include deaths from events of undetermined intent (part of which should be considered as suicides).

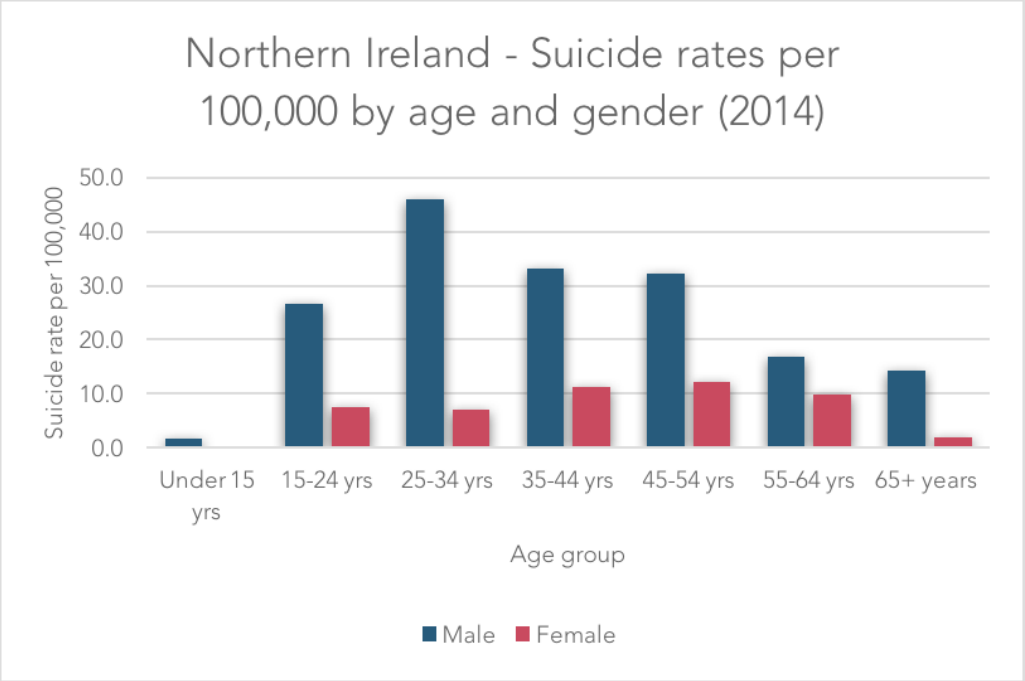
males across all age groups in comparison to females. The overall rate of suicide in Northern Ireland is higher than in Ireland, but keep in mind that the rates are not directly comparable on account of the different definitions of suicide.

Figure 9: Suicide rates in Ireland by age and gender (2014)



Source: Central Statistics Office

Figure 10: Suicide rates in Northern Ireland by age and gender (2014)



Source: NISRA

Looking at Figures 9 and 10 it is clear that the patterns in suicide by age and gender are different in the two jurisdictions. In 2014 in Northern Ireland, the suicide rate was highest in the 25–34 years age group, especially among men. In Ireland, suicide rates are highest in the 45–54 years age group, and also especially among men; however, male rates are also high in the 25–34 years and 15–24 years age groups. The highest rate of suicide for women in both jurisdictions is in the 45–54 years age group.

Rates of suicide are of huge concern around the world. The WHO has committed to addressing mental health issues and suicide in its *Mental Health Action Plan 2013–2020.*[48] Moderate and severe depression are identified within the plan, and there is a target to increase service coverage for people with severe mental disorders by 20% by 2020. Suicide prevention is also a critical aspect of the action plan, with the target aim of a 10% reduction in suicide rates around the world by 2020.

3.7 Suicide clustering

A suicide cluster is defined as *'a situation in which more suicides than expected occur in terms of time, place, or both,'*[49] with suicide contagion – sometimes referred to as 'copycat suicides' – often being the point of origin of a cluster. Suicide clustering is rare, but empirical evidence indicates that young adults can be more at risk.[50]

There are generally two types of suicide clusters: **mass clusters** and **point (space-time) clusters**.[51] **Mass clusters** are a temporary increase in the total frequency of suicides in an entire population relative to the period immediately before and following the cluster, without the spatial/area clustering. Generally, these are associated with high-profile celebrity suicides which are publicised widely in the media. **Point clusters**, on the other hand, are a temporary increase in the frequency of suicides within a small community or institution relative to the rates recorded before and after the event in surrounding areas.

There have been many reasons put forward for these so called 'copycat' suicides in the literature, primarily referring to the saliency of the social group and social status, i.e. importance of their peer group for adolescents, potentially increasing their vulnerability to being influenced by suicides.[52] There are also indications of increasing clustering and

48 World Health Organization, 2013

49 Public Health England, 2015

50 Andriessen et al, 2016

51 Joiner, 1999

52 Abrutyn and Mueller, 2014

contagion effects in suicidal behaviour associated with modern communication technologies and behaviours, including the internet and the various types of social media.[53] In this respect, responsible and sensitive reporting of suicides by the media and more broadly online is critical in addressing potential contagion.[54]

The second report of the Suicide Support and Information System (SSIS), a pilot study to assess suicide clustering and contagion in two areas of County Cork in Ireland, highlighted the following three risk factors for suicide clustering and contagion:[55]

- Severe alcohol and drug abuse
- Exposure to and grief related to loss of friends by suicide
- Non-communication of suicidal intent.

Additional contributing factors were over-attachment to peers and glorification of suicide.

53 Robertson, Skegg, Poore, Williams and Taylor, 2012

54 The Samaritans, 2017

55 Arensman et al, 2012

CHAPTER 4

4. What influences youth mental health?

Factors such as stigma, gender, socioeconomic status, family structure and peers all have an impact on youth mental health outcomes. Individual factors, such as lifestyle behaviours and personality, are also significant influences. Some of these factors are 'close' to the individual, while others relate to the broader external environment. The risk of poor mental health can increase when several of these influences are at work and can add further complexity. By understanding these influences and how they interact, practitioners can observe and identify young people at risk, support them during critical times and intervene where appropriate.

Children who experience adversity are at particular risk of developing mental health problems. Adverse experiences may include poverty or homelessness, child abuse or neglect, family violence, parental separation, divorce, or bereavement. They may occur as single or multiple events, and can be transient or over a long period of time. Adversity affects children and young people in different ways, and can have long-term outcomes on mental health, particularly where children experience a number of adverse events.[56]

Children who experience adversity are at particular risk of developing mental health problems

Some vulnerable groups – such as ethnic minorities, people with physical and sensory disabilities, people with intellectual disabilities and the LGBT community, are at risk of poor mental health outcomes, and may be particularly vulnerable during adolescence.

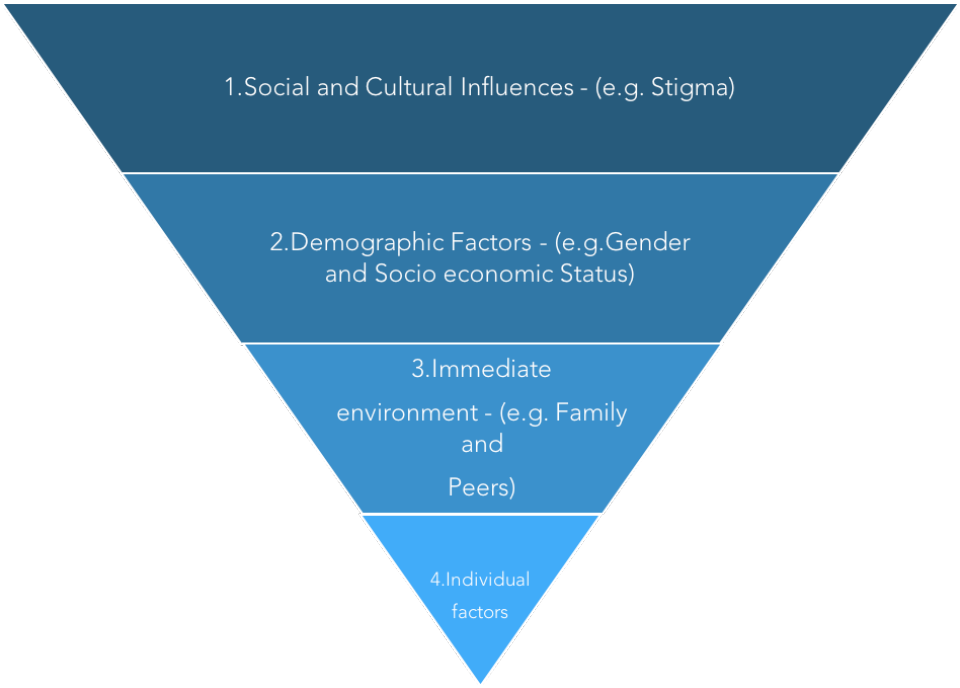
There are also times in their lives when young people are vulnerable to poor mental health. Transitions – in the school system, and from school to further education, training or university – have been identified as challenging times for young people.

The ecological model of social influence[57] can help in understanding the various factors that influence young people during adolescence and the opportunities for practitioners to intervene. In this model, **immediate factors** are those which directly influence an individual, for example interpersonal experiences and relationships with friends and family. **Distal factors** include external influences, such as cultural and demographic factors.

56 Morgan, Rochford and Sheehan, 2016

57 Bronfenbrenner, 1979

Figure 11: Distal and immediate influences on youth mental health



While studies show that the effects of individual factors may be modest, they often interact with each other. For example, social background may be associated with family structure, and the outcomes that are observed may occur due to how they interact. The exposure to a specific risk factor in itself does not necessarily cause difficulty. Instead, it is an accumulation of family disadvantages, social and economic life events, and adverse conditions that predicts mental health difficulties. In general, the more of these risks that a young person experiences, the greater the likelihood of an impact on his or her mental health.

4.1 Social and cultural influences

Social and cultural influences which are particularly powerful during adolescence include stigma and self-image. Studies show that some groups are particularly vulnerable to social and cultural influences, which can have a negative impact on their mental health. These groups include young LGBT individuals, ethnic minority groups, and young people with physical, sensory or intellectual disabilities. They may even be more at risk of poor mental health outcomes as they go through adolescence. Stigma may also develop as a result of structural adversities, for example through the experience of poverty or homelessness.

4.2 The impact of stigma

Stigma involves stereotyping and belief in prejudiced attitudes towards particular people and groups. One of the negative outcomes of stigma is that the stigmatised group may internalise the beliefs that are held about them. This can affect their own well-being. Minority groups, such as ethnic minorities, Travellers, asylum seekers and members of the LGBT community, may experience a range of mental health issues as a result of stigma. Individuals with mental health issues may also experience stigma.

A synthesis of the effects of stigma and mental health, based on 49 empirical studies, focused on a variety of stigmatised beliefs as well as mental health indices.[58] Based on this research synthesis, **stigma was found to have a moderately strong effect on the mental health of stigmatised groups**. The findings also suggested that the impact of stigma on mental health symptoms was relatively greater in Europe and Australia than in North America. The authors suggest that this difference may be due to institutional, legal and societal efforts that different regions have put into stigma reduction.

As adolescence is a time when confidence, identity, self-esteem and self-image are critical, young people are vulnerable to the impact of stigma. In qualitative studies, young men reported that stigma surrounding mental health prevents them from being able to articulate their problems without shame or fear of judgement:[59]

> *'many young men from…where I am from…are afraid to express themselves among their peers as they feel it would be perceived as a sign of weakness and as a result often never address serious issues of depression, insecurity or anger'*[60]

> *'As a male, I know for a fact almost every male teenage that I know (and that's a good amount) will ALWAYS hide what they are feeling.'*[61]

Stigma may also influence how they access and experience services. Among the respondents in the Supporting LGBT Lives study, over one-quarter had accessed mental health counselling services, one- fifth had accessed an LGBT-specific health service and 3% had accessed substance abuse/addiction services. Some respondents experienced barriers or had negative

58 Mak and Poon et al, 2007

59 Lalor et al, 2012

60 Lalor et al, 2012, page 34

61 Chambers et al, 2017, page 25

experiences in accessing health services because of their LGBT identities. Almost one-quarter of respondents who had interacted with health services reported concealing their LGBT identity and one-fifth of survey participants actively sought out LGBT-friendly professionals in response to negative past experiences.

The risk of stigma can also prevent people from seeking out services. As Corrigan[62] argues, many individuals, irrespective of age group, who might benefit from mental health services opt not to avail of them in order to avoid the label of mental illness and the consequent implications of this labelling, as they see them. A series of studies has shown that persons with mental health difficulties receive fewer services and also are less likely to receive the same range of insurance benefits than persons who had other conditions.[63]

4.1.2 Self-image

According to the 2016 report, *State of the Nation's Children*, 57.3% of children aged 10–17 reported being happy with the way they are. Although boys have consistently higher self-esteem than girls, this decreases for both genders with age, with only 49% of 15–17-year-olds being happy with the way they are by comparison with 74.9% of 9-year-olds.[64] Young people expressed concern that they are frequently judged on their appearance. Girls in particular expressed frustration at the pressure to conform to a narrow beauty ideal.[65] While girls referenced the pressure to be 'skinnier', boys are under similar pressure to be 'bulkier', sometimes engaging in unhealthy behaviour, such as the use of steroids, to achieve this.[66]

> *'you are constantly being shown what beauty is – you must be skinny, pretty and never wear the same outfit twice – and you are constantly trying to live up to that'*[67]

> *'… everybody wants to be thin …//… I think a lot of people starve themselves to be thin …//… cus [sic] I used to do it you know'*[68]

The media was cited as a driving force for unrealistic beauty standards, with young people feeling under pressure to look like the celebrities they see in magazines and online.

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62 Corrigan, 2004

63 Druss and Rosenheck, 1998

64 Department of Children and Youth Affairs, 2016

65 McEvoy, 2009, pages 16–17

66 Martin et al, 2016, page 34

67 McEvoy, 2009, page 17

68 McAlister et al, 2007, page 143

Social media was also implicated, as young people compare themselves to the polished online personas that others display via these virtual networks, and also because the photos that young people share can be subject to negative comments from others online.[69]

> *'Social media is a snapshot of somebody's life, and people consistently compare themselves to those images'*[70]

4.1.3 At-risk groups

Vulnerable groups may experience low levels of confidence and self-esteem, stigma, stress and discrimination – all of which can contribute to poor mental health. Individuals are particularly at risk during adolescence.

Lesbian, gay, bisexual and transgender youth (LGBT)

Data on the number of young LGBT people in Ireland and Northern Ireland is difficult to analyse. There may be differences in how data is gathered, and surveys depend on what people are willing to divulge. Data on the number of young transgender people is sparse, internationally and in Ireland and Northern Ireland. Both the Transgender Equality Network Ireland (TENI)[71] and Transgender NI[72] estimate that 1% of people in Ireland and Northern Ireland experience some form of gender variance.

Research conducted by the Gay and Lesbian Equality Network (GLEN) and BeLonG To on the mental health and well-being of LGBT people living in Ireland and Northern Ireland found that half of all current school students surveyed reported incidents of homophobic bullying in their schools.[73] The research also identified strong trends of depression and self-harm.

Results of analysis of Irish data from the ongoing Saving and Empowering Young Lives in Europe (SEYLE) study indicate that adolescents with concerns about their sexual orientation are more vulnerable to both physical and sexual assault. The SEYLE study reported that adolescents in Ireland who had been physically assaulted were almost six times more likely to have made a suicide attempt than their peers, and 17 times more likely to have attempted suicide if they had been sexually assaulted.[74]

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69 McEvoy, 2009

70 Martin et al, 2016, page 34

71 Lacey, 2013

72 Transgender NI, 2015

73 Mayock et al, 2008

74 McMahon et al, 2017

It is estimated that two out of every three LGBT young people in Northern Ireland have experienced a personal, emotional, behavioural or mental health problem which required professional help in the past three years. LGBT individuals living in rural areas were slightly more likely to experience depression and less likely to seek help for it than those living in urban areas.[75]

Ethnic minority communities

Ethnic minority groups can experience particular adversities and stigma which can make them vulnerable to poorer mental health outcomes. This phenomenon is known as 'minority stress' and has been defined by Meyer as the process through which 'stigma, prejudice, and discrimination create a hostile and stressful social environment that causes mental health problems'.[76] In Ireland, organisations such as the Economic and Social Research Institute (ESRI), the Equality Authority and the European Network Against Racism have all published research about the prevalence of racial discrimination in Ireland.

There is little data available on the prevalence of mental health difficulties among minority groups in Ireland and Northern Ireland. A 2005 health needs assessment conducted by the charity Cairde with members of minority communities in central North Dublin reported that 38% felt that anxiety, depression and/or stress was the main negative influence on their health.[77]

Travellers are at risk in terms of mental health, and are particularly vulnerable when they are young. The All-Island Traveller Health Study (AITHS) reported that suicide was the cause of 11% of all Traveller deaths. The suicide rate for Traveller women was six times higher than that for settled women and seven times higher than that for Traveller men. Suicide was highest among young Traveller males aged 15–25 years.[78] According to a study of suicide within the Irish Traveller community, the rate of suicide over the period 2000–2006 was 3.7 per 10,000, which was over three times the figure for the overall population.[79]

Ethnic minority groups may be even more at risk due to the influence of other factors, such as language barriers and cultural beliefs, practices, and traditions. There may be shame and stigma attached to seeking professional help. On a practical level, ethnic groups may need the support of interpreters or translators in order to understand the available information about services and how to access them. Services may require specialist training and support facilities to enable their personnel to understand and navigate some of the challenges

75 O'Doherty, 2016

76 Meyer, 2003, page 674

77 Bojarczuk et al, 2015

78 University College Dublin, 2010

79 Walker, 2008

presented by cultural factors.

Physical, sensory and intellectual disabilities

Persons challenged by physical, sensory or intellectual disabilities are at greater risk of experiencing mental health problems than those without a disability. They are more likely to be exposed to other mental health risk factors, such as low socioeconomic status or a lack of social support.[80]

The latest data from the National Physical and Sensory Disability Database from the HRB highlights the barriers and challenges people with these disabilities face in their everyday lives, which can undoubtedly have a negative impact on their mental health and well-being. According to the latest report (2017), 86% of individuals with a physical or sensory disability feel that their disability interferes with their lives overall; 71% reported that such interference was due to the emotional impact of their disability.[81]

The risk for poorer mental health outcomes appears to be especially marked for individuals with an intellectual disability. Such individuals have been reported to be more at risk of abuse, neglect, social disadvantage, difficult family circumstances, stigma, and peer exclusion than individuals without an intellectual disability.[82] Mental health problems can often be underdiagnosed or missed among children, young persons and adults, and can thus go untreated and unsupported.[83] In addition, there is a serious lack of suicidality risk screening measures which are appropriate for use with people with an intellectual disability.[84]

Mental health problems may be difficult for a person with an intellectual disability to communicate to others, due to cognitive or language difficulties. For some people with an intellectual disability, challenging behaviour may mask or indeed be an alternative expression of their experience of a mental health problem.

Some studies report that those with a mild intellectual disability are more at risk than those with severe impairment. Prevalence rates of co-morbid or co-occurring psychiatric disorders among those with an intellectual disability vary, but some studies report co-morbidity rates as high as 40%.[85] One study estimates that in the UK, 3% of children with an intellectual disability represent 14% of all children attending psychiatric services.[86]

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80 Gannon and Nolan, 2006; Emerson et al, 2009

81 Doyle and Hourigan, 2017

82 Martorell et al, 2009; Emerson, 2003

83 Ludi et al, 2012

84 Ibid.

85 Cooper et al, 2007

86 Einfield et al, 2011

4.2 Demographic factors

Demographic factors which influence youth mental health include gender and socioeconomic status.

4.2.1 Gender

Research and data from services indicate that boys experience different mental health difficulties to girls. Gender influences not only how young people behave when they have a mental health difficulty but also how they seek out support and services. While gender can be a risk factor, in some cases it may act as a protective factor. Boys and girls may adopt different coping strategies to deal with a mental health difficulty. This can include **externalising** or **internalising** their problems.

Externalising problems (or 'low control') involves the expression of aggressive, impulsive, antisocial and challenging behaviours. This has an immediate impact on others around them. The signs of **internalising problems** (or 'excessive control') include forms of social withdrawal, inhibition, depression or various forms of anxiety. Internalising problems have immediate consequences on the child or young person themselves, limiting social experiences and creating obstacles for how they develop socially and psychologically.[87]

From adolescence onwards, girls are more likely to experience internalising problems than boys, which may result in feelings of self-blame and helplessness.[88] In contrast, boys are more likely to experience externalising problems, showing patterns of behaviour that are aggressive and antisocial in character. They may develop difficulties in forming and maintaining close relationships. The risk factors for internalising and externalising problems can depend on conceptions of masculinity and femininity; for example, the different stresses that boys and girls are exposed to as they grow up, the coping strategies that they use and the vulnerabilities that they develop as a result.[89] With school achievement a pressure for many adolescents, it has been shown that poor academic performance has an effect on externalising and internalising behaviours, but only in girls. These gender differences reflect theories which suggest that girls are more self-critical and tend to want to please their parents and teachers.[90]

87 Aunola and Nurmi, 2005

88 Rosenfield and Mouzon, 2013

89 Ibid

90 Panayiotou and Humphrey, 2017

The influence of gender on mental health also emerged in the My World survey,[91] which was the first national study on the mental health and well-being of children and young people aged 12–25 years in Ireland based on a sample of almost 15,000. Results indicated that gender is both a risk and a protective factor. For example, males consistently reported higher self-esteem and satisfaction with life in comparison to females. At the same time, they engaged in more risk-taking behaviours, including excessive drinking, substance misuse and violence towards others. Females reported higher levels of perceived social support and help-seeking behaviours, but also engaged in more avoidant coping strategies. Avoidant coping strategies included denying the impact of their distress or pretending something had not happened.

The Growing Up in Ireland (GUI) study of social and emotional problems shows how boys and girls in Ireland respond differently to mental health problems as they grow up. One of the core measures used in this study is the Strengths and Difficulties Questionnaire (SDQ),[92] which explores the following four sub-scales:

- Emotional symptoms (e.g. often unhappy, downhearted or tearful)
- Conduct problems (e.g. often fights with other children)
- Hyperactivity/inattention (e.g. restless, overactive)
- Peer relationship problems (e.g. picked on or bullied by other children).

The questionnaire is completed by children themselves, and there is also a version for caregivers and teachers to complete. The influence of gender is visible from early on and, at age 13,[93] boys score higher on conduct and hyperactivity sub-scales and on total difficulties, whereas girls score higher on emotional difficulties and on pro-social behaviour. Levels of misbehaviour reported by boys and girls at age 13[94] also indicate a significant gender dimension. Over half of the males in the study reported that they had got into trouble for not following school rules, whereas less than one-third of females indicated that this was the case for them. There were major differences regarding how young people perceived experiences of anxiety. Nearly half of boys in the study saw themselves as free from anxiety, including fear, unhappiness and shyness, as well as feelings of being 'left out'. In contrast, this was the case for only just over one-quarter of girls. These statistics reflect similar data on mental health disorders recorded by the HSE CAMHS.

Similar patterns of behaviour in boys and girls have been found in other countries. The study

91 Dooley and Fitzgerald, 2012

92 Nixon, 2012

93 Williams et al, 2014

94 Ibid.

by Rothenberger and colleagues[95] on over 2,000 children in Germany found that parents' ratings of emotional symptoms and pro-social behaviour were significantly higher for girls while, in an Australian study, Mellor[96] found that boys scored higher on conduct problems, hyperactivity and peer relationship problems.

Gender and self-harm

More recent data on mental health issues from Growing Up in Ireland continues to show significant gender differences at age 17–18 years.[97] When asked if they had been diagnosed with depression or anxiety by a professional, 13% of the females indicated that they had received such a diagnosis, compared with 8% of males. There were substantial gender differences with respect to the reporting of self-harm. Twenty-three per cent, or approximately one in five girls, said that they had 'hurt themselves on purpose' at some time, whereas the corresponding figure for boys was 12%.

Studies in Northern Ireland indicate that rates of self-harm are also influenced by gender, with girls more likely to report self-injurious behaviour than boys. In 2010, the Northern Ireland Lifestyle and Coping Survey, which was modified from the existing Child and Adolescent Self-Harm in Europe Study, was carried out in 28 post-primary schools in Northern Ireland. The final sample comprised 3,596 pupils aged 15–16 years.[98] Results indicated that girls were almost 3.5 times more likely to report self-harm than boys. However, national data from the Northern Ireland Registry of Self-Harm show rates that are slightly higher among young males. This is clearly an important area and one which warrants further study and exploration.

How young men and women access services

Generally, the evidence indicates that females are more likely to seek out help and support from services, which is reflected in data from services – particularly from adolescence onwards – where the number of females accessing services is higher than the number of males. Research conducted by the Young Men and Suicide Project[99] indicates that young males are less likely to seek out help and access relevant services, with the main reasons cited by young males including embarrassment, shame, stigma, concerns about confidentiality and fear of others finding out. A similar finding appeared in the College Lifestyle and Attitudinal National (CLAN) Survey[100] on the health of Irish students, which reported that male students

95 Rothenberger et al, 2008

96 Mellor, 2005

97 Growing Up in Ireland Study Team, 2016

98 O'Connor et al, 2010

99 Richardson et al, 2013

100 Hope et al, 2005

were less likely than female students to seek help for mental health problems and more likely to turn to alcohol and drugs as coping strategies. A higher proportion of males than females reported being unwilling to discuss feelings of anxiety or depression with others.

4.2.2 Socioeconomic position

'Socioeconomic position' refers to an individual's or group's position in society. Education, employment, occupation, income or even where a person lives can affect an individual's socioeconomic position. **Socioeconomic position has long been associated with mental health outcomes, and suicide has been particularly cited as a health inequality issue**.[101]

This is of particular significance in Ireland and Northern Ireland, which have experienced a sharp economic downturn since 2008. The recession has had far-reaching impacts on communities across the island.

Income inequality or economic vulnerability can impact on a host of risk factors for mental health by affecting one's general quality of life and being a cause of persistent and chronic stress. Economically vulnerable households may result in people having to live in substandard housing, an issue which has reached critical levels in Ireland, with over 3,000 children recorded as homeless in October 2017.[102] Parents may need to have more than one job or work long hours and this can potentially negatively impact on parenting. Caregivers may be trapped in precarious employment arrangements, such as zero-hours contracts, unable to predict their income from month to month or week to week.

For young people, low socioeconomic position is often associated with poorer adaptive functioning, an increased likelihood of depression, and delinquent behaviour.[103] Research in the UK shows a strong connection between mental health difficulties, family socioeconomic position and income,[104] with young people from poorer families more likely to experience higher rates of emotional difficulty than their more affluent peers. Figures from the National Health Interview Survey in the US in 2009 indicated that 8% of children living below the poverty level had serious difficulties, compared with 4% of children with family incomes that were twice greater or more than the poverty level.[105] A review of the literature by the Canadian Council on Learning[106] found that low-income children tended to experience a higher risk of emo-

101 House of Commons Health Committee, 2016

102 According to data available from the Department of Housing, Planning and Local Government

103 Nolan et al, 2006

104 e.g. Green et al, 2004

105 Pleis et al, 2010

106 Canadian Council on Learning, 2006

tional difficulty, although many of the studies also showed that positive family characteristics could protect young people from the negative effects of low income or low socioeconomic status. The My World study reported that young peoples' experiences of financial stress were strongly related to poor mental health and well-being.[107]

Socioeconomic position in Ireland

One of the main sources of data in Ireland on the impact of socioeconomic position on youth mental health is the Growing Up in Ireland study. The series examined the effects of economic vulnerability, and especially its consequences for social-emotional development.[108] It examined the association between the economic vulnerability of families and the SDQ scores of their children during two waves, i.e. with the cohorts born in 1998 and 2008, respectively, which offered an unintentional opportunity to assess the impact of the recession on children. Interviews were carried out at the onset of the economic recession and again three years later. The results showed an estimated 10% of the families that were economically vulnerable in both waves of the study had high levels of social-emotional problems. In contrast, the corresponding figure was just 4% for children whose families were not economically vulnerable in either wave. The study also identified particular groups who had a greater risk of economic vulnerability, including lone parents and families where the main caregiver had a low level of education. Furthermore, findings indicated that the economic downturn had an impact on a large number of households which would not traditionally have been at risk of experiencing economic disadvantage.

An analysis by Nixon[109] of data from Growing up In Ireland study found that children from lower- income households had higher SDQ scores, indicating greater behavioural and/or emotional issues. While the differences between income groups were statistically significant, they were small, especially when parenting practices were taken into account.[110] While young people with a vulnerable socioeconomic background might be at greater risk of poorer social and emotional outcomes, other factors, including parental caregiving skills, act as crucial mediating influences. **In other words, income matters, but the influence of a positive, nurturing environment provided by caregivers can help to compensate or provide a valuable protective factor.** This will be discussed in greater detail later in this report.

A more recent Growing up in Ireland study of young people aged 17–18 years showed that general life satisfaction was quite high but dependent on social background.[111] Young

107 Dooley and Fitzgerald, 2012

108 Watson et al, 2014

109 Nixon, 2012

110 Ibid.

111 Growing Up in Ireland Study Team, 2016

people from less advantaged home backgrounds reported lower life satisfaction scores. Over one-quarter of respondents from the most disadvantaged group rated their life satisfaction negatively, while only 12% of those from a professional/managerial background gave this rating.

Socioeconomic position in Northern Ireland

There is little data available on child mental health problems in Northern Ireland in comparison to that available for England, Scotland and Wales. Some data was included in a study published by the Office of National Statistics in 2005. Across the UK, data showed a high risk of mental health problems for 'looked-after' children (children in care), for young offenders, and for homeless young people, and a greater risk of antisocial behaviour among the children of prisoners. Young people in Northern Ireland may experience similar risks, but a conclusion of the Bamfort report was that a specific study of Northern Irish youth mental health was necessary.[112] The report acknowledged that, based on higher levels of socioeconomic deprivation and other factors, Northern Ireland had a higher rate of mental health problems than the rest of the UK.

Some evidence of the effect of socioeconomic factors can be seen in the results of the Northern Ireland Lifestyle and Coping Survey, which indicated higher rates of self-harm among children in secondary schools in comparison to grammar schools, and in schools where more than 17% of students were entitled to free school meals.[113] A regional analysis of recorded suicides in Northern Ireland in 2015 reveals suicide rates in the most deprived areas of Northern Ireland are three times higher than in the least deprived areas.[114]

Similarly, in Ireland there is a strong link between deprivation and mental health problems, in particular suicide rates. A recent ecological study reported that the overall level of deprivation in an area had the strongest independent effect on rates of suicide.[115] Results showed that the association between area-level deprivation and suicide was observed across both men and women, with the association greatest in the 15–39 years age group. The authors highlighted the importance of prioritising suicide prevention resources in areas of high deprivation to tackle this.

There is also some evidence that this link may extend to self-harm presentations.[116] In Ireland, Limerick City is an example of an area with a high deprivation rate and, in addition to having high suicide rates, it is reported that the extent of self-harm among males and

112 Macdonald et al, 2011

113 O'Connor et al, 2010

114 Betts and Thompson, 2017

115 O'Farrell et al, 2016

116 O'Farrell et al, 2014

females is approximately twice the national average.[117]

A number of risk factors contribute to increased rates of mental health problems in disadvantaged communities. A recent report by the Samaritans identifies the following factors which can increase the risk of suicidal behaviour:[118]

- Physical (inadequate housing)
- Cultural (attitudes where suicide is accepted or seen as inevitable)
- Political (policy measures which have an adverse effect on at-risk groups in society)
- Economic (lack of employment)
- Social (poor social support and social networks)
- History (suicides in the community)
- Infrastructure (inadequate community services)
- Health and well-being (poor physical and mental health).

The impact on mental health can be even more significant when several of these risk factors are present.

4.3 The immediate environment

Factors in the immediate environment which influence youth mental health can include family structure and parenting, peer influences, bullying, the school environment and the Internet.

4.3.1 Family structure and parenting

Consultations with young people by Headstrong indicate the highly influential role families play in teenagers' lives. Data showed the value of support from other family members, particularly cousins, in seeking help and support on topics which teenagers did not feel comfortable discussing with their parents.[119] Overall, young people placed a high value on familial relationships that are based on time spent together as well as on mutual understanding and respect. A negative family environment, however, was identified as 'one of the greatest stresses for young people'. Intra-familial conflict, high parental expectations, family breakdown and invasions of privacy – such as reading of diaries or text messages – were identified as sources of stress and hurt for many of the young people consulted.[120]

117 Griffin et al, 2017

118 The Samaritans, 2017, page 9

119 Bates et al, 2009

120 Ibid.

The impact of family structure is complex, as it may include divorce, lone parenthood, bereavement, cohabitation or remarriage.[121] The timing of these events, combined with other factors, can affect young people in different ways. While there is evidence indicating that children who live with only one parent are more prone to emotional distress and drug use,[122] the reality may be much more complex. A frequent finding in the research is that, relative to two-parent families, children of single- parent families are generally more likely to experience poverty, especially in female-headed households.[123] It is not the structure of the family that is problematic for children, but rather that other risk factors are more likely to be present. These include lower income, parental depression, and parental conflict (which often occurs around separation or divorce). These factors can influence important child outcomes.

How do parents influence their children's mental health?

Parental behaviour and attributes have a significant impact on the mental health of their children. Parents who systematically monitor their children's behaviour raise young people who are less likely to engage in delinquency[124] or to participate in substance use.[125] Parental stress and mental health may influence these critical aspects of parenting.[126] In contrast, up to one-third of children born to parents with a mental illness are likely to suffer persistent emotional and behavioural disturbance.[127] Other studies have noted much higher rates of child psychiatric diagnosis among children of parents with mental illness compared to those in the general population.[128]

Depression in parents increases the risk of mental health disorders in children. These may include anxiety, conduct, and substance abuse disorders.[129] As depression often manifests itself through the family system can have the biggest impact on those close to the individual. Children may be particularly vulnerable to parental depression, especially if it persists over time. When both depression and marital problems are present in families at the same time, children and young people are particularly vulnerable to mental health difficulties.[130] This may be because parental depression affects marital functioning (e.g. higher levels of conflict

121 Raley and Wildsmith, 2004

122 e.g. Amato, 2005; Cummings et al, 2005

123 Amato, 2005

124 Pettit et al, 2001

125 Dishion et al, 1995

126 Woolfolk and Perry, 2011

127 Rutter and Quinton, 1984

128 Oyserman et al, 2000

129 Weissman et al, 2006

130 Rutter and Quinton, 1984

and lower levels of marital satisfaction), which in turn affects how parents interact with their children.[131]

The behaviours that parents engage in from early on in their child's development will have an impact on their mental health outcomes as they grow up. There are two key aspects of parents' behaviour: parents' responsiveness (R) and parents' demandingness (D).[132] These are used to identify four different parenting styles:

- ***Authoritative parenting*** involves high demandingness and high responsiveness. These parents tend to use rational, issue-orientated discipline in which the emphasis is on development and self-direction. They involve their children in setting boundaries and standards and are more likely to explain and reason with the child rather than being punitive. Using warm, firm control, they encourage verbal give-and-take by discussing their reasoning with their children. They exert firm control but do not wholly restrict their child – they are assertive, but not intrusive or restrictive.
- ***Authoritarian parenting*** is characterised by high demandingness and low responsiveness. Authoritarian parents generally use punitive, forceful and abusive discipline. They place a premium on conformity and obedience and expect their order to be obeyed without explanation.
- ***Permissive parenting*** involves low demandingness and high responsiveness. These parents are mainly concerned with their child's happiness. They are more lenient and do not require mature behaviour from their children, allowing self-regulation and, for the most part, avoiding confrontation.
- ***Disengaged parenting*** is where parents demonstrate low demandingness and low responsiveness to their child's needs. In extreme cases, this type of parenting can become neglectful.

Research indicates that an authoritative parenting style has the most positive influence on child and youth mental health and well-being. Authoritative parenting is strongly associated with both cognitive and social competence and lower levels of risky or problem behaviours in both boys and girls across all developmental stages.

The following three aspects support an authoritative approach to parenting and discipline:[133]

- Demonstrations of warmth in loving and caring for your child
- Provision of structure and expectations of behaviour, with these explained clearly
- Support and encouragement for your child's individualism.

Research consistently reports that children who have been raised in authoritative households

131 Cummings and Davies, 1994

132 Baumrind, 1991

133 Coie et al, 1995

rate themselves as being more socially and psychologically mature.[134] They tend to be more responsible, more socially skilled and more academically successful in school.[135] They are also more likely to avoid risk-taking behaviour, such as drug-taking and sexual activity at a young age.[136] By contrast, children with permissive or disengaged parents tend to become more involved in risky behaviour and crime in their adolescent years.[137]

Findings from Growing Up in Ireland[138] showed that family structure influenced parental behaviours. In two-parent households, children were less likely to experience a neglectful parenting style, while single parents with three or more children were more likely to adopt such a parenting style. There were also differences in single-parent households where single parents with one or two children were less likely to use an authoritarian (i.e. punitive) parenting approach in comparison to single parents with three or more children. Factors such as stress or poverty can have an impact on parenting approach.

4.3.2 Peer influences

Peer influences are especially important during adolescence, as peer groups and friendships are more important at this stage. Social support from peers is important for self-esteem.[139] Furthermore, there is evidence that peer group rejection is a cause of children's adjustment difficulties.[140] Longitudinal studies have found that childhood peer group rejection not only precedes emerging emotional and behavioural difficulties,[141] but it also predicts these problems independently of other potential risk factors, such as a child's behavioural disposition. The combination of displaying aggression and peer rejection at school has been consistently linked to later delinquency.[142] Children who have not shown signs of antisocial behaviour or aggression in earlier childhood may do so in adolescence as a result of mixing with antisocial peers.[143]

Peers are particularly important for young people experiencing adversity or problems at home. Reciprocal, positive friendships can provide emotional support for young people. A

134 Weiss and Schwarz, 1996

135 Blondal and Adalbjarnardottir, 2009

136 Adalbjarnardottir and Hafsteinsson, 2001

137 Scott et al, 2012

138 Nixon, 2012

139 Franco and Levitt, 1998

140 e.g. McDougall et al, 2001

141 Ladd, 1999

142 Coie et al, 1995

143 Rodkin et al, 2006

supportive relationship, even with a single friend, may act as a protective factor from the negative effects of both peer rejection and other adverse circumstances,[144] since it supports well-being. Boys are more likely to experience improved social well-being, and girls experience more positive changes in their school well-being from mid-childhood onwards when they have supportive friendships.[145]

The features of a friendship can be either positive (e.g. intimacy, companionship) or negative (e.g. rivalry, conflict), and together these features define friendship quality. Friendship quality may moderate the impact of young people's behaviour, but may also have a strong influence on mental health. Friendships encourage intimacy and affection and can provide emotional security, which is likely to increase a child's well-being and how they relate to others, irrespective of the child's characteristics.[146]

A review by Rueger and colleagues[147] involving a synthesis of 341 studies was concerned with the effects of social support on depression in childhood and adolescence. The review concluded that there are general benefits to social support, regardless of the level or frequency of stress encountered by the young person. Social support also has a stress-buffering effect which reduces the effects of adverse events on children. The review also found no evidence for gender differences and led the authors to conclude that social support may be somewhat more influential in the case of boys than is generally acknowledged.

The impact of bullying

Bullying can take various forms – usually physical, verbal, or relational (e.g. threatening, taunting, spreading rumours, pushing and kicking, and excluding), and more recently, cyberbullying (bullying via smartphones, social media platforms and the Internet).[148] The topic of bullying has emerged consistently across national consultations held on teenage mental health by the Department of Children and Youth Affairs.[149]

Bullying affects victims in the short term and may have a longer-term effect on their mental health, but it may also leave an impact on the bully. One US study[150] observed seventh and eighth-grade students over 10 months and concluded that problem behaviour was a consequence rather than a cause of bullying experiences. The outcomes for both children who bully and children who are bullied are negative in the long term. **Bullying behaviours that**

144 Bolger and Patterson, 2003

145 Newcomb et al, 1993

146 Parke and Buriel, 2006

147 Rueger et al, 2016

148 Smith et al, 2008

149 McEvoy, 2009

150 Kim et al, 2006

manifest in childhood can escalate in adolescence and adulthood, affecting not only the individual but also their future social relations and contribution to society.[151]

Some of the outcomes for victims of bullying include social isolation, depression and anxiety,[152] low self-esteem and poor social skills. Furthermore, being bullied in childhood has been found to predict suicide attempts up to the age of 25 years among females.[153] The impact of being bullied is also associated with externalising problems, such as violent behaviour,[154] while young people who are chronic victims of bullying often show increased risk of bullying others. Young people who are frequently bullied may show increased levels of psychotic symptoms.[155]

Behaviours associated with being a bully or with being a victim of bullying are found to be relatively stable over time. For example, longitudinal work carried out by Scholte and colleagues[156] with a sample of 517 children and adolescents aged 11 to 14 years explored some of the characteristics of bullies and victims. They found that 46% of childhood bullies in the sample persisted into adolescence (i.e. stable bullies); the rest had either stopped being involved in bullying (i.e. childhood-only bullies (45%)) or had become victims (9%). Meanwhile, 43% of children who were victims in childhood were still victims in adolescence (i.e. stable victims). 51% of the childhood victims were not involved in bullying in adolescence (i.e. childhood-only victims), while 6% had turned into bullies. Of all the children not involved in bullying in childhood, 15% started bullying in adolescence (i.e. adolescence-only bullies) and 7% became victims (i.e. adolescence-only victims). Male and female childhood victims were equally likely to become stable victims, except that the continuity of bullying other children was lower in girls and higher in boys.

Children who were bullied at an early age were more likely to be bullied at a later age. Of the 8-year- old victims studied, 15% were still being targeted by bullies at age 12, while 25% of the bullies were still victimising others.[157] Children from low socioeconomic status households were more likely to be involved in bullying activity. Children who were chronically bullied were less popular, had fewer friends and were shyer than either victims who were bullied during childhood only or children who were never bullied at all.

The results of a recent systematic review[158] support the findings that bullying influences

151 Ttofi et al, 2011

152 Nansel et al, 2001

153 Sourander et al, 2009

154 Arseneault et al, 2010

155 Campbell and Morrison, 2007

156 Scholte et al, 2007

157 Kumpulainen et al, 1999

158 Ttofi et al, 2011

longer-term psychosocial development. It is not yet clear whether being bullied causes depression to develop later or if individual characteristics enhance the risk of being bullied.[159] The review finds that **being the victim of school bullying is a unique childhood risk factor for later depression, even after controlling for a large number of pre-existing risk factors.[160]** In other words, being the victim of childhood bullying can have unique and long-term effects on mental health. It may be that anxious and depressed children are more vulnerable and may not retaliate if other children are unpleasant to them, although aggressive children may also attract hostility from other children.

Recent research by Collins, Keating and Morgan[161] was concerned with the prevalence of homophobic and transphobic bullying in Ireland as well as schools' awareness of such incidents. The findings showed that 19% of schools had dealt with incidents of homophobic bullying, while 70% of respondents were aware of children using homophobic language to label a peer's behaviour. In a study of the prevalence of homophobic bullying in post-primary schools in Ireland, Minton[162] found that homophobic bullying was present at about the same level in both second and fifth year students, with over 30% saying that they had experienced such bullying. Gender exerted a greater influence than did age, with **males more likely to be both perpetrators and victims of homophobic bullying**.

4.3.3 The school environment

> *'I would change the Leaving Cert so that there is less pressure on students at the end of 6th year. I would do this by introducing continuous assessment.'*[163]

Exams and transitions through the school system are times when young people can feel under pressure. The *What's Wrecking your Head?* survey of 2,508 teenagers in Ireland asked participants to identify what caused them stress. Exams and school were selected most frequently, by 81% and 80% of respondents respectively.[164]

Dissatisfaction with the Leaving Certificate and CAO points system was consistently referenced in young people's comments within the literature in Ireland, with many expressing a preference for continuous assessment as an alternative to the current Leaving Certificate

159 Arseneault et al, 2010; Ttofi and Farrington, 2010

160 Ttofi et al, 2011

161 Collins et al, 2016

162 Minton, 2013

163 Coyne et al, 2012, page 53

164 Chambers et al, 2017

exams.[165] Similarly, the stresses of GCSEs and A levels were referenced in the Northern Irish study *Still Waiting: The stories behind the statistics of young women growing up in Northern Ireland*, where focus groups and exploratory interviews were conducted with 48 sixteen-year-old and 45 twenty-five-year-old Northern Irish women.[166]

> *'… it's all you, I mean you are responsible for your future …//… like I felt it more at GCSEs more than A-Levels because suddenly at like age 16 you're supposed to get all these exams and this is going to be the basis of your future career …//… when I look back now I'm like GCSEs weren't even that bad but at the time exams are just so much on you, it's like you're all alone'*[167]

4.3.4 Use of the Internet

Seventy-three per cent of Irish teenagers report daily use of the Internet in their homes.[168]

> *'Bullying goes on outside of school but school policy on bullying is enforced until the uniform is off'*[169]

> *'Online bullying is more dangerous because people don't see it… People don't take it seriously.'*[170]

> *'I think it [cyberbullying] causes more damage, because it's more permanent. If someone tells you something that upsets you, you can kind of brush it off. Whereas something on social media, everybody will see it, so you kind of feel attacked by everyone.'*[171]

According to a YouGov survey, 60% of Irish teenagers (aged 13–18 years) believe that cyberbullying is worse than face-to-face bullying. Moreover, it appears to be far more

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165 Lalor et al, 2012; McEvoy, 2009; Children Living in Ireland, 2015; Coyne et al, 2012; Chambers et al, 2017

166 McAlister et al, 2007

167 McAlister et al, 2007, page 51

168 O'Neill et al, 2015

169 Martin et al, 2016

170 Children Living in Ireland, 2015, page 67

171 Perry, 2016

prevalent, as one in four (26% of) Irish teenagers report being cyberbullied personally and 85% report knowing of it happening to someone else.[172] Websites and social media channels popular with young teenagers, such as Curious Cat and Ask.fm, which enable Internet users to send anonymous messages to one another, have caused repeated controversy due to their association with cyberbullying and the tragic suicides of some young users.[173]

4.4 Individual factors

Individual factors which affect mental health include:

- **Individual lifestyle behaviours** (e.g. substance abuse, physical activity and sleeping-patterns)
- **Personality dimensions** (ways of being, thinking and feeling) that can influence mental health.

Other individual factors include genetic and neurobiological influences.

Individual factors can be even more influential when they interact with other factors, such as family and peer influences.

4.4.1 Lifestyle behaviours

Recent analysis of Irish data from the Saving and Empowering Young Lives in Europe (SEYLE) study identified three behaviours linked with suicidal ideation:[174]

- **Substance use** – Regular alcohol drinking, smoking and a history of illegal drug use were all linked to an increased likelihood of a suicide attempt.
- **Physical activity** – Low levels of physical activity were linked with the lowest levels of well- being and the highest levels of depression and anxiety.
- **Sleep** – Getting at least eight hours of sleep per night was linked with better well-being and lower levels of depression and anxiety.

Many young Irish people move beyond the normal range for alcohol consumption at age 18 or 19 and continue to drink excessively until at least age 25.[175] According to the 2012 My World survey, '*for young adults, strong links were found between excessive drinking and*

172 YouGov, 2015

173 e.g. Boyd, 2014; Kiberd, 2016

174 McMahon et al, 2017

175 Dooley and Fitzgerald, 2012

suicidal behaviour', both of which are more common among young men.[176] In a number of consultations with young people, alcohol use was discussed as a coping mechanism:

> *'Me and my mates, we can't afford to pay €50 for a GP, a six-pack is a lot cheaper, sometimes you drink just so you can sleep at night.'*[177]

> *'…it helps as you don't have to deal with the problems you are facing, the drug numbs it'*[178]

In *Still Waiting*, the Northern Irish study of young women, the consumption of alcohol and other substances was identified as a source of entertainment in the absence of adequate youth service provision:

> *'… what else is there just for like to have a bit of fun there's only substances, nobody offers anything better.'*[179]

4.4.2 Lifeskills/psychosocial competencies

The following life skills are associated with the development of positive mental health:

- **Self-regulation**
- **Self-efficacy**
- **Coping skills.**

Self-regulation refers to the capacity of an individual to monitor and control their own behaviour, emotions and thoughts and to adapt their behaviour to particular contexts or situations. It has also been referred to as 'the capacity to persist in goal-directed behaviour despite distractions'.[180] Self- regulation is identified as a critical developmental milestone for young people, and one that helps them to maintain positive mental health. Effective self-regulation can help young people understand the significance of particular events and routines in their lives and to behave appropriately. It helps them deal with distress, elation and frustration, competition in team sports, family problems, and the break-up of relationships or

176 Dooley and Fitzgerald, 2012, page 99

177 Bates et al, 2009, page 22

178 Bates et al, 2009, page 14

179 McAlister et al, 2007, page 102

180 Carr, 2015

friendships. Self-regulation has been shown to be important for emotional control,[181] school completion[182] and abstention from drug use,[183] all of which are important for positive mental health. Young people who lack self-regulation skills can sometimes present with externalising problems and challenging behaviour.

Young people develop self-efficacy when they can successfully complete a task and attribute their success to their own abilities. Young people high in self-efficacy are more likely to persist in attempts to solve a problem than those with low self-efficacy. This is one of the primary ways in which self- efficacy can impact on mental health.[184] In their positive expression, the individual risk factors discussed here serve as protective factors, such as healthy lifestyle behaviours, not abusing substances, getting enough sleep and having a good sense ofself-efficacy.

It is important to note that these individual risk factors are usually manifested through exposure to adversities and systemic and structural inequalities. Consistent exposure to inequalities or adversities, such as poverty, can chip away at a young person's resilience or capacity to develop the positive individual behaviours described in this section. It is not the case that the young people just need to 'cope better' or have more control over their behaviour, because such positive indicators as coping skills and self-regulation are difficult to develop when a young person is faced with an accumulation of risks in their lives. In other words, **it can be those most at risk who are least likely to have the opportunity to develop these protective psychosocial competencies.[185]**

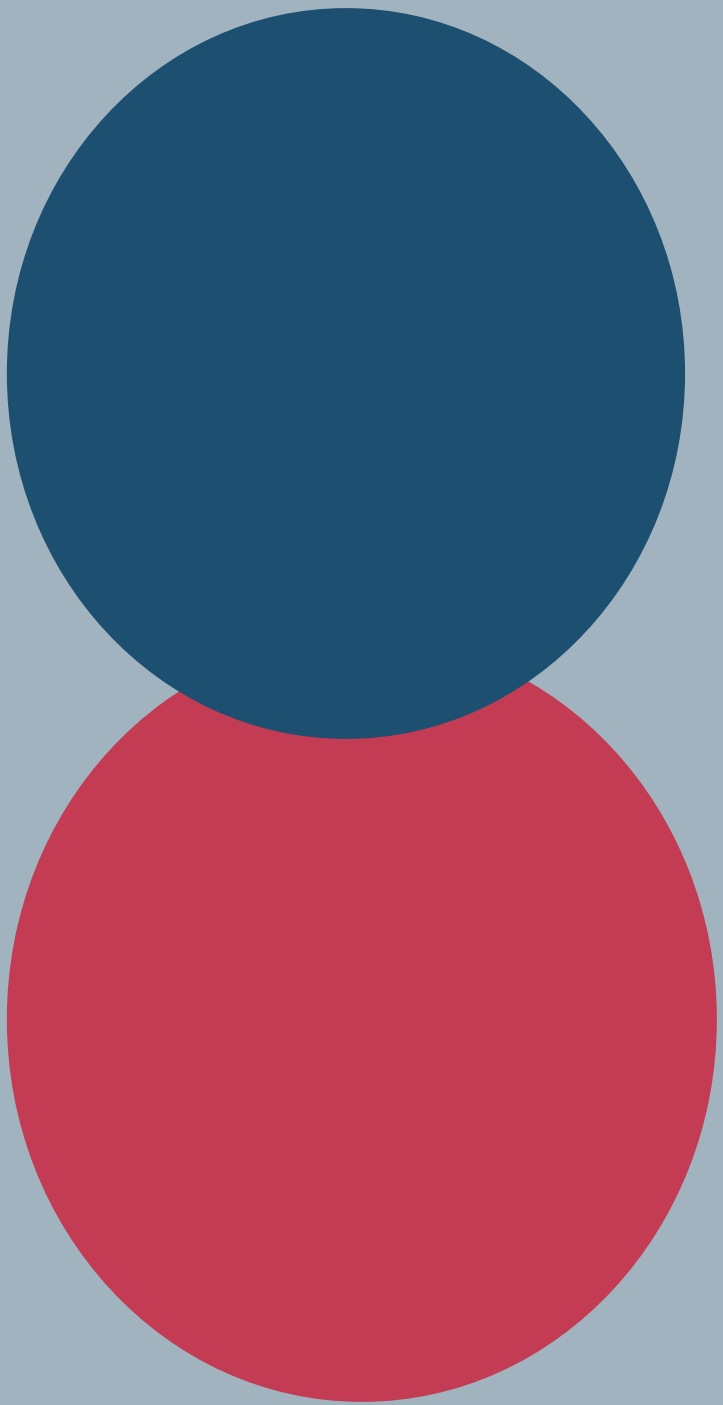
181 Durlak et al, 2011

182 Freeney and O'Connell, 2012

183 Sirocco et al, 2012

184 Carr, 2014

185 Morgan et al, 2016



CHAPTER 5

5. What supports youth mental health?

Many of the influences described in the previous section of this report provide opportunities to support the development of positive mental health. For example, supportive parenting behaviours and positive relationships with families and carers are associated with the development of positive mental health. Achievements at school, personal accomplishments and the development of skills through extracurricular activities all help young people to develop confidence and resilience.
Experiences and relationships at home, at school and in the community all provide opportunities for young people to develop self-regulation and coping skills.

Some young people may not have access to support at home as they experience poverty, homelessness, parental mental health problems, loss of a parent, or other adversities. This can affect their confidence, self-image and ability to develop and maintain supportive friendships outside of home.

Targeted services and interventions can help to support both children and young people. Learning from the experience of interventions can inform wider services to promote good mental health and prevent problems from deteriorating.

5.1 The role of services

Services have a critical role to play in supporting youth mental health. General medical services, such as the GP, are usually the point of referral to more targeted mental health supports, such as the local community CAMHS team or special counselling services. There are also valuable community-based supports where a referral is not required and mental health supports can be accessed, including primary care services or community supports provided by charities and other local organisations.

Young people identify a series of issues primarily around access to Irish mental health services. They refer to a lack of awareness of available services; high barriers to entry, such as associated costs or being perceived as not being 'sick' enough; and a fear of being pathologised and stigmatised.[186]

> *'although supports are available they are often hard to use because you feel that compared to other people's problems yours is so small that you shouldn't use the supports because you don't want to take them from someone who has it harder than you, even if you cry yourself to sleep every*

186 Lalor et al, 2012; Higgins et al, 2016

night and feel like you have no friends.'[187]

5.2 The importance of prevention

The Durlak and Wells[188] study of primary school programmes, designed to prevent the development of mental health problems in children and young people, identified the following key messages.

Interventions which aim to change the school and classroom environment are especially successful. Many of the interventions reviewed by Durlak and Wells were aimed at changing the psychosocial aspects of the typical classroom environment. For example, Hawkins and colleagues[189] trained teachers in effective classroom management procedures and introduced new interactive teaching strategies that encouraged more supportive contact between teachers and students. This intervention was effective in reducing aggressive behaviour in boys and self-destructive behaviour in girls.

Interpersonal problem-solving programmes can prevent children and young people from developing mental health difficulties. This same study found that while programmes focused on different skills, most of them encouraged children to use cognitively based skills to identify interpersonal problems and develop effective mechanisms for resolving difficulties. There were indications that this approach was relatively more effective with young children.

Supporting children though difficult experiences can enhance their coping skills and mental well- being. The study examined seven programmes designed to support children through their parents' divorce proceedings. Programmes were generally brief and used group sessions to help children understand and cope with changes.

The study also looked at interventions for children and young people undergoing difficult medical procedures. These procedures can result in persisting fears and anxieties. Most of the interventions were based on teaching children coping skills. Results showed that interventions helped children to remain calm, and showed less behavioural problems when they left hospital. Programmes were effective in reducing problems and supporting children by providing them with coping skills.

The work of Sandler and colleagues[190] involves a synthesis which examined the prevention outcomes for mental health, as well as substance use, conduct problems, depression and

187 Chambers et al, 2017, page 27

188 Durlak and Wells, 1997

189 Hawkins et al, 1991

190 Sandler et al, 2014

anxiety. Overall, the outcomes resulted in small but positive changes. However, **the most common outcome was that the effects were different and were associated with differences in the characteristics of the programme, features of the participants, and how the programme was implemented**.

There is consistent evidence that approaches involving interactive strategies, such as discussion and opportunities to practice skills, are more effective than those without interaction and feedback.

Targeted programmes aimed specifically at young people at risk are most effective than universal programmes. Universal programmes are also relevant, given their potential to reach a larger number of young people. Interactive approaches and targeting emerge as being more important than the duration of a particular programme.

Effects were larger for young people with higher levels of initial problems and for those who had experienced disruption recently. These effects were apparent where a young person took part in an intervention shortly after their parents divorced or experienced a family bereavement.

Gender, social background and ethnicity did not appear to influence the outcome of the programmes.

The study drew particular attention to the role of implementation. Although implementation was assessed in different ways, the study found more positive outcomes where programmes were implemented effectively. This was important in terms of mental health, but also for programmes such as curriculum innovations.

5.3 Challenging stigma

In a review of the evidence on strategies that diminish the stigma associated with mental health issues, Corrigan[191] suggests that three approaches may diminish aspects of the public stigma that people can experience. These are **protest, education and contact**. There is some evidence that protest, i.e. challenging inaccurate representations of mental illness in the mass media, can result in greater awareness, to present a balanced picture and a reduction in stigma.[192] Other studies suggest that such campaigns can have a rebounding effect as people react against being told what to think, with an outcome in which their negative attitudes may be strengthened.[193]

191 Corrigan, 2004

192 Wahl, 1999

193 Corrigan, 2004

There are indications that broad educational approaches to mental health can improve attitudes to persons with mental health problems.[194] In reviewing the evidence on the effectiveness of education programmes, Corrigan[195] suggests that **education programmes could be made more effective if they underlined the evidence showing that participation in treatment can be very successful**.

There is also evidence that stigma can be diminished when members of the general public have contact with persons suffering from mental illness; the opportunities for such meetings may result in a discounting of the stigma. It is especially noteworthy that some studies have shown that contact with persons who have a mental illness, but who are able to hold down a job and live as good neighbours in the community, are especially effective.[196]

5.4 Targeting 'at risk' groups

Russell and Fish[197] reviewed the research revolving around the mental health of LGBT youth, paying particular attention to school factors, legal initiatives, and peer-led interventions. They concluded that young people who live in U.S. states that have active anti-bullying laws with provisions relevant to sexual orientation and gender identity report less victimisation and harassment than students attending schools in states without these protections.

There is also evidence that school-based, student-led clubs that are open to all youth and that are supportive of LGBT students can reduce prejudice within the school environment. LGBT students in such schools often report feeling safer and are less likely to report depressive symptoms, substance use, and suicidal thoughts and behaviours by comparison with students in schools that lack such resources. The benefits are also seen at later developmental stages. Toomey and colleagues[198] found that youth who attended schools with supportive programmes reported better psychological health during young adulthood. Further, these positive experiences of school diminished some of the negative effects of LGBT victimisation on young adult well-being.

Additionally, there is evidence that LGBT training for teachers, staff and administrators can foster an understanding of, and empathy for, LGBT students and is associated with more frequent adult intervention in bias-based bullying.[199]

194 Penn et al, 1994

195 Corrigan, 2004

196 e.g. Pinfold et al, 2003

197 Russell and Fish, 2016

198 Toomey et al, 2011

199 Russell and Fish, 2016

Beyond the formal school curriculum, recent studies document some ways that school strategies can influence interpersonal relationships within schools through supportive peers and friends. For example, Poteat[200] found that youth who engage in more LGBT-based discussions with peers and who have LGBT friends are more likely to participate in LGBT- affirming behaviour and intervene when hearing homophobic remarks.

200 Poteat, 2015

CHAPTER 6

6. Resources

HSE's National Office for Suicide Prevention (NOSP)

The National Office for Suicide Prevention (NOSP) is charged with supporting, monitoring, promoting and coordinating the implementation of Connecting for Life, Ireland's national strategy for the reduction of suicides from 2015 to 2020. It operates in partnership with a range of organisations working on the implementation of this strategy. The NOSP's role includes providing support to partners, promoting evidence-informed approaches, commissioning research and evaluations, commissioning services, monitoring both implementation and outcomes, and coordinating training, education and stigma-reduction campaigns. **A range of resources is available to download from the NOSP website** for use by practitioners, communities and young people. Resources include mental health promotion posters, details of regional suicide prevention officers, guidance documents on best practice, information booklets, and practical guidance resources for communities and schools engaging in suicide prevention work.

The NOSP also provides information on **relevant events and training opportunities** both for practitioners hoping to upskill and for people in need of mental health support. Training and education provision by the NOSP varies in emphasis and intensity, ranging from general awareness raising, to teaching alertness skills with an emphasis on prevention, to the development of intervention skills in practitioners or others in contact with people at risk.[201]
http://www.hse.ie/eng/services/list/4/Mental_Health_Services/NOSP/Resources/

Public Health Agency (PHA)

The Public Health Agency (PHA) is one of the joint partners in Northern Ireland's regional mental health anti-stigma and anti-discrimination campaign. The Change Your Mind campaign was launched in March 2016 and builds on both the work of the PHA and the mental health charity organisation Inspire (formerly known as Niamh, the Northern Ireland Association for Mental Health). It is a grassroots campaign which relies on the support of individuals, organisations and communities to help fight against mental health stigma in Northern Ireland.

The PHA has also been involved in the Helping Others mental health campaign which focuses on tackling stigma around mental health in schools and workplaces. The campaign features a guide to speaking with friends, family members or colleagues undergoing a mental health problem. The guide gives the simple message to 'ask, listen, talk' when it is believed

201 Health Service Executive, 2017

that someone is experiencing a mental health problem. The campaign has also launched a TV advertisement under the heading 'Life changing,' which urges people to reach out to associates, friends or family members who may be having problems with their mental health.

http://www.changeyourmindni.org/
https://www.mindingyourhead.info/

yourmentalhealth.ie

yourmentalhealth.ie is a joint initiative of the HSE and the NOSP in Ireland. It is designed to be an online space where anyone can access information on how to look after their own mental health and how to support those around them. A diverse range of material is available on this website, including resources for the **#LittleThings** mental health promotion campaign, as well as material of benefit to individuals seeking to promote wellness and positive mental health in themselves and others and to individuals concerned with assisting others in crisis. Links include **online wellness workshops and videos**, **podcasts**, **a cognitive behavioural therapy (CBT) app** called WorkOut, and an **online service directory** (available on the home page) which can be searched by area and provides a list of relevant mental health support services.

www.yourmentalhealth.ie

National Youth Council of Ireland – Youth Mental Health Services Signposting Tool

The National Youth Council of Ireland recently developed an online mental health services signposting tool. This tool provides information on available youth mental health services, training programmes, community supports and children's rights. Searches can be conducted by region and by support service required. http://www.youthhealth.ie/signposts

esuicideTALK

This programme is focused on enhancing **general awareness** of mental health and suicide. This is a one- to two-hour online community-oriented programme available to Irish residents, ideally aged 15 or over,[202] which has been designed to promote and enable safe, honest and open conversations about suicide.[203] It can be **accessed for free** through the yourmentalhealth.ie website here, which provides registration details.

safeTALK

This programme is focused on improving skills that help spot suicide risk in others, or **alertness**. safeTALK is a half-day training programme designed to equip participants with the skills necessary to identify persons at risk of suicide within their communities, and to assist them in accessing suicide first aid resources.

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202 Living Works Education, 2012

203 Ibid.

In Ireland, the service is usually delivered locally through the HSE Regional Resource Officers for Suicide Prevention. A list of these officers is available here and training opportunities can be accessed on the yourmentalhealth.ie website here.

In Northern Ireland, training is usually provided through the Health and Social Care Trusts, and relevant contact details for training can be found in the Health and Social Care Trust areas' training directories.

ASIST (Applied Suicide Intervention Skills Training)

This programme is directed at improving **intervention** skills. ASIST is a two-day interactive workshop designed to train practitioners and caregivers in suicide and self-harm first aid. Participants are encouraged to examine their own beliefs and relationships and how these may impact on their approach to intervention. They are trained in how to reduce the immediate risk of suicide and to provide positive support to those engaging in self-harm.

In Ireland, ASIST is usually delivered locally through the HSE Regional Resource Officers for Suicide Prevention. A list of these officers is available here and training opportunities can be accessed on the yourmentalhealth.ie website here.

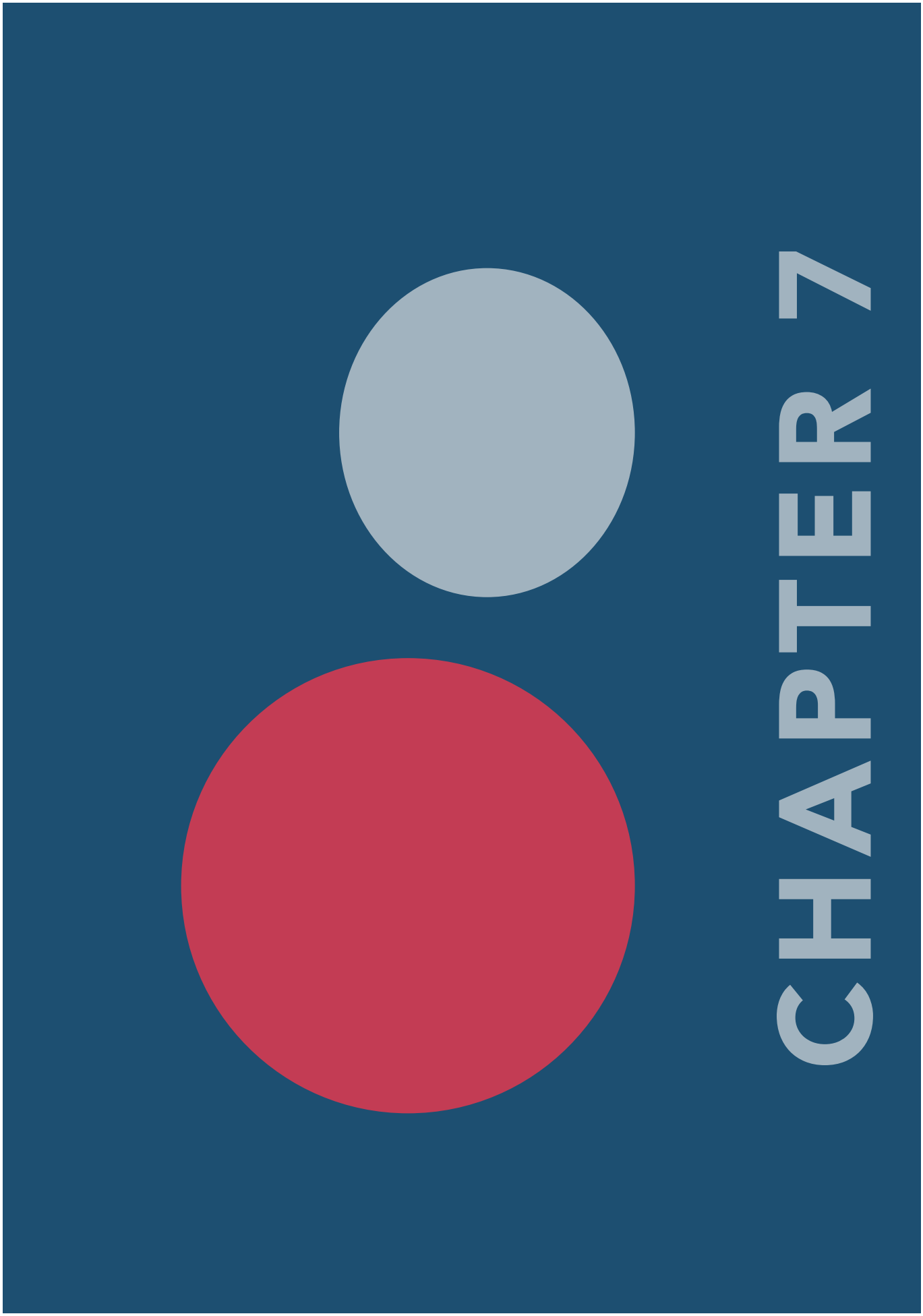
In Northern Ireland, training is usually provided through the Health and Social Care Trusts and relevant contact details for training can be found in the Health and Social Care Trust areas' training directories.

Mental Health First Aid

Mental Health First Aid is a programme focused on improving **intervention skills**. It is the help offered to a person who is developing a mental health problem or who is experiencing a mental health crisis, until appropriate professional treatment is received or until the crisis resolves. It follows the model that has been successful with conventional first aid. It is an evidence-based programme which was originally developed in Australia and is now internationally recognised and endorsed by the HSE in Ireland and by the Public Health Agency in Northern Ireland. Training is available to everyone. There are also specifically tailored courses designed for corporate groups. Mental Health First Aid has an extensive and robust evidence base attesting to its effectiveness. It is also included in the US Substance Abuse and Mental Health Services Administration's (SAMHSA's) National Registry of Evidence-based Programs and Practices.

In Ireland, it is available through Mental Health First Aid Ireland which is supported in making the programme available by the HSE and Saint John of God Hospitaller Services.

In Northern Ireland, the programme is made available with the support of the PHA and training can be accessed through a number of different organisations across the Health and Social Care Trust areas, including AWARE NI, for which information is available here. Further information can be found in the Health and Social Care Trust areas' training directories.


CHAPTER 7

7. References

Abrutyn, S. and Mueller, A.S. (2014) 'Are Suicidal Behaviors Contagious in Adolescence? Using Longitudinal Data to Examine Suicide Suggestion', *American Sociological Review*, Vol. 79, No. 2, pp. 211–227.

Adalbjarnardottir, S. and Hafsteinsson, L.G. (2001) 'Adolescents' Perceived Parenting Styles and Their Substance Use: Concurrent and Longitudinal Analyses', *Journal of Research on Adolescence,* Vol. 11, No. 4, pp. 401–423.

Amato, P.R. (2005) 'Parenting through family transitions', *Social Policy Journal of New Zealand,* No. 23, pp. 31–44.

Andriessen, K., Draper, B., Dudley, M. and Mitchell, P.B. (2016) 'Pre- and postloss features of adolescent suicide bereavement: A systematic review', *Death studies*, Vol. 40, No. 4, pp. 229–246.

Arensman, E., Wall, A., McAuliffe, C., Corcoran, P., Williamson, E., McCarthy, J., Duggan, A. and Perry, I.J. (2013) *Second Report of the Suicide Support and Information System.* Cork: National Suicide Research Foundation.

Arensman, E., McAuliffe, C., Corcoran, P., Williamson, E., O'Shea, E. and Perry, I.J. (2012) *First Report of the Suicide Support and Information System*. Cork: National Suicide Research Foundation.

Arseneault, L., Bowes, L. and Shakoor, S. (2010) 'Bullying victimization in youths and mental health problems: 'Much ado about nothing'?', *Psychological Medicine*, Vol. 40, No. 5, pp. 717–729.

Aunola, K. and Nurmi, J.E. (2005) 'The role of parenting styles in children's problem behaviour', *Child Development,* Vol. 76, No. 6, pp. 1144–1159.

Bates, T., Illback, R.J., Scanlan, F. and Carroll, L. (2009) *Somewhere To Turn To, Someone To Talk To*. Dublin: Headstrong – The National Centre for Youth Mental Health.

Baumrind, D. (1991) 'The Influence of Parenting Style on Adolescent Competence and Substance Use', *Journal of Early Adolescence,* Vol. 11, No. 1, pp. 56–95.

Betts, J. and Thompson, J. (2017) *Mental Health in Northern Ireland: Overview, Strategies, Policies, Care Pathways, CAMHS and Barriers to Accessing Services.* Belfast: Northern Ireland Assembly.

Bloom, D.E., Cafiero, E.T., Jané-Llopis, E., Abrahams-Gessel, S., Bloom, L.R., Fathima, S., Feigl, A.B., Gaziano, T., Mowafi, M., Pandya, A., Prettner, K., Rosenberg, L., Seligman, B., Stein, A. and Weinstein, C. (2011) *The Global Economic Burden of Non-communicable Diseases*. Geneva: World Economic Forum.

Blondal, K.S. and Adalbjarnardottir, S. (2009) 'Parenting practices and school dropout: a longitudinal study', *Adolescence*, Vol. 44, No. 176, pp. 729–749.

Bojarczuk, S., Marchelewska, E. and Prontera, M. (2015) *Ethnic Minorities and Mental Health in Ireland: Barriers and Recommendations.* Dublin: Cairde.

Bolger, K.E. and Patterson, C.J. (2003) 'Sequelae of child maltreatment: Vulnerability and resilience'. In: S.S. Luthar (ed.), *Resilience and Vulnerability: Adaptation in the Context of Childhood Adversities*. New York: Cambridge University Press (pp. 156–181).

Boyd, B. (2014, 8 November) 'Ask.fm may base itself in Ireland, but social-media abuse isn't about geography', *The Irish Times.* Available at: https://www.irishtimes.com/life-and-style/ask-fm-may-base-itself-in-ireland-but-social-media-abuse-isn-t-about-geography-1.1992430

Bronfenbrenner, U. (1979) *The Ecology of Human Development: Experiment by Nature and Design.*
Cambridge, MA: Harvard University Press.

Campbell, M.L.C. and Morrison, A.P. (2007) 'The relationship between bullying, psychotic-like experiences and appraisals in 14–16-year olds', *Behaviour Research and Therapy*, Vol. 45, pp. 1579– 1591.

Canadian Council on Learning (2006) *The Social Consequences of Economic Inequality for Canadian Children: A Review of the Canadian Literature*. Canada: Canadian Council on Learning.

Carr, A. (2009) 'The effectiveness of family therapy and systemic interventions for child-focused problems', *Journal of Family Therapy*, Vol. 31, No. 1, pp. 3–45.

Carr, A. (2015) *The Handbook of Child and Adolescent Clinical Psychology: A Contextual Approach*. London: Taylor and Francis.

Chambers, D., Ryan, F., Doolan, R., Kavanagh, N. and Healy, C. (2017) *What's wrecking your head? –*
A report on teenage mental health. Dublin: ReachOut Ireland.

Children Living in Ireland (2015) *Picture your rights: A Report to the UN Committee on the Rights of the Child.* Dublin: Children's Rights Alliance and UNICEF Ireland.

Coie, J.D., Terry, R., Zakriski, A. and Lochman, J. (1995) 'Early adolescent social influences on delinquent behavior'. In: J. McCord (ed.), *Coercion and Punishment in Long-Term Perspectives.* New York: Cambridge University Press (pp. 229–244).

Collins, B., Keating, S. and Morgan, M. (2016) *All Together Now! Pilot Project on Homophobic and Transphobic Bullying In Primary Schools.* Dublin: St. Patrick's College.

Cooper, S.A., Smiley, E., Morrison, J., Williamson, A. and Allan, L. (2007) 'Mental ill-health in

adults with intellectual disabilities: prevalence and associated factors', *The British Journal of Psychiatry*, Vol. 190, No. 1, pp. 27–35.

Corrigan, P. (2004) 'How stigma interferes with mental health care', *American Psychologist,* Vol. 59, No. 7, pp. 614–625.

Coyne, I., Dempsey, O., Comiskey, C. and O'Donnell, A. (2012) *Life as a Child and Young Person in Ireland: Report of a National Consultation*. Dublin: Department of Children and Youth Affairs, Government Publications.

Cummings, E.M. and Davies, P.T. (1994) 'Maternal Depression and Child Development', *Journal of Child Psychology and Psychiatry*, Vol. 35, No. 1, pp. 73–112.

Cummings, E.M., Keller, P.S. and Davies, P.T. (2005) 'Towards a family process model of maternal and parental depressive symptoms: exploring multiple relations with child and family functioning', *Journal of Child Psychology and Psychiatry,* Vol. 46, No. 5, pp. 479–489.

Department of Children and Youth Affairs (2016) *State of the Nation's Children: Ireland 2016*. Dublin: Government Publications. Available at: https://www.dcya.gov.ie/documents/stateofthenationschildren/20170302SOTNCReport2016.pdf

Department of Health (2015) *Healthy Ireland Survey 2015: Summary of Findings.* Dublin: Government Publications. Available at: http://health.gov.ie/wp-content/uploads/2015/10/Healthy-Ireland-Survey-2015-Summary-of-Findings.pdf

Department of Health (2016) *Protect Life 2: A draft strategy for suicide prevention in the north of Ireland.* Available at: https://www.health-ni.gov.uk/sites/default/files/consultations/health/protect-life-2-consultation.pdf

Department of Health (2017) *Suicide prevention*. Available at: https://www.health-ni.gov.uk/articles/suicide-prevention

Department of Health (2017) *Healthy Ireland Annual Survey 2016: Summary of Findings.* Dublin: The Stationary Office. Available at: http://health.gov.ie/wp-content/uploads/2016/10/Healthy-Ireland-Survey-2016-Summary-Findings.pdf

Detail Data (2016) *Suicide Deaths, 2009-2015 Quarterly*. Available at: http://data.nicva.org/dataset/suicide-deaths/resource/95b6f50b-bd63-40f0-b6e5-db703f8b06bc

Dishion, T.J., Capaldi, D., Spracklen, K.M. and Li, F. (1995) 'Peer ecology of male adolescent drug use',
Development and Psychopathology, Vol. 7, No. 4, pp. 803–824.

Dooley, B. and Fitzgerald, A. (2012) *My World Survey: National Study of Youth Mental Health in Ireland*. Dublin: Headstrong – The National Centre for Youth Mental Health and UCD School of Psychology.

Doyle, A. and Hourigan, S. (2017) *Annual Report of the National Physical and Sensory Disability Database Committee 2016: Main Findings*. Dublin: Health Research Board.

Druss, B.G. and Rosenheck, R.A. (1998) 'Mental disorders and access to medical care in the United States', *American Journal of Psychiatry,* Vol. 155, No. 12, pp. 1775–1777.

Durlak, J. A., & Wells, A. M. (1997). Primary prevention mental health programs for children and adolescents: A meta-analytic review. *American journal of community psychology*, Vol. 25, No. 2, pp. 115-152.

Durlak, J.A., Weissberg, R.P., Dymnicki, A.B., Taylor, R.D. and Schellinger, K.B. (2011) 'The impact of enhancing students' social and emotional learning: a meta-analysis of school-based universal interventions', *Child Development*, Vol. 82, No. 1, pp. 405–432.

Einfeld, S.L., Ellis, L.A. and Emerson, E. (2011) Comorbidity of intellectual disability and mental disorder in children and adolescents: a systematic review', *Journal of Intellectual and Developmental Disability*, Vol. 36, No. 2, pp. 137–143.

Emerson, E. (2003) 'Mothers of children and adolescents with intellectual disability: social and economic situation, mental health status, and the self-assessed social and psychological impact of the child's difficulties', *Journal of Intellectual Disability Research*, Vol. 47, No. 4-5, pp. 385–399.

Emerson, E., Madden, R., Robertson, J., Graham, H., Hatton, C. and Llewellyn, G. (2009) *Intellectual and Physical Disability, Social Mobility, Social Inclusion and Health.* Lancaster: Centre for Disability Research, Lancaster University.

Eurostat (2017) *Causes of death statistics.* Available at: http://ec.europa.eu/eurostat/statistics-explained/index.php/Causes_of_death_statistics

Franco, N. and Levitt, M.J. (1998) 'The Social Ecology of Middle Childhood: Family Support, Friendship Quality, and Self-Esteem', *Family Relations,* Vol. 47, No. 4, pp. 315–321.

Freeney, Y. and O'Connell, M. (2012) 'The predictors of the intention to leave school early among a representative sample of Irish second-level students', *British Educational Research Journal*, Vol. 38, No. 4, pp. 557–574.

Gannon, B. and Nolan, B. (2006) *The dynamics of disability and social inclusion.* Dublin: The Equality Authority.

Green, H., McGinnity, Á., Meltzer, H., Ford, T. and Goodman, R. (2004) *Mental health of children and young people in Great Britain, 2004.* Newport: The Office for National Statistics.

Griffin, E., Dillon, C.B., Arensman, E., Corcoran, P., Williamson, E. and Perry, I.J. (2017) *National Self-Harm Registry Ireland Annual Report 2016.* Cork: National Suicide Research Foundation.

Growing Up in Ireland Study Team (2016) *Growing Up in Ireland: Key Findings: Child Cohort at 17/18 Years No. 3: Life Satisfaction, Relationships and Mental Health*. Dublin: Economic and Social Research

Institute/Trinity College Dublin/Department of Children and Youth Affairs.

Haase, T. and Pratschke, J. (2012) *The 2011 Pobal HP Deprivation Index for Small Areas (SA): Introduction and Reference Tables*. Available at: https://www.pobal.ie/Publications/Documents/Introduction%20and%20Reference%20Tables.pdf

Hawkins, J.D., Von Cleve, E. and Catalano, R.F. Jr. (1991) 'Reducing Early Childhood Aggression: Results of a Primary Prevention Program', *Journal of the American Academy of Child and Adolescent Psychiatry,* Vol. 30, No. 2, pp. 208–217.

Health Research Board (2017) *National Psychiatric In-patient Reporting System (NPIRS) – National Bulletin 2015.* Dublin: Health Research Board.

Health Service Executive (2014) *Fifth Annual Child & Adolescent Mental Health Service Report 2012 - 2013.* Dublin: Health Service Executive.

Health Service Executive (2017) *National Office for Suicide Prevention*. Available at: http://www.hse.ie/eng/services/list/4/Mental_Health_Services/NOSP/

Higgins, A., Doyle, L., Downes, C., Murphy, R., Sharek, D., DeVries, J., Begley, T., McCann, E., Sheerin, F. and Smyth, S. (2016) *The LGBTIreland Report: national study of the mental health and wellbeing of lesbian, gay, bisexual, transgender and intersex people in Ireland*. Dublin: GLEN and BeLonG To.

Hope, A., Dring, C., & Dring, J. (2005). College lifestyle and attitudinal national (CLAN) survey. The health of Irish students. Dublin: Department of Health and Children.

House of Commons Health Committee (2017) *Suicide Prevention – Sixth Report of Session 2016-17.* HC 1087. London: House of Commons.

HSE Mental Health Division (2016) *Delivering Specialist Mental Health Services 2014-2015*. Dublin: Health Service Executive.

Joiner, T.E. Jr. (1999) 'The Clustering and Contagion of Suicide', *Current Directions in Psychological Science,* Vol. 8, No. 3, pp. 89–92.

Kendall, P.C. and Kessler, R.C. (2002) 'The impact of childhood psychopathology interventions on subsequent substance abuse: Policy implications, comments, and recommendations', *Journal of Consulting and Clinical Psychology,* Vol. 70, No. 6, pp. 1303–1306.

Kiberd, R. (2016, 15 August) 'Why do "anonymous ask" apps keep coming back?', *New Statesman*. Available at: http://www.newstatesman.com/science-tech/internet/2016/08/why-do-anonymous-ask-apps-keep-coming-back

Kieling, C., Baker-Henningham, H., Belfer, M., Conti, G., Ertem, I., Omigbodun, O., Rohde, L.A., Srinath, S., Ulkuer, N. and Rahman, A. (2011) 'Series: Child and adolescent mental health worldwide: evidence for action', *The Lancet*, Vol. 378, No. 9801, pp. 1515–1525.

Kim, Y.S., Leventhal, B.L., Koh, Y.J., Hubbard, A. and Boyce, W.T. (2006) 'School Bullying and Youth

Violence: Causes or Consequences of Psychopathologic Behavior?', *Archives of General Psychiatry*, Vol. 63, No. 9, pp. 1035–1041.

Kumpulainen, K., Räsänen, E. and Henttonen, I. (1999) 'Children involved in bullying: psychological disturbance and the persistence of the involvement', *Child Abuse and Neglect,* Vol. 23, No. 12, pp. 1253–1262.

Lacey, V. (2013, July) *Transgender Equality Network Ireland Presentation.* Presented at the meeting of the Oireachtas Committee on Health and Children. Available at: https://www.oireachtas.ie/parliament/media/committees/healthandchildren/TENI-Presentation---Heath-and-Children.pdf

Ladd, G.W. (1999) 'Peer relationships and social competence during early and middle childhood', *Annual Review of Psychology,* Vol. 50, pp. 333–359.

Lalor, K., Bowden, M., Griffin, K., McElvaney, R., Quinn, B. and Kelleher, C. (2012) *Take Charge of Change: Being Young and Irish, Full Report.* Dublin: Áras an Uachtaráin.

Living Works Education (2012) *eSuicideTALK: Be a part of suicide awareness in your community*. Available at: https://www.esuicidetalk.net/queries

Ludi, E., Ballard, E.D., Greenbaum, R., Pao, M., Bridge, J., Reynolds, W. and Horowitz, L. (2012) 'Suicide Risk in Youth with Intellectual Disability: The Challenges of Screening', *Journal of Developmental and Behavioral Pediatrics: JDBP*, Vol. 33, No. 5, pp. 431–440.

Lynch, F., Mills, C., Daly, I. and Fitzpatrick, C. (2006) 'Challenging times: Prevalence of psychiatric disorders and suicidal behaviours in Irish adolescents', *Journal of Adolescence*, Vol. 29, No. 4, pp. 555–573.

Macdonald, G., Livingstone, N., Davidson, G., Sloan, S., Fargas, M. and McSherry, D. (2011) *Improving the Mental Health of Northern Ireland's Children and Young People: Priorities for research.* Belfast:
Institute of Child Care Research, Queen's University. Available at:
http://www.publichealth.hscni.net/sites/default/files/ChildrenandYoungPeople.pdf

Mak, W.W.S., Poon, C.Y.M., Pun, L.Y.K. and Cheung, S.F. (2007) 'Meta-analysis of stigma and mental health', *Social Science and Medicine,* Vol. 65, No. 2, pp. 245–261.

Martin, S., Horgan, D. and Scanlon, M. (2016) *Healthy Lifestyles: A Consultation with Children and Young People*. Dublin: Government Publications.

Martorell, A., Tsakanikos, E., Pereda, A., Gutiérrez-Recacha, P., Bouras, N. and Ayuso-Mateos, J.L. (2009) 'Mental Health in Adults With Mild and Moderate Intellectual Disabilities: The Role of Recent Life Events and Traumatic Experiences Across the Life Span', *Journal of Nervous and Mental Disease,* Vol. 197, No. 3, pp. 182–186.

Mayock, P., Bryan, A., Carr, N. and Kitching, K. (2008) *Supporting LGBT lives: A study of the mental health and well-being of lesbian, gay, bisexual and transgender people*. Dublin: Gay and

Lesbian Equality Network (GLEN) and BeLonG To Youth Service.

McAlister, S., Gray, A. and Neill, G. (2007) *Still Waiting: The stories behind the statistics of young women growing up in Northern Ireland*. Belfast: Youth Action Northern Ireland.

McDougall, P., Hymel, S., Vaillancourt, T. and Mercer, L. (2001) 'The consequences of childhood peer rejection'. In M.R. Leary (ed.), *Interpersonal Rejection*. Oxford: Oxford University Press (pp. 213– 247).

McEvoy, O. (2009) *Teenage Mental Health: What helps and what hurts? Report on the outcome of consultations with teenagers on mental health*. Dublin: The Stationary Office.

McMahon, E. M., Keeley, H., Cannon, M., Arensman, E., Perry, I. J., Clarke, M., Chambers, P. and Corcoran, P. (2014). The iceberg of suicide and self-harm in Irish adolescents: a population-based study. *Social psychiatry and psychiatric epidemiology*, *49*(12), 1929-1935.

McMahon, E.M., O'Regan, G., Corcoran, P., Arensman, E., Cannon, M., Williamson, E. and Keeley, H. (2017) *Young Lives in Ireland: A school-based study of mental health and suicide prevention.* Cork: National Suicide Research Foundation.

Mellor, D. (2005) 'Normative data for the strengths and difficulties questionnaire in Australia', *Australian Psychologist*, Vol. 40, No. 3, pp. 215–222.

Mental Health Foundation (2016) *Mental Health in Northern Ireland: Fundamental Facts 2016.* UK: Mental Health Foundation.

Meyer, I.H. (2003) 'Prejudice, Social Stress, and Mental Health in Lesbian, Gay, and Bisexual Populations: Conceptual Issues and Research Evidence', *Psychological Bulletin,* Vol. 129, No. 5, pp. 674–697.

Minton, S. (2013, May). *Homophobia and heterosexism in schools in Ireland.* Presented at the New Foundations: School 'Ethos' and LGBT Sexualities conference of the University of Limerick, Limerick.

Morgan, M., Rochford, S. and Sheehan, A. (2016) *Adversity in Childhood – Outcomes, Risk and Resilience.* Dublin: Centre for Effective Services. Available at: http://www.effectiveservices.org/downloads/Final_Adversity_Lit_Review_September_2016.pdf

Nansel, T.R., Overpeck, M., Pilla, R.S., Ruan, W.J., Simons-Morton, B. and Scheidt, P. (2001) 'Bullying Behaviors Among US Youth: Prevalence and Association With Psychosocial Adjustment', *Journal of the American Medical Association,* Vol. 285, No. 16, pp. 2094–2100.

The National Academies (2010) *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities*. Report brief: A focus on costs and benfits March 2009. Available at: http://www.nationalacademies.org/hmd/~/media/Files/Report%20Files/2009/Preventing-Mental-Emotional-and-Behavioral-Disorders-Among-Young-People/Prevention%20Costs-Benefits.pdf

National Council for Curriculum and Assessment (2009) *Aistear: Principles and Themes.* Dublin: NCCA.

National Suicide Research Foundation (2016a) *Suicide*. Available at: http://www.nsrf.ie/statistics/suicide/

National Suicide Research Foundation (2016b) *National Self-Harm Registry Ireland: Report for January-June 2016*. Available at: http://www.nsrf.ie/wp-content/uploads/Interim%20Report%20Jan_June%202016%20NSHRI.pdf

Newcomb, A.F., Bukowski, W.M. and Pattee, L. (1993) 'Children's peer relations: A meta-analytic review of popular, rejected, neglected, controversial, and average sociometric status', *Psychological Bulletin*, Vol. 113, No. 1, pp. 99–128.

Nixon, E. (2012) *Growing Up in Ireland: National Longitudinal Study of Children: How families matter for social and emotional outcomes of 9-year-old children.* Report 4. Dublin: Department of Children and Youth Affairs.

Nolan, B., Layte, R., Whelan, C.T. and Maître, B. (2006) *Day In, Day Out: Understanding the Dynamics of Child Poverty*. Dublin: Institute of Public Administration and Combat Poverty Agency.

Northern Ireland Statistics and Research Agency (2014) *Northern Ireland Census 2011: Key Statistics Summary Report.* Available at: https://www.nisra.gov.uk/sites/nisra.gov.uk/files/publications/2011-census-results-key-statistics-summary-report.pdf

Northern Ireland Statistics and Research Agency (2016) *Suicide statistics*. Available at: https://www.nisra.gov.uk/publications/suicide-statistics

O'Connor, R., Rasmussen, S. and Hawton, K. (2010) *Northern Ireland lifestyle and coping survey*.

O'Doherty, J. (2016) *OUTstanding in your field: exploring the needs of LGB&T people in rural Northern Ireland*. Belfast: The Rainbow Project.

O'Farrell, I.B., Corcoran, P. and Perry, I.J. (2014) 'Characteristics of small areas with high rates of hospital-treated self-harm: deprived, fragmented and urban or just close to hospital? A national registry study', *Journal of Epidemiology and Community Health,* Vol. 69, No. 2, pp. 162–167.

O'Farrell, I.B., Corcoran, P. and Perry, I.J. (2016) 'The area level association between suicide, deprivation, social fragmentation and population density in the Republic of Ireland: a national study', *Social Psychiatry and Psychiatric Epidemiology*, Vol. 51, No. 6, pp. 839–847.

O'Neill, B. and Dinh, T. (2015) *Net Children Go Mobile: Full Findings from Ireland.* Dublin: Dublin Institute of Technology.

Oyserman, D., Mowbray, C.T., Meares, P.A. and Firminger, K.B. (2000) 'Parenting among mothers with a serious mental illness', *American Journal of Orthopsychiatry*, Vol. 70, No. 3, pp. 296–315.

Panayiotou, M. and Humphrey, N. (2017) 'Mental health difficulties and academic attainment: Evidence for gender-specific developmental cascades in middle childhood', *Development and Psychopathology,* pp. 1–16.

Parke, R.D. and Buriel, R. (2006) 'Socialization in the family: Ethnic and ecological perspectives'. In: W. Damon, R.M. Lerner and N. Eisenberg (eds.), *The Handbook of Child Psychology, Volume 3: Social, Emotional, and Personality Development* (6th edition). New York: Wiley (pp. 429–504).

Penn, D.L., Guynan, K., Daily, T., Spaulding, W.D., Garbin, C.P. and Sullivan, M. (1994) 'Dispelling the stigma of schizophrenia: What sort of information is best?', *Schizophrenia Bulletin*, Vol. 20, No. 3, pp. 567–578.

Perry, C. (2016) *Addressing Bullying in Schools Bill: Views of Young People.* Belfast: Northern Ireland Assembly. Available at: http://www.niassembly.gov.uk/globalassets/documents/raise/publications/2016/education/1416.pdf

Pettit, G.S., Laird, R.D., Dodge, K.A., Bates, J.E. and Criss, M.M. (2001) 'Antecedents and Behavior-Problem Outcomes of Parental Monitoring and Psychological Control in Early Adolescence', *Child Development*, Vol. 72, No. 2, pp. 583–598.

Pinfold, V., Toulmin, H., Thornicroft, G., Huxley, P., Farmer, P. and Graham, T. (2003) 'Reducing psychiatric stigma and discrimination: evaluation of educational interventions in UK secondary schools', *British Journal of Psychiatry*, Vol. 182, pp. 342–346.

Pleis, J.R., Ward, B.W. and Lucas, J.W. (2010) *Summary Health Statistics for U.S. Adults: National Health Interview Survey, 2009* (Vital and Health Statistics Series 10, Number 249). Hyattsville, MD: U.S. Department of Health and Human Services.

Poteat, V.P. (2015) 'Individual Psychological Factors and Complex Interpersonal Conditions that Predict LGBT-Affirming Behavior', *Journal of Youth and Adolescence,* Vol. 44, No. 8, pp. 1494–1507.

Public Health Agency (2015) *Northern Ireland Registry of Self-Harm: Annual Report 2013/14*. Available at: http://www.thehealthwell.info/node/933856

Public Health Agency (2016) *Northern Ireland Registry of Self-Harm: Three-Year Report 2012/13 to 2014/15*. Available at: http://www.nsrf.ie/wp-content/uploads/reports/NIRSH%203%20year%20report%2014.11.06.pdf

Public Health England (2015) *Identifying and responding to suicide clusters and contagion: A practice resource.* London: Public Health England. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/459303/Identifying_and_responding_to_suicide_clusters_and_contagion.pdf

Raley, R.K. and Wildsmith, E. (2004) 'Cohabitation and Children's Family Instability', *Journal of Marriage and Family*, Vol. 66, No. 1, pp. 210–219.

Richardson, N., Clarke, N. and Fowler, C. (2013) *A Report on the All-Ireland Young Men and Suicide Project*. Dublin: Men's Health Forum in Ireland.

Robertson, L., Skegg, K., Poore, M., Williams, S. and Taylor, B. (2012) 'An Adolescent Suicide

Cluster and the Possible Role of Electronic Communication Technology', *Crisis: The Journal of Crisis Intervention and Suicide Prevention,* Vol. 33, No. 4, pp. 239–245.

Rodkin, P.C., Farmer, T.W., Pearl, R. and Van Acker, R. (2006) 'They're Cool: Social Status and Peer Group Supports for Aggressive Boys and Girls', *Social Development*, Vol. 15, No. 2, pp. 175–204.

Rosenfield, S. and Mouzon, D. (2013) 'Gender and Mental Health'. In: C.S. Aneshensel, J.C. Phelan and A. Bierman (eds.), *Handbook of the Sociology of Mental Health*. New York: Springer (pp. 277–296).

Rothenberger, A., Becker, A., Erhart, M., Wille, N., Ravens-Sieberer, U. and the BELLA study group (2008) 'Psychometric properties of the parent strengths and difficulties questionnaire in the general population of German children and adolescents: results of the BELLA study', *European Child and Adolescent Psychiatry,* Suppl. 1, pp. 99–105.

Royal College of Psychiatrists (2017) *Attention-deficit hyperactivity disorder and hyperkinetic disorder: information for parents, carers and anyone working with young people* (Mental Health and Growing Up Factsheet). Available at: http://www.rcpsych.ac.uk/healthadvice/parentsandyouthinfo/parentscarers/adhdhyperkineticdisorder.aspx

Rueger, S.Y., Malecki, C.K., Pyun, Y., Aycock, C. and Coyle, S. (2016) 'A meta-analytic review of the association between perceived social support and depression in childhood and adolescence', *Psychological Bulletin,* Vol. 142, No. 10, pp. 1017–1067.

Russell, S.T. and Fish, J.N. (2016) 'Mental Health in Lesbian, Gay, Bisexual, and Transgender (LGBT) Youth', *Annual Review of Clinical Psychology*, Vol. 12, pp. 465–487.

Rutter, M. and Quinton, D. (1984) 'Long-term follow-up of women institutionalized in childhood: Factors promoting good functioning in adult life', *British Journal of Developmental Psychology,* Vol. 2, No. 3, pp. 191–204.

Samaritans (2017) *Dying from inequality: Socioeconomic disadvantage and suicidal behaviour – Summary report 2017.* Surrey, UK: Samaritans.

Sandler, I., Wolchik, S.A., Cruden, G., Mahrer, N.E., Ahn, S., Brincks, A. and Brown, C.H. (2014) 'Overview of Meta-Analyses of the Prevention of Mental Health, Substance Use, and Conduct Problems', *Annual Review of Clinical Psychology,* Vol. 10, pp. 243–273.

Scarlett, M. and Denvir, J. (2016) *Health Survery (NI): First Results 2015/16.* Belfast: Public Health Information and Research Branch, Information Analysis Directorate, Department of Health.

Scholte, R.H.J., Engels, R.C.M.E., Overbeek, G., de Kemp, R.A.T. and Haselager, G.J.T. (2007) 'Stability in Bullying and Victimization and its Association with Social Adjustment in Childhood and Adolescence', *Journal of Abnormal Child Psychology*, Vol. 35, No. 2, pp. 217–228.

Scott, A. and Guo, B. (2012) *For which strategies of suicide prevention is there evidence of effectiveness?* (HEN synthesis report: July 2012). Copenhagen: WHO Regional Office for Europe.

Scott, A., Shaw, M. and Joughin, C. (2001) *Finding the Evidence: A Gateway to the Literature in Child and Adolescent Mental Health* (2nd edition). London: Gaskell.

Scott, S., Doolan, M., Beckett, C., Harry, S., Cartwright, S. and the HCA team (2012) *How is parenting style related to child antisocial behaviour? Preliminary findings from the Helping Children Achieve Study*. Darlington: Department for Education.

Sirocco, K.Y., Lynne-Landsman, S.D. and Boyce, C.A. (2012) 'Developmental Cognitive Neuroscience to Inform Cognitive-Control Interventions for Drug Abuse: Introduction to the Special Section', *Child Development Perspectives*, Vol. 6, No. 4, pp. 351–353.

Smith, P.K., Mahdavi, J., Carvalho, M., Fisher, S., Russell, S. and Tippett, N. (2008) 'Cyberbullying: its nature and impact in secondary school pupils. *Journal of Child Psychology and Psychiatry,* Vol. 49, No. 4, pp. 376–385.

Smyth, E. (2015) *Learning in Focus: Wellbeing and School Experiences among 9- and 13-Year-Olds: Insights from the Growing Up in Ireland Study*. Dublin: The Economic and Social Research Institute.

Sourander, A., Ronning, J., Brunstein-Klomek, A., Gyllenberg, D., Kumpulainen, K., Niemelä, S., Helenius, H., Sillanmäki, L., Ristkari, T., Tamminen, T., Moilanen, I., Piha, J. and Almqvist, F. (2009) 'Childhood Bullying Behavior and Later Psychiatric Hospital and Psychopharmacologic Treatment: Findings From the Finnish 1981 Birth Cohort Study', *Archives of General Psychiatry*, Vol. 66, No. 9, pp. 1005–1012.

Toomey, R., Ryan, C., Diaz, R.M. and Russell, S.T. (2011) 'High School Gay–Straight Alliances (GSAs) and Young Adult Well-Being: An Examination of GSA Presence, Participation, and Perceived Effectiveness', *Applied Developmental Science*, Vol. 15, No. 4, pp. 175–185.

Transgender NI (2015) *TransgenderNI*. Available at: https://transgenderni.com/

Ttofi, M.M., Farrington, D.P., Lösel, F. and Loeber, R. (2011) 'The predictive efficiency of school bullying versus later offending: a systematic/meta-analytic review of longitudinal studies', *Criminal Behaviour and Mental Health*, Vol. 21, No. 2, pp. 80–89.

UNICEF (2017) *Building the Future: Children and the Sustainable Development Goals in Rich Countries*
(Innocenti Report Card no. 14). Innocenti, Florence: UNICEF.

University College Dublin (2010) *All Ireland Traveller Health Study: Summary of Findings*. Available at: https://www.ucd.ie/t4cms/AITHS_SUMMARY.pdf

Wahl, O.F. (1999) 'Mental health consumers' experience of stigma', *Schizophrenia Bulletin,* Vol. 25, No. 3, pp. 467–478.

Walker, M.R. (2008) *Suicide Among the Irish Traveller Community: 2000–2006.* Wicklow: Wicklow County Council.

Watson, D., Maître, B., Whelan, C.T. and Williams, J. (2014) *Growing Up in Ireland: National*

Longitudinal Study of Children – Dynamics of child economic vulnerability and socio-emotional development: An Analysis of the First Two Waves of the Growing Up in Ireland study. Dublin: Department of Children and Youth Affairs.

Weiss, L.H. and Schwarz, J.C. (1996) 'The Relationship between Parenting Types and Older Adolescents' Personality, Academic Achievement, Adjustment, and Substance Use', *Child Development,* Vol. 67, No. 5, pp. 2101–2114.

Weissman, M.M., Wickramaratne, P., Nomura, Y., Warner, V., Pilowsky, D. and Verdeli, H. (2006) 'Offspring of Depressed Parents: 20 Years Later', *American Journal of Psychiatry*, Vol. 163, No. 6, pp. 1001–1008.

Williams, J., Murray, A. and Whelan, C.T. (2014) 'Multi-Dimensional Deprivation Among 9-Year-Olds in Ireland: An Analysis of the Growing Up in Ireland Survey', *Child Indicators Research*, Vol. 7, No. 2, pp. 279–300.

Woolfolk, A. and Perry, N.E. (2011) *Child and Adolescent Development.* New York: Pearson.

World Health Organization (2003) *Mental Health Action 2013-2020.* Geneva: World Health Organization.World Health Organization (2004) *Promoting Mental Health: Concepts, Emerging Evidence, Practice: Summary Report/A Report from the World Health Organization, Department of Mental Health and Substance Abuse in collaboration with the Victorian Health Promotion Foundation (VicHealth) and the University of Melbourne.* Geneva: World Health Organization

World Health Organization (2016) *World Health Statistics 2016: Monitoring Health for the SDGs, Sustainable Development Goals.* Geneva: World Health Organization.

World Health Organization (2017) *Suicide* (Fact sheet). Available at: http://www.who.int/mediacentre/factsheets/fs398/en/

YouGov (2015) *Results for Vodafone Cyberbullying.* Available at: http://www.vodafone.com/content/index/media/vodafone-group-releases/2015/groudbreaking_global_survey.html#