



National Children's
Bureau

Gender and children and young people's emotional and mental health: manifestations and responses

A rapid review of the evidence

Emily Hamblin, July 2016

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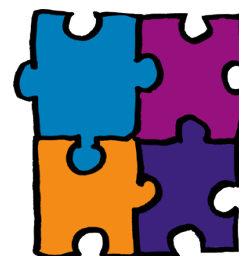
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Glossary of terms and abbreviations

ADHD – attention deficit hyperactivity disorder.

Assigned male/female at birth – assigned male/female sex based on biological characteristics.

BAME – Black, Asian and minority ethnic.

CAMHS – Child and Adolescent Mental Health Services.

Cisgender – a person whose gender identity is congruent with the gender they were assigned at birth is described as cisgender.

Conduct disorders – mental health conditions characterised by repetitive and persistent patterns of antisocial, aggressive or defiant behaviour that amounts to significant and persistent violations of age-appropriate social expectations.

Gender – refers to the roles, behaviours, activities, and attributes that a given society considers appropriate for males and females.

Gender-blindness – 'the failure to recognise that the roles and responsibilities of men/boys and women/girls are given to them in specific social, cultural, economic and political contexts and backgrounds. Projects, programmes, policies and attitudes which are gender-blind do not take into account these different roles and diverse needs, maintain the status quo and will not help transform the unequal structure of gender relations' (UN Statistics Division, 2013).

GD – gender dysphoria, a medically recognised condition in which the mismatch between the biological sex of a person and their gender identity causes significant distress.

Gender identity – a person's internal sense of their own gender.

LGBT – lesbian, gay, bisexual and trans.

Non-binary – an umbrella term for a person who does not identify as a binary gender, be that male or female. Non-binary children and young people are included in the definition of 'trans' used.

PTSD – post-traumatic stress disorder.

Trans – an umbrella term for various people who experience a mismatch between their gender identity and the sex that they were assigned at birth. It includes transgender and transsexual people and cross-dressers, as well as anyone else who is in any way gender variant. This evidence review uses related terms such as transgender and trans* to reflect terminology used in research. Both trans individuals and research will use slightly different meanings for terms, and the literature often includes explanations of terminology used.

Introduction

Children and young people's mental health is one of the most challenging health issues of our times. It is estimated that half of all mental health problems emerge before the age of 14, with three quarters having appeared by the age of 24 (Kessler and others 2005). The serious consequences of emotional and behavioural problems for children and young people's life outcomes in many domains, and even their life expectancy, are well-documented (Goodman and others 2011; Richards and others 2009). The use of effective, evidence-based interventions with children, young people and families can help to avert such consequences and save public money (Khan 2016).

In 2014, the Department of Health and NHS England established a taskforce to examine how to improve child and adolescent mental health and well-being, as part of a government commitment to achieve better access to mental health care for people of all ages by 2020 (DH 2014). The taskforce published its report, *Future in Mind* (DH and NHSE 2015), making clear proposals for whole-system change. Major transformation programmes for both child and adult mental health services are now underway (NHS England 2016a).

This rapid review presents evidence of clear gender differences in children and young people's emotional and mental health, in terms of:

1. the general picture of children and young people's emotional and mental health
2. the prevalence of specific difficulties and issues among children and young people
3. children and young people's coping strategies and help-seeking behaviours
4. responses to children and young people's emotional and mental health needs from parents and carers, schools, and public services
5. service responses to the needs of some particular groups of children and young people.

'Gender determines the differential power and control men and women have over the socioeconomic determinants of their mental health and lives, their social position, status and treatment in society and their susceptibility and exposure to specific mental health risks.'

World Health Organization

This document aims to provide a snapshot of the most recent and salient evidence from published research and grey literature, as relevant to children and young people living in England in 2016. It addresses children and young people's emotional and mental health difficulties as they manifest and are responded to, highlighting and exploring gender-related issues behind observed patterns across areas of mental health.

This is not a systematic review, and is not exhaustive. It is part of a small-scale project that aims to inform gender-responsive approaches to children and young people's mental health. Other outputs include by bringing evidence together with findings from engagement with young people and practice examples from services¹.

It is important to acknowledge that many of the issues covered in this review are contested and inextricably linked to the broader context in which differences in mental health arise. Social inequalities relating to gender, socioeconomic status, ethnicity, disability, sexual orientation and other factors intersect to impact on individuals throughout the life course in ways that affect their mental health: for example, socio-economically disadvantaged children and young people are up to three times more likely to have a mental health problem than their better-off peers (Reiss 2013).

¹ All related publications are available at <https://www.ncb.org.uk/genderandmentalhealth>

Gender differences are observable in relation to many of these social inequalities, as well as to various biological, developmental and sociocultural factors relevant to emotional and mental health (WHO 2011). Interrelationships between such factors, health behaviours, and mental and physical health outcomes are complex. There is also significant diversity in young people's needs and experiences, and how effectively these are understood and addressed, according to a wide range of characteristics, experiences or circumstances.

Detailed exploration of all the above dimensions and how they relate to gender is beyond the scope of this project. The sociology of mental health is a substantial area of scholarship and debate, in which gender features prominently (e.g. Rogers and Pilgrim 2014). The source materials cited here provide a great deal of further information, as well as other evidence reviews: for example, exploring causes, consequences, risk and protective factors, trends over time, effectiveness of interventions, policy and investment (e.g. Khan 2016; Hagell and others 2015; FPH and MHF 2016).

Source material for this evidence review was identified via NCB's existing networks and activity; Health and Care Strategic Partnership contacts; secondary sources (e.g. Khan 2016), and online searches. Search engines and databases used included the NCB Library Catalogue, Social Care Online, Google, and LGBT Foundation's Evidence Exchange.

A note on evidence relating to trans and non-binary children and young people

This review includes evidence relating to trans and non-binary children and young people throughout. Trans and non-binary children and young people are a diverse population, and they may not be clearly visible in research that includes them, either because they self-identify as male or female, or, for those who do not, because of a lack of non-binary gender options in data collection and/or reporting. There is variation within this group, in terms of emotional and mental health needs and difficulties, according to personal experiences and identities, as well as the gender the individuals were assigned at birth (e.g. Skagerberg and others 2013a), along with significant diversity in the specific terms trans young people use to self-identify, if they use any at all (METRO 2013¹).

Some evidence relates only to children and young children presenting to services with gender dysphoria (see page 13). Not all trans or non-binary children and young people will experience gender dysphoria, and not all those who do will have access to, or engage with, specialist services.

The use of data on trans and non-binary people from surveys of LGBT people is restricted, where possible, to sources in which responses from trans and non-binary individuals are clearly distinguishable.

Summary of key points

The following points are general patterns supported by evidence. Connections between gender and mental health manifest differently for each child and young person, in combination with a wide range of individual, social and structural factors, and in ways that change over the course of childhood and shift over time.

The general picture of children and young people's emotional and mental health

- Girls report lower subjective well-being than boys, with the gap appearing to widen throughout adolescence. They express lower satisfaction with themselves.
- Girls and young women are particularly concerned about mental health issues.
- A higher proportion of girls than boys reach the expected level of personal, social and emotional development in early childhood.
- Mental health problems are more frequently identified in school-age boys than girls, and boys are more likely to be identified as having multiple different difficulties.
- The gender gap in the prevalence of diagnosable mental health conditions begins to narrow in adolescence, as emotional problems become more common in girls. By early adulthood, women are more likely to be diagnosed with a mental health condition than men.
- Very high levels of mental health need are evident in trans and non-binary young people.
- In general, 'internalising' problems (in which distress is directed inwards) are more common among girls and young women than boys and young men, who are more likely to exhibit 'externalising' problems (that manifest through 'acting out').

The prevalence of specific difficulties and issues in children and young people

- Girls and young women are more likely than boys and young men to have depressive disorders and anxiety disorders.
- Conduct disorders are the most common mental health problems identified in children and young people, and are significantly more prevalent in boys than girls.
- High levels of self-harm are evident among girls and young women in particular; however, males aged 15–24 are more likely to die by suicide than females.
- Gender-based violence severely impacts on the mental health of girls and women at individual and population levels.
- Trans young people are disproportionately affected by depression, anxiety, self-harm and suicidality; their mental health is significantly undermined by transphobic victimisation.
- The majority of young people with eating disorders are female; there is also evidence that eating disorders are a particular concern for trans young people.
- Patterns of drug and alcohol use by young people indicate higher levels of dependence among males than females.
- Boys and young men are much more likely to be diagnosed with ADHD and autism than girls and young women.

Children and young people's coping strategies and help-seeking behaviours

Coping strategies

- Complex gender differences in children and young people's regulation of their emotions have been observed.
- Girls and young women use more emotion-focused strategies than boys and young men, such as ruminating and talking about their feelings. However, rumination in particular (including in conversation with others) has been found to contribute to symptoms of depression and anxiety.
- Adolescent girls perceive higher amounts of interpersonal stress than boys. They are also more likely to report and seek help for unexplained physical symptoms that may be related to psychological distress.
- Gender plays a role in how adverse experiences impact on children and young people.

Help-seeking

- Gender differences in help-seeking behaviours have been noticed in children from a young age.
- In general, girls and young women seek help for emotional and mental health problems more readily than boys and young men; this is facilitated by awareness and understanding about mental health, and emotional competence.
- Concealing information relevant to emotional and mental well-being has negative impacts for young people, and gender is relevant to what young people may keep secret, e.g. risk-taking or gender identity. Children and young people with experience of victimisation face particular barriers to help-seeking, which impact upon them in gendered ways.
- Stigma relating to mental health issues affects young people in general, but young males are among the groups most susceptible to stigma. This has been linked to gender roles.
- Young people consistently prefer to seek help from friends, family and other informal sources than from professionals. In adolescence, girls begin to seek help from friends and services more, whilst boys remain more dependent on family. Trans young people value support from friends highly.
- Gender differences have been observed in what young people seek support for and their preferred sources of support.

Responses to children and young people's emotional and mental health needs

- In general, parents, carers and professionals including teachers are better able to recognise behavioural problems in boys and emotional problems in girls. Emotional problems are more likely to go unidentified, whilst there is evidence that mental health needs underpinning behavioural problems in children and young people are under-recognised. Where children and young people's difficulties do not conform to gender expectations, they may be overlooked, misunderstood, met with harsh responses or not effectively addressed.

Responses from parents and carers

- Parental influences play a significant role in children's emotional and mental health and in facilitating access to professional help.
- Parental-child communication about, and responses to, emotions can be gendered from early in life.
- For trans young people, parental support to live openly as their self-identified gender is associated with better mental health.

Responses from schools

- Education professionals are well-placed to respond to children and young people's mental health needs, but are often not sufficiently equipped to do this in gender-responsive ways.
- Conduct disorders, which disproportionately affect boys, are strongly associated with school exclusion.

Responses from health and other services

- A wide range of public services plays important roles in children and young people's emotional and mental health, and can contribute to gender-responsive approaches.
- There are ongoing debates regarding gender bias in the diagnosis and treatment of mental health conditions in children and adults.
- Young people value similar qualities in mental health provision, regardless of gender, whilst there are some gender differences in how services can best engage individuals.
- Girls and young women appear more likely to access mental health services overall, but young men are over-represented in acute services.
- There are high levels of unrecognised and unmet emotional and mental health needs among young people at risk of offending or in contact with the youth justice system. Young males are massively over-represented, whilst young females are particularly vulnerable, within this system.
- There is evidence of gender bias in professionals' recognition of, and responses to, children and young people's experiences of violence and abuse, as well as a lack of gender-responsive support.
- Ethnicity has a bearing on responses to children and young people's well-being and mental health in complex, gendered ways.
- Improvements are needed in how mental health services support trans and non-binary young people; experiences of gender identity services can also affect the emotional and mental health of this group.

Conclusion

Gender plays out in many ways important to children and young people's emotional and mental health and well-being. Gender-blind approaches to protecting and promoting children and young people's emotional and mental well-being miss important aspects of their needs and experiences; therefore, gender-informed policy-making, commissioning and service provision are required. Forthcoming developments in data collection and an evolving evidence base on the effectiveness of specific interventions can be drawn upon to achieve this.

1. Gender differences in children and young people's emotional and mental health: a general picture

Children and young people's concerns and subjective well-being

Many children and young people are thriving (Children's Society 2015; Brooks and others 2015). However, as many others have mild to moderate difficulties that do not reach clinical thresholds, attention should be paid to subjective well-being in addition to diagnosed or diagnosable mental health conditions.

The Children's Society's annual Good Childhood Report presents research into the subjective well-being of children aged 10–17 in England, based on individuals' self-reported life satisfaction and experience of positive and negative emotions at a particular point in time. It is part of a research programme initiated in 2005. One consistent finding from the decade-long programme is a substantial gender gap in satisfaction with self – with girls, for example, having much lower satisfaction with their appearance (Children's Society 2015). The latest report identifies the most notable gender differences in 2013–2015 relating to four items in The Good Childhood Index: appearance, time use, friends and health. In all four cases, males were more satisfied than females.

The 2014 Health Behaviour in School-aged Children (HBSC) survey in England (Brooks and others 2015) found similar disparities, with 79% of boys and 69% of girls aged 11–15 rating their life satisfaction as high. The proportions of young people rating their life satisfaction as high decreased across the age groups for both boys and girls; it was lower for girls in all instances and this gendered difference becomes more pronounced with age. The researchers noted a significant decrease in the proportions of older girls who report high life satisfaction since 2002. Reported feelings of loneliness increased with age among both boys and girls, but the change was more pronounced among girls. Girls were also more likely than boys to report feeling pressured by school work.

These findings raise concerns about girls' well-being, but also questions about boys, in light of the high rate of suicide among young men (see page 15) and evidence of gender differences in social connectedness and communication (see page 24).

A 2015 survey of girls and young women aged 11 to 21 found that they rated self-harm, smoking and mental illness as the top issues affecting young people (Girlguiding 2015). The data suggests a shift in concern since the 2010 survey away from more 'traditional' risks facing young people, such as drug and alcohol use. Girls aged 7 to 10 were also surveyed, using different questions. In this age group, one in ten reported feeling sad or down most days or every day (Girlguiding 2015).

The METRO (2013) survey found that trans young people report lower overall satisfaction with their lives than others: 36% of trans respondents agreed with the statement 'In most ways my life is close to my ideal', compared to 47% of LGBTQ respondents (of whom a large majority are cisgender) and 51% of heterosexual cisgender respondents.

Internalising and externalising behaviours

Children's emotional and behaviours problems are often characterised in terms of 'internalising' and 'externalising' behaviours (Achenbach 1978):

- Externalising behaviours manifest outwardly, through problems with attention, self-regulation, and noncompliance, as well as antisocial, aggressive, and other under-controlled behaviours
- Internalising behaviours are directed inwardly, through depression, withdrawal, and anxiety, as well as feelings of inferiority, self-consciousness, shyness, hypersensitivity, and somatic complaints (Bornstein and others 2012).

These concepts are also used to describe behaviours and problems in adults (APA 2013). In general, males are more likely than females to present with 'externalising' behaviours and

problems, whereas the opposite is true for 'internalising' behaviours and problems (Morrison Gutman and others 2015; McManus and others 2009). Possible reasons for, and implications of, these gender differences are addressed in Section 3.

The broad gender differences are reflected in the prevalence of clinically-defined mental health conditions, many of which are described as internalising (e.g. depressive and anxiety disorders) or externalising (e.g. conduct disorders). However, these two categories are not without ambiguities, overlap and exceptions. Also, many children and young people show signs of both internalising and externalising behaviours and disorders (Eisenberg and others 2009; Green and others 2005).

These general differences apply to behaviours within the general population, not only among individuals who meet clinical thresholds. For example, boys and young men are more likely to commit acts of physical violence (ONS 2016a; Brooks and others 2015), whilst girls and young women are more likely to report low self-esteem (see page 9) and physical complaints (see page 25).

Some exceptions to these broad patterns will be explored in this review.

Overall prevalence of emotional and mental health difficulties

Recent population data on children and young people's mental health is lacking, with the most recent government survey conducted in 2004 (Green and others 2005). A new UK prevalence survey – with a wider age range than the previous one – has been commissioned and is due to report back in 2018. The presentation of findings from the previous survey included detailed information on gender differences, so this may also be expected from the next one.

Prevalence data naturally reflects how difficulties are identified and conditions diagnosed, which is often not straightforward (see page 30). It is also important to note that many children will have multiple different difficulties: this is more common in boys than girls (Morrison Gutman and others 2015; Green and others 2015).

Young children

The most reliable information on the prevalence of difficulties in young children currently comes from early years foundation stage (EYFS) profile results and from Egger & Angold (2006) (Khan 2016). EYFS profile results for England show that 89% of girls and 78% of boys reached the expected level in personal, social and emotional development in 2015. In terms of communication and language, 86% of girls and 75% of boys reached the expected level (DfE 2015).

Egger & Angold (2006) found no significant gender effects on the prevalence of conduct disorders, attention deficit hyperactivity disorder (ADHD), anxiety disorders or depression in a large non-clinical sample of US preschool children, although they did suggest that boys were more than twice as likely as girls to meet full diagnostic criteria for ADHD.

School-age children

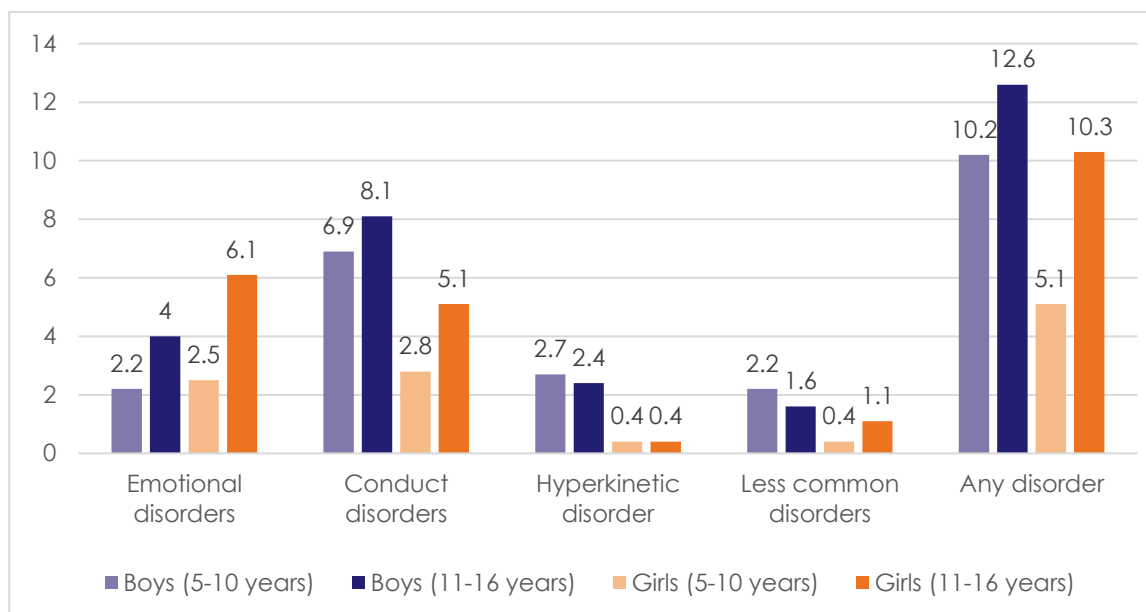
Morrison Gutman and others (2015) analysed findings from 12,798 children for the UK Millennium Cohort Study, for which parents reported on their children's mental health. Parents identified severe mental health problems (indicative of a clinically diagnosable disorder) in 13% of 11-year-old boys and 8% of girls in 2012; 8% of boys and 6% of girls had moderate problems.

Data from a longitudinal sample (Morrison Gutman and others 2015) show that 26% of 11-year-old boys were assessed as having had severe mental health problems at least once in their lifetimes (based on surveys undertaken at age 3, 5, 7 or 11), compared with 18% of girls. Twice as many boys as girls were assessed with severe problems at three different ages, and over three times as many had severe problems at all four ages.

The latest data on the estimated prevalence of diagnosable disorders in children and young

people is presented in Figure 1².

Figure 1: Percentage of children with mental disorders, by age and sex, 2004



Source: Green and others (2005) *Mental health of children and young people in Great Britain, 2004*.

It is evident that the gender gap in diagnosable mental health conditions begins to narrow in adolescence, with girls experiencing more problems (Green and others 2005). More recent, though less nationally representative, research suggests that emotional problems became increasingly common in girls aged 11–13 between 2009 and 2014, whilst boys' overall problems declined (Fink and others 2015).

Young adults

By young adulthood, the gender gap in diagnosable mental disorders is reversed: adult females of all ages are more likely to be diagnosed with a mental disorder than males (HSCIC 2015a). In 2014, 22% of women aged 16–24 and 13% of men reported having had at least one mental health diagnosis in their lifetime (HSCIC 2015a). A further 21% of women and 23% of men reported having experienced a mental health problem without ever being diagnosed.

In the latest national adult psychiatric morbidity survey, 22% of young women aged 16–24, compared with 13% of men, were assessed as having common mental disorders (which are all anxiety or depressive disorders) (McManus and others 2009). In 2014 19% of women aged 16–24 and 11% of men reported having ever been diagnosed with a common mental disorder (HSCIC 2015a).

Child and adult statistics cannot be straightforwardly compared. However, conduct disorder diagnoses (see page 14) will contribute to the higher proportion of mental health conditions in male children when compared with the adult population. Women's mental health is particularly affected by gender inequality and gender-based violence (WHO 2009; see also page 16–17); there are also gender differences in help-seeking, diagnosis and service responses, discussed later in relation to young women and men.

² Some children will have more than one disorder, and therefore appear in multiple categories. The 'any disorder' columns represent the proportion of all children assessed as having one or more mental disorder. Emotional disorders include anxiety disorders (e.g. separation anxiety, phobias, panic, PTSD, obsessive compulsive disorder, and generalised anxiety) and depression. Hyperkinetic disorder broadly describes ADHD although the diagnostic criteria for the two, and therefore the prevalence, differ. 'Less common disorders' include autism, tic disorders, eating disorders and mutism.

Gender differences are also observed in young adults for less common conditions. The estimated prevalence of antisocial personality disorder in 2007 was 1.7% in men aged 18-34 compared with 0.4% in women (McManus and others 2009). For borderline personality disorder, the age band used was 16-34, and observed prevalence was 0.3% for young men and 1.4% for young women (McManus and others 2009). However, these differences should be interpreted with caution, as the overall number of cases was so small.

Gender differences in psychotic disorders in the young adult population are less clear, although schizophrenia is more prevalent in young men than young women (Kirkbridge and others 2012).

Gender and sexual minority children and young people

Six in ten trans young adults report having a mental health condition which affects them and interferes with their normal activities (METRO 2013). The evidence presented in the following section confirms high levels of mental health need among trans and non-binary children and young people. Sources vary in terms of inclusion criteria and terminology used, but broadly highlight significant risk factors and challenges for children and young people who experience some mismatch between their gender identity and the sex that they were assigned at birth (Holt and others 2014; Skagerberg and others 2013; METRO 2013). Nodin and others (2015) point out that 'being LGB or having a Trans* identity is not in itself associated with mental distress and increased rates of mental illness, but that negative impact of transphobic, homophobic and heterosexist cultural norms that spur the discrimination, bullying, marginalisation and stigmatisation of LGB&T people may be'. The term 'minority stress' is used to summarise the psychological effect of these social phenomena (see also page 16–17).

This evidence review focuses on gender rather than sexual orientation, although potential intersections between the two concepts should be acknowledged, particularly as LGB young people, like their trans peers, are disproportionately affected by depression, anxiety, suicidal ideation and suicide attempts (McDermott and others 2016; Fay 2016; METRO 2013). Links have been suggested between high rates of body dissatisfaction in gay and bisexual men and pressures to conform to masculine body ideals (Nodin and others 2015). US studies have identified links between gender variance and suicide risk in lesbian, gay and bisexual young people (D'Augelli and others 2005; Fitzpatrick and others 2005); some have identified gender non-conformity as a more significant predictor of mental health symptoms than sexual orientation (Fitzpatrick and others 2005; Roberts and others 2012; Rieger and Savin-Williams 2012).

It is also important to consider children and young people living with differences of sex development (DSDs), also known as intersex people³, who are born with a mix of male and female sex characteristics. Whilst stress associated with DSDs is recognised, the evidence base on the mental health of children and young people with a DSD is limited (Wisniewski and Sandberg 2015), and tends to focus on psychosexual development and gender identity (Sandberg and others 2012). Research recognises stigma (Rolston and others 2015) and psychosocial implications (Sandberg and others 2012) of DSDs for affected children and their families. Broader research on psychological outcomes and well-being for individuals with DSD is adult-focused and findings are mixed (e.g. De Neve-Enthoven and others 2016; Schützmann and others 2009). There is a need for further research and more holistic approaches to clinical care for this group of children and young people (Brain and others 2010).

³ Some advocacy groups prefer the term 'intersex', and there is debate about implications of different terms and which is most respectful. DSD is used here, reflecting the main UK-based resource for affected children, young people and families: dsdfamilies.org.

Gender dysphoria

Gender dysphoria (GD) is a medically recognised condition in which the mismatch between the biological sex of a person and their gender identity causes significant distress. GD is not itself a mental illness, and not all trans and non-binary children and young people experience gender dysphoria.

The Gender Identity Development Service (GIDS) in London (see page 37) works with children and young people who experience difficulties in the development of their gender identity. It has seen a huge increase in referrals of children and young people to the GIDS in recent years (BBC 2016).

Holt and others (2014) conducted a case review of 218 children and young people with features of gender dysphoria who were referred to the GIDS in London in 2012. Of these young people, 63% were assigned female at birth, contradicting historical trends. The mean age of referral for the whole sample was 14 years, and 43% of those for whom data was available reported having their first gender dysphoric feelings before the age of seven.

Holt and others (2014) concluded that living with gender dysphoria in our current society undoubtedly predisposes a young person to a number of other difficulties ranging from social isolation, stigma and shame to psychological issues such as depression, anxiety, self-harm and eating disorders. For young people assigned female at birth, self-harm (reported by 46%) and bullying (45%) were the two most common difficulties, whereas for those assigned male at birth it was bullying (49%) and low mood/depression (46%). Many of the difficulties increased with age, reflecting other evidence that adolescence is a particularly challenging time for these young people (e.g. Skagerberg and others 2013b). There was a significant difference in the occurrence of self-harming, which was indicated more often in the young people assigned female at birth, and autism spectrum conditions, indicated more often in those assigned male at birth.

2. Gender differences in the prevalence of specific difficulties and issues

Depressive disorders and anxiety disorders

Depressive disorders and anxiety disorders are often grouped together as 'emotional disorders' or 'common mental disorders', data for which are presented in the previous section. These are more prevalent in girls than boys from a young age, but the gap increases with age (see page 11). Although the most comprehensive prevalence estimates of mental disorders in general child and adult populations are now old, newer research provides insight into the current picture.

'Psychological distress' is used as a measure of emotional and mental well-being, and may be defined as a state of emotional suffering characterised by symptoms of depression and anxiety (Drapeau and others 2011). Girls aged 14–15 recorded higher levels of psychological distress than boys in both 2005 and 2014, with average levels of distress in girls' increasing over the period (Lessofo and others 2016). The proportion of girls deemed 'psychologically distressed' (indicating potential clinical significance) also increased (to 37% in 2014, compared with 15% of boys).

Trans young people are disproportionately affected by depression and anxiety, with over half reporting having ever sought medical help for either condition (METRO 2013; Nodin and others 2015). A recent US study found that transgender children who identified as the gender 'opposite' to that which they were assigned at birth, and were supported to live openly as that gender, 'have developmentally normative levels of depression and only minimal elevations in anxiety' compared with cisgender peers; this is striking in contrast with the prevalence of poor mental health among children with gender dysphoria (see page 13) living within the gender role assigned at birth (Olson and others 2016).

Conduct disorders and behavioural problems

Conduct disorders are more common in boys than girls at all ages (see Figure 1), although it has been suggested that they are under-recognised in girls (Delligatti and others 2003).

Conduct disorders are characterised by 'repetitive and persistent patterns of antisocial, aggressive or defiant behaviour that amounts to significant and persistent violations of age-appropriate social expectations' (NCCMH 2013). The four subtypes of conduct disorder constitute the most common group of mental health problems in children and young people, and are found in those children and young people with the most severe and enduring behavioural problems. A further 15–20% of children have more moderate behavioural problems that do not meet the threshold for a conduct disorder diagnosis (Parsonage and others 2014).

Conduct disorder diagnoses are typically assigned to children under 18 and generally cease to apply beyond this age (though up to half of children with a conduct disorder may go on to develop antisocial personality disorder, diagnosed in adults) (NCCMH 2013). The prevalence of conduct disorders increases throughout childhood.

Of all childhood mental health issues, conduct problems, especially those emerging at a young age, have the clearest and strongest associations with poor life outcomes across the life course in a wide range of dimensions, including mental health (Parsonage and others 2014; Richards and others 2009). Conduct disorders also commonly coexist with other mental health problems: 46% of boys and 36% of girls have at least one coexisting mental health problem; concurrence with ADHD is particularly common (NCCMH 2013).

Self-harm and suicide

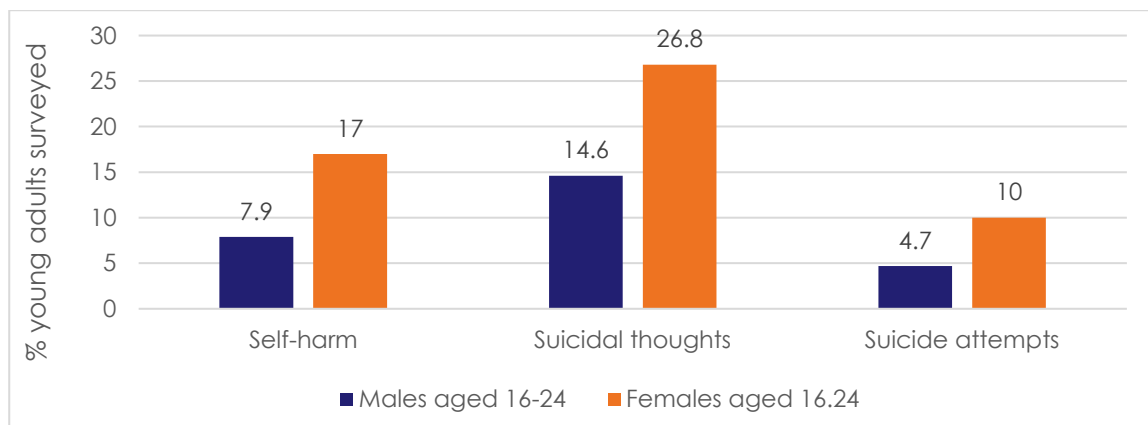
Definitions of self-harm vary across studies and surveys, but can include acts such as cutting, burning, biting or self-poisoning. Self-harm is strongly connected to internalising problems and drug and alcohol misuse, although ADHD and conduct disorders are also commonly associated (Hawton and others 2012). It can be a coping strategy (NCCMH 2004) (see Section 3).

Of young women aged 16–24 surveyed in 2007, 17% reported having ever deliberately harmed

themselves (without suicidal intent) compared with 8% of men in the same age group (McManus and others 2009). The broad evidence base suggests rising levels of self-harm among young people, particularly young women (YoungMinds 2012): with 32% of 15-year-old girls reporting ever having self-harmed (intent not specified) in a recent survey, nearly three times the proportion of their male peers (Brook and others 2015). Figures from 2012–13 through to 2014–2015 show over four times as many hospital admissions for self-harm in females aged under 20 years (n=59,368) than for males (n=14,190) (HSCIC 2015b). In 2014–2015, male admissions peaked in the 20–24 age group, though were still outnumbered by female admissions (HSCIC 2015c). Intentional self-poisoning (usually by drug overdose) accounts for most admissions (HSCIC 2015b and 2015c).

Prevalence of self-reported suicidal thoughts and suicide attempts appears to be higher in young women than men (McManus and others 2009).

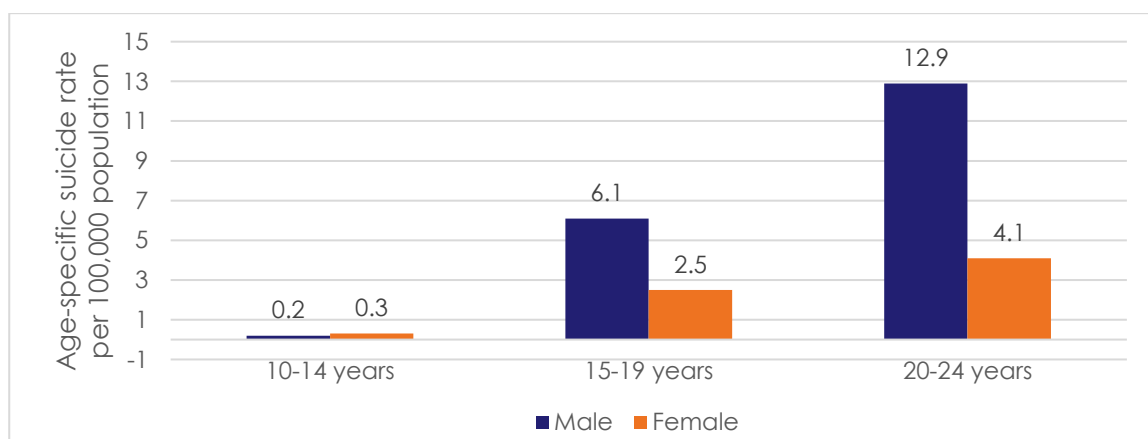
Figure 2: Lifetime suicidal thoughts, suicide attempts and self-harm reported by young adults in self-completion questionnaires



Source: *Adult Psychiatric Morbidity Survey 2007 (McManus and others 2009)*

However, more young men die by suicide. This suggests that first suicide attempts are more likely to be fatal among young men than women. Suicide was the leading cause of death for males aged under 50 and for females aged 20–34 in England and Wales in 2014 (ONS 2015a).

Figure 3: Age-specific suicide⁴ rates by sex and five-year age group, England 2014 registrations



Source: *Suicide in the United Kingdom 2014 Registrations (ONS 2016b)*

⁴ In England and Wales, verdicts of suicides cannot be returned for children under the age of 10 years. The definition for suicides used here includes deaths from intentional self-harm in 10- to 14-year-old children in addition to deaths from intentional self-harm and events of undetermined intent in people aged 15 and over.

An examination of suicides in children and young people in England (NCISH 2016) found that many identified antecedents of suicide were more common in females than males, including abuse, bullying, bereavement, physical health conditions, and exam pressures. Females were more likely to have self-harmed in the past, and to have had contact with mental health, social care or local authority care services. In contrast, males more often had no recent service contact.

Various studies show high levels of self-harm, self-harm thoughts, suicidal thoughts and suicide attempts among trans young people, which far exceed prevalence among their cisgender peers (e.g. Nodin and others 2015; Holt and others 2015; Skagerberg and others 2013b; McDermott and others 2016). In a survey of trans young adults aged 16–25, 72% reported having ever self-harmed; 39% had ever had a plan to kill themselves (not carried out); 27% had ever attempted suicide; and 23% felt it was likely that they would attempt suicide one day (METRO 2013).

Gender and the impact of violence and abuse

It is well-established that violence and abuse have wide-ranging and long-lasting impacts on individuals' physical and mental health and broader life outcomes (Khan 2016; Scott and McManus 2015a; Radford and others 2011; YoungMinds 2016). This review focuses on manifestations of, and responses to, children and young people's mental health needs; the sources cited provide rich background on the contexts and causes underpinning these needs. However, the gendered nature of violence and abuse must be acknowledged: violence against women and girls is a gender-based inequality that severely impacts on the mental health of girls and women at individual and population levels (Scott and McManus 2015b; Davies 2015).

Girls and women are disproportionately affected by domestic abuse and sexual violence, which include child sexual abuse, child sexual exploitation, sexual harassment, forced marriage, honour-based violence, and female genital mutilation (FGM). For example:

- Research into young people's self-reporting of violence and abuse found that 31% of young females aged 18–24 reported having experienced exposure to some form of severe maltreatment¹ in their lifetime, compared with 25% of males. The gender difference for reported contact sexual abuse was highest: 18% of females compared with 11% of males (Radford and others 2011).
- People aged under 25 comprise 36% of the total population of England and Wales, yet in the year ending March 2015, 77% of rapes and 76% of all other sexual offences recorded by the police¹ were perpetrated against females aged 0–24, compared with 11% and 17% respectively for males (ONS 2016c; ONS 2016d).
- Recent analysis highlights that the more extensive the violence and abuse, the higher the proportion of the group that is female. Around one in 20 women in England has experienced repeated, serious physical and sexual abuse both as a child and an adult, compared to one in 100 men (Scott and McManus 2015b). Mental health outcomes for these adults are extremely poor, and it is suggested that the levels of violence and abuse experienced by women may largely account for gender differences in the prevalence of common mental disorders among adults (Scott and McManus 2015b).
- Gender disparities in abuse within intimate relationships emerge at a young age: one study found that 14–17 year old girls were several times more likely than boys to report having experienced all forms of violence and abuse in this context, with almost half reporting emotional violence, one in five reporting physical violence and four in ten reporting sexual violence (Barter 2015a).

(Continued on next page)

Findings from the Crime Survey for England and Wales, which surveys the public (thereby including unreported crimes), shows that, within the total population, young men are the group most likely to be victims of violent crime, with 5.9% of men aged 16–24 having experienced wounding or assault, compared with 2.4% of women (ONS 2016e). Acquaintances or strangers perpetrated the majority of this violence; young women were still more likely to be victims of domestic violence.

Trans young people are at extremely high risk of discrimination, harassment and assault; they are also more likely than the general population of young adults to report a history of domestic, familial and/or sexual abuse (METRO 2013). In a sample of 13–25 year olds with experience of self-harm or suicidal feelings, 85% of trans males, 80% of those with 'other' gender identity¹ and 60% of trans females reported that, whilst these issues were affecting them, they were also experiencing some kind of abuse or negative interactions related to their sexual orientation or gender identity (McDermott and others 2016).

It is difficult to get an accurate picture of violence and abuse, due to under-reporting by victims to the police, but also in surveys. However, these issues clearly have a severe impact on the mental health of children and young people affected, and their occurrence and impact are distinctly gendered.

Body image and eating disorders

The most marked gender difference noted in the latest Good Childhood Report (Children's Society 2015) of the subjective well-being of 8,000 children aged 10–17 related to appearance: 17% of females had low satisfaction with their appearance compared with 9% of males. Only 52% of girls aged 11–15 feel their body is 'about the right size' compared with 60% of boys (Brook and others 2015); positivity about body size decreases with age in both boys and girls.

A complex interaction of sociocultural, psychological, and biological influences are understood to cause eating disorders; idealisation of thinness is a risk factor (Culbert and others 2015). The gendered impact of sociocultural factors is the subject of much research and discourse. Comprehensive and consistent prevalence data on eating disorders in the UK is not readily available, and many eating problems will go undiagnosed. Studies generally estimate that around 90% of people with eating disorders are female (PwC 2015), though some estimates suggest that up to a quarter of young adults affected are male (McManus and others 2009). Young people are disproportionately affected by eating disorders, and the most recent national adult psychiatric morbidity survey found that 20% of women and 6% of men aged 16–24 screened positive for a possible eating disorder (McManus and others 2009). Mortality rates in individuals with eating disorders are high, particularly for anorexia nervosa (Arcelus and others 2011).

Eating disorders are also a concern for trans young people. High levels of disordered eating are self-reported by both trans young people (METRO 2013) and adults (McNeil and others 2012). A recent US study found that trans college students were four times more likely to self-report an eating disorder than their cisgender, heterosexual female peers (Diemer and others 2015).

Post-traumatic stress disorder (PTSD)

PTSD can be difficult to diagnose in children. Many children with PTSD may have been subjected to multiple traumas such as childhood sexual abuse or domestic violence (NCCMH 2005; see also page 16–17). In the latest UK prevalence survey, 0.5% of girls aged 11–16 screened positive for PTSD compared with 0.1% for boys (Green and others 2005).

In the 2007 national adult psychiatric morbidity survey, 5% of men and 4% of women in the 16–24 age group screened positive for PTSD, despite experiences of trauma having been more common in women; the authors attribute this to high levels of violent assault among young men. Men aged 25 and over are more likely than women to have experienced trauma but, having done so, less likely to develop PTSD (McManus and others 2009; McLean and Anderson 2009).

Drug and alcohol dependence

Patterns of drug and alcohol use by young people vary by gender to different extents depending on the aspects in question (Fuller and others 2015). There are gender differences in some behaviours that might indicate dependence. In a recent survey, 83% of 15-year-old boys who drank regularly reported having been drunk more than 10 times in the last 30 days, compared with 57% of girls (Brooks and others 2015).

Survey data from 2014 (Fuller and others 2015) shows similar proportions of girls and boys aged 11–15 reporting having taken illicit drugs at least once a month in the last year, though boys were slightly more likely to report more frequent drug use, and drug use at younger ages. An examination of suicides in children and young people in England (NCISH 2016) found that a higher proportion of males had a history of illicit drug use.

The most recent prevalence estimates for drug and alcohol dependence in young adults are from the 2007 national adult psychiatric morbidity survey, and are likely to be under-estimates (McManus and others 2009). Whilst 13% of men aged 16–24 were identified as dependent on alcohol compared with 10% of women aged 16–24, the prevalence of hazardous or harmful drinking was 42% among men and 32% among women. In this age group, 13% of men reported signs of dependence on any drug (usually cannabis) in the last year, compared to 7% of women.

More recent data shows that recent alcohol consumption in excess of recommended limits is slightly more common among men aged 16–24 compared to women (ONS 2016f).

There has been limited research into drug and alcohol use among trans and non-binary people. However, there is some evidence of high levels of alcohol dependence among the adult trans population, and of substance use (not necessarily felt to be problematic) (MacNeil and others 2012). The largest survey of trans young people to date did not reveal substantially different levels of drug and alcohol use among this group compared to their cisgender peers (METRO 2013).

Alcohol and drug use can be a coping strategy (see Section 3), employed by adult men more than women (Nolen-Hoeksema 2012). There is some evidence that in early adolescence, girls are more likely to use alcohol in this way than boys, and that this difference is reversed by late adolescence (Kuntsche and others 2006). One third of women aged 18–34 experiencing mental health problems has admitted to regularly drinking to get drunk as a direct result (Platform 51 2010).

Neurodevelopmental disorders

ADHD and autism are the neurodevelopmental disorders for which gender differences in prevalence are most noted and discussed. Prevalence estimates for autism and ADHD vary widely and use different measures.

Diagnoses of autism are much more common in males than females. One British study estimated that autism affects around 1% of the child population (Baird and others 2006). Studies and education statistics indicate that at least five in six children with autism are male (NAS 2016; Pinney 2014; Green and others 2015).

ADHD is estimated to affect 3 to 9% of school-aged children and young people in the UK (NCCMH 2009). In the latest UK prevalence survey, 2.6% of boys aged 5–16 screened positive for hyperkinetic disorder – a diagnosis restricted to a severe subtype of ADHD – compared with 0.4% for girls (Green and others 2005). For about two-thirds of people diagnosed with ADHD in childhood, some symptoms will persist into adulthood (Faraone and others 2006). Studies generally find a male-female gender ratio of around 3:1, although this becomes more equal in adulthood (NCCMH 2009).

Both autism and ADHD are thought to be under-recognised in girls. See pages 30 and 31.

Children, adolescents and young adults with ADHD and/or autism are at significant risk of having mental health and behavioural difficulties (Green and others 2005; Madders 2010; McManus and others 2009; Rosenblatt 2008).

3. Gender differences in children and young people's coping strategies and help-seeking behaviours

Coping strategies

People use many different strategies to cope with stressors and difficulties. These strategies may focus on addressing a problem itself or a person's thoughts and feelings about the problem. Some coping strategies are adaptive, (and many activities are associated with emotional and mental well-being, whether or not the primary motivation for engaging in them is coping). Other strategies are maladaptive (see self-harm and drug and alcohol dependence in Section 2).

Coping is related to how emotions are regulated and expressed. Complex gender differences have been observed in how individuals cope, as well as how mental health conditions develop. The causes and processes involved have been attributed to a range of biological, psychological, environmental and other factors (Else-Quest and others 2006; McLean and others 2009; Nolen-Hoeksema 2012; Zahn-Waxler and others 2006). Biological explanations explore gender differences relating to genetics, hormones, and brain structure and function (e.g. Ruigrok and others 2014).

A meta-analytic review of gender differences in how children from infancy to adolescence express emotions (Chaplin and Aldao 2013) found small but significant gender differences. Girls showed greater positive emotion expressions than boys, and this difference increased among older participants, in the presence of an unfamiliar adult, and in situations featuring social pressure to mask negative emotions. Girls also expressed more internalising emotions than boys, who showed greater externalising emotion expressions in early and middle childhood, in negative situations, and when with peers or alone. Unexpectedly, by adolescence, girls expressed more externalising emotions than boys. The researchers emphasised the importance of context, situation and demographic factors.

'Effortful control' is the ability to exert voluntary control over emotional reactions and impulses to act (Nolen-Hoeksema 2012). In general, girls have been found to show greater effortful control abilities than boys (Else-Quest and others 2006), which may contribute to their lower prevalence of externalising behaviours and problems.

One US study found that girls as young as six evaluated emotion-focused strategies (such as expressing feelings or seeking support) as more effective for regulating sadness and anger than boys did (Waters and Thompson 2014); boys did not endorse distraction more highly than girls as expected. McLean and others (2009) suggest that caregivers and other influencers (e.g., teachers, peers, and media) may 'encourage gender conforming behaviors by differentially reinforcing agency and assertiveness among boys and anxious behaviors among girls'.

There is evidence that adolescent girls perceive higher amounts of interpersonal stress than boys, and score higher on maladaptive coping strategies, such as rumination, and emotional distress (Hampel and Petermann 2006; Li and others 2006). Since it is linked to rumination, girls' and women's emotional competence may be 'an asset or a liability' (Nolen-Hoeksema 2012). McNeish and Scott (2014) describe how gender expectations encourage girls 'to develop characteristics and competencies which are not well suited to exercising power, but which are compatible with a position of subordination', noting that such characteristics are also risk factors for mental health and often invisible because consistent with 'acceptable "feminine" behaviour'. On the other hand, girls and women who respond to adversity with externalising behaviours are more likely to experience punitive responses (see page 36). In this respect, gender conformity itself may be seen as a strategy used to cope with or avoid stressors, and both attempting and not attempting to meet expectations can have consequences for girls' mental health and how others respond to them.

Likewise, a review of evidence relating to men's mental health concluded that 'men often have mental health needs that are distinct from those of women and which are particularly associated with the lived experience of being male' (Wilkins 2010). Wilkins argued that 'normal' male

behaviours such as 'soldiering on' through distress, drinking excessively, displaying aggression or misbehaving at school, could be detrimental to male mental health. In this respect, 'simply being male could – and should – be seen as a primary risk factor for several specific mental health problems' including alcohol or drug dependence, suicide, and offending behaviour associated with emotional distress (Wilkins 2010). The importance of not pathologising maleness is emphasised, however; Nolen-Hoeksema (2012) also suggests that men may regulate their emotions in ways that are not currently obvious, and provide social support to one another in different ways from women.

A US study identified four aspects of psychological resilience among transgender young people: a sense of personal mastery, self-esteem, perceived social support, and emotion-oriented coping (Grossman and others 2011).

The impact of childhood adversity

The prevalence of different adverse childhood experiences varies by gender (Radford and others 2011; Bellis and others 2014; see also page 16–17). Evidence on gender differences in the impact of such experiences shows a complex picture, with impacts varying according to factors including the child's age and the nature and number of adverse experiences (Hughes and others 2016). Children and young people can adopt risky, self-destructive or challenging behaviours in order to cope with or try to process trauma (YoungMinds 2016). Those whose risk-taking is significant are at increased risk of being labelled as having a clinical disorder or criminalised, rather than having their experiences of adversity identified (Greenwald 2015, cited in YoungMinds 2016).

Adverse childhood experiences include victimisation, such as crime, maltreatment, peer and sibling victimisation, sexual victimisation, and witnessing and other exposure to violence (Crimes Against Children Research Center, n.d.). There are obvious difficulties with comparing individual experiences, but Radford and others (2011) identified some broad gender-based patterns in the independent impact of specific types of maltreatment and victimisation, based on over 6,000 interviews with caregivers, children and young people:

- Among 3–10 year olds, the effect of child maltreatment on trauma symptoms was almost twice as large for boys as for girls
- Witnessing family violence and experiencing physical violence were associated with increased delinquent behaviour in girls aged 5–10, but not in boys
- Among 11–17 year olds, the effect of sexual abuse on emotional well-being was slightly stronger for girls than for boys; sexual abuse and physical violence also appeared to have strong effects in girls in terms of delinquent behaviour
- Among 18–24 year olds, the effect of victimisation by peers or siblings on trauma symptoms was almost twice as large for young women as for young men; it was also stronger for girls than for boys in the 3–10 age group
- Among those children and young people who had experienced the most multiple maltreatment and victimisation types during their lifetimes, the associated with increased delinquency was slightly stronger for girls aged 11–17 than boys.

In a US study, Schilling and others (2007) investigated specific effects of adverse childhood experiences on young adults from urban, disadvantaged communities. Experiences included victimisation but also parental unemployment, parental drug or alcohol problems, and family breakdown. Young men and women were equally likely to exhibit depressive symptoms. Boys were much more likely than girls with similar adverse experiences to engage in antisocial behaviour, and the cumulative effect of multiple adverse experiences on drug use was much greater for boys than girls. Sexual abuse/assault was associated with much higher levels of drug use, depressive symptoms and antisocial behaviour in young men than in young women, although the number of sexually victimised boys was small.

UK studies exploring violence and abuse in young people's intimate relationships have identified that girls are significantly more likely than boys to be negatively impacted by the physical and sexual violence they experience (Barter and others 2009; Barter and others 2015a), with little evidence that this effect is caused by better recognition and reporting by girls.

Help-seeking behaviours

Help-seeking is defined as a behaviour involving 'actively seeking help from other people', 'communicating with others to obtain assistance in terms of understanding, advice, information, treatment, and general support in response to a problem or distressing experience' (Rickwood and others 2005). It may be considered a life skill. Much of the available evidence comes from an Australian research programme exploring young people's help-seeking for mental health problems, which gathered data from 2721 young people aged 14–24 years. Findings from several studies were summarised by Rickwood and others (2005), who also proposed the following process model for help-seeking for emotional and mental health problems.

After recognising their difficulties and need for help, young people must be comfortable and able to communicate about their needs in terms that can be understood. Young people then need access to available services, to which they are willing and able to disclose their inner state. A range of barriers and facilitators may help or hinder this process (Gulliver and others 2010).



Source: Rickwood and others 2005

Studies show that reluctance to seek help for symptoms of mental health problems is common from late childhood into adulthood (MacLean and others 2013; Chandra and Minkovitz 2007; Rickwood and others 2005; Jorm and others 2007; Gulliver and others 2010). Gender differences in help-seeking behaviours have been noticed in children as young as three, with girls seeking help with tasks more rapidly than boys (Benenson and Koulhazarian (2008). In the case of emotional and mental health problems, girls are also more likely to seek help than boys (Rickwood and others 2005). Various theories attempt to explain gender differences in help-seeking behaviours (see Vaswani 2014, and Addis and Mahalik 2003).

Mental health literacy and emotional competence

Mental health literacy is defined as 'knowledge and beliefs about mental disorders which aid their recognition, management or prevention' (Jorm and others 1997). This includes awareness of available services and what to expect from them.

Accurate knowledge of mental health contributes to reduced stigma among young people (Chandra and Minkovitz 2007), thereby addressing a known barrier to help-seeking. Evidence suggests that adolescent males have lower levels of mental health literacy than their female peers, more stigmatising attitudes, and less curiosity or perceived need to learn about mental health (Williams and Pow 2007; Bone and others 2015; Chandra and Minkovitz 2007, cited in Khan 2016). One Australian study found that girls were better able than boys to identify depression in a case scenario featuring a young person, and to recognise individual symptoms of depression; they also expressed greater concern (Burns and Rapee 2006). However, a more recent study of young adults aged 17–22 concluded that gender differences in mental health literacy might not be as great as previously thought (Furnham and others 2014). It is possible that gender stereotypes about different mental health difficulties hinder young people's recognition of their own symptoms: for example, symptoms of eating disorders in young men (Räsänen and Hunt 2014). In one British study, adults - especially men - were less able to identify symptoms of depression in a male, and saw the case of a female as more distressing and deserving of sympathy (Swami 2012).

In general, girls feel more able to talk about their emotional life with others than boys, and are more likely to recognise and articulate their own psychological distress (Rickwood and others 2005). These qualities are associated with emotional competence (also termed 'emotional intelligence'), which is defined as 'the ability to perceive and express emotion, assimilate emotion in thought, understand and reason with emotion, and regulate emotion in the self and others' (Mayer and Salovey 1997). Emotional competence facilitates help-seeking (Rickwood and others 2005).

MacLean and others (2013) noted only subtle gender and age differences in school-age children's understandings of mental health symptoms, and beliefs about help seeking. They observed that these differences were not significant enough to explain the marked excess of psychological distress that emerges in girls during early-mid adolescence (MacLean and others 2013).

Stigma and attitudes to mental health

Stigma is the perception that a certain attribute makes a person unacceptably different from others. It involves labelling, stereotyping, separation, status loss, and discrimination (Link and Phelan 2001). Stigma can be enacted, anticipated and internalised. It is a significant barrier to help-seeking for mental health difficulties, and disproportionately deters young people and males (Clement and others 2015; Gulliver and others 2010; Ilic and others 2015). This aligns with evidence of significant reluctance to seek help for mental health issues amongst adult males. However, stigma is not only a male concern. A recent survey of girls and women found that 29% of those who had experienced mental health problems had not sought help, often due to fears of being labelled, judged, not being taken seriously or appearing to make a fuss (Platform 51 2010). Furthermore, most people with eating disorders - which particularly affect young women - do not seek treatment for these problems (Hart and others 2011; Swanson and others 2011).

Stigma and attitudes to help-seeking are interlinked, and relevant to theories explaining gender differences in help-

Keeping secrets

Besides not seeking help, children and young people may actively conceal information relevant to their emotional and mental states. Keeping secrets is generally considered burdensome, and has a negative impact on young people's mental health over time (Frijns and others 2009). Information concealed may relate to mental health symptoms or problems and experiences such as victimisation (see page 16–17). It may also pertain to children and young people's own behaviour: whilst being withdrawn or exhibiting challenging or risky behaviour can be a way of communicating distress (YoungMinds 2016), some young people withhold information about their unsupervised time in ways that affect caregivers' understanding of their emotional state. More disclosure and less concealment is associated with less depressed mood and with less antisocial and rule-breaking behaviour (Laird and Marrero 2010; Frijns and others 2013), with increases in adolescents' delinquent behaviour predicting decreases in parental knowledge and vice versa (Laird and others 2003). This is particularly relevant to boys, given their higher prevalence of externalising problems compared with girls.

Issues around secret-keeping also affect the support young people can access in relation to gender identity, or for victimisation linked to this. In the largest survey of trans young people to date, respondents frequently reported not having disclosed their trans identity to parents or siblings (approximately half), anyone at school (34%) or anyone at all (28%), and many had never participated in any LGBTQ social activities (METRO 2013). Trans young people and their cisgender peers reported having similar numbers of people they could count on for advice and support relating to any problems (METRO 2013) and do not appear less likely to seek help for suicidal feelings and self-harm (McDermott and others 2016). However, among young people who had experienced self-harm and suicidal feelings, hiding their sexual orientation or gender identity was common and usually distressing (McDermott and others 2016). Many reported that this secret-keeping strongly affected their self-harming and suicidal feelings, especially trans females. Young trans males and trans females appeared to be at increased risk of negative effects compared with peers who identified their gender identity as 'other'.

seeking. Mansfield and others (2005) proposed that several factors are instrumental to men's disinclination to seek help for physical and mental health concerns:

- gender role conflict, defined as 'a psychological state in which socialized gender roles have negative consequences for the person or others' (O'Neil 2008)
- the degree to which a problem is perceived to reflect an important quality about oneself
- the degree to which a problem is considered normal or common
- the tendency to take steps to restore control when one perceives that autonomy has been threatened
- the opportunity to offer help in return at some point in the future.

These concepts do appear in studies of children and young people. In one, accounts from children and young people implied that mental health symptoms are particularly unexpected in boys, and could threaten valued masculine identities at a critical life stage; although girls also expressed worries about being seen as weak or different if they sought help, they showed less of a sense that their entire identity would be questioned (MacLean and others 2013). One explanatory factor may be that health is also 'often socially constructed as a feminine concern and men therefore have to present as if they are unconcerned about their health' (White and others 2011). Male stoicism may be a response to fears of illness and of expressing vulnerability as threats to masculine ideals characterised by qualities such as strength, control, dominance, competitiveness and success (White and others 2011; Möller-Leimkühler 2003). However, other evidence suggests that associations between social constructions of gender and help-seeking are not straightforward (Rughani and others 2011), and research with adult men suggests that ethnicity and sexual orientation are relevant to how men's experience of conformity to dominant masculine norms relates to their attitudes towards seeking help (Vogel and others 2011).

Preferred sources of help

Along with emotional competence, mental health literacy and positive attitudes towards help-seeking, the studies summarised by Rickwood and others (2005) found past experience and supportive social influences to be important predictors of young people's help-seeking for mental health problems.

Much of the evidence relates to young people's stated intentions and preferences, but, importantly, Rickwood and others (2005) have noted a generally modest relationship between stated help-seeking intentions and actual help-seeking behaviour. They observed higher correlations between intentions and behaviour for help-seeking from informal than formal sources.

Informal help-seeking

In the literature on young people's preferred sources of help for issues relating to emotional and mental health, informal sources of help feature prominently (e.g. Balding and others 2014 cited in Hagell and others 2015), including for trans and non-binary young people (McDermott and others 2016). A large-scale Australian survey found that the sources seen as most accessible by 15–17 year olds with a probable mental illness were friends, the internet, parents and relatives or family friends (Mission Australia 2015). Males were more comfortable than females to go to a relative or family friend (other than a parent) for help.

One study of all young people accessing mental health services in Australia over 12 months (Rickwood and others 2015) found that the influence of family on help-seeking was stronger for males than females across all age groups. Recent UK surveys indicate that adolescent males are significantly more likely than females to seek mental health information from family (YoungMinds 2014), and more frequently report easier communication with both mothers and fathers, feeling listened to and emotionally supported, and believing that the important things are talked about in their families (Brooks and others 2015). Whilst most young people report finding it easy to talk to their parents about things that really bothered them, more find it easy to talk to their mothers than fathers (Brooks and others 2015). There can be a mismatch between young people's actual concerns and those they perceive their parents to have. For example, although mental health was

the main concern among girls aged 11–21 participating in a survey (Girlguiding 2015), only one in four thought their parents were concerned about mental health issues, believing they were more focused on 'traditional' risks such as drug use and unplanned pregnancy.

Rickwood and others (2005) observed that, as they get older, girls became 'increasingly socialised to use their friends as a source of help and reduce their dependence on their parents and family, and slightly increase their formal help-seeking behaviour', whilst boys did 'not compensate for their reduced reliance on family by building up supportive friendships or starting to seek professional help'. Various studies exploring social connectedness in adults have found that men are more likely than women to lack social support and intimacy in friendships, and that this poses a risk to their mental health (Wilkins 2010). The influence of partners is especially relevant for men (Rickwood and others 2015; Wilkins 2010).

Girls use more social support but this may decrease girls' self-efficacy and thereby increase avoidant behaviour (McLean and Anderson 2009). Co-rumination, described as 'extensively discussing and revisiting problems, speculating about problems, and focusing on negative feelings', is more common in girls and has been observed to strengthen their relationships but also to contribute to increased depression and anxiety (Rose and others 2007). Disclosing troubles and concerns to friends appears to have a more straightforwardly protective effect for boys, although they do it less frequently (Landoll and others 2011; Rose and others 2007).

In early adulthood, a minority of women and smaller minority of men accessing in-person services report that their dominant help-seeking influence was themselves, over family, friends, partners and health workers (Rickwood and others 2015).

Whilst family and friends can play a crucial role in facilitating help-seeking when a child or young person requires professional help, it should be noted that the ability of individuals to perform that role depends on a range of factors including their own mental health literacy and experiences (Farrand and others 2007). In some cases, help-seeking may not be safe for young people (see page 26). Adolescent girls may be more likely than boys to engage an adult to help when concerned about a peer's mental health (Kelly and others 2006). One US study found that female college students were more likely than male students to have been prompted by others (including doctors) to seek help from mental health services, and more likely to know somebody else who had sought help (Vogel and others 2007). This is concerning in light of reporting from adult men that they have sought, or would seek, help for a mental health issue only after being influenced by others (Cusack and others 2004, cited in Rickwood and others 2005; Hamblin and Kane 2015; Wilkins and Kemple 2011).

Friends are frequently reported by trans people to be key sources of support, with more mixed experiences of, or barriers to accessing, support from family members (McDermott and others 2016; McNeil and others 2012). Trans females appear most likely to find friends helpful, followed by trans males and then those with other gender identities (McDermott and others 2016).

Formal help-seeking

A range of professionals in different settings, including schools and youth groups, provide mental health services and support for children and young people. Young people tend to prefer informal sources of help to formal (i.e. professional) sources at all ages, regardless of gender, and studies show low rates of professional help-seeking for both boys and girls (Rickwood and others 2005). Trans young people are more self-motivated to seek help from friends and online than from GPs and mental health services (McDermott and others 2016).

Perceptions of the benefits of seeking professional help for emotional problems influence young people's intentions to seek help, and these perceptions are informed by past experiences (Rickwood and others 2005). Findings from recent research suggest that adolescent boys who had not used specific types of mental health support or information provision within schools were less likely than girls to consider that these might be helpful (YoungMinds 2014). Trust and faith in services is particularly low among some groups (e.g. BAME young people and families – see page 35).

Physical symptoms as an expression of psychological distress

Gender differences have been observed in the presentation and significance of somatic symptoms in children and young people, with higher levels of symptoms reported by girls (Egger and others 1999; Vila and others 2009; Brooks and others 2015). Complaints such as headaches and low energy can be associated with somatisation: the experiencing of psychological distress in the form of physical symptoms, and a tendency to seek help for those symptoms. This is significant given that recurrent, medically unexplained physical symptoms are common in children and young people, and are often associated with other psychiatric symptoms (Campo and Fritsch 1994; Green and others 2005), which frequently go undiscussed in GP consultations (Sayal 2006; Zwaanswijk 2005).

In recent surveys (YoungMinds 2014), young people who had not previously used a service to address mental health needs were asked to rank five services in order of preference, should they need help. A predominantly female sample ranked CAMHS the highest, putting GPs in fourth position. In a separate, all-male sample, GPs emerged as the preferred source of support, with CAMHS in last place. Private counselling and counselling from a charity ranked in the middle, and school counselling ranked lowly, for both groups. Interestingly, these answers did not reflect the patterns of actual service use by other respondents who had accessed support.

There is some evidence that boys and men favour mental health support that is direct, practical and solution-focused (Robertson and others 2015; Wilkins and Kemple 2011; NSPCC 2009).

A survey conducted in Devon that focused on emotional and behavioural difficulties commonly experienced by adolescents (i.e. not clinical conditions) found that young people expressed good willingness to seek help from professionals (though did not identify actual behaviour). Among 968 school pupils aged 13–16, girls were more likely to intend to seek help than boys for almost all difficulties, particularly for wanting advice on a sexual matter, being 'worried about coming into school every morning', and worries about academic work. Boys were slightly more likely than girls to intend to seek help for family-related difficulties, though of all difficulties listed, willingness to seek help for conflict with family and friends was least common in boys and girls. Both most frequently showed willingness to seek help for difficulties related to issues with teachers, alcohol or drugs, and academic work. For most difficulties, both girls and boys preferred to approach school-based professionals first as opposed to health professionals, except if they were to need advice about body changes or sexual matters, or were experiencing sleep problems. The exception was 'feeling "down" for a long time', for which there was less consensus overall, and more girls than boys identified health professionals as their first port of call.

Indirect help-seeking

Young people do use websites and apps to seek mental health information and support (NSPCC 2015a; YoungMinds 2012). Online support is a preferred source of help for trans and non-binary young people (McDermott and others 2016). However young people's feelings about digital services appear to be mixed, and they value face-to-face support (YoungMinds 2014). In particular, it is sometimes assumed that males may be more willing to access anonymous or 'one-step-removed' services than face-to-face services, but whilst evidence suggests young men do benefit from such services, face-to-face support is still important (Best and others 2014). Specific efforts to may be needed improve helpline uptake among boys and young men, who are still the minority of users (Wilkins 2013); NSPCC 2009).

Evidence on gender differences in young people's perceptions and use of indirect sources of mental health information and support is unclear, with surveys generating contradictory findings (YoungMinds 2014; Mission Australia 2015). Data on a major telephone and online counselling service for children, NSPCC's ChildLine, showed that over half of the service's counselling sessions in 2014/2015 were with girls and 13% were with boys (NSPCC 2015a). A significantly higher proportion of boys made contact by telephone, as opposed to online, compared to girls. However, one third of total counselling sessions were with young people who did not disclose their gender, and gender was recorded for fewer online than telephone counselling sessions, so contact from boys may be

under-recorded, particularly in terms of online contact.

Girls were much more likely than boys to contact ChildLine about domestic/partner abuse, eating disorders, pregnancy and parenting, and self-harm; boys were more likely to be concerned about sexual or gender identity, physical abuse or their own behaviour.

Help-seeking and victimisation

Children and young people's help-seeking in relation to experiences of victimisation is clearly closely related to their mental health. All too frequently, children and young people either do not seek help at all; disclose only to peers; wait a long time to disclose; access services without disclosing; or do not get the help they need following disclosure (Smith and others 2015; Beckett 2013; METRO 2013; Barter and others 2015b; OCC 2015). The majority of crimes against children are not reported to the police (Beckett and Warrington 2014). There are many reasons for children and young people's non-disclosure, including not recognising their experiences as abuse; resignation; coercion; self-blame; shame; fear of not being believed; fear of consequences for themselves or others; lack of confidence or opportunity; and perceptions of authorities and services (Beckett and others 2013; Imkaan 2013; Berelowitz and others 2012; Beckett and Warrington 2014; OCC 2015; Fox 2016). These evidence sources explain the serious mental health implications of abuse going undisclosed, unreported and unrecognised. They also highlight how gender-related beliefs, stereotypes and power imbalances frequently play a role in victimisation (see also page 16–17), help-seeking and responses.

It is always difficult to establish the extent to which victimisation is reported, and to identify gender differences. Clear differences relate to forms of victimisation that are linked to gender-based violence: girls and young women are certainly significantly more likely than boys and young men to experience these, but boys and young men are less likely to seek help when they do experience them. For example, these trends apply to violence and abuse in intimate relationships (Barter and others 2009; Barter and others 2015b); child sexual abuse (with the exception of boys aged 0–11, who are more likely to report or come to the attention of authorities) (OCC 2015); and child sexual exploitation and gang-related sexual violence (Beckett and others 2013; Berelowitz and others 2012; Fox 2016). Under-reporting in males is often attributed to the perceived impact of abuse on their masculinity, the additional stigma of not being fitting the 'expected' profile of a victim, and a lack of recognition of, and support for, their particular needs (OCC 2015).

There are specific issues around help-seeking for BAME children and young people, including the threat of forced marriage and 'honour'-based violence (OCC 2015; Berelowitz and others 2012; Imkaan 2013).

Trans young people are particularly vulnerable to some forms of victimisation, including but not limited to transphobic bullying and hate crime, and face some distinct barriers to seeking help (Berelowitz and others 2012; METRO 2013; LGYM 2008; Roche 2008; Fox 2016).

4. Responses to children and young people's emotional and mental health needs

Despite strong ethical, social and economic arguments for protecting and promoting children and young people's emotional and mental health and well-being (Knapp and others 2016; Khan and others 2015), an estimated 60–70% of children and young people who experience clinically significant difficulties have not had appropriate interventions at a sufficiently early age (Children's Society 2008). On average, three in every ten children and young people referred to CAMHS are not offered a service (OCC 2016). This section explores gender dimensions in how parents and carers, schools, and health and other services respond when children and young people are experiencing difficulties.

Parents and carers

Parental influences, and parental mental health, play a significant role in children's emotional and mental health (Khan 2016) and good communication between young people and parents is associated with decreased likelihood of psychological complaints (Moreno and others 2009). Parents play an important role in facilitating access to mental health services for children and young people (Sayal 2006), particularly prior to late adolescence; parental disapproval can also inhibit young people from seeking help (Chandra and Minkovitz 2006). Despite this, a recent survey showed that over half of parents had never spoken to their children about mental health, and 45% did not feel the need to (Opinion Matters 2015). It is common for both parents and children and young people to find broaching mental health difficult (e.g. YoungMinds 2012; Girlguiding 2015).

There is evidence that gender role socialisation begins in the first months of life (Bronstein 2006), and parental-child communication about emotion can be gendered from early on. Studies of preschool children and their parents have observed that girls talk more about emotional aspects of their experiences than boys and express submissive emotions such as sadness and anxiety more, and that parental responses to different emotions vary according to their child's gender (Fivush and others 2000; Chaplin and others 2005).

Parents experience barriers to recognising mental health issues in their children, seeking help on their behalf, and obtaining appropriate professional support (Sayal and others 2010; Khan 2014; YoungMinds 2014; Ryan and others 2015). The most recent prevalence data suggests that most parents seek help for children with indications of diagnosable mental health condition, with the highest proportion of parental help-seeking for hyperkinetic disorders and the lowest for emotional disorders; parents appear less likely to correctly identify emotional disorders than behavioural disorders in their children (Green and others 2005).

In one US study, college students were asked who, if anyone, had ever prompted them to seek therapy for a mental health issue. Of those who reported having been prompted, 47% had been urged to seek help by their mothers – the most frequent answer – compared to 5% who had been prompted by fathers (Vogel and others 2007). The researchers concluded that 'silence from fathers about seeking help may be further reinforcing gender stereotypes of help seeking'. UK research into parents' and carers' experiences and dilemmas about seeking help for their children's severe behavioural problems identified particular reservations among males about attending parenting programmes, which were seen by some as inconsistent with their perception of male identity (Khan 2014). Women are also more likely to participate in research about their children's mental health needs (Sayal and others 2010; YoungMinds 2014).

Parental affirmation and support for LGBT children and young people's gender expression has been found to be important for their mental health (e.g. Olson and others 2016; D'Augelli and others 2005). Based on interviews with parents of pre-pubescent children with gender identity issues, Gregor and others (2015) identified five key themes in parents' experiences: loss, uncertainty, ambivalence, being unable to think and acceptance. A study of children and young people with features of gender dysphoria found that significantly more of those who were assigned female at birth were living in their chosen gender than those who were assigned male (Holt and others 2014).

Schools

Children and young people spend a large proportion of their time at school, and participation in education can expose them to risk factors for mental health (e.g. bullying, academic pressure); and resilience factors (e.g. positive social relationships, educational achievement, opportunities to explore talents and interests) affecting mental health. Education professionals are well-placed to recognise children and young people's mental health needs and provide information, support and referrals (ASCL and NCB 2016; Hagell and others 2015); parents may also approach them with concerns about children's behaviour and well-being (Green and others 2005). Schools are also one location in which children and young people access early intervention mental health provision.

Teacher reports relating to 7,085 children from the Millennium Cohort Study sample (see page 10) suggest a much wider gender difference in children's mental health than parents' reports (Morrison Gutman and others 2015). The teacher ratings reflect a prevalence of severe conduct problems three times as high in boys as in girls, while the prevalence of severe hyperactivity/inattention problems is nearly five times as high. These discrepancies provide useful insights into possible prevalence by reflecting on children's presentation in both home and school contexts. They are also interesting in light of studies suggesting that teachers are more likely to identify boys than girls as having problems that concern them, and that this is linked to teachers' readier identification of externalising than internalising problems (Molins and Clopton 2002). Loades and Mastroyannopoulou (2010) observed that primary school teachers' were better able to recognise symptoms of a behavioural disorder in boys than girls, and symptoms of an emotional disorder in girls than boys; symptoms of a behavioural disorder stimulated more concern from teachers than those of an emotional disorder, which may be due to a lower tolerance of externalising problems in the classroom (Molins and Clopton 2002). Teachers may also find it difficult to gauge severity of anxiety in primary school-age children (Headley and Campbell 2011). Children and young people with internalising problems, or problems that do not conform to gender expectations, may then be overlooked in school. Although this evidence relates to primary school-age children, the pattern is worrying given that two in five girls aged 11 to 21, who are disproportionately affected by these issues, say they have personally needed help with their mental health, and that school/college is one of their preferred sources of information and support (Girlguiding 2015). On the other hand, school and college leaders have identified anxiety or stress as the most prevalent mental health and well-being issue among school populations (ASCL and NCB 2016).

Conduct disorders have been strongly associated with school exclusion (Cole 2015; Green and others 2005). Boys are three times more likely than girls to be excluded, and children of black Caribbean ethnicity and of mixed ethnicity (white and black Caribbean heritage) are overrepresented in the statistics (DfE 2015). Cole (2015) has explored the complexities of school exclusion being seen, or not seen, as related to mental health issues. Khan (2016) highlights that despite evidence of black boys having lower rates of diagnosable mental health problems (and therefore conduct disorders) than other children, they are most likely to be excluded from school and more likely to develop a severe mental illness in young adulthood, suggesting that recognition of, and professional responses to, the mental health needs of black boys are lacking in comparison with their peers.

Four out of five 11–15 year olds say that they have at least one teacher they can go to if they have a problem, with little difference according to gender (Brooks and others 2015); however, other evidence indicates that young people will not necessarily seek help (see page 23). Trans young people report difficult experiences at school, with poor access to support and information, little or no coverage of transgender issues in sex and relationships education, and limited efforts to promote inclusion and tackle discrimination (METRO 2013). Universities appear to be experienced more positively by trans young people.

Children's well-being can also be affected by the rigid ways in which gender norms are often enacted in school environments (Ringrose and Renolds 2008). The extent of sexual harassment and sexual violence in schools (Fixers 2016), transphobic bullying (McDermott and others 2016) and concerns about academic underachievement among boys (Wilkins 2010) highlight the relevance of gender to children and young people's well-being at school, and the need for gender-

responsiveness within education.

In terms of what young people want from schools, findings from YoungMinds suggest that adolescent females are more likely to choose face-to-face counselling as their preferred form of mental health support provided by schools, whilst males are more likely to choose counselling for pupils delivered online (YoungMinds 2014).

Health and other services

A wide range of public services plays important roles in children and young people's emotional and mental health. These include primary care; emergency care; child and adult mental health services; drug and alcohol services; the care system; children's and adult social care; early intervention services; and the criminal justice system among others. The voluntary sector plays a key role in supporting individuals and families - often with specialist knowledge, holistic approaches and closeness to communities served - but access to these services is compromised by lack of funding and resources (NCB 2011; Youth Access 2015; Imkaan 2015). Religious authorities or groups did not arise in the literature as a preferred source of help for children and young people, though the importance of access to services that understand how faith-based values and expectations relate to mental health was noted (Street and others 2005; FORWARD 2016).

This section focuses on health services, although, where evidence-based interventions can be effectively provided outside specialist mental health settings, this can reduce medicalisation and stigma associated with children and young people's behaviours and needs (e.g. Brown and others 2012), which can be gendered.

Gender and the visibility of needs and experiences

Professional practice and research may overlook gender dimensions in favour of gender-neutral approaches. Whilst there are good reasons for such approaches, they miss important aspects of children and young people's needs and experiences. For example, male experiences of eating disorders may be invisible (Räsänen and Hunt 2014; Wilkins and Kemple 2011), whilst social and cultural aspects of eating disorders may be marginalised in treatment for affected women (Holmes 2016) despite eating disorders being widely perceived as a 'female' issue.

There are ongoing debates regarding gender bias in the diagnosis and treatment of mental health conditions (WHO 2009). For example, a range of theories explains the gender split in autism (see NAS 2016) and ADHD (Rucklidge 2010). Many of these relate to under-referral of women and girls and historical bias towards men and boys in the diagnostic criteria. It has been proposed that each condition manifests differently in males and females; that females may mask their symptoms; and that the diagnostic frameworks do not reflect these variations (Gould and Ashton-Smith 2011 and Attwood 2007, cited in NAS 2016; Quinn and Madhoo 2014). The diagnostic criteria for conduct disorder have also been questioned in terms of their suitability for girls (Moffitt and others 2008).

The Men's Health Forum has suggested that common mental health conditions may be under-diagnosed in males, citing gender disparities in a range of areas including suicide, missing people, rough sleepers, the prison population, and compulsory detention of psychiatric inpatients, which 'suggest that male emotional and psychological distress may sometimes emerge in ways that do not fit comfortably within conventional approaches to diagnosis' (Wilkins 2010). There is concern that when children and young people present with risky or challenging behaviours, parents and professionals often focus on correcting a problem with the individual, labelling them as naughty, anti-social, oppositional, defiant or disruptive at the expense of understanding the cause (YoungMinds 2016; Brown and others 2012) (see page 20). Wilkins and Kemple (2011) suggest that 'boys are a population group for which society lacks tolerance'. Wilkins (2010) also argues that 'the internationally recognised symptomatology for depression inclines towards a view of the disease that emphasises a more "typically female" form of presentation i.e. one in which the patient is tearful, withdrawn, and lacking in motivation and energy'; more 'typically male' externalising behaviours may not be recognised as symptoms of depression, and may also 'militate against a sympathetic response' from professionals and others.

Primary care

Young children are among the groups most frequently seen by GPs. Data shows that consultation rates are similar for male and female children, and decline across the age groups until middle childhood (HSCIC 2009). However, in their teens and early adulthood, young women visit their GP more than young men (Hagell and others 2015); despite this, a survey of 11–15 year olds found that 15-year-old girls were the group least likely to say they felt at ease with their GP and able to discuss personal problems (Brooks and others 2015). Whilst the reasons for and content of many consultations will be unrelated to mental health symptoms, these patterns show that GPs have better opportunities to identify young women with potential difficulties than young men, if not the most conducive patient-doctor relationships.

An investigation into GPs' perceptions of children's mental health problems found that, whilst most GPs can identify symptoms of a common emotional or behavioural disorder in primary school-age children, they were more concerned when the child was male or displaying symptoms of a behavioural disorder (Jacobs and Loades 2016).

Mental health services

Young people are in broad agreement about the elements of good mental health support provision. When asked by YoungMinds (2014), adolescent females prioritised 'The person that gives me support is someone I feel comfortable talking to and can be honest with'; 'The support is

confidential and private and no one would know I have used it'; and 'I can get help quickly when I need it'. Males rated confidentiality and privacy as their top priority, followed by the person providing support. 'The support is provided somewhere I can get to easily and quickly' was the third most important element for males. Given the importance to young people of the individuals supporting them, it should be noted that the practice of individual professionals can be gender-informed even if they operate in a largely gender-neutral environment. When consulting mental health professionals on male mental health, Wilkins and Kemple (2011) found that many had developed through experience 'a clear professional sense of the differences between working with men and working with women'.

It is difficult to identify any gender differences in how well specialist services are serving children and young people. The limited available data on children and young people's pathways into, experiences of, and outcomes after accessing CAMHS generally includes limited gender-disaggregated information (NHS England 2014; House of Commons Health Committee 2014; Frith 2016; OCC 2016). The evidence base supporting specific interventions for children and young people with different emotional and mental health difficulties is evolving (see DH and NHSE 2015; Murphy and Fonagy 2013; Khan and others 2015; Knapp and others 2016). However, the government has acknowledged the urgent need for significant investment and the use of evidence-based approaches in children and young people's mental health provision, and a major programme of service transformation is underway. Reporting from the recently developed CAMHS Minimum Dataset will allow specific outcome metrics by condition, activity and evidence-based interventions (DH and NHSE 2015).

A recent investigation into CAMHS referrals indicates a slight over-representation of females (OCC 2016). An analysis of recent trends in children's mental health and well-being concluded that these 'suggest that an increased focus on interventions to tackle disruptive behaviour has helped boys, but there have been no similar interventions to tackle emotional problems, which are more likely to affect girls' (ONS 2015b). Children with conduct disorders comprise a considerable

The use of pharmacological interventions in children and young people

The prescription of antidepressants for children and adolescents in the UK increased by over 50% between 2005 and 2012 (Bachmann and others 2016). The researchers found no substantial evidence of an increase in mental health conditions, and suggested that limited availability of psychological therapies may have been a factor. Girls aged 12–18 are more likely than boys to be prescribed antidepressants, at least by GPs (Wijlaars and others 2012), so this is of particular concern for them, given recent research findings that children and young people's risk of suicidality and aggression doubles with the use of antidepressants (Sharma and others 2016). NICE clinical guidelines state that antidepressants may be considered for children and young people with moderate to severe depression only in combination with psychological therapy (NICE 2005).

Concerns have been expressed about over-medication of children with ADHD (e.g. Boffey 2015) in light of a steep rise in drug prescriptions over the past two decades. However, researchers have attributed this trend to improved understanding of the condition, and prescribing has levelled off in recent years (Beau-Lejdstrom and others 2016). Of nearly 15,000 children prescribed at least one drug to treat ADHD between 1992 and 2013, 85% were male. The diagnosis and medication of children and young people with ADHD is a controversial area, attracting much debate, including on gender issues (Parens and Johnston 2009; Timimi 2005). UK prescribing rates for ADHD drugs are considerably lower than in many other countries; however, children stay on treatment for longer (Beau-Lejdstrom and others 2016). There is uncertainty about the effects of drug treatment for ADHD in the long-term and in less well-studied groups; NICE guidelines recommend that drugs should be used only as a last resort (NCCMH 2009).

There is widespread concern about the use of psychotropic drugs in people with learning disabilities without clinical justification, often to treat challenging behaviour (McQuire and others 2015; Sheehan and others 2015; NHS England 2016b). Boys and young men are likely to be disproportionately affected by this issue (see page 37).

proportion of the work of CAMHS and the wider health and social care system (NCCMH 2013).

Data on contact between individuals and adult mental health and learning disability services in 2014/2015 (HSCIC 2015d; HSCIC 2015e) show some gender differences for children under 18, though numbers are small. Females aged 18–19 were more likely to have contact with these services than males, though males in this age group were the most likely, out of any group aged below 50, to be hospitalised under the Mental Health Act 1983. Clearer patterns are evident in the 20–29 age bracket: males are more likely to be detained for up to 72 hours under the Mental Health Act; more likely to spend time in hospital after coming into contact with services; and more likely to be subject to compulsory admission. This reflects other evidence that boys and men often reach crisis point before receiving services, first experiencing what Brownhill and others (2005) describe as the 'big build': 'a trajectory of emotional distress manifest in avoidant, numbing and escape behaviours which can lead to aggression, violence and suicide'.

McNeish and Scott (2014) have raised concern about the issue of girls under 18 being admitted to adult mental health wards, in particular mixed-sex facilities. Wilkins and Kemple (2011) have commented that some inpatient staff have a damaging 'generalised perception' that all male inpatients are potentially violent. They noted the potential value of inpatient stays for men (of any age), and the need for effective information provision, activities to counter boredom, safe spaces to talk, and recovery-based approaches.

What works in prevention, health promotion and early intervention?

The Centre for Men's Health at Leeds Beckett University, in collaboration with the Men's Health Forum, has identified elements of mental health provision that work well for boys and men, focusing on health promotion, early intervention and stigma reduction. This work gathered evidence from research, projects and experts (Robertson and others 2015).

Naturally, no 'one-size-fits-all' solution is identifiable, but a number of elements can encourage male engagement with interventions: personal approaches, providing reassurance about confidentiality; removal of stigma through embedding initiatives in generalised services; hopeful stories of men recovering from mental health problems; 'male positive' leadership; and 'male friendly' language not overly linked to health. Solution-focused interventions that encourage ownership, involvement and action can be motivating. The settings that appear most appealing to boys and young men are schools, physical activity settings and virtual settings. Interventions based around activities, including exercise and sport, have shown good results with men. Interventions for which there is positive or mixed evidence include peer support in some settings; mentoring for boys; mindfulness-based interventions; and 'arms-length' (telephone and online) suicide prevention. There is also evidence that secondary school counselling interventions can effectively reduce distress, with similar results for girls and boys, despite lower uptake in boys (Robertson and others 2015).

Wilkins and Kemple (2011) have proposed a range of approaches to improve practice in male mental health, including for men and boys with diagnosed mental health problems and other specific experiences or needs. They concluded that inter-agency working in the early years could contribute significantly to the emotional development of boys.

McNeish and Scott (2014) have summarised the variable evidence for interventions that may address risk factors in the lives of girls and young women, and ameliorate negative outcomes. These include programmes to reduce domestic abuse within families and young women's own intimate relationships; promote attachment in early childhood; home-visiting programmes; pre-school education; interventions with parents to address conduct problems; school-based programmes to improve emotional and social competencies or promote mental health; dialectical behaviour therapy adapted for adolescents; multi-systemic and functional family therapies; and programmes to prevent offending and teenage pregnancy.

McDermott and others (2016) have identified that trans young people prefer to access mental health provision that is LGBT youth specific and delivered online or face-to-face in non-clinical settings. Further development of, and research into, interventions is needed.

5. Service responses to the needs of some particular groups of children and young people

This section addresses service responses to some specific groups, though gender differences and considerations will also be relevant to other services, groups of children and young people and areas of need. Some attention is devoted to the criminal justice system, given that it is characterised by punitive responses to children and young people's behaviours and stark gender disparities.

Children and young people with experience of violence and abuse

Experiences of violence and abuse are strongly related to subsequent mental health and the services people need and use (Scott and McManus 2015a; YoungMinds 2016). Children and young people often do not seek help for themselves and evidence suggests that their experiences are often missed by services and agencies, particularly in the groups least likely to self-disclose (see page 26 and sources cited). There is evidence that asking children and adults about past or present experiences of trauma, violence and abuse is not embedded as routine across all relevant public services (Smith and others 2015). Research suggests that many child and adult survivors of domestic abuse and child sexual abuse, if they seek help, have limited access to a range of support services and therapeutic interventions that appropriately address the impact of their experiences⁵ (Holly and others 2012; Smith and others 2015). In 2015, a survey by NSPCC of 1,308 professionals (including psychologists, GPs, teachers and social workers) found that over 95% believed that the availability of CAMHS and other services for children with experience of abuse or neglect was lacking (NSPCC 2015b).

Individuals affected by violence and abuse, and the specialist organisations that support them, have raised concerns that gender-neutral approaches and responses cannot effectively meet the needs of affected children and young people. In particular, a lack of gender-specific, age-appropriate services wanted and needed by girls and young women has been highlighted (WRC 2007; FORWARD 2016; Imkaan and others 2016), including services for Black, Asian and minority ethnic (BAME) girls and young women that reflect their identities in their leadership and staffing, speak their languages and understand their needs and experiences (FORWARD 2016).

An Inquiry into Child Sexual Exploitation In Gangs and Groups by the Office of the Children's Commissioner identified that 'while boys and young men might not be identified as victims, [...] girls and young women who were victims were often described by professionals in ways that were gender-stereotyped, such as being "promiscuous", and were in effect being seen as the agents of their own abuse' (Berelowitz and others 2012). This illustrates how gender-sensitive professional responses to violence and abuse are important for girls and young women, but also for boys and young men, as they experience different barriers to access. Understanding and responding to the needs of specific groups and diverse individuals, including trans and non-binary young people, is a challenge for statutory and non-specialist services (Berelowitz and others 2013).

Future in mind calls for trauma-focused care, to include greater professional awareness of the impact of trauma, abuse or neglect on mental health, and sensitive enquiry with children and young people about their experiences (DH and NHSE 2015). Since the publication of *Future in mind*, NSPCC has analysed local plans to take the *Future in mind* agenda forward (NSPCC 2016), and has identified a small number of plans that show good promise to close the gap in therapeutic support for children who have experienced abuse or neglect. However, NSPCC is concerned that, overall, many do not address the needs of these children. Inadequate or insufficient provision to address the mental health needs of children and young people who have experienced violence and abuse will disproportionately impact girls and young women (see page 16–17), as well as vulnerable boys and marginalised groups including trans and non-binary young people.

⁵ See Itzin and others (2010) for more on interventions.

Black, Asian and minority ethnic (BAME) children and young people

Ethnicity has a bearing on children and young people's well-being and mental health in diverse, complex and gendered ways, shaped by individual factors, social determinants, inequalities and discrimination, public policy and service responses (Street and others 2005; Malek 2011; Lavis 2014). The literature exploring these highlights significant progress still needed to improve BAME children's experiences and outcomes, including increased focus, further research and better data collection. Data from the Millennium Cohort Study indicates that severe mental health problems in 11-year-olds are most common among girls whose ethnic background is mixed, then among white boys, closely followed by black boys, though the discussion of these findings suggests these patterns are not straightforward (Morrison Gutman and others 2015).

Data on the representation of BAME children in CAMHS is inconsistent but suggests differences between ethnic groups and, in general, under-representation (DCSF and DH 2008), although recent data on CAMHS referrals indicates that mixed race children are more likely than any other ethnic group to be referred⁶ (OCC 2016). Meanwhile, BAME children and young people are over-represented in terms of other, more negative service responses relevant to their mental health need (Malek 2011). For example, 1.8 times as many black children come into contact with the youth justice system as would be expected given the composition of the population (Bateman 2015). Wright and others (2015) explain that:

BAME young people face more 'ingrained' pathways into the criminal justice system (CJS) as a result of greater levels of disengagement and exclusion from school, over representation in the care system and mistrust of mental health services (avoidance of which may put young people with 'challenging behaviour' at greater risk of CJS intervention). As a result, they are over-represented in all stages of the CJS, with differential treatment 'fast-tracking' them through criminal justice pathways.

BAME adults are more likely than their white counterparts to experience problems accessing mental health services, aversive pathway into services, and severe and coercive treatments (DH 2003).

The role of gender in this picture is particular to groups and individuals. BAME girls and young women affected by gender-based violence are particularly underserved by public services (FORWARD 2016), including non-specialist sexual violence services (Imkaan and University of Warwick 2015). However, responses to the mental health needs of black boys and young men⁷ have attracted the most observation, concern, research and debate, given the hugely disproportionate frequency with which their trajectories reflect the descriptions above (Bateman 2015; Young Review 2014). According to a review by the Sainsbury Centre for Mental Health (Keating and others 2002), 'stereotypical views of Black people, racism, cultural ignorance, and the stigma and anxiety associated with mental illness often combine' to create cycles of mutual fear and mistrust between black people and mental health services, perpetuating negative experiences and outcomes. This can apply to parents as well as young people (ROTA and YoungMinds n.d.). Keating (2007) has suggested that black males are particularly affected as barriers to male help-seeking (see Section 3) are compounded by black male perceptions of mental health services: young men can find that 'being seen as "big, black, bad, dangerous and mad" can lead to conceptions that they are less deserving of treatment that would lead them to pathways of recovery.' Keating explores the role that high profile cases can play in shaping perceptions of and about black men in relation to mental health services.

Whilst the literature features many examples of good practice and interventions, a recent review on improving outcomes for young black and/or Muslim men in the criminal justice system led by

⁶ Evidence on the mental health and well-being of mixed race children has been presented by Morley and Street (2014)

⁷ In the literature that discusses black people's mental health specifically, the term 'black' generally refers to people of African descent or origin, including those who are Black British, Black African and Black Caribbean ethnicity, and mixed heritage/origin.

Baroness Young concluded that 'despite the existence of knowledge and understanding of what the problem is, there has not previously been the level of leadership or sufficiently sustained effort to find solutions' (Young Review 2014). Meanwhile, the overrepresentation of black and mixed heritage young people – mainly male – in the youth justice system increases in line with the intensity of intervention, and appears to be worsening over time (Bateman 2015).

Young people involved in the criminal justice system

An estimated 30% of all criminal activity can be related to conduct disorder in childhood and adolescence, and a further 50% to other conduct problems (Sainsbury Centre for Mental Health 2009).

Gender is a major predictor of severe childhood behavioural problems and offending behaviour, which have strong links with mental health (see page 20) (Brown and others 2012; Cole 2015; YoungMinds 2013). Over 95% of young people in the youth secure estate, and of 18–24 year olds in prison, are male (MoJ and YJB 2016; PRT 2012). Girls are less likely than boys to come into contact with criminal justice agencies, committing fewer and less serious offences, with less likelihood of reoffending (Bateman 2015).

Offending behaviour in young men and women is met with different criminal justice responses, which are influenced by gender norms and stereotypes (Bateman and Hazel 2014). Females appear to receive more lenient treatment than males, with the exceptions of some specific responses and recent time periods (Nacro 2008). Research with adults has suggested that sentencers tend to see female offenders as 'troubled' and males as 'troublesome' (Gelsthorpe and Loucks 1997, cited in Bateman and Hazel 2014). However, there is evidence that young women are met with harsher responses than their male peers when their behaviour transgresses female norms (Bateman and Hazel 2014; Sharpe and Gelsthorpe 2015, cited in Bateman 2015). Also, sexually exploited girls and young women are routinely caught and convicted of crimes relating to their sexual exploitation, despite the victim and child-oriented approach enshrined in national policy (Phoenix 2012).

There is evidence that girls and young women in custody have higher levels of needs and vulnerabilities than males on a range of indicators, including mental health (Bateman and Hazel 2014), that require gender-sensitive responses. An inquiry into girls in the penal system concluded that 'gender neutral youth justice system based on the risk of offending has the potential to discriminate against girls, particularly when welfare needs are confused with risk [...] Girls are effectively pigeon-holed into a criminal justice system designed for the male majority' (APPG on Women in the Penal System 2012). *Girls in the Criminal Justice System*, the report from a joint inspection led by HM Inspectorate of Probation, presents examples of gender-sensitive approaches but also identifies 'serious deficiencies' and a lack of joined-up working and strategic-level thinking (HMIP 2014). The report makes recommendations aimed at Youth Offending Teams, local authorities and police forces.

Wilkins (2010) has noted a potential assumption that 'because most offenders are male, the existing services must have evolved to meet the needs of men well'. This is likely not the case: there are high levels of unrecognised and unmet mental health needs among young people at risk of offending or in contact with the youth justice system (Lennox and Khan 2013; YoungMinds 2013). Despite existing strategies with the potential to improve mental health provision for young people at risk of or engaged with offending behaviour, research by YoungMinds (2013) identified critical issues and obstacles to appropriate help.

Trans and non-binary children and young people

Guidance on supporting trans and non-binary children and young people's mental health and well-being is available, e.g. for nurses (PHE and RCN 2015) and psychologists (BPS 2012).

In one survey, over a third of trans young people had accessed counselling; some had also used mental health outpatient services (14%) and inpatient services (4%) since knowing they were trans (METRO 2013). The majority of trans young people felt that their gender identity was either not relevant to or had not adversely affected their experiences of health services (including GPs and

hospital clinics), help lines and counselling. Trans young people were more likely to report negative experiences of mental health services, including not 'connecting' with practitioners (METRO 2013; McDermott and others 2016). McDermott and others (2016) found that only one third of trans young people who had accessed NHS mental health services found them helpful. Trans adults have reported negative experiences when accessing general health services, mental health services and Gender Identity Clinics (McNeil and others 2012). Issues highlighted include the pathologisation of trans identities by professionals and the attribution of any presenting mental health issues to being trans. Trans people have expressed the need for health and social care services to recognise their identities, but to understand identity in the context of specific health problems with which individuals present – and not always as the first or most important aspect of their health care (National LGB&T Partnership 2016). McDermott and others (2016) have identified some of the reasons unrelated to sexual orientation and gender identity that most concern LGBT young people with experience of self-harm and suicidal feelings, e.g. academic pressure.

Findings from a survey of mental health professionals illustrate the importance and potential of LGBT awareness training to improve practice with trans young people (McDermott and others 2016).

Within the NHS, there is one specialist Gender Identity Development Service (GIDS) to support children and young people who experience difficulties in the development of their gender identity, based at the Tavistock Clinic in London. The GIDS comprises an interdisciplinary team led from within a mental health trust: the team includes child and adolescent psychiatrists, psychologists, social workers, psychotherapists and paediatricians. Although gender dysphoria is not a mental illness, left untreated, it can have serious consequences for mental health, including suicide. A recent inspection by the Care Quality Commission, which included feedback from young people and families, rated the service as 'good' (CQC 2016). However, Mermaids, a charity that supports children and young people with gender identity issues and their families, raises a range of concerns in a strongly-worded submission to a House of Commons Women and Equalities Committee inquiry into transgender equality (House of Commons Women and Equalities Committee, HC390 Ev TRA0156). These include problems with referral and access; the impact of waiting times on children and young people's mental health; transition to adult services; and criteria for the provision of hormone-blocking medication to delay the onset of puberty, and cross-sex hormone therapy to align a young person's secondary physical sexual characteristics with their gender identity. The report from the inquiry (House of Commons Women and Equalities Committee 2016), which also reviews gender identity services for adults, notes that the care of gender dysphoria in children and adolescents is a contentious and ethically complex area. It recognises the important and pioneering work of the Tavistock Clinic whilst making recommendations for the review of the service specification for the GIDS that is now underway.

Children and young people with learning disabilities and behaviours that challenge

Children and young people with learning disabilities are significantly more likely than those without to have autism, ADHD, conduct disorders, emotional mental health problems or psychosis (Emerson and Hatton 2007). Despite this, they experience additional barriers to getting their mental health needs met effectively (Bernard and Turk 2009). Those who display behaviours that challenge (including aggression, destruction and self-injury) are at greater risk of 'social exclusion, institutionalisation, deprivation, physical harm, abuse, misdiagnosis, exposure to ineffective interventions, and failure to access evidence-based interventions' (Emerson and Einfeld 2011 cited in CBF 2014). Better early intervention has been called for to improve outcomes for children and young people with learning disabilities whose behaviours challenge (CBF 2014), along with research on how best to meet the mental health needs of this group (Blackburn and others 2013).

Males are more likely than females to have learning disabilities and significantly more likely to be diagnosed with autism (Emerson and others 2012; Pinney 2014; see also page 18). Boys account for almost two thirds of inpatients aged under 18 in hospital settings for people with learning disabilities, autism and/or behaviour that challenges (HSCIC 2013 cited in Pinney 2014). In these settings, young people are frequently given antipsychotic medication (see page 31) and are more likely than older inpatients to experience self-harm, hands-on restraint and seclusion (HSCIC 2014 cited in Pinney 2014).

Conclusions

(Updated August 2017)

Gender plays out in many ways important to children and young people's emotional and mental health and well-being, influencing:

- the social environments in which they live, and their relationships with others
- their subjective well-being
- the stressors and difficulties they face, in particular any experiences of violence or abuse, and how they deal with these
- their knowledge and attitudes relating to mental health and help-seeking
- whether, where and how they seek help
- the ways in which parents and carers, teachers, health services and other agencies recognise and respond to their needs and behaviours, including treatments provided.

This will happen differently for each child or young person, in combination with a wide range of individual, social and structural factors, and in ways that change over the course of childhood. The literature also describes how gender differences shift over time, reflecting changes in demographics; stressors; public policy; the availability of evidence-based treatments and interventions; and professional practice.

Implications for policy and practice

Gender-blind approaches to children and young people's emotional and mental well-being miss important aspects of their needs and experiences. Gender needs active consideration in policy-making, commissioning, service design and delivery and workforce development. This is important in relation to mental health services for children and young people, but also other settings and systems that impact on their health and well-being, such as schools and the youth justice system. Greater gender-sensitivity would help to address particular areas of concern, such as:

- girls' and young women's subjective well-being and levels of self-harm
- the impact of gender-based violence and transphobia
- young male suicide
- responses to externalising behaviours, including the over-representation of young males, and BAME young males in particular, in the criminal justice system and acute mental health settings
- recognition of, and responses to, the needs of young people whose identities or behaviours do not neatly fit gender norms and expectations.

Future development of national policy and guidance should incorporate gender into frameworks relating to children and young people's mental health and well-being. Services should be encouraged and supported to address gendered issues.

Broader workforce development on mental health should address professionals' needs for skills and confidence to use gender-sensitive approaches when planning and delivering services. Our collection of practice examples illustrates some such approaches.

More detailed recommendations for policy and practice are provided in *Just getting on: Young people's views on gender, emotional well-being and mental health*.

The role of research and evidence

A 'National Study of Health and Wellbeing: Children and Young People' is due to report in 2018. This study will hopefully provide valuable gender-disaggregated data on the prevalence of mental and emotional disorders; other areas of health, well-being and development; social support; and service use. Importantly, it also takes account of other demographic characteristics. Data from this study should be used to underpin further research into how mental health promotion and support can be more gender-informed.

A report from the UK's Chief Medical Officer has called for more gender-specific research into resilience and well-being, protective factors and interventions for children (Davies 2013). There is a particular need for data on children and young people's experiences of using services, including children and young people's mental health services (CYPMHS) but also other provision important for individuals who do not meet the thresholds for CYPMHS support. Research into children, young people and parents' help-seeking behaviour would also be of value. Much of the available literature is from Australia and published a decade ago. Rickwood and others (2005) found that negative past experiences create barriers to seeking professional help, whilst positive past experiences act as a facilitator; intentions to seek help did not always translate into action. Available UK data is mostly from surveys in which young people are asked about help-seeking preferences, and responses cannot be differentiated by young people's level of need for help. More evidence on children and young people's pathways into health and other services, and the role of gender, is needed.

Evaluations of specific interventions should seek to identify gender influences and their practical implications, supporting evidence-informed commissioning.

Find out more

Other outputs from this project include:

- *Gender-sensitive approaches to addressing children and young people's emotional and mental health and well-being: Examples of promising practice*
- *Just getting on: Young people's views on gender, emotional well-being and mental health.*

All publications are available at <https://www.ncb.org.uk/genderandmentalhealth>. A wide range of other resources from NCB on children and young people's health and well-being can also be found on our website.

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