

# THE NEED FOR A GENDER-SENSITIVE APPROACH TO THE MENTAL HEALTH OF YOUNG CANADIANS

BY GIRLS ACTION FOUNDATION  
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# THE NEED FOR A GENDER-SENSITIVE APPROACH TO THE MENTAL HEALTH OF YOUNG CANADIANS:

## EXECUTIVE SUMMARY

By POWER Camp National, Lia DePauw and Juniper Glass, June 2008

### 1. INTRODUCTION

Mental health and mental illness are leading health issues faced by Canadian youth (Waddell et al., 2005). Yet, the child and youth mental health system is fragmented and under-funded, leading to the dubious distinction of “the orphan of the orphan” of the Canadian health care system (Kirby & Keon, 2006). Efforts to address these shortcomings need to go beyond enhancing early intervention and treatment to also focus upstream to understand and address the factors that affect young people’s mental health.

This paper is intended to help inform and increase the effectiveness of policies, programs and services to promote mental health and prevent mental illness among young people. The paper seeks to illustrate the need to take gender and other intersecting forms of diversity into account to truly meet the needs of Canada’s young people by examining how mental health outcomes are affected by social and economic characteristics. Recommendations, promising practices, and gaps in the evidence base are also identified.

The paper presents current evidence on mental health outcomes among young Canadians aged 10 to 24 as well as some of the pathways that contribute to inequities in these outcomes. Evidence was collected from peer-reviewed and grey literature examining mental health and mental illness among young people, published



between 2000 and 2008. In some cases, evidence from prior to 2000 was included and research on young people from the United States was used where sufficient Canadian evidence was not available.

## 2. DOES GENDER MATTER IN YOUTH MENTAL HEALTH?

### **A Snapshot: Gender differences in mental health and mental illness among Canadian young people**

*Data collected through national and provincial surveys provide a snapshot of mental health among Canadian young people.*

#### **Mental Health**

- Young women are more likely to report feeling constantly stressed than young men (44.0% vs. 28.7%) (CAMH, 2005).
- Aboriginal girls are more likely to feel seriously distressed than the general population of girls in BC (14% vs. 10%); among Aboriginal youth, more females experience severe distress compared to males (14% vs. 5%) (McCreary 2005).
- As girls grow older, they experience a steady decline in their confidence that is not seen in their male counterparts. In 2002, 4.7% of Grade 6 girls reported not feeling confident compared to 17.5% of Grade 10 girls (PHAC, 2004).

#### **Mental Illness**

- Higher rates of depression are consistently documented among adolescent girls and women than their male counterparts. The female-to-male incidence of depression averages 2 to 1 (Parry et al, 2006; PHAC, 2006; Diaz et al. 2006).
- Young women are more likely to report having thought about (18.6% vs. 12.1%) and attempted (5.9% vs. 2.2%) suicide than their male counterparts. Girls 10 to 14 years are 5 times as likely to be hospitalized as their male counterparts. The mortality rate due to suicide for young men, however, is 2.8 times higher than young women (PHAC, 2006).
- Young men are half as likely to be hospitalized for problems related to mental health



or substance abuse than young women (1.9% vs. 4.1%) (PHAC, 2006).

- Young women aged 15 to 24 are more likely to report an unmet service need related to their mental health or substance use than young men (27.6% vs. 17.5%) (PHAC, 2006).

It is clear that differences exist between male and female youth on many indicators of mental health and mental illness. Generally, the data reveals that girls and young women are more likely to ‘act-in’ or internalize mental health issues and mental illnesses, while boys and young men are more likely to ‘act-out’ or externalize mental health issues (see tables 1 and 2).

**Table 1: Lifetime Prevalence of Selected Mental Illnesses among Youth 15 to 24 (2002 Canadian Community Health Survey)**

<b>Mental Illness</b>	<b>Female</b>	<b>Male</b>
Depression	13.9%	6.6%
Anxiety disorder	14.7%	9.6%
Eating disorder	1.5%	N/a
Proportion of population meeting criteria for alcohol or illicit drug use during lifetime	5.5%	11.6%

**Table 2: Prevalence of Selected Externalized Indicators of Mental Health among Ontario Students (2005 Ontario Student Drug Use and Health Survey)**

<b>Indicator</b>	<b>Female</b>	<b>Male</b>
Delinquent behaviour	10%	16%
Violent behaviour	7%	16%
Bullying	25%	29%
Gambling problem	2%	7%



Gender also intersects with other key factors. While most surveys do not provide data disaggregated by ethno-racial groups or newcomer status, available data suggests that there are differences in mental health and mental illness outcomes based on these factors. Findings from BC, for example, indicate that Aboriginal youth experience poorer mental health and mental illness compared to their non-Aboriginal counterparts. American studies suggest that this may also be true of other racialized<sup>1</sup> young people: depression, for example, is more common in both male and female racialized youth than their white counterparts (Brown et al., 2007; Meadows et al., 2006).

The evidence raises important questions, including why are there differences in these indicators between groups of young people, what do these differences indicate, and are the causes behind these differences problematic. Answers to such questions were sought through available qualitative research studies and inequality theory.

### **3. WHY DO MENTAL HEALTH DIFFERENCES EXIST BETWEEN DIFFERENT GROUPS OF BOYS AND GIRLS?**

Understanding how the intersections of gender, poverty, racialization, Aboriginal status and other factors affect youth mental health.

There is great diversity among Canadian children and youth, including differences due to gender, ethno-racial background, Aboriginal status, poverty, ability, newcomer status, and sexual orientation. These characteristics are valued and responded to differently by Canadian society, contributing to inequalities in young people's exposure to risk and protective factors, health outcomes, and their access to health services (Hutchinson et al, 2004).

Gender socialization has a particularly important impact in a young person's life and their mental health (Bell-Gadsby et al., 2006; Feder et al., 2007; Hoskin, 2002; Powelson, 2004). Every day, young people encounter messages about the roles,

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<sup>1</sup> 'Racialization' is defined as the complex processes through which ethno-racial groups are seen as different and treated unequally, resulting in social, economic, and political inequities; "racialized" refers to groups subjected to these processes (Access Alliance, 2007).



attributes, identities, and expectations considered appropriate for people of their sex, through media images; treatment by educational, health, immigration and other institutions and systems; interactions with parents, teachers, and other adults; and peer relationships.

This creates pressures that can lead to negative impacts on the mental health of girls (see Girls Inc., 2006; Hoskin, 2002; Zurbriggen et al., 2007) and, as is increasingly recognized in the research, the mental health of boys (see CMHA, n.d.; Feder et al., 2007; Meadows, 2007; Tyyska, 2008). The evidence also suggests that male and female youths are taught to cope with life's challenges in different ways, often resulting in the internalization of problems among girls and the externalization of problems among boys (Bell-Gadsby et al., 2006; Meadows, 2007).

Gender intersects with other socio-economic factors influencing mental health, such as ethno-racial background, Aboriginal status, poverty, (dis)ability, newcomer status, and sexual orientation. Aboriginal youth, for example, face many social, political, and economic inequities related to a history of cultural oppression, including poverty, racism, inter-generational effects of residential schools, and lack of access to health, social, and educational programs (Brown, 2004; Kirmayer et al., 2000; MCFD, 2003). These conditions heighten the likelihood that Aboriginal young people will encounter a wide range of risk factors that affect their mental health.

As a result of the concentration of poverty and income insecurity in racialized communities (Access Alliance 2007; Crowe 2006; Khanlou et al 2003; PHAC 2004), racialized youth are more likely to grow up in environments with more risk factors and fewer protective factors. Social biases that privilege whiteness and white culture also affect the mental health of young people from racialized communities (Anisef & Kilbride 2000; Khanlou & Crawford 2006; Lee 2004; WHIH 2003). While all young people struggle to develop a sense of self, racialized youth “face added challenges, such as being labeled ‘other,’ ‘dissimilar,’ and ‘foreign’” (CAMH 2006, 27).

In addition to often experiencing racialization, newcomer youth face additional stresses related to settlement and cultural adaptation processes (Anisef & Kilbride, 2000; Crowe, 2006). Refugee youth may also be coping with trauma related to having lived in war-torn countries and entering a formal school system for the first time or after a long break (Crowe, 2006).



#### **4. CONCLUSION & RECOMMENDATIONS**

Available research suggests that there are marked differences in mental health outcomes between female and male youth, and that these differences are related to inequalities and inequities in the lives of young Canadians, as a result of gender and several intersecting social and economic attributes. There is a need for a gender- and diversity-sensitive approach to designing policies, programs and services to promote mental health and prevent mental illness among young people. The following recommendations emerged from the review of available evidence.

##### **1) DEVELOP AND COORDINATE POLICY FRAMEWORKS TO PROMOTE MENTAL HEALTH AND PREVENT MENTAL ILLNESS AMONG CHILDREN AND YOUNG PEOPLE**

According to the WHO (2005), policy and legislation are important for children and young people's mental health. Such a framework should take a public health approach. This would involve broadening the current emphasis on treatment to focus more heavily upstream on the promotion and prevention by supporting healthy development among all young people and targeting of resources and services towards vulnerable young people (Waddell et al., 2002; Waddell et al., 2005).



**II) BASE THE POLICIES, PROGRAMS, AND SERVICES OF THE YOUTH MENTAL HEALTH SYSTEMS ON AN ANALYSIS OF GENDER AND OTHER FORMS OF DIVERSITY**

The effectiveness of the mental health system and policy frameworks is contingent on their ability to be responsive to gender differences and other forms of diversity and inequalities within Canada's child and youth population (Hutchinson et al. et al., 2004). A thorough gender-based analysis (GBA) involves identifying and understanding differences in health outcomes, pathways, and access to services related to gender and the intersecting factors of socio-economic status, ethno-racial background, Aboriginal status and other inequalities.

**III) ENHANCE THE EVIDENCE BASE TO INCREASE UNDERSTANDING OF THE INFLUENCE OF GENDER AND OTHER FORMS OF DIVERSITY ON YOUNG PEOPLE'S MENTAL HEALTH**

The availability and quality of evidence impacts the effectiveness and efficiency of efforts to promote mental health and prevent mental illness among children and youth (Waddell et al., 2005). There is a need to enhance the Canadian evidence base on health outcomes, health inequities among groups of youth and the pathways that contribute to these differences, and the effectiveness of mental health policy frameworks, programs, and services.



**IV) INVEST IN GENDER-SPECIFIC, DIVERSITY-SENSITIVE PROGRAMS THAT PROMOTE YOUTH MENTAL HEALTH AND EMPOWERMENT AT THE COMMUNITY LEVEL**

More and better programs are required to promote young people's mental health. The evidence from both the health promotion and youth development fields suggest that the young people's active and meaningful engagement in their community has positive impacts on their health and development (Joubert & Raeburn, 1998; McCreary, 2002; Valatais, 2002). Community participation and taking action on issues that impact their lives contributes to young people's empowerment, which is critical for mental health (Joubert & Raeburn, 1998).

To address challenges to girls' health and development, some youth-serving organizations have developed all-girl programs that enhance empowerment through community action. These programs typically include activities that build the capacity of female youth by enhancing their knowledge, critical-thinking, and skills; safer spaces in which girls can acknowledge their experiences and find out they are not alone; interaction with supportive role models; and learning and empowerment through community action. There is potential that such program elements could be transferred to programs seeking to enhance the mental health of other groups of young people, such as newcomer youth and male youth.

It is recommended that multi-year pilot projects be supported that use an approach informed by gender and diversity analysis to empower young people and increase their resilience. Adequate resources are required for testing, evaluation and knowledge transfer to ensure that successful programs can be initiated in other communities across Canada.



## **V) CREATE SUPPORTIVE ENVIRONMENTS**

Interventions are also required at the community-level to create environments that support young people's development and mental health, such as ensuring availability and access to health promoting social and material resources (Joubert & Raeburn, 1998). Universal and targeted programs are required to bolster protective factors and reduce risk factors in key social environments - namely the family, school, and community. This includes reducing poverty and violence, enhancing student readiness and engagement, and providing a wide range of accessible extracurricular activities and non-formal learning opportunities.



# THE NEED FOR A GENDER-SENSITIVE APPROACH TO THE MENTAL HEALTH OF YOUNG CANADIANS

## 1. INTRODUCTION

### BACKGROUND

Mental health and mental illness<sup>2</sup> are leading health issues faced by Canadian youth: It is estimated that the 20% of 4 to 17 year olds live with a mental health problem, while 14% live with a clinically important mental disorder (Waddell et al., 2005). Yet, the child and youth mental health system is fragmented and under-funded, leading to the dubious distinction of “the orphan of the orphan” of the Canadian health care system (Kirby & Keon, 2006). Efforts to address these shortcomings need to go beyond enhancing early intervention and treatment to also focus upstream to understand and address the factors that affect young people’s mental health.

Moving upstream means broadening the frame of reference from the individual to examine the context and circumstances of their life. Indeed, there is increased recognition that the health of young people is shaped by the contexts<sup>3</sup> in which they live, learn, and play (Hutchinson et al. et al., 2004; Waddell et al., 2005; WHO, 2007). This understanding is also reflected in Health Canada and the Public Health Agency of Canada’s population health approach, which is intended to enhance health and

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<sup>2</sup> Mental health is “the capacity of each and all of us to feel, act, and think in ways that enhance our ability to enjoy life and deal with the challenges we face.” Mental health is often confused with mental illness, which is “a biological condition of the brain that causes alternations in thinking, mood, or behaviour (or some combination thereof) associated with significant distress and impaired functioning” (PHAC, 2006, i).

<sup>3</sup> “Context...is the social, temporal and geographic location in which culture is manifested.” (Ungar et al, 2007, 291).



well being and to reduce health inequalities among population groups by addressing the broad range of social, political, and economic factors that influence health.

## **APPROACH**

By providing gender- and diversity-sensitive evidence, this paper is intended to help inform and increase the effectiveness of policies, programs and services to promote mental health and prevent mental illness among young people. Recommendations, promising practices, and gaps in the evidence base are also identified to facilitate the development of more effective responses to improve the mental health of young people in Canada.

While there are many similarities among young Canadians, this population group is increasingly characterized by its diversity (Hutchinson et al., 2004). The evidence base indicates that mental health outcomes are experienced by different groups of girls and boys depending on several intersecting social and economic attributes, such as gender, ethno-racial background, Aboriginal status, poverty, (dis)ability, newcomer status, sexual orientation, and other differences.

It is beyond the scope of the paper to provide a comprehensive review of evidence on young people's mental health. Rather, the paper seeks to illustrate the need to take gender and other intersecting forms of diversity into account to truly meet the needs of Canada's young people. While it is not within the scope of this paper to examine all of these intersections in depth, by highlighting some of them an attempt has been made to illustrate the great need for approaches to mental health promotion and mental illness prevention that are sensitive to gender and other forms of diversity among youth.

## **METHODOLOGY**

This paper presents current evidence on mental health outcomes among young Canadians aged 10 to 24 as well as some of the pathways that contribute to inequities in these outcomes. Evidence was collected from peer-reviewed and grey literature examining mental health and mental illness among young people, published between 2000 and 2008. In some cases, evidence from prior to 2000 was included and research on young people from the United States was used where sufficient



Canadian evidence was not available. This paper focuses on pre-adolescents and youth, rather than young children, and uses the terms ‘children’ (under 15 years), ‘youth’ (15 to 24), and ‘young people’ (10 to 24).

## 2. DOES GENDER MATTER IN YOUTH MENTAL HEALTH?

### **Differences in mental health outcomes for female & male youth**

Data collected through national<sup>4</sup> and provincial surveys<sup>5</sup> provides a snapshot of mental health and mental illness among Canadian young people, namely the prevalence of various health outcomes among young people and differences in outcomes between groups of young people. The findings raise three important points in relation to young people’s mental health and mental illness.

First, young people are affected by mental health and mental illness problems at a higher rate than other age groups. For example, in the 2002 CCHS, young people aged 15 to 24 years had the highest prevalence of mood or anxiety disorders and substance dependence problems of any age group, with 19.8% of young women and 17.5% of young men affected (PHAC, 2006).

Second, differences exist between male and female youth on many indicators of mental health and mental illness. Generally, the data reveals that girls and young women are more likely to ‘act-in’ or internalize mental health issues and mental illnesses, reporting higher rates of depression, psychological distress, eating

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<sup>4</sup> This includes the Health Behaviours of School-Aged Children (HSBC) and the Canadian Community Health Survey (CCHS). The HSBC is a school-based study of young people aged 11 to 15 administered by the World Health Organization (WHO) in 35 European and North America countries, including Canada under the Public Health Agency of Canada (PHAC). The CCHS is a cross-sectional survey of Canadians aged 15 and older administered by Statistics Canada.

<sup>5</sup> Provincial surveys include the Ontario Student Drug Use and Health Survey (OSDUHS) and BC’s Adolescent Health Survey (AHS). The OSDUHS is a population survey of young people in grades 7 to 12 administered by the Centre for Addictions and Mental Health, a WHO collaborating centre. It gathers epidemiological trends on drug use, mental health, physical activity, and risky behaviour. The OSDUHS is the longest ongoing school survey in Canada, started in 1977. The AHS is a population survey of BC students in grades 7 to 12, administered by the McCreary Centre Society in collaboration with the provincial government.



disorders, and anxiety disorders (see Table 1). Boys and young men are more likely to ‘act-out’ or externalize mental health issues, reporting higher rates of delinquency, substance use, and problem gambling (see Table 2).

**Table 1: Lifetime Prevalence of Selected Mental Illnesses among Youth aged 15 to 24 as reported in 2002 Canadian Community Health Survey**

<b>Mental Illness</b>	<b>Female</b>	<b>Male</b>
Depression	13.9%	6.6%
Anxiety disorder	14.7%	9.6%
Eating disorder	1.5%	N/A
Proportion of population meeting criteria for alcohol or illicit drug use during lifetime	5.5%	11.6%

**Table 2: Prevalence of Selected Externalized Indicators of Mental Health among Ontario Students as reported in 2005 Ontario Student Drug Use and Health Survey**

<b>Indicator</b>	<b>Female</b>	<b>Male</b>
Delinquent behaviour	10%	16%
Violent behaviour (assault)	7%	16%
Bullying	25%	29%
Gambling problem	2%	7%

Third, while most of the surveys do not provide data disaggregated by ethno-racial groups or newcomer status, available data suggests that there are differences in mental health and mental illness outcomes based on these factors. The findings from BC’s AHS, for example, indicate that Aboriginal youth experience poorer mental health and mental illness compared to their non-Aboriginal counterparts. American



studies suggest that this may also be true of other racialized<sup>6</sup> young people: depression, for example, is more common in both male and female racialized youth than their white counterparts (Brown et al., 2007; Meadows et al., 2006).

These findings raise important questions, including why are there differences in these indicators between groups of young people, what do these differences indicate, and are the causes behind these differences problematic. For example, the finding that Ontario girls are twice as likely to be prescribed medication for depression as boys raises questions about whether this is a result of a higher prevalence of depression in girls, over-prescription of medications, enhanced access to care for mental illness, or other factors. Answers to such questions were sought through available qualitative research studies and inequality theory.

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These findings raise important questions, including why are there differences in these indicators between groups of young people, what do these differences indicate, and are the causes behind these differences problematic. For example, the finding that Ontario girls are twice as likely to be prescribed medication for depression as boys raises questions about whether this is a result of a higher prevalence of depression in girls, over-prescription of medications, enhanced access to care for mental illness, or other factors. Answers to such questions were sought through available qualitative research studies and inequality theory.

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<sup>6</sup> 'Racialization' is defined as the complex processes through which ethno-racial groups are seen as different and treated unequally, resulting in social, economic, and political inequities; "racialized" refers to groups subjected to these processes (Access Alliance, 2007). The authors have elected to use 'racialization' and 'racialized' rather than 'visible minority' in an effort to draw attention to these processes on the mental health of young people of colour.



## **A Snapshot of Outcomes: Mental health and mental illness among Canadian young people**

### **Mental Health**

- Young women are more likely to report feeling constantly stressed than young men (44.0% vs. 28.7%); Reports of feeling constantly stressed increases for all youth as grade-level increases (22% of 7<sup>th</sup> Graders vs. 48% of 12<sup>th</sup> Graders) (CAMH, 2005).
- Aboriginal girls are more likely to feel seriously distressed than the general population of girls in BC (14% vs. 10%); among Aboriginal youth, more females experience severe distress compared to males (14% vs. 5%) (McCreary 2005).
- As girls grow older, they experience a steady decline in their confidence that is not seen in their male counterparts. In 2002, 4.7% of Grade 6 girls reported not feeling confident compared to 17.5% of Grade 10 girls (PHAC, 2004).
- Girls in Ontario are more likely to report low self-esteem (11% vs. 8%) and to think of their self as worthless (16.2% vs. 9.4%) than their male counterparts (CAMH, 2005).

### **Mental Illness**

- Young women are more likely to report having thought about (18.6% vs. 12.1%) and attempted (5.9% vs. 2.2%) suicide than their male counterparts. The hospitalization rate for suicide is also higher in young women than young men: Girls 10 to 14 years are 5 times as likely to be hospitalized as their male counterparts. The mortality rate due to suicide for young men, however, is 2.8 times higher than young women (PHAC, 2006).
- The suicide rate among Aboriginal youth (aged 15-24) is 5 to 7 times higher than the rate for all Canadian youth: 35 Aboriginal young women per 100,000 commit suicide, versus only 5 per 100,000 for all young women. For Aboriginal young men, the rate is 126 per 100,000, compared to 24 per 100,000 for all young men (CICH, 2000).
- Young men are half as likely to be hospitalized for problems related to mental health or substance abuse than young women (1.9% vs. 4.1%) (PHAC, 2006).
- Young women aged 15 to 24 are more likely to report an unmet service need related to their mental health or substance use than young men (27.6% vs. 17.5%) (PHAC, 2006).
- Girls are twice as likely to be prescribed medication for depression as boys (2% vs. 1%) (CAMH, 2005).
- School-aged boys are more likely to report use Ritalin than their female counterparts (3% vs. 1%) (CAMH, 2005).



### 3. WHY DO MENTAL HEALTH DIFFERENCES EXIST BETWEEN DIFFERENT GROUPS OF BOYS AND GIRLS?

#### **UNDERSTANDING HOW THE INTERSECTIONS OF GENDER, POVERTY, RACIALIZATION, ABORIGINAL STATUS AND OTHER FACTORS INFLUENCE YOUTH MENTAL HEALTH.**

Research has identified many factors that influence the health and development of young people. Some factors increase a young person's risk of mental health or mental illness problems (known as risk factors), while others buffer a young person from these risks (see Appendix 1 for a summary) (CAMH, 2004; PHAC, 2006; Waddell et al., 2005).

There is great diversity among Canadian children and youth, including differences due to gender, ethno-racial background, Aboriginal status, poverty, ability, newcomer status, and sexual orientation. These characteristics are valued and responded to differently by Canadian society, contributing to inequalities and inequities<sup>8</sup> in young people's exposure to risk and protective factors, health outcomes, and their access to health services (Hutchinson et al, 2004).

Gender socialization has a particularly important impact in a young person's life and their mental health (Bell-Gadsby et al., 2006; Feder et al., 2007; Hoskin, 2002; Powelson, 2004). Every day, young people encounter messages about the roles, attributes, identities, and expectations considered appropriate for people of their sex, through media images; treatment by educational, health, immigration and other institutions and systems; interactions with parents, teachers, and other adults; and peer relationships. These messages create pressures for young people to meet idealized standards of femininity and masculinity, which can lead to negative impacts

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<sup>8</sup> Inequality refers to discrimination in opportunities, access to services, or allocation of resources and benefits. Inequity refers to fairness and justice in the distribution of benefits and responsibilities. It recognizes that groups of people have different needs and power, and that these differences must be taken in to account in order to achieve balanced outcomes (WHO, 2007).



on the mental health of girls (see Girls Inc., 2006; Hoskin, 2002; Zurbriggen et al., 2007) and, as is increasingly recognized in the research, the mental health of boys (see CMHA, n.d.; Feder et al., 2007; Meadows, 2007; Tyyska, 2008). Gender socialization also contributes to how young people express mental health problems: the evidence suggests that boys and girls are taught to cope with life's challenges in different ways, often resulting in the internalization of problems among girls and the externalization of problems among boys (Bell-Gadsby et al., 2006; Meadows, 2007).

Gender is an important factor in youth mental health that intersects with other socio-economic factors. While the data demonstrates marked differences in mental health outcomes between male and female youth, the evidence also shows that different groups of boys and girls (for example Aboriginal and non-Aboriginal girls, or newcomer and Canadian-born boys) also face inequities in the risks and protective factors that influence mental health.

Aboriginal children and youth face many social, political, and economic inequities related to Canada's history of cultural oppression (Brown, 2004; Kirmayer et al., 2000; MCFD, 2003). Poverty, racism, inter-generational effects of residential schools, and lack of access to health, social, and educational programs affect the ability of Aboriginal families and communities to support the optimal development and health of children and youth (MCFD, 2003). These conditions heighten the likelihood that Aboriginal children and young people will encounter a wide range of risk factors that affect their mental health.

As a result of the concentration of poverty and income insecurity in racialized communities (Access Alliance, 2007; Crowe, 2006; Khanlou et al., 2003; PHAC, 2004), racialized children and youth are more likely to grow up in environments with more risk factors and fewer protective factors. Poverty and low socio-economic status (SES) limits the range of resources and opportunities available to young people and their families, thereby increasing risk factors for mental health challenges and reducing people's ability to cope with unexpected challenges (PHAC, 2006).

Social biases that privilege whiteness and white culture also affect the mental health of children and youth from racialized communities (Anisef & Kilbride, 2000; Khanlou & Crawford, 2006; Lee, 2004; WHIH, 2003). Racialized children and youth contend with media and social messages that portray white culture as natural and normal



(Lee, 2004; WHIH, 2003). While all young people struggle to develop a sense of self, racialized youth “face added challenges, such as being labeled ‘other,’ ‘dissimilar,’ and ‘foreign’” (CAMH 2006, 27). Many racialized young people also experience racist acts, discrimination, and challenges accessing services and systems intended to support young people, but which are often not sensitive to their realities (CAMH 2006; Lee, 2004; WHIH, 2003). Young people’s experiences with racism include name-calling, stereotyping, ignorance and lack of sensitivity towards cultural differences, and physical violence (Lee, 2004; WHIH, 2003). Anisef and Kilbride (2002) found that males reported having experienced racism more than females, although the impacts on mental health appear to be significant for both boys and girls.

In addition to often experiencing racialization, newcomer youth face additional stresses related to settlement and cultural adaptation processes; learning a new language; lack of recognition of previous learning; adjusting to an unfamiliar educational system; and a decrease in their family’s SES (Anisef & Kilbride, 2000; Crowe, 2006). Refugee youth may also be coping with trauma related to having lived in war-torn countries and entering a formal school system for the first time or after a long break (Crowe, 2006). Newcomers under 15 are more than two times as likely to live in poverty compared to their peers born in Canada (42% vs. 17%) (Crowe, 2006).

## **HOW GENDER AFFECTS PATHWAYS IN KEY MENTAL HEALTH ISSUES**

The following is a brief review of some key mental health issues prevalent in the lives of male and female youth in Canada, providing additional evidence that sheds light on the influence of gender and other intersecting socio-economic factors.

### **1) Stress, self-esteem and emotional well-being**

The recent report by Canada’s Advisor on Healthy Children & Youth states that “youth are experiencing increasing levels of pressure and stress at a younger and younger age. A greater number of Canadian children and youth are exhibiting signs of mental distress as a result of anxiety, bullying... low self-esteem and insecurity” (Leitch 2007, 130). The evidence indicates that this rising stress and lack of self-esteem is significantly affected by gender.



Girls consistently report higher levels of stress and lower self-esteem than boys on provincial and national health surveys (see Section 2). In the 2002 CCHS, female youth aged 15 to 24 were almost twice as likely to rate their mental health as fair or poor than their male counterparts (7.9% vs. 4.5%) and were more likely to rate their ability to handle unexpected problems as poor or fair (14.1% vs. 9.1%) (PHAC, 2006). Over one-fifth of Ontario girls (21.9%) reported that they are losing self-confidence, compared to only 11.1% of boys in the OSDUHS (CAMH, 2005).

The data also indicates a steady decline in girls' mental health over the course of adolescence: girls' stress levels increase, while their confidence, self-esteem and satisfaction with their lives steadily decline. This suggests growing pressures on girls' lives as they move from childhood to adolescence and adulthood, which are not as marked as for boys.

Data from the AHS reveals that these gendered trends are also seen in Aboriginal youth, but at higher rates than their non-Aboriginal counterparts. The 2003 AHS found that 14% of female Aboriginal students were severely distressed compared to 5% of their male counterparts (McCreary, 2005). Severe emotional distress among BC Aboriginal students has increased from 6% in 1992 to 10% in 2003. Emotional distress also increased slightly among non-Aboriginal youth, from 6% in 1992 to 8% in 2003. There is insufficient disaggregated data to report on the indicators of stress and low self-esteem among other groups of racialized male and female youth.

Multiple pressures on girls' lives are a major factor in the increasing stress and declining self-worth they experience. Today's girls and young women face what some call the 'supergirl dilemma' (Girls Inc., 2006): conflicting expectations to fulfill both liberated and traditional female roles. While restrictions around traditional gender norms for girls and young women have lessened, girls face increasing pressures to look pretty, be nice, and please others, in addition to excelling at school and helping care for their families and friends (Girls Inc., 2006). Newcomer girls and young women often experience tensions between gender roles and expectations in their homes and in Canadian society. These girls and young women are more likely to face restrictions on their leisure time and mobility and are expected to do a greater share of domestic duties (Khanlou & Crawford, 2006).



Representations of girls, women and femininity in popular culture continue to emphasize physical attractiveness over intelligence, portray an ideal body size that is unrealistic and unattainable, and are increasingly sexually explicit (Hoskin, 2002). The American Psychological Association reports that girls and young women are “sexualized”,<sup>9</sup> resulting in negative impacts on their self-esteem, satisfaction with their body and appearance, and other indicators of mental health (Zurbriggen et al., 2007). There are few positive representations of racialized girls and women in popular culture (Logio, 2003) and racialized young women receive many limiting messages regarding both their race and their gender, potentially compounding the negative impacts on confidence and self-worth (CAMH, 2006).

Whiteness and white culture is taken as normal and natural within Canadian society. A growing evidence base indicates that this affects racialized girls’ self-esteem, identity formation, and sense of belonging (Anisef & Kilbride, 2000; Khanlou & Crawford, 2006; Lee, 2004; WHIH, 2003). For example, in a Toronto-based study with racialized young women aged 16 to 18, nearly 40% felt racism was detrimental to their psychological well-being. They said racism had increased their stress (18.5%), lowered their self-esteem (11.1%), and caused negative emotional reactions such as hurt or anger (14.8%) (WHIH, 2003).

Racialized girls use a variety of strategies to cope: Some learn how to become ‘white’ and may deny, disassociate, or ignore their ethno-racial identity, by, for example, anglicizing their name (Lee, 2004; Khanlou & Crawford, 2006). Others blame themselves for not being ‘enough’ – pretty enough, smart enough, popular enough, etc. (Lee, 2004). Research with newcomer female youth has revealed that they lack a sense of inclusion in Canadian culture (Khanlou & Crawford, 2006) and may silence themselves by avoiding speaking in the presence of English-speaking youth (Khanlou & Crawford, 2006).

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<sup>9</sup> According to the American Psychological Association, “sexualization occurs when a person’s value comes only from his or her appeal or behavior, to the exclusion of other characteristics; a person is held to a standard that equates physical attractiveness (narrowly defined) with being sexy; a person is sexually objectified – that is, made into a thing for other’s sexual use, rather than seen as a person with the capacity for independent action and decision making; and/or sexuality is inappropriately imposed upon a person.” (Zurbriggen et al., 2007, 2).



It is suspected that racialized and newcomer male youth face similar experiences. Further research is required to understand these experiences, their implications, and the coping strategies that male youth use.

## **II) Mood and anxiety disorders**

Mood and anxiety disorders are the most common mental illnesses experienced by Canadians (PHAC, 2006). There are distinct gender differences in the rates of mood and anxiety disorders, as well as medication and hospitalization for these mental illnesses. Generally, prevalence rates are higher for women than men and are highest during adolescence and young adulthood:

- Higher rates of depression are consistently documented among adolescent girls and women than their male counterparts. The female-to-male incidence of depression averages 2 to 1 (Parry et al, 2006; PHAC, 2006; Diaz et al. 2006).
- Young women (15 - 24) had the highest 12-month prevalence of depression among all ages and genders in the 2002 CCHS (PHAC, 2006).
- Young women aged 15 - 24 were twice as likely to report an anxiety disorder as young men in the 2002 CCHS, the greatest gender difference of any age category (PHAC, 2006).
- Girls and young women are twice as likely to be prescribed medication for depression (CAMH, 2005) and to be hospitalized for problems related to mental health or substance abuse (PHAC, 2006), compared to boys and young men.

### **Depression among female youth**

Recent Canadian research has linked the suppression of adolescent girls' anger to depression and the erosion of their mental health (Van Daalen-Smith 2006). Anger is one of the normal responses to discrimination and unrealistic expectations, such as those that girls face due to social ideals of femininity, racism and other forms of social inequities. However, the expression of anger is not consistent with the 'nice' behaviour of the stereotypical 'good girl' that girls and young women are encouraged to embody. Van Daalen-Smith found that girls and young women who expressed anger, were faced with dismissal, disbelief, judgment, and pathologization by adults instead of being heard and affirmed. Female youth learn that expressing negative emotions is a threat to their relationships and come to dislike themselves



when they feel anger and silence and doubt their authentic responses. The suppression of anger, however, leaves girls and young women with fewer tools to cope with and respond to the complex pressures, devaluation, harassment and other challenges they may face in daily life.

### **Depression among male youth**

Recent research suggests that depression in boys and young men may be underestimated (CMHA, n.d; Powelson, 2004; Tyyska, 2008). It has been suggested that that this is because male socialization encourages boys and young men to provide overly positive rankings of their emotion and psychological well-being, be silent about their emotional health, and avoid seeking help for mental health issues (CMHA, n.d.; PHAC, 2006; Tyyska, 2008). Depression in boys and young men may also be overlooked because they tend to act out rather than displaying signs such as withdrawal (Powelson, 2004).

### **Depression among Aboriginal and racialized youth**

While there is not yet a sufficient evidence base, available data suggests that Aboriginal and racialized youth have higher prevalence rates than the general population. Canadian research indicates that Aboriginal youth may have an unacceptably high prevalence of depression and that young women are likely particularly vulnerable. A Nova Scotia study of Mi'Kmaq youth aged 12 to 18 years, for example, found that half of the young women and one quarter of the young men have experienced depression and related symptoms (CIHC, 2000a).

Research from the United States has found that racialized youth have higher rates of depression than white youth. The National Longitudinal Study of Adolescent Health, involving 20,126 youth participants, revealed that depression is more common in both male and female racialized youth than their white counterparts (Brown et al., 2007; Meadows et al., 2006). Clearly, data on depression disaggregated by Aboriginal and ethno-cultural status would better illuminate the mental health status of Canada's young people.



### III) Violence

Experiences of violence threaten young people's mental health and increase their vulnerability to mental illness, in childhood and into adulthood (PHAC, 2006). There are gender differences in young people's exposure to and experience of violence.

#### Child abuse

Early trauma related to maltreatment as a child has been linked to a wide range of mental illnesses, including depression, post-traumatic stress disorder, anxiety disorders, eating disorders, and substance abuse, among others (Heise et al 1999; Logan et al 2003). Early and chronic sexual abuse can also result in feelings of powerlessness, disassociative symptoms, and self-blame. Female survivors of abuse average more mental health consultations and pharmacy visits than other women (Heise et al 1999). Suicide attempts are also influenced by experiences of child abuse. Male Aboriginal youth who had been sexually abused or physically abused were 9.9 and 5 times more likely to attempt suicide than male youth who had not been abused. These rates among female youth were 3 and 2.9, respectively (McCreary, 2005).

In 2005, 206 in 100,000 children and youth were sexually abused and 563 in 100,000 were physically abused (Brzozowski, 2007). Girls were sexually assaulted at a rate almost 4 times higher than their male counterparts, while boys are 1.5 times as likely to be physically abused as their female counterparts.

Girls from marginalized groups – such as girls with disabilities, and Aboriginal, refugee, newcomer, racialized and queer<sup>10</sup> girls - tend to experience violence at higher levels than the general population; (ACRV 2002; NCWC 1999). Aboriginal youth in BC report being victim of higher rates of physical abuse (20% vs. 15%) and sexual abuse (13% vs. 7%) than their non-Aboriginals counterparts (McCreary, 2005). Aboriginal girls are more likely to report having experienced physical (26% vs. 14%) and sexual abuse (20% vs. 4%) than their males.

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<sup>10</sup> 'Queer' is here used to indicate youth who identify as gay, lesbian, bisexual, are questioning their sexual orientation, or simply are not heterosexual.



### Peer Violence: Physical Fights, Bullying and Sexual Harassment

Peer violence is both a symptoms of and risk factor for mental health problems (CAHM, 2005; McCreary, 2004; PHAC, 2004). Young people who engage in peer violence are more likely to develop other aggressive behaviours and mental health problems over time. Those who have been victimized are more likely to experience low self-esteem, emotional distress, depression, and isolation. Boys and young men report higher rates of physical fighting and bullying than their female counterparts (see Table 3), with the exception of bullying among eighth grade students. Similarly, the OSDUHS found that nearly 3 times as many boys committed assaults than girls (17% vs. 6%). The 2002 HSBC found that boys are more likely than girls to report being involved in a physical fight and that fighting behaviour among boys is highest in Grade 6 (see Table 3).

**Table 3: Bullying and Violence among School-Aged Youth, HBSC 2002**

Indicator	Gender	Grade 8	Grade 8	Grade 10
Students involved in a physical fight in the last 12 months	Boys	53%	46%	43%
	<b>Girls</b>	<b>24%</b>	<b>27%</b>	<b>24%</b>
Students who were bullies but were not victimized	Boys	23%	25%	28%
	<b>Girls</b>	<b>18%</b>	<b>23%</b>	<b>13%</b>
Students who were both victims and bullies	Boys	23%	25%	28%
	<b>Girls</b>	<b>18%</b>	<b>23%</b>	<b>12%</b>

A longitudinal study from Ontario involving over 1800 students in 23 schools indicates that sexual harassment<sup>11</sup>, a form of gender-based violence, is common within Canadian high schools (Wolfe & Chiodo, 2008). Boys were more likely to report perpetrating sexual harassment than girls, and girls are more likely to report being victimized than boys.

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<sup>11</sup> Sexual harassment includes unwanted or unwelcome sexual attention that interferes with a student's ability to participate in or benefit from educational programs, or creates a hostile environment. (Wolfe & Chiodo, 2008).



Nearly half of girls (46%) reported having been the victim of sexual comments, jokes, gestures, or looks during their Grade 9 and 11 years. Thirty-six percent of Grade 9 boys reported having been the victim of sexual harassment; this dropped to 27% in Grade 11. Girls are subjected to more forms of sexual harassment than their male peers. Boys are likely to be subjected to homophobic sexual harassment in schools; one-third of boys (34%) reported being called “gay”, “fag”, or similar terms in Grade 9.

Evidence suggests that the socialization of boys and young men contributes to the higher rates of violence perpetration by encouraging them to ‘act-out’ and externalize their mental health issues (Feder et al., 2007; Powelson, 2004; Tyyska, 2008). Traditional notions of masculinity emphasize toughness, dominance, and the restriction of emotions. Boys and young men are discouraged from exploring their inner world and expressing their vulnerability (Feder et al, 2007). This leaves them with fewer resources to cope with life’s problems and with their emotional and psychological needs. Some theorists suggest that the restriction of vulnerability and emotional expression combined with the encouragement of aggression and dominance increases violent or aggressive behaviours in boys and young men (Ibid, 2007).

#### **IV) Suicide**

Canada has the highest adolescent suicide rate in the industrialized world and this rate has increased four-fold since the 1960s (Links, 1998 in Tyyska, 2008). Young women are far more likely to think about about (18.6% vs. 12.1%) and attempt (5.9% vs. 2.2%) suicide than their male counterparts (PHAC, 2006). The mortality rate due to suicide among young men, however, is 2.8 times higher than young women (PHAC, 2006), and young men in rural areas are 50% more likely to die of suicide than their urban counterparts (Armstrong, 2006). The higher mortality rate among men results from the more frequent use fatal acts of suicide such as shooting, while women are more likely to choose less lethal acts such as an overdose of pills (Health Canada 2002).

Certain groups of youth are particularly vulnerable to suicide. For example, youth who are gay, lesbian, bisexual or unsure of their sexual orientation are at greater risk of suicide and suicide attempts. A 2007 study of BC youth found that while only 3%



of heterosexual males had attempted suicide, 9% of gay and 13% of bisexual males reported suicide attempts. Similarly, 8% of heterosexual females attempted suicide, while 30% of bisexual females and 38% of lesbian youth reported attempting suicide in the past year (Saewyc et al 2007). D'Augelli et al (2001) found that 42% of gay, lesbian and bisexual youth had thoughts of suicide at some time; 48% said thoughts of suicide were clearly or to some degree related to their sexual orientation.

Aboriginal youth are also at a higher risk of committing suicide. In fact, suicide has been called an epidemic among Aboriginal peoples in Canada (Brown, n.d.). The suicide rate among Aboriginal youth (aged 15-24) is 5 to 7 times higher than the rate for all Canadian youth (CICH 2000), while the rate for Aboriginal youth ages 10 to 19 is 5 to 6 times higher than for their non-aboriginal counterparts (Brown, n.d.). Similar to the general population, Aboriginal girls are more likely than their male counterparts to seriously consider (29% vs. 14%) and attempt suicide (16% vs. 6%) (McCreary 2005). One factor that may play a role in the higher rates of suicide among Aboriginal youth is the experience of racism. Boys and girls who have experienced acts of racial discrimination are respectively 1.8 and 2.1 times more likely to attempt suicide than youth who have not experienced racism (McCreary 2005).

It is important to note, however, that there is significant variation in suicide rates among Aboriginal communities (Kirmayer et al., 2000). Strong ethno-cultural identity, community integration and political empowerment have been found to have a positive effect on the mental health of Aboriginal peoples (Kirmayer et al., 2003). Suicide rates in BC are lower among First Nations that have made progress toward self-government and land claims, have cultural facilities, and have control over local services such as health care, education, and police (Chandler & Lalonde, 1998 in Kirmayer et al., 2000).

## 4. CONCLUSION

National and provincial surveys provide a snapshot of mental health and mental illness among Canada's young people. This snapshot highlights the need for a gender and diversity-sensitive approach to understanding these issues and designing



policies, programs and services to promote mental health and prevent mental illness among young people.

This snapshot indicates that a significant proportion of this population contends with mental health and mental illness issues and that there are marked differences among groups of young people. Namely, a higher prevalence of indicators such as distress, low self-esteem, depression and anxiety are consistently seen in female youth; violent and addictive behaviour in male youth; while Aboriginal youth experience a higher prevalence of mental health challenges than their non-Aboriginal counterparts.

Numerous questions are raised by these findings, such as: Why do we see differences in these indicators between groups of young people? What do these differences mean? Are these differences problematic? Qualitative research was sought to provide further insight into these questions. Many gaps were identified, for example there is very little research on mental health and mental illness among racialized youth and depression among young men.

Available research suggests that these differences are related to inequalities and inequities in the lives of young Canadians, as a result of their gender and several intersecting social and economic attributes, such as gender, ethno-racial background, Aboriginal status, poverty, (dis)ability, newcomer status, sexual orientation, and other differences.

The following recommendations emerged from the review of available evidence. These gender- and diversity-sensitive strategies could enhance the effectiveness of policies, programs and services to promote mental health and prevent mental illness among young people. Promising practices have been identified to provide concrete examples.



## RECOMMENDATIONS AND PROMISING PRACTICES TO PROMOTE MENTAL HEALTH AND PREVENT MENTAL ILLNESS AMONG CANADIAN YOUNG PEOPLE

### 1. DEVELOP AND COORDINATE POLICY FRAMEWORKS TO PROMOTE MENTAL HEALTH AND PREVENT MENTAL ILLNESS AMONG CHILDREN AND YOUNG PEOPLE

According to the WHO (2005), policy and legislation are important for children and young people's mental health. Policies and legislation must grapple with the reality that children and young people's mental health require intersectoral coordination and collaboration, involving such systems as health, education, child welfare, and juvenile justice. Currently, there is no national mental health strategy for children and young people (Waddell et al., 2005) and significant disparities and disconnections exist in the provincial/territorial policies related to young people's mental health across the country (Wood's Homes, 2006).

**Promising Practice:** The BC Child and Youth Mental Health Plan (MCFD, 2004) uses a public health approach that encompasses both population and individual interventions, including initiatives to provide early recognition and effective treatment of mental health problems and illnesses; foster resilience among children; reduce children's risk factors and strengthen protective factors; and enhance the capacity of children, families, and communities to create supportive environments. While the Plan does not reflect an effective gender analysis, an essential element for addressing gender differences in youth mental health, it does include a special focus on the vulnerabilities, inequalities, and inequities faced by Aboriginal children and youth.

See [http://www.mcf.gov.bc.ca/mental\\_health/mh\\_publications/cymh\\_plan.htm](http://www.mcf.gov.bc.ca/mental_health/mh_publications/cymh_plan.htm)



Further, the primary approach to mental health problems and mental illness within Canada has focused on the provision of clinical treatment to affected children, youth and families (Waddell et al., 2002; Waddell et al., 2005). Researchers from the Children's Health Policy Research Centre have argued that this approach is insufficient and should be replaced with a public health approach that focuses more heavily upstream on the promotion and prevention, by supporting healthy development among all young people and ensuring the targeting of resources and services towards vulnerable young people.

## 2. BASE THE POLICIES, PROGRAMS, AND SERVICES OF THE YOUTH MENTAL HEALTH SYSTEMS ON AN ANALYSIS OF GENDER AND OTHER FORMS OF DIVERSITY

The effectiveness of the mental health system and policy frameworks is contingent on their ability to be responsive to gender differences and other forms of diversity and inequalities within Canada's child and youth population (Hutchinson et al. et al., 2004). All too often, policies, funding decisions, and direct services and programs for children and youth do not take into account gender and the effects of social exclusion on their daily lives and health outcomes (Anisef & Kilbride, 2000; Hutchinson et al., 2004; Khanlou et al., 2003; Lee, 2004; WHIH, 2003).

**Promising Practice:** The WHO Regional Committee for Europe recently released a 'gender tool' to assist policy-makers and practitioners to incorporate gender analysis in the implementation the European Strategy for Child and Adolescent Health, adopted in 2005 (WHO, 2007). The gender tool assists with the identification of key factors that affect health during the many stages of infant, child, and adolescent development. The tool also assists in analyzing the pathways which contribute to health inequalities and inequities between boys/young men and girls/young women. Such an analysis is critical for designing action plans that effectively meet the health needs of all young people in an equitable way.

See [http://www.euro.who.int/document/gem/eurostrat\\_gender\\_tool.pdf](http://www.euro.who.int/document/gem/eurostrat_gender_tool.pdf).



A thorough gender-based analysis (GBA) involves identifying and understanding differences in health outcomes, pathways, and access to services. GBA should be more widely applied as an important tool for identifying health inequalities and inequities related to gender and the intersecting factors of socio-economic status, ethno-racial background, Aboriginal status and other inequalities.

### 3. ENHANCE THE EVIDENCE BASE TO INCREASE UNDERSTANDING OF THE INFLUENCE OF GENDER AND OTHER FORMS OF DIVERSITY ON YOUNG PEOPLE'S MENTAL HEALTH

The availability and quality of evidence impacts the effectiveness and efficiency of efforts to promote mental health and prevent mental illness among children and youth (Waddell et al., 2005). There is a need to enhance the Canadian evidence base on health outcomes, health inequities among groups of youth and the pathways that contribute to these differences, and the effectiveness of mental health policy frameworks, programs, and services.

Most provinces do not gather comprehensive data on mental health outcomes among children and youth (Waddell et al., 2005). Data comes from self-reported survey data, such as the HBSC and CCHS at the national level as well as the AHS in BC and the OSDUHS in Ontario. There is limited comparability among these studies as there are variations in the outcomes examined, indicators used, and the age range of participants.

While most of the studies are designed to be gender-sensitive, fewer are designed to be sensitive to other forms of diversity. This creates challenges in identifying and addressing inequities in health outcomes and pathways among children and young people.

#### **SPECIFIC RECOMMENDATIONS**

- Increase the collection of mental health surveillance data disaggregated by age, sex, ethno-racial background, Aboriginal background, income levels and newcomer status.



- Increase qualitative research to understand how inequalities and inequities related to gender and intersecting factors such as race and newcomer status affect young people's development and mental health.
- Increase the evidence base examining the effectiveness of youth mental health promotion and prevention programs.

**Promising Practice:** The McCreary Centre Society, in partnership with the Government of British Columbia, administers the Adolescent Health Survey (AHS) every five years. The AHS collects data on the health status of young people and factors that contribute to their health. The survey instruments are designed to be sensitive to gender, Aboriginal status, ethno-racial background, and factors that leave some young people especially vulnerable such those who are in custody of the province or street-involved. This makes it possible to identify health inequities and contributing factors, and, in turn, to enhance decision-making about policies, programs, and services for young people.

See <http://www.mcs.bc.ca> for more information.

#### 4. INVEST IN GENDER-SPECIFIC, DIVERSITY-SENSITIVE PROGRAMS THAT PROMOTE YOUTH MENTAL HEALTH AND EMPOWERMENT AT THE COMMUNITY LEVEL

More and better programs are required to promote young people's mental health. The evidence from both the health promotion and youth development fields suggest that the young people's active and meaningful engagement in their community has positive impacts on their health and development (Joubert & Raeburn, 1998; McCreary, 2002; Valatais, 2002). Community participation and taking action on issues that impact their lives contributes to young people's empowerment, which is critical for mental health (Joubert & Raeburn, 1998).

To address challenges to girls' health and development, some youth-serving organizations have developed all-girl programs that enhance empowerment through community action. Many of these programs are based on an understanding of the diversity of girls' experiences due to experiences of poverty, Aboriginal status, ethno-racial background, sexual orientation, newcomer status and other diversities.



**Promising Practices:** Anti-dote Multi-racial Girls' and Women's Network, based in Victoria BC provides programs and tools for racialized and Aboriginal girls and young women. These resources all female youth to explore and strengthen their sense of belonging by identifying and taking action on issues affecting their psychological and social well-being. Anti-dote's programs include intergenerational mentoring, participatory action research projects, youth-friendly forums and workshops on issues affecting girls' lives, and skills training that allow girls to contribute to change in their communities. Projects include youth-made documentaries on girls' experiences and perspectives on racism, health, identity, etc.; a summer research camp in which girls co-investigated their everyday lives; and an 'unlabel fashion' workshop in which girls explore labels, stereotypes, racism, and culture through the medium of fashion.

[www.anti-dote.org](http://www.anti-dote.org)

Power Camp National / Filles d'action (PCN) provides programs and resources to support the resiliency, healthy development and empowerment of girls across Canada. PCN's programs are adapted to girls' specific needs in the communities where they take place. Through educational and creative workshops, female mentors support girls to develop their self-advocacy, critical thinking, skill-building and participation in community actions to address discrimination and social inequities experienced by girls.

External evaluations have found that PCN's programming provided girls with a place where they felt safe and that girls' skills and awareness in dealing with stress and discrimination increased. Teachers, parents, school counsellors and administrators and the girls themselves reported improvements in girls' abilities to:

- speak up for themselves and have confidence in themselves (self-esteem)
- think critically (for example, understanding and accepting difference in others)
- deal with stress and violence (for example, responding to bullying situations and accessing community supports)

[www.powercampnational.ca](http://www.powercampnational.ca)

These programs typically include activities that build the capacity of female youth to promote mental health and prevent violence in their communities by enhancing their knowledge, critical-thinking, and skills; safer spaces in which girls can acknowledge their experiences and find out they are not alone; interaction with supportive role models; and learning and empowerment through community action. There is



potential that such program elements could be transferred to programs seeking to enhance the mental health of other groups of young people, such as newcomer youth and male youth.

It is recommended that multi-year pilot projects be supported that use an approach informed by gender and diversity analysis to empower young people and increase their resilience. Adequate resources are required for testing, evaluation and knowledge transfer to ensure that successful programs can be initiated in other communities across Canada.

**Promising Practices:** To address high rates of depression among young women, the Centre for Addictions and Mental Health created the VALIDITY project (Vibrant Action Looking into Depression in Today's Young Women). This research project involved a team of female youth to gather information about young women's experiences of mental health challenges, depression risk factors and prevention strategies. The young women developed a guide for service providers called Hear Me, Understand Me, Support Me.

The guide is available at:

[http://www.camh.net/Publications/Resources\\_for\\_Professionals/Validity/index.html](http://www.camh.net/Publications/Resources_for_Professionals/Validity/index.html)

YouthNet / Réseau Ado (YN/RA) in conjunction with the VALIDITY project developed a group intervention for adolescent girls called Girls Talk. This program initially focused on preventing and educating young women about depression, and has now expanded its objective to the building of resiliency in young women. Since 2004, 34 Girls Talk programs run in school and community settings across Ontario. Evaluations of YN/RA's Ottawa programs found that Girls Talk helped two-thirds of participants to develop better coping strategies deal with daily life events, the majority of whom reported that they planned to use those coping strategies in the future. The program also aims to increase girls' understanding of the correlations between depression and self-esteem, body image, stress, relationships and the media and their awareness of local supports and resources in their community. YN/RA is currently in the development phase of a Guys Talk program which will focus on mental health challenges faced by male youth and provide a support and learning network.

[www.youthnet.on.ca](http://www.youthnet.on.ca)



## 5. CREATE SUPPORTIVE ENVIRONMENTS

Interventions are also required at the community-level to create environments that support young people's development and mental health, such as ensuring availability and access to health promoting social and material resources (Joubert & Raeburn, 1998). Universal and targeted programs are required to bolster protective factors and reduce risk factors in key social environments – namely the family, school, and community. This includes reducing poverty and violence, enhancing student readiness and engagement, and providing a wide range of accessible extracurricular activities and nonformal learning opportunities.

**Promising Practice:** The Joint Consortium for School Health (JCSH) is an intergovernmental mechanism initiated in 2005 to encourage cooperative initiatives to support child and youth health. The JCSH published a resource in 2007 entitled *Mental Resilience: Quick Scan of Activities and Resources in Resilience/Positive Social Development in Canadian Schools*. This resource underscores the importance of the school environment in supporting positive development among children and youth. Initiatives to promote positive school climates are explored. This includes strengthening relationships with teachers, police, public health, community recreational services, and local businesses; preventing violence and bullying; fostering peaceful schools by developing respect, building community, and encouraging conflict resolution; as well as specifically targeting mental health promotion and suicide prevention.

[www.jcsh-cces.ca](http://www.jcsh-cces.ca) for more information.

# APPENDIX 1: PROTECTIVE AND RISK FACTORS FOR MENTAL HEALTH AND MENTAL ILLNESS

	Individual	Family	School	Life Events and Situations	Community and Culture
<b>Protective Factors</b>	<ul style="list-style-type: none"> <li>• Easy temperament</li> <li>• Adequate nutrition</li> <li>• Attachment to family</li> <li>• Above-average intelligence</li> <li>• School achievement</li> <li>• Problem-solving skills</li> <li>• Internal locus of control</li> <li>• Social competence</li> <li>• Social skills</li> <li>• Good coping style</li> <li>• Optimism</li> <li>• Sense of purpose</li> <li>• Moral beliefs</li> <li>• Positive values</li> <li>• Positive self-related cognitions</li> <li>• Religious affiliation</li> <li>• History of competence and success</li> </ul>	<ul style="list-style-type: none"> <li>• Supportive, caring parents</li> <li>• Family harmony</li> <li>• Secure and stable family</li> <li>• Small family</li> <li>• Responsibility within the family</li> <li>• More than two years between siblings</li> <li>• Supportive relationships with an adult (for a child or adult)</li> <li>• Strong family norms, morality</li> </ul>	<ul style="list-style-type: none"> <li>• Sense of belonging</li> <li>• Positive school climate</li> <li>• Prosocial peer group</li> <li>• Required responsibility and helpfulness</li> <li>• Opportunities for some Success and recognition of achievement</li> <li>• Social norms against violence</li> </ul>	<ul style="list-style-type: none"> <li>• Involvement with significant other</li> <li>• Availability of opportunities at critical turning points or major life transitions</li> <li>• Economic security</li> <li>• Good physical health</li> </ul>	<ul style="list-style-type: none"> <li>• Sense of connectedness</li> <li>• Attachment to, and networks within, the community</li> <li>• Participation in church or other community group</li> <li>• Strong cultural identity and Ethnic pride</li> <li>• Access to support services</li> <li>• Community cultural norms against violence</li> </ul>

	Individual	Family	School	Life Events and Situations	Community and Culture
<b>Risk Factors</b>	<ul style="list-style-type: none"> <li>• Prenatal brain damage</li> <li>• Premature birth</li> <li>• Birth injury</li> <li>• Low birth weight, birth complications</li> <li>• Physical or intellectual disability</li> <li>• Poor health in infancy</li> <li>• Insecure attachment in infant or child</li> <li>• Low intelligence</li> <li>• Difficult temperament</li> <li>• Chronic illness</li> <li>• Poor social skills</li> <li>• Low self-esteem</li> <li>• Alienation</li> <li>• Impulsivity</li> </ul>	<ul style="list-style-type: none"> <li>• Having a teenage mother or a single parent</li> <li>• Absence of father in childhood</li> <li>• Large family</li> <li>• Antisocial role models in childhood</li> <li>• Family violence or disharmony</li> <li>• Marital discord in parents</li> <li>• Poor supervision or monitoring</li> <li>• Neglect in childhood</li> <li>• Low parental involvement in child's activities</li> <li>• Long-term parental Unemployment</li> <li>• Criminality in parent</li> <li>• Parental substance misuse</li> <li>• Parental mental disorder</li> <li>• Harsh or inconsistent Discipline style</li> <li>• Social isolation</li> <li>• Experiences of rejection</li> <li>• Lack of warmth and affection</li> </ul>	<ul style="list-style-type: none"> <li>• Bullying</li> <li>• Peer rejection</li> <li>• Poor attachment to school</li> <li>• Inadequate behaviour management</li> <li>• Deviant peer group</li> <li>• Failure at school</li> </ul>	<ul style="list-style-type: none"> <li>• Physical, sexual or emotional abuse</li> <li>• Changing schools frequently</li> <li>• Divorce and family break-up</li> <li>• Death of family member</li> <li>• Physical illness or disability</li> <li>• Unemployment</li> <li>• Homelessness</li> <li>• Incarceration</li> <li>• Poverty or economic insecurity</li> <li>• Job insecurity</li> <li>• Unsatisfactory workplace relationships</li> <li>• Workplace accident or injury</li> <li>• Caring for someone with an illness or disability</li> <li>• Living in a nursing home</li> <li>• War or natural disasters</li> </ul>	<ul style="list-style-type: none"> <li>• Socio-economic disadvantage</li> <li>• Social or cultural discrimination</li> <li>• Isolation</li> <li>• Neighbourhood violence or crime</li> <li>• Deviant peer group</li> <li>• High population density and poor housing conditions</li> <li>• Lack of support services, including transport, shopping and recreational facilities</li> </ul>

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