Information-Seeking Behaviour of Young People & Mental Health

Knowledge Synthesis Report 2014

www.cyccnetwork.org/info-seeking

Prepared by: James Bray

Co-Leads: David Este, Maria Luisa Contursi, Alicia Raimundo, and Christa Sato

Project Manager: Emily Zinck
The views expressed in this report are those of the authors and do not necessarily represent those of the Government of Canada.

For further information or to obtain a paper copy of the report, please contact: cycc@dal.ca.

CYCC Network
School of Social Work
6420 Coburg Road
PO Box 15000
Halifax, NS B3H 4R2

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Judi Fairholm, Canadian Red Cross
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Linda Liebenberg, Resilience Research Centre
David Este, University of Calgary
Maria Luisa Contursi, mindyourmind
Alicia Raimundo, Centre for Innovation in Campus Mental Health
Christa Sato, University of Calgary
David Black, Dalhousie Centre for Foreign Policy Studies (CFPS)
Patrick McGrath, IWK Health Centre (Assistant- Cheryl Provo)

Jimmy Ung, UNSECO
Isabelle Levert-Chiaisson, WUSC
Anna Huguet, IWK Health Centre
Gordon Phaneuf, Child Welfare League of Canada (CWLC) (Assistant- Rachelle)
Dawne MacKay-Chiddenton, Red River College
Ilse Derluyn, Centre for Children in Vulnerable Situations (Belgium)
Wanda McDonald, Nova Scotia Department of Health and Wellness
Tim Crooks, Phoenix Youth
David Morgan, Dalhousie University
Eugenia Canas Western University
Phoenix Youth- hosts of service providers working group
Valerie Shapiro, Phoenix Youth Program
Hillary Rankin, Laing House
Laura Swaine, Heartwood Centre for Community Youth Development
Ian Manion, Children’s Hospital of Eastern Ontario (CHEO)
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Executive Summary:

Children and youth in challenging contexts, both in Canada and overseas, face common threats to their mental health. These challenges can be better addressed when researchers, service providers, practitioners and communities pool their knowledge and resources, and share their lessons learned of what works best for improving the mental health of young people. If these groups continue to work within their occupational and disciplinary boundaries, they will fail to mobilize the full potential of evidence documented by researchers, the practice-related knowledge of service providers and practitioners, and the local knowledge of communities.

The CYCC Network was developed in response to this need. In the summer of 2013, the Network released three thematic knowledge synthesis reports on the topics of violence, technology, and youth engagement.

**Violence** against children and youth, in particular, is a complex public health problem that affects communities worldwide, and can lead to potentially devastating consequences for young people and their families if left unaddressed. To tackle this problem, a coordinated effort to share and document best practices for addressing young peoples’ mental health needs is urgently needed. Without opportunities to share this knowledge, there is a risk of delivering potentially ineffective interventions that are difficult for young people and their families to access or relate to. Additionally, poorly researched or evaluated interventions often ignore the structural barriers (e.g. access to mental health practitioners, stigma, narrow focus on a single problem, and the coordination of mental health services offered by different service providers) that shape young peoples’ mental health and wellbeing. In light of these challenges, the knowledge synthesis report on violence explores the effective strategies that help children and youth in challenging contexts who have been exposed to violence, in order to help them overcome trauma and feel safe in their families, schools, and communities.

Recent years have seen an explosion of new, innovative programs that focus on improving the lives of vulnerable young people through the use of **technology**. The Internet has opened doors of opportunity to reach these children and youth in more effective ways with the information and support they need to lead healthy lives. Today, mobile phones are one of the most prolific mediums through which interventions can be delivered. While the rapid developments made in technology present many opportunities, the expansion of this field has not been mirrored in the development of research and evaluation of those innovations. There is a need for more evidence to support the use of technology as a means of intervention with children and youth in challenging contexts. In response to this gap, the knowledge synthesis report on technology reviews innovations in technology that are known to be effective in helping children and youth in the most challenging of contexts, to nurture resilience, prevent mental health problems, and build a special place for themselves in the collective life of their communities.
Finally, there has been an increasing recognition that youth engagement is central to any best practice or intervention that involves young people. Valuing youth engagement puts the focus on the positive contribution that youth make to programs and their effectiveness. Programs and services that acknowledge the independence and agency of at-risk youth provide opportunity for young people to give feedback on the relevance and appropriateness of the programs that serve them. Additionally, youth engagement can promote a sense of empowerment on an individual level, and facilitate healthy connections between young people and their community. Despite these benefits, however, there remains a gap in our understanding of the implications of engaging vulnerable youth. In order to better understand and optimize youth engagement, different strategies need to be explored that identify their appropriateness for youth living in different challenging contexts, representing all genders and age categories. With these gaps in mind, the knowledge synthesis report on youth engagement explores strategies that have been shown to work in engaging children and youth in challenging contexts as full members of their communities and in ending feelings of disempowerment and abandonment.

As a next step to this process, the Network is launching four new knowledge synthesis reports in 2014. These reports explore the themes of violence prevention, ethics, information-seeking behaviour, and supportive environments.

While children and youth are always particularly vulnerable to violence, young people living in contexts that are devoid of programs and services that focus on protection become significantly more vulnerable. The purpose of the knowledge synthesis report on violence prevention is to examine the ways in which complex emergencies and disasters expose children and youth to violence, and to highlight promising practices that foster the resilience in these challenging environments. Given what we know about the impacts of violence and the prospects for prevention, identifying contexts where protection services are non-existent must be a primary objective of child protection advocates and practitioners. Disasters and complex emergencies are contexts that expose children and youth to increased risks of violence. Due to the lack of services available in these contexts, immediate action is required.

Social research conducted with youth in challenging contexts attempts to gain insight into the lives and perspectives of a wide variety of young people. While there are risks associated with such research, there are also potential rewards both for participants in research and society at large. The knowledge synthesis report on Ethics explores the ethical approaches and issues in conducting research with children and youth in challenging contexts. This shift towards including youth in research has the potential to give young people a greater opportunity to voice their views and perspectives in an effort to influence both policy and practice. There remains a need to translate existing rights into workable ethical practices. In addition, the move toward including the voices of youth has created a number of ethical dilemmas that challenge researchers, practitioners, and REBs.
Youth experience mental health differently, depending on their cultural, social and economic positioning. It should come as no surprise that these same factors also influence the way in which young people find information and support related to mental health. Studies have shown that young adults in Canada have higher rates of mental health concerns compared to other age groups, and yet they have lower rates of accessing mental health services. This knowledge synthesis report attempts to shed light on the information-seeking experiences of youth. There is a need to provide mental health information in various formats in order to take the many different needs of youth into account. It is important to engage youth in the creation of spaces and activities that support mental health knowledge. Ultimately, this will serve to increase youth mental health literacy and the capacity of youth to recognize disorders and risk factors and to seek the necessary and relevant support.

And finally, the last knowledge synthesis report reviews the effectiveness of supportive service environments that have been used to help children and youth with complex needs. These include children/youth with intellectual disabilities, children/youth with severe emotional and behavioral disorders, aboriginal children/youth, homeless youth and refugee or displaced children/youth. Mental health being at the centre of the complexity, these children and youth have multiple serious issues that compromise their physical, mental and emotional well-being and development. In order to best meet the needs of these young people, interdependence between different services and systems is an important principle. Effective models identified fall within three categories: child/youth focused, family-centred, and community-based interventions. It is because of the complex needs of these young people that the provision of services from different disciplines across various service sectors is crucial.

The Goal of the Knowledge Synthesis Reports

Ultimately, the seven knowledge synthesis reports are interconnected in ways that can help to form a comprehensive strategy for researchers, practitioners, service providers, and communities to address the needs of vulnerable children and youth in Canada and overseas. In synthesizing evidence from researchers, practitioners, service providers, and communities, these knowledge synthesis reports bring together disciplinally specific approaches and lessons learned in working with vulnerable and at-risk children and youth. The goal of the CYCC Network is to create an integrated and sustainable community of researchers, practitioners, communities, policy makers, and young people working together to share and improve programs that support the wellbeing and positive mental health of children and youth in challenging contexts.
Section 1: Introduction

I. Youth & Mental Health Information

The available data on the prevalence of mental health challenges in children and youth in Canada is somewhat dated and not necessarily reflective of variations within the Canadian population. While there is a large knowledge gap, it is possible to determine from epidemiological information that a significant number of young Canadians are challenged by mental health difficulties (Davidson, Manion, Davidson & Brandon, 2006). The available evidence suggests that psychiatric disorders, including anxiety and depression are common in young adults with 28% of Canadian youth aged 14-24 experiencing symptoms of anxiety and 13% experiencing symptoms of depression (Cunningham, C., Walker, J., Eastwood, J., Westra, H., Rimas, H., Chen, Y., Marcus, M., Swinson, R., Bracken, K., 2013). Research has shown that many adult mental health disorders originate in childhood with 50% emerging before the age of 14 and 75% by the age of 24 (Manion, Short and Ferguson, 2013; Kessler, Berglund, Demler, Jin, & Walters, 2005). Suicidality is recognized as a public health concern and the relationships between suicidality, depression and completed suicide have been well documented (Cheung & Dewa, 2007).

The mental health and illness experiences of youth are diverse and are shaped by a number of factors. These may include the political context within which the young person lives (Nguyen, Giacaman, Naser, Boyce, 2008; Beiser, Hou, Hyman, & Tousignant, 2002), the socioeconomic position of youth and their families (Honey, 2011; Canadian Alliance on Mental
Illness and Mental Health, 2007), cultural and demographic factors (Chandler & Lalonde 1998) and gender or sexual orientation (Ferguson, 2002; Cox, Berghe, Dewaele & Vincke, 2010). Both culture and context have strong impacts not only on the experiences of mental health and wellness, but also a broad spectrum of help-seeking activities. Activities related to info-seeking range from identifying problems to choosing treatment, to selecting service providers (Cauce, Domenech-Rodriguez, Paradise, Cochran, Shea, Srebnik & Baydar, 2002).

Compared to other age groups, young adults (18-24) in Canada experience higher rates of mental health challenges, but access mental health services at lower rates (Marcus, Westwood, Eastman & Barnes, 2012). It is estimated that 50% of Canadians between 19 to 24 who experience depression or suicidal tendencies have not sought mental health treatment (Cheung, 2007). Most youth who deal with mental health challenges never seek support (Cunningham et al., 2013; Cunningham, Walker, Eastwood, Westra, Rimas, Chen, Marcus, Swinson, Bracken, mobilizing Minds, 2013). As this report will outline, there are multiple factors that discourage youth from seeking help or information (Rickwood, Deane, Wilson & Ciarrochi, 2005).

Although many youth do not seek mental health information independently, there is evidence to suggest that those who do search for information have identifiable preferences for how they would like this information to be presented (Marcus et al., 2012; Boldero & Fallon, 1995; Cheung & Dewa, 2007). This finding suggests that it is preferable to tailor that information to the preferences of youth in a way that they find to be accessible and valuable. Understanding how mental health information is perceived by young people could lead to more efficient and effective mental health information dissemination.
II. The Knowledge Synthesis Report on the Information-Seeking Behaviour of Children and Youth

The purpose of this knowledge synthesis report is to use the existing literature to explore questions related to how youth seek information related to mental health. This exploration is organized around two central questions:

How do youth access mental health information?

What pathways are likely to be successful?

Social scientists have long recognized the social nature of individuals; each individual exists within a set of environmental systems that affect his or her psychological well being (Cauce, Domenech-Rodriguez, Paradise, Cochran, Shea, Srebnik, & Baydar, 2002). Drawing accurate general conclusions that remain meaningful across the spectrum of the diversity of mental health experiences is a challenge. Similarly, focusing on the research questions presented above threatens to isolate and simplify a single aspect of a complex network of processes. Considering these questions in more detail raises further questions such as:

What are the barriers that youth face in seeking mental health information?

How do the experiences of youth seeking mental health information differ?

A great deal of the research on questions related to how youth seek mental health information is focused on the factors that either help or hinder their efforts to seek information. As will be explored in more detail below, there are a number of barriers that make
successfully obtaining mental health information difficult for youth. These barriers vary quite significantly according to the social, economic and cultural background of a given youth. The abilities of youth to work through these barriers also vary widely.

Taking this information into account, the goals of this report are:

1. To synthesize evidence, practice, and local-based knowledge that informs the improvement of programs and interventions with children and youth in challenging contexts. This report will contribute to this synthesis of knowledge by presenting best and promising practices for assisting children and youth in challenging contexts to access mental health information.

2. To develop peer-reviewed recommendations that will become the basis for a number of strategies by the CYCC Network to share the results and get the results integrated into policy and practice.

**III. Children and Youth in Challenging Contexts**

Consultations were held with organizations and individuals involved with the CYCC Network to decide what populations of children and youth to include in the definition of children and youth that forms the basis of this report. The groups selected for inclusion are:

- Children and youth affected by war
- Child soldiers
- Children and youth in military families
- Refugee children and youth
• Children and youth affected by natural disasters
• Immigrant children and youth
• Children and youth subject to maltreatment
• Children and youth in alternative care
• Children and youth in institutions
• Youth in juvenile detention
• Aboriginal children and youth

IV. Organization of this Report

Section 2 outlines the key terms and concepts used in the report, including the different forms of knowledge, best practices, and resilience. It then presents the methodology used in the synthesis process, which included a scoping review of the literature, a services scan, meetings with Network Partners and experts in the field, and data analysis. The section concludes with a discussion of the limitations of the report.

Section 3 examines the diversity of experiences of young people facing mental health challenges. Information gathered in the review of the literature, as well as in consultations, shows that the experiences of youth seeking mental health information are both diverse and complex, with a wide variety of factors impacting both the ability of youth to access mental health information, as well as the likelihood that they will do so.

Section 4 provides a synthesis of these barriers as they apply to children and youth in challenging contexts. There is a large body of literature that addresses barriers to accessing mental health services that frustrate access to mental health resources, including mental health
related information. Two case studies are presented to show how programs are working to overcome these barriers.

Section 5 presents an overview of important themes identified in this report, including informational preferences of young people, youth engagement, the role of social media, and mental health literacy.

Finally, Section 6 presents a comprehensive list of recommendations for developing a collaborative and multi-level approach to mental health care for at-risk children and youth. This section provides some practical tips for working with children and youth in challenging contexts, and identifies next steps for moving forward.
Section 2: Methodology

Summary: This section will present the process followed for this knowledge synthesis report. There are three different stages of this methodology:
1. Scoping Review
2. Environmental Scan
3. Case examples
These three steps were done in order to capture the three different types of knowledge identified in this report:
- Evidence-based practice
- Practice-based evidence
- Local knowledge

I. Background of Knowledge Synthesis Reports

In 2012, the CYCC Network published three knowledge synthesis reports that addressed key topics identified by the principle investigators on this project. These topics included: violence, youth engagement, and technology (these reports are available on the CYCC Network website). A second round of knowledge syntheses were carried out to address the following questions:

1. What strategies exist to prevent violence toward children and youth displaced by natural disasters and complex emergencies?

2. What are the ethical approaches and issues in conducting evaluations of interventions with children and youth in challenging contexts?

3. How do youth access mental health information and which pathways are likely to be most helpful?

4. What kinds of services and supports work best for children and youth with complex needs in challenging contexts?
Together, these seven report topics are all linked together by one guiding question:

What works for Canada’s most vulnerable young people (see Figure 1).

**Figure 1: Seven Knowledge Syntheses**

II. **Types of Knowledge**

Different types of knowledge are challenging to synthesize, as they continue to be divided along disciplinary and geographic lines. Advocates of evidence-based practice, for instance, prioritize “the use of treatments for which there is sufficiently persuasive evidence to support their effectiveness in attaining the desired outcomes” (Roberts & Yeager, 2004, p. 5).

Based on the assumption that empirical, research-based evidence is the most reliable for
practice (Proctor & Rosen, 2006), this evidence is generally categorized hierarchically in accordance with the scientific strength of derived outcomes, with meta-analyses or replicated randomized controlled trials ranking among the most authoritative evidence. Case studies, descriptive reports and other unsystematic observations rank among the weakest (Roberts & Yeager, 2004). Qualitative evidence in particular is not always given weight among the advocates of evidence-based practice. In many cases, the results of experimental designs are prioritized where randomized control trials (RCTs) are held up as the “gold standard” (Oktay & Park-Lee, 2004, p. 706). It is also important to note how the evidence is shared. Making information accessible and understandable to different audiences is a key knowledge mobilization principle.

These types of knowledge may be usefully conceptualized as residing within a circle of evidence. Figure 2 depicts how the CYCC Network has conceptualized these different types of knowledge and how they interact. The purpose of the diagram is to demonstrate the relative amount of knowledge that exists within each category. In other words, there is a great deal of local knowledge that is largely undocumented, and extremely little evidence that meets the criteria necessary for quantitative meta-analyses. By selecting only the inner most circle, it is likely that best practice knowledge relevant to populations of at-risk young people may be overlooked.
Community ownership increases towards the outer perimeter of the circle, as interventions are matched to the unique needs and customs of communities. However, our understanding of the fluidity among these forms of analysis and the resultant balance between scientific rigor and community ownership remains limited. In the diagram, the gaps between the types of knowledge represent the intersections of these forms of knowing that have not yet been fully explored.

For the purposes of this report, the CYCC Network defines best practices and promising practices as follows:

Best practices- or promising practices- are interventions that reflect what we have learned from evidence-informed practice, identify, and employ the right combination of
program elements to ensure targeted outcomes, and match these interventions to the local needs and assets of communities.

III. Knowledge Synthesis Process

In order to capture these different types of knowledge, these reports followed three methodological steps (Figure 3), which are described in detail in this section:

   Step 1- Scoping Review
   Step 2- Environmental Scan
   Step 3- Case Studies

   a. Scoping Review of the Literature: A focused search and review of the academic literature

   A scoping review is a search tool used to “map” or identify the extent and nature of the literature that currently exists in the field of interest (Arksey 2003; Mays et al 2001). The purpose of scoping this field of academic literature was to be as comprehensive as possible in finding evidence-based practice. Relevant articles were retrieved through key databases including Proquest Social Services Abstract, Proquest (general), EBSCO and PAIS International. All sources that pre-date 2000 were excluded from this report, with the exception of foundational reports and studies, for the sake of making the scoping exercise reasonable. Some of the search terms used include: youth, mental health, stigma, information seeking social
media, social networks, search, and health literacy. The full list of search terms used for this report can be found in Appendix C.

This scoping review involved a clear research question and an evaluation grid for the sources found. The evaluation grid was developed by the team at the CYCC Network, outlining six criteria that was looked for in all the resources gathered: relevance, peer-reviewed, number of citations (three categories indicating 1 to 3, 3 to 10, or more than ten citations), rigorous methodology, sample size, internal validity, and external validity. A detailed description of these criteria is presented in Appendix B.

The scoping review was limited to literature demonstrating evidence-informed practice, practice-based evidence, and/or local knowledge. This includes studies demonstrating meta-analytic or meta-ethnographic findings, randomized controlled trials, participatory action research, and examples of community development with youth populations. The goal was to identify themes that repeated in the literature regarding lessons learned, gaps in knowledge, and ways that service providers could work more effectively in the future.

b. Environmental Scan: Capturing Practice-Based Evidence

Leading from the scoping review, an environmental scan was done to capture the practice-based evidence that was outside the academic literature (Chrusciel 2011). For this report, an environmental scan was done to search and review the “grey literature” found on websites as well as unpublished information from within organizations. The Internet has greatly facilitated the production, distribution, and access of grey literature.
This search for grey literature was done using Google search. The first 50 sources that came from this search were viewed, as Google searches are set up to sort for relevance of results (Google Basics 2014). The limit was set at 50 to keep the search manageable. Google searches were one strategy to capture these resources. The programs and services of CYCC network members were included in this scan. All search terms used for this report can be found in Appendix 3. The results were assessed according to their relevance to the report topic. Relevance was defined as having addressed the key concepts embedded in each research question.

c. Case Studies: Capturing Local Knowledge

The third phase of this methodology used case studies drawn from our network of members which showcase different themes and issues that arise from the scoping review and environmental scan. Based on the promising practices that were identified, case studies were used as examples of how to put these practice principles in action.

IV. Consultations

Throughout the development of the knowledge syntheses reports, there were key groups that helped guide and inform the process of these reports: the knowledge mobilization steering committee, a working group of service providers located in Halifax, NS, and the Network’s youth advisory committee.
a. Knowledge Mobilization Steering Committee (KMbSC)

The knowledge mobilization steering committee (KMbSC) was a group of 18 Network Members from different sectors, including students and youth, who provided expert direction in the development of the knowledge synthesis reports. Within the committee, 2-3 members functioned as the co-leads for each report. They were responsible for directing the research assistants in their searches and writing for these reports, and also helping to develop the recommendations from this research. This committee met regularly throughout the development of these reports.

b. Service Providers Working Group

In an effort to ensure that the reports meet the needs of different stakeholders, the CYCC Network organized a series of working lunches, in partnership with Phoenix Youth Programs. Phoenix is a non-profit community-based organization working with street-involved youth in Halifax, Nova Scotia. This was an open invitation sent to services providers from across the city that work with youth in some capacity. Meetings were held to discuss the progress of the reports, what themes were being identified, and what recommendations were being identified through the research. This was an opportunity for service providers to provide feedback on the focus of the reports and the relevant findings. There were four such meetings held during the development of these reports.
c. CYCC Network Youth Advisory Committee (YAC)

The CYCC Network’s Youth Advisory Committee (YAC) was involved in the progress of the reports by providing feedback to the research assistants. A few members of the YAC were engaged in the report process as co-leads, giving direct input into the progress of the reports. A one-day in-person meeting was held in Ottawa after the completion of a first draft for the purpose of reviewing the findings and recommendations arising from the reports. Feedback was gathered by the research assistants and project managers, and integrated back into the second draft of the reports.

d. Youth Workshop: YouthNet

To review the recommendations from this knowledge synthesis report, a youth workshop was held with the youth advisory committee at YouthNet, at the Children’s Hospital of Eastern Ontario (CHEO), one of our network members. YouthNet is a mental health promotion program at CHEO run by youth for youth, working to reduce stigma and provide support for those struggling with mental illness. The objective of this workshop was for youth to comment on the findings and the recommendations that follow as well as make suggestions for improving them. The conversations generated in this workshop were very important in bringing youth perspective into the report and helping to inform its key messages and recommendations. This was also a way to access local knowledge, by connecting with individuals in this community who are part of the collective social context.
V. Limitations

The limitations encountered in preparing this report include:

1. The difference between technological change and the ability of the literature to keep up with this change. This is particularly relevant to research which focuses on the use of social media and the Internet. There are several notable exceptions to this.

2. A lack of information on youth mental health in non-western, low income, countries and the resultant bias in the literature.
Section 3: Diverse Experiences of Mental Health

A central challenge encountered in compiling this report was taking the diversity of mental health experiences, and of information seeking experiences, into account. Various factors shape the experiences of members of different populations. Each of these factors is experienced within the milieu of the life of the individual and so plays a varying role. As a result, writing in general terms about the factors that affect information seeking behaviour necessitates a large degree of reduction. Extracting general statements from specific experiences that are shaped by various contextual factors is bound to be, at best, an incomplete project.

The review of the literature shows that both the pathways used to access mental health information and the barriers encountered along the way had significant elements of contextual specificity. For some youth, political context plays an important role in defining experiences of mental health (Nguyen et al, 2007). For others socio economic status and social exclusion were found to be factors determinative of mental health (Honey et al, 2011). For others accessing culturally specific resources provided a way of reducing suicide (Chandler & Lalonde, 1998). The contextual factors that affect experiences of info-seeking include, but are not limited to: gender, age, immigration status, geographic location, level of service provision, political context, socioeconomic status, cultural background (Cauce et al., 2002). Each of these factors
does not act upon experiences of mental health or of info-seeking in isolation; a single person may be affected by multiple dynamics according to the context in which they live.

In recognition of the limitations of any approach that attempts to provide general descriptions that can be applied to complex and diverse experiences, the diversity encountered in the literature review will be addressed in several different ways. First, several theoretical frameworks useful for conceptualizing diversity in the context of mental health are considered. These frameworks are the resilience framework and the intersectional framework. The resilience framework provides a model for understanding how individuals respond to the influences and resources that are present within their contexts, while the intersectional framework provides a lens that can be used to understand the intersecting effects of social dynamic which work to socially marginalize members of various populations.

Second, several axis of difference that impact upon the mental health experiences of individuals, as well as upon info-seeking experiences have been identified for closer analysis. These axis of difference are: gender, refugees and migration experience and belonging to Aboriginal groups. Each of these axis of difference was identified for closer analysis as a result of their prevalence within the literature.

I. Framing Diverse Experiences of Mental Health: Resilience and Intersectionality

Recognizing that experiences of mental health vary widely is relevant to understanding mental health info-seeking. While understanding this variance is important, focusing exclusively on the ways in which experiences of info-seeking are different runs the risk of producing
individualized understandings of mental health. The review of the literature suggests that collective factors such as gender, immigrant status and racial background play a role in determining the likelihood that a young person will experience mental health challenges and in determining how they will meet these challenges.

Multiple theoretical frameworks provide ways of interpreting the diversity of mental health experiences. The body of academic work on resilience is one such framework. Resilience research attempts to provide insight into the ability of individuals to thrive despite adversity, and also the ability of communities to support an individual in meeting the challenges that they encounter (Ungar, 2005; Ungar, 2008; Liebenberg & Ungar, 2011; Ungar, Liebenberg & Armstrong, 2013). Academic work on resilience emphasizes the uniqueness of the contexts that young people find themselves in (Ungar, 2008), and the uniqueness of the pathways that youth within various contexts take while navigating themselves to mental health and wellness (Ungar 2008, Hagan & McCarty 1997; Theron, Cameron, Didkowsky, Lau, Liebenberg & Ungar, 2011). In this conception, resilience is characterized as the interaction between individuals and their contexts, with a focus on understanding how individuals use available resources to meet the challenges that they face.

Intersectional research and theorizing provides a framework for understanding diverse experiences of mental health which has more overtly political implications. Intersectional theorizing focuses on the social dynamics that shape a particular experience and provides a way of understanding how characteristics that are socially meaningful (such as race, socioeconomic background and gender) interact and shape the experiences of individuals (Seng et al., 2012; Viruell-Fuentes et al., 2012).
II. The Resilience Framework

The resilience framework provides a model for understanding processes associated with human development that enhance well being among individuals who experience adversity (Anthony, 1987; Kaplan, 1999; Klevens 1999, Ungar et al., 2013). While in common speech resilience is often recognized as the capacity of individuals to respond positively to adversity and to thrive after experiencing adversity, the study of resilience provides a more nuanced definition in that it attempts to recognize the role that contextual factors play in shaping the ability of individuals to be resilient (Morgan et al., 2013).

As Ungar (2007) outlines, early research on resilience and the role it plays in mediating youth mental health was largely focused upon individual or individually mediated factors such as a healthy temperament and a nurturing family environment. As a result of this focus on individual factors, the ‘first wave’ of resilience research has been criticized for oversimplifying the often-complex reality of children and youth who experience adversity (Boyden & Mann, 2005; Ungar, 2005; Morgan et al., 2013). As academic work on resilience developed, the focus of research expanded to address contextual concerns and resilience began to be conceived of in terms of interactions between individuals and their environments, and as the processes that mediate these interactions (Rutter 2005, Ungar et al., 2007). This expanded focus included attention given to developmental pathways and trajectories leading to resilience (Mafile’o & Api, 2009; Liebenberg & Ungar, 2011; Ungar et al., 2007, p. 287).

Defined within this broader ecological perspective, resilience can be seen to encompass qualities of both individuals and their environments. Environments are seen to be the space in which the material and social resources necessary for positive development are located
(Boyden & Mann, 2005, p. 10; Liebenberg & Ungar, 2011). Taking into account the environments which individuals inhabit led to the development of an understanding of resilience which emphasizes the “capacity of young people to navigate their way to the resources they need during crises, and their ability to negotiate for these resources to be provided in meaningful ways” (Liebenberg & Ungar, 2011).

III. Resilience and Culture

Nearly a half-century of resilience-focused studies have shown that there is great diversity in how individuals and communities adjust to adversity (Rutter, 2006; Theron et al., 2011; Luthar, Cicchetti & Becker, 2000). Recent approaches to resilience research argue that the abilities of youth to resile must be understood within the context in which youth live. According to Ungar (2006), “there are global, as well as culturally and contextually specific aspects to young people’s lives that contribute to their resilience” (2006, p. 218).

Acknowledging the role that social and cultural context plays in mediating the behaviour of individuals helps to render visible the diverse values, beliefs, and everyday practices that are associated with coping across populations (Boyden & Mann, 2005, p. 10; Ungar et al., 2007, p. 288). Similar to the way in which effective coping mechanisms may appear diverse across socioeconomic contexts, resilient behaviour within one cultural context may look quite different from what constitutes resilience in another cultural context.

Authoritative resilience scholars argue that the study of resilience remains an incomplete project that requires more attention (Masten & Wright, 2010; Rutter, 2009; Ungar, 2011, Theron et al., 2011). Luther & Cicchetti. (2000) argue that theorizing about resilience
draws heavily upon data from Western, economically privileged contexts and as a result has produced a theory that is enmeshed in Western norms of positive adjustment and Western accounts of processes that nurture healthy functioning. This line of argument holds that, at present, there is a dearth of explorations of “processes of resilience from Afrocentric, and other non-western, world views and within such contexts” (Theron, 2011, p. 800).

While they may be relatively underrepresented in the resilience literature, a number of comparative studies which examine resilience in non-western/non-mainstream contexts have been conducted (Ungar 2008; Waller, Okamoto, Miles & Hurdle, 2003; Klevens & Roca, 1999; Laverack & Brown, 2003). These studies push back on the claim that studies of resilience are dominated by a focus on mainstream or Western contexts. Resilience studies that recognize cultural specificity provide a challenge to ethnocentric notions of what constitutes positive behavioural outcomes for youth. Rather than generalizing from specific tropes of what constitutes positive behaviour (i.e. staying in school, delaying sexual activity, maintaining attachment to a primary caregiver etc.), this approach to understanding resilience provides space for understanding positive behaviour as rooted within the context in which it takes place (Ungar et al., 2013).

Ungar et al. (2007), identify seven tensions that children and youth typically navigate and resolve in their pathways toward resilience. These tensions are resolved by individuals using the resources available to them individually and within their families, communities and cultures. These resources include access to material resources, empowering relationships, identity or sense of purpose and social and cultural cohesion (see Figure 5) (2007, p. 295). This perspective suggests that there is not a singular method of resolving tensions that is necessarily
better than any other and serves to highlight the uniqueness of the pathways that individuals use to move toward living more resilient lives (Ungar et al., 2007, p. 294).

**IV. Intersectionality**

Intersectional analysis has been developed to understand the complex interactions of marginalizing characteristics, and the impacts they have on the experiences of individuals. Some individuals experience the effects of multiple marginalizing characteristics simultaneously. These characteristics can include race, gender and socioeconomic position (Seng et al., 2012, p. 2437). Intersectionality provides a “theoretical approach and mode of inquiry that can help to illuminate and interpret complex systems of power, penalty, and privilege” (Grace, 2014: 161).

Scholars who apply an intersectional lens to their research emphasize the need to consider complex interactions between structures of power and oppression and interconnected aspects of individual and group identity and social location (Crenshaw 1989; McCall, 2005; Hankivsky, 2011; Grace, 2014, p.3). This focus makes a richer understanding possible, and outlines the necessity for understanding the experiences of individuals both in individual and structural terms. For example, an intersectional approach to thinking about health suggests that dynamics of gender, social inequality, race, class, immigration status and other categories which has been made socially relevant, play a role in defining the health of individuals, and that these factors interact in complex ways that have the potential to doubly or triply marginalize some individuals (Davis et al., 2009, p.68; Viruell, 2012, p. 2099).
While intersectional thinking outlines a broad theoretical position from which social analysis can be conducted, what it means in practice is not immediately clear. Seng et al. (2012) propose an approach for measuring and modeling the intersecting impacts of marginalization and discrimination on mental health. A premise of this analysis is drawn from the work of Bronfenbrenner (1979), who posited that the development of the individual takes place within “five concentric circles of mutually-influencing, social-ecological systems, moving from the intra-psychic to the familial and ever broader contexts” (cited in Seng et al., 2012, p. 2438).

At the interpersonal level, Seng et al. (2012) argue that interpersonal exchanges that involve discrimination or privilege, take place on a daily basis. While the identities associated with these experiences might not be internalized by the person that experiences them, the discriminatory, aversive, and stressful interpersonal exchanges potentially increase in frequency as the number of marginalized identities increased (Kessler, Mickelson, & Williams, 1999). At the contextual level, Seng et al. argue that living as a member of a racial/ethnic or sexual minority or out-group, can impinge as additional stressors (Klest, 2012). Out-group status has the potential to increase risk of victimization in terms of crime, threats to civil liberties, or other identity-based trauma exposures (Seng et al., 2012). At the macro-level, Seng et al. characterize differentials in education and income as salient structural factors, which have the capacity to shape the experiences of individuals.

While individual demographic characteristics such as race, gender, education level and income can explain a large amount of variance individually, difference can be more fully explained by analyzing multiple levels, and by considering the ways in which these levels intersect. While a robust, intersectionally driven analysis is necessarily complex and incomplete
due to the potentially large number of relevant intersections, attempting to incorporate the complexity suggested by an intersectional analysis in explanations of differential outcomes could produce a “less partial, less distorted understanding” (Seng et al., 2012; Harding, 1991).

While intersectional analysis may not provide tools that can be used to produce neat and tidy analysis, intersectional thinking does serve to outline the complexity of social dynamics that may affect the lives of individuals. For many vulnerable youth, the forces that marginalize come not from one direction, but from many. Understanding that these forces work together to strengthen or weaken the positions of children and youth is important to understanding the barriers that frustrate effectively accessing mental health information.

V. Axis of Diversity

The review of the literature produced a number of resources which outline the nature of variable experiences of mental health. In the following section several axis of diversity are outlined in some detail, with the goal of providing sufficient information to illustrate some of the particular challenges encountered by individuals who belong to each group. These aspects are:

- Gender and mental health
- Migration and mental health
- First Nations/Métis/Inuit and mental health

These particular axis of diversity were chosen for further analysis based upon their prevalence within the literature, and based upon consultations with the CYCC Knowledge Mobilization advisory board. Describing experiences of mental health in this way is necessarily
an imperfect project. While it is possible to outline the essential elements of some experiences of mental health, it is not possible to examine all relevant points of difference, nor to provide an in-depth analysis of the ways in which these axis interact.

**VI. Gender and Mental Health**

Gender is a major determinant of health, as well as of social roles that individuals fill within many societies (Harding, 1991). As such, gender should be regarded as significant to understanding experiences of mental health (Piccinelli & Homen, 2007). Gender is an important factor which impacts upon the nature of mental health challenges encountered (Piccinelli & Homen, 2007; MHCC, 2013), on whether youth access mental health information (Kids Help Phone, 2012; Cheung & Dewa, 2007) and on attitudes toward help-seeking (Jagdeo et al. 2009).

For some mental challenges, males and females are affected at similar rates. For others, the rates of occurrence vary according to gender (Piccinelli & Homen, 1997). Significant gender differences exist in the occurrences of depression, anxiety and somatic complaints in established economies (Piccinelli & Homen, 1997). Beyond rates of occurrence, gender impacts upon the timing of onset mental health challenges, upon diagnosis and upon treatment (Piccinelli & Homen, 1997).

There is evidence that the pathways that males and females take toward developing psychopathology, as well as factors relevant to seeking mental health information and treatment vary considerably (Jagdeo 2009; Cheung, Dewa, Cairney, Veldhuizen & Schaffer, 2009; Zona & Milan 2011). In a longitudinal study of youth in Chicago, Zona and Milan (2011) found gender to have a moderating effect on the association between exposure to violence and
mental health problems (externalizing, internalizing, PTSD, dissociation). For both genders, exposure to violence predicted an increase in symptoms. Although boys reported higher exposure to violence, girls exposed to violence were more likely to report symptoms (2011).

Literature encountered in the knowledge synthesis suggests that gender impacts upon experiences of mental health, and of info-seeking at several different points. First, some (but not all) mental health challenges are experienced at different rates by males and females. Second, gender plays some role in determining the impacts that a given disorder or pathology may have. Third and perhaps most significant to this report, gender impacts upon whether and how people who experience mental health challenges seek information and assistance. Females are more likely to seek information and assistance related to mental health difficulties than males.

Kids Help Phone provides an example that quantifies gender differences in help and information seeking. Kids Help Phone provides confidential and anonymous counselling services to children and youth living in Canada using a phone helpline and Internet based live-chat service. A more detailed overview of Kids Help Phone activities will be provided later in the report. Young people reach out for help from Kids Help Phone an average of 5000 times each week. Of those youth who used the phone based counselling service, 73% identified as female, 13% identified as male and 4% identified as trans. The report states that this gender differential is not out of the ordinary when compared to similar services that cater to youth in other countries (Kids Help Phone, 2012, p.15).

Attitudes toward help-seeking appear to vary according to gender and also play a role in determining successful engagement with mental health services. In a study based on the 1990
Ontario Health Survey and the US National Comorbidity Survey, Jagdeo et al. (2009) found that negative attitudes toward mental health service use are prevalent in both the US and Ontario. Negative attitudes were most commonly found in young adults, and more particularly in young adults with relatively little social or economic capital. While this study is based on a relatively old data set, the gender difference with regard to negative attitudes toward help seeking - 23% for men vs. 13% for women - speaks to a trend that presents itself elsewhere in the literature (Jagdeo et al. 2009, p.761).

In an earlier study which uses data from the Canadian Community Health Survey: Mental Health and Well Being, Cheung et al. (2007) note that 40% of young adults with depression had not accessed any formal mental health services. Amongst those young people experiencing suicidal ideation this number climbed to 50% (2007, p. 228). In contrast with other studies, this study found little difference between the professional service use of males and females. However, the study found that women are more likely to access services from non-specialty mental health care providers. (Cheung et al., 2007, p. 231).

One Canadian study estimated the risk of suicide to be 14 times higher for LGBT youth than for non-LGBT peers (Rainbow Health, 2011; Benibgui, 2011). A recent US study also found that 15% of LGBT youth met the criterion for major depression (Mustanski et al. 2006). Further, sexual minority women were found to be at high risk for substance abuse related disorders while sexual minority men had a higher risk of suicide (Rainbow Health 2011; Meyer, 2013).

VII. Migration and Mental Health

The distinct pre-migration experiences of immigrants and refugees can result in widely
divergent post-migration experiences. Similarly, the legal status accorded to a migrant has a significant impact on determining their access to health care, education, social services and legal rights (Khanlou, 2010; Khanlou, 2008; Georgiades, Boyle & Fife, 2013; Menezes & Boyle, 2011). In line with Khanlou (2010), the following discussion uses the term migrant as one that includes immigrants, newcomers, refugees, refugee claimants and/or individuals with precarious immigration status.

One in five children living in Canada was born outside the country, or was born to recent immigrants. Given this number, understanding the dynamics of immigration is important to understanding not only the mental health seeking behaviour of migrant and first generation youth, but is also important to understanding the health seeking behaviour of a significant portion of youth living in Canada (Beiser, 2002).

Some claim that information on what promotes successful adaptation and integration and on what constitutes a threat to the mental wellness of immigrant and refugee children is limited (Beiser, 2002). However, the review of the literature shows that, relative to many other populations, there is a significant amount of information on the mental health related experiences of refugee and immigrant youth. While research on the mental health experiences of migrants exists, significant criticisms have been raised against this body of work. Concerns have been raised with regard to adopting a mental health focus in understanding the experiences of refugees, arguing that such a focus has the potential to medicalize aspects of the refugee experience which have their roots elsewhere. Such a position serves to gloss over questions of social, political, economy and moral significance (Antiss & Ziaian, 2010, p. 10) and replace them with technical healthcare-related questions.
While this is a relevant note of caution, several authors provide a resolution to this tension, arguing that research that examines the mental health experiences of migrants should be explicitly situated within the appropriate political, economic, historical and social context. Such understandings would not medicalize mental health at the expense of understanding it in other terms, but would incorporate the context in which mental health challenges occur into the analysis (Antiss & Ziaian, 2010; Miller & Rasco, 2004; Rousseau & Drapeau, 1994). The intersecting effects of gender, life stage, cultural, migrant and racialized status impact upon the mental health experiences of migrants (Khanlou, 2003; Khanlou et al., 2002).

The social determinants of health framework helps to illustrate how influences working at social and interpersonal levels can impact upon both resiliency and coping networks (MHCC, 2009, p.10). A study prepared for the MHCC argues that the social determinants of health, a set of factors which can be used to understand the health and illness of large populations, provides a framework which is especially revealing when applied to immigrant populations. As defined by the Public Health Agency of Canada, the social determinants of health are:

1. Income and social status
2. Social support networks
3. Education and literacy, i.e. health literacy
4. Employment/Working conditions
5. Social environments
6. Physical environments
7. Healthy child development

(Mental Health Commission of Canada, 2009)
The social determinants of health perspective can be applied broadly in order to explain the mental health experiences of many populations, not only migrants. When applied to migrants, this perspective serves to illustrate the role that contextual factors place in shaping experiences of mental health. For example, in a study of mental health service users who had migrated from the Mediterranean to the Netherlands, Knipscheer and Kleber (2005) found that ethnic difference did not have a significant bearing on choosing to seek mental health related help. Socio-demographic factors like age, educational background and length of residence were found to be stronger predictors of mental health help seeking.

a. Migrants Who Have Been Exposed to Violence

For some migrants, exposure to violence or conflict shapes pre-migration experiences. In a systemic review of studies that consider the prevalence of mental disorders among children exposed to war, Attanayake et al. (2009) found that the rates of posttraumatic stress disorder among children who have been exposed to war to be at 50%. This is compared to an average of 1-10% of youth in a general population not exposed to war. While research which would provide conclusive evidence on the types, severity and distribution of such illnesses was not found in the literature review, and the number of studies available relative to the number of existing conflicts is small, this study outlines what is a potentially serious set of problems for refugees who have been exposed to violence (Attanayake et al., 2009).

b. Unaccompanied Minors

Children have always made up significant portions of refugee populations, with about 50% of the current global refugee population recognized as children. Approximately 2-5% of the
population of recognized refugee camps is made up of minors who have been orphaned or abandoned (Bhaba, 2009). Unaccompanied children and youth are an especially vulnerable group - not only do they face the same risks and challenges as others refugees, but they also face additional risks such as traumatic experiences, violence or abuse. In addition to this, unaccompanied minors do not have the opportunity to benefit from the resilience that can come from a relatively stable family network (Deluyn & Broekaert, 2008; Ungar, 2008).

**VIII. First Nations/Métis/Inuit and Mental Health**

Throughout the world, indigenous populations have experienced and continue to experience rapid cultural change, social and economic marginalization and the impacts of colonialism, all occurrences that have the potential to negatively impact upon mental health (Kirmayer, Brass & Tait, 2000; Blackstock, 2008).

Canadian First Nations, Inuit and Métis communities experience mental health problems and their consequences - depression, anxiety and suicide – at dramatically higher rates than the general population. First Nations, Inuit and Métis youth commit suicide five to six times more often than non-Aboriginal youth. The suicide rates of Inuit youth are 11 times the national average and for young Inuit men the rates are 28 times higher than the national average (MHCC, 2012, p. 99).

While proximate causes such as social isolation and feelings of hopelessness are identified in the literature (Blackstock, 2008; Kielland & Simeone, 2014), the underlying causes of the elevated occurrence of mental health problems in indigenous communities has been linked to a history of cultural disruption, social and economic marginalization and oppression
Racial discrimination, the weakening of social and political institutions and the systematic dispossession of land have had lasting effects on the collective identities and sense of belonging of First Nations and Inuit populations, and these things have had a tremendous cumulative effect on the health and mental health of youth (Kielland & Simeone, 2014, p. 5).

a. Accessing Mental Health Services

Access to appropriate and effective mental health services is a challenge for many First Nations, Inuit and Métis youth. The nature of this challenge varies considerably depending on where these communities are located; some communities are located in urban areas, others are in rural, northern and remote areas (MHCC, 2012, p. 98). Northern and remote communities face particularly complex challenges related to mental health and social issues. These challenges consist of, but are not limited to, poor housing conditions, lack of access to affordable food and clean drinking water as well as high rates of communicable diseases (MHCC, 2012, p. 86). More directly related to mental health, many remote communities have a shortage or complete lack of mental health services (MHCC, 2012, p. 86).

Ensuring equitable access to mental health services for First Nations, Métis and Inuit populations is complicated by a number of factors. For one, the multiple levels of authority involved in delivering services complicate the provision of these services (Kielland & Simeone, 2014). The complexity of the current framework also leads to unequal provision of mental health services among provinces and territories, and among First Nations communities themselves. As a result of this, First Nations and Inuit people that live off reserve face
challenges in accessing comprehensive and culturally appropriate mental health services (Kielland & Simeone, 2014, p. 8).

b. Culture and Mental Health

Chandler and Lalonde (1998) argue that the disruption of group identities and resulting difficulties in forming positive personal identities are important factors which play a role in explaining high rates of suicide amongst First Nations and Inuit populations (p. 191). According to the theory of cultural continuity, if an individual’s identity is undermined by radical personal and cultural change, the risk of suicide is elevated and the connection that the individual has to future commitments may be compromised.

Drawing upon a study conducted in Mi’kmaq communities in Nova Scotia, Vukic et al. (2009) argue that there is a clear need for community-based, culturally appropriate, coordinated and sustainable services. The Mental Health Strategy for Canada advocates recognizing communities as their own best resources for support in dealing with and preventing mental health problems (MHCC, 2012, p. 101), enhancing the abilities of service providers to delivering effective and culturally safe services, treatments and supports for First Nations mental wellness (MHCC, 2012, p. 101), and strengthening relationships among federal, provincial, territorial and First Nations governments to improve policies, programs and services related to mental wellness (MHCC, 2012, p.101).

Any understanding of mental health is rooted within a worldview and different worldviews provide different understandings of mental health and well-being. A key challenge is to “create pathways that elevate Aboriginal approaches to mental health while
acknowledging the value of collaboration with some aspects of western knowledge and understanding” (Blackstock, 2008, p. 5).
Section 4: Barriers to Mental Health Care and Information

There is a large body of literature that addresses barriers to accessing mental health services that frustrate access to mental health resources, including mental health related information. The pathways chosen by youth to access the resources needed to support their mental health, as well as the ways in which these pathways are navigated are significantly diverse (Ungar et al., 2013). Similarly, both the barriers that young people encounter in the process of seeking information, and the tools that have to address these problems with, are diverse (Jagdeo, 2009). A barrier that may be significant in the life of one young person may have little impact on the life of another. Similarly, one youth may have a well-developed ability to respond effectively to a barrier that they encounter, while another youth may not have developed this ability.

I. Access to Information

The information seeking strategies that youth use as well as their expectations for what they will find, are diverse (Gowan, 2013). It is important not to conflate having access to formal services with being able to access information; many young people who access information do so through informal social networks, such as family and friends (Canadian Alliance on Mental Illness and Mental Health, 2007). For some youth, the unavailability of formal mental health services can be regarded as a barrier in their pathway of information seeking (Rasmussen-Pennington, Richardson, Garinger & Contursi, 2013; MHCC, 2012, p. 52). Access to formal
mental health services varies within Canada, with different populations having different levels of access to mental health services (Kirby, 2006; CMHA, 2009). While many people living in Canada have access to a relatively robust set of formal mental health services (such as those offered in primary care facilities), a significant number who live in rural, remote and underserved areas have limited access to formal mental health services (MHCC, 2012, p. 52-55).

In a paper prepared by the Canadian Mental Health Association on issues in mental health care as related to rural and northern communities, it was found that the basket of services available in rural and northern Ontario is not comprehensive in comparison to other parts of Ontario. Residents of these regions have limited access to primary health care, specialists, hospitals and community services and supports (CHMA, 2009, p. 3). In addition to expanding training opportunities for psychologists from rural areas and increasing efforts to recruit rural and Aboriginal persons into psychology, the CMHA recommends efforts to develop, implement and evaluate programs which are aimed at the prevention and treatment of mental health problems in rural areas (CMHA, 2009, pp. 4-5).

First Nations and Inuit communities are affected disproportionately by poor provision of mental health services. A study conducted by the MHCC First Nations, Inuit and Métis Advisory Committee identified a number of barriers to accessing mental health services that affect First Nations, Inuit and Métis populations (MHCC, p. 13). These barriers included access due to geographic location, access to reliable and affordable transport and access to affordable housing (MHCC, p. 13).

Sources confirm that the Internet can be a useful tool which youth can use to engage with mental health information (Rasmussen-Pennington et al., 2013). While the Internet can
provide useful opportunities for youth to engage in information sharing, the utility of the Internet depends upon having reliable (and in some cases confidential) access to an Internet connection. In circumstances in which Internet access is limited, information sharing can be hindered (McMahon et al., 2011) and thus web-based mental health interventions or information sharing may not be helpful.

Limited access to the Internet is a problem which particularly affects rural and remote communities. In a study that examines data from across Canada McMahon et al. (2011) argue that there is a significant ‘digital divide.’ Many rural and remote communities have unreliable Internet access, and the possibilities for using Internet based mental health interventions with youth are consequently limited (McMahon et al., 2011). There is also evidence to suggest that many street-involved youth do have relatively reliable access to the Internet through drop-in centers, public libraries and shelters (Karabanow, 2010). This example helps to illustrate the idea that the abilities of youth to access the Internet are not dependent solely upon socio economic standing, but are affected by more complex set of factors.

Looking beyond Canada, there is little information on Internet use for obtaining mental health information in developing countries (Borzekowski, 2006). The exploratory study by Borzekowski attempts to develop information on this topic and shows that, amongst Ghanian youth between the ages of 15-18 across ages and genders and ethnicity and school status, youth were interested in, and occasionally searched for health information. There are not a large number of studies on this issue, and the analysis provided by Borzekowski suggests that more research on the use of the Internet for mental health purposes in non-western countries may be warranted (2006, p.1-2).
II. Stigma and Mental Health

Stigma has been described as “the most formidable obstacle to future progress in the arena of mental illness and health,” according to the United States Surgeon’s General report on mental health (Abdullah, 2010, p. 935; Hinshaw, 2007; U.S. Department of Health & Human Services, 1999).

Reidpath, Chan, Gifford and Allotey (2005) define stigma as “a mark borne by a person judged as unfit for the sharing of social resources” (p. 472). Schambler (2009) views stigma as a social process characterized by exclusion, rejection, blame, or devaluation, while Link and Phelan (2001) describe stigma as the co-occurrence of labeling, stereotyping, separation, status loss, and discrimination in a context where some people have more power than others (Pasiciel, Hudson & Aube, 2013, p. 15). The Mental Health Commission of Canada refers to stigma as both negative, unfavourable attitudes and the behaviours they produce (MHCC, 2012).

Contextual factors play a role in the formation of stigmatizing beliefs, in reproducing stigma, and in sharpening the blows dealt by stigma. Stigma “is not just a feature of a particular disease or disability but is inevitably situated in a web of social interactions that reflect the influence of cultural meanings” (Raguram et al., 2004 p. 736). Conceived broadly, stigma can have wide ranging impacts on the lives of people with mental illnesses including marginalization from housing and jobs, diminished self-esteem, a decreased likelihood to seek help when experiencing symptoms of mental illness, a diminished sense of self worth and diminished social participation in order to avoid rejection (Abdullah, 2010, p. 936; Corrigan, 2004, p. 617).

Stigma can be divided into two categories: public stigma and self stigma.
a. **Public Stigma**

Public stigma has been conceived of as the product of discriminatory responses directed toward people with mental illnesses (Abdullah 2010; Corrigan & Kleinlein, 2005). It can affect a person experiencing mental illness, as well as their friends, families and acquaintances. The effects of public stigma can go beyond the mental health of the person stigmatized; public stigma can create difficulties for stigmatized person to obtain jobs or adequate and affordable housing (Corrigan, 2004) and can increase the probability that a person will interact with the criminal justice system (Corrigan & Kleinlein, 2005).

b. **Self Stigma**

Self-stigma, on the other hand, has been conceived of as the internalization of public stigma regarding mental illness (Corrigan, 2004; Corrigan, 2007; Corrigan & Wassell, 2008, Abdullah, p.4). According to Corrigan (2007), self-stigma “leads to automatic thoughts and negative emotional reactions; prominent among these are shame, low self-esteem, and diminished self-efficacy” (p. 32). Experiences of public stigma can lead people with mental illness to believe that they are less appreciated and respected as a result of the mental health challenge they face. This can lead to a diminished sense of self worth and self-efficacy (Corrigan, 2004).

Denial has also been incorporated into understandings of the relationship between public and self-stigma. People facing mental health challenges may deny the existence of these challenges and, when experiencing symptoms of mental illness, may attribute these symptoms to personal failings or inadequacies rather than understanding them as symptoms of an illness.
However, stigma is not the only cause of denial (Abdullah, 2010; Eysenbach, 2007).

c. **How Stigma Works**

The literature review produced various theories that attempt to explain how stigma operates. There has been significant evolution in this body of theory. The “psychiatric perspective” which was prominent in the 1970’s and 1980’s holds that stigma is a rational response to abnormal or socially undesirable behaviour exhibited by people with mental disabilities (Gove, 1982). From this perspective stigmatizing behaviour is regarded as rational and is not considered to be a factor that could heighten the recurrence of mental health problems (Corrigan & Klein 2005; Abdullah, 2010, p. 937)

Moving forward, labeling theory came to occupy a prominent role in academic thinking on stigma. A central tenet of early labeling theory was that mental health stigma was a manifestation of the “heavy weight of moral condemnation” (Scheff, 1984, p. 30; Abdullah, 2010 p. 937) that labels like “mentally ill” carry. Labeling has seen to lead to the development of negative emotions in the general public, which affect their behaviour toward people labeled mentally ill. In addition, being labeled can cause a person to conform to the stereotype promoted by that label (Abdullah, 2010, p. 4; Corrigan & Kleinlein).

Cullen et al. (1989) proposed a modified labeling theory in which the impact of being labeled by a health professional as having a mental illness is seen to have an impact on the subjective experience of the individual with a mental illness are seen to play a role. Once this labeling occurs, the consequences of the label are internalized by the individual and affect their behaviour (Abdullah, 2010).
Still more recently, a socio-cognitive approach takes into account cues or indicators exhibited by a person with a mental illness and relies less on the participation of a medical professional as a legitimizer of the label. In this theory, social cues are interpreted as symptoms of psychiatric problems and act as cues for members of the public that a person is a mental health challenge. These cues invoke stereotypes about people with mental illness, which then lead to the mobilization of stereotypes that can lead to prejudicial behaviour (Corrigan 2007, Abdullah, 2010).

d. Media and Stigma

The relationship between media exposure and personal attitudes and beliefs is complex. The media does appear to play a role in fostering perceptions of dangerousness that are related to mental illnesses (Canadian Mental Health Association, 2004). In a literature review on mass media and mental health prepared for the Canadian Mental Health Association, it was found that media can have a significant impact on reproducing the stereotypes that underlie the stigmatization of people with mental illness (Corrigan, 1998; Canadian Mental Health Association, 2004). In addition, this literature review found that:

1. Mass media is the primary source of information about mental illness for many people

2. Media representations can and do promote false and negative stereotypes.

3. There is a connection between the public’s negative attitude toward people with mental health difficulties and negative media portrayals of mental illness.

4. Negative media portrayals have a direct impact on individuals living with mental
illness.

5. There is a relationship between negative media portrayal of mental illness and
government responses to mental health issues.

(Canadian Mental Health Association, 2004, P. 3)

While mass media can play a role in promoting negative stereotypes of mental health, it
 can also be used to deconstruct these stereotypes. In the national mental health strategy
produced by the MHCC, the role of the media in deconstructing negative stereotypes of mental
health is outlined (MHCC, 2012, p. 14).

III. Social Media and the Internet

The literature on the relationship between social media/the Internet and mental health
stigma is less developed than that on mass media and mental health stigma. This may be a
result of the inability of academic research to keep up to fast-moving changes in the ways that
social media is used.

Social media and the Internet play significant roles in the lives of many young people.
The Internet has a strong appeal to people who wish to seek advice on important but
Anonymously seeking information online about mental illness is one way that young people can
avoid some forms of stigma (Rasmussen-Pennington et al., 2013; Cunningham et al., 2013).
However, young people (as well as the larger general population) may not have the skills or
interest to carefully evaluate the online information they encounter (Eysenbach, 2007; Fields,
While social media can play a significant role in spreading mental health related information, the abilities of some young people to differentiate between helpful and non-helpful information may impact upon effectiveness.

In a study which involved conducting focus groups of youth, Rasmussen-Pennington et al. (2013) found that, while most of the youth involved in the study used social media on a regular basis, many found social media to be a problematic method with which to access mental health information. Hesitation to use social media for mental health information was based on fear of stigma. Social media networks are often similar to existing social networks (Thackeray et al. 2011), and young people felt that using social media to search for mental health information might expose them to the real life stigma (Rassmussen-Pennington et al., 2013, p. 13).

IV. Case Studies

In the following section two case studies are provided which detail the activities of two organizations that facilitate building connections between young people and mental health information. The subjects of these case studies were chosen in order to illustrate several of the themes that are prominent within the body of academic and grey literature that was assembled through the literature review process and will be used a basis for further discussion of these issues.
a. Case Study #1: Kids Help Phone

Kids Help Phone is a service provider located in Canada that provides telephone and Internet-based counselling services to children and youth who live in urban, rural and remote communities across Canada. Services are available in both English and French and are provided free of charge and on an anonymous and confidential basis (Kids Help Phone, 2012, p. 2). According to an evaluation conducted by Kids Help Phone on itself, the various services it offers are associated with statistically significant reductions in distress and increases in clarity. In addition, the professional counselling services offered help young people to develop their own coping and problem solving skills. Approximately 5000 children and youth access Kids Help Phone counselling services each week (Kids Help Phone, 2012, p. 48).

**Telephone Counselling**

More females (73%) than males (23%) and transgendered (4%) youth accessed Kids Help Phone counselling services. Further, 16% identify as lesbian, gay, bisexual or questioning. While there are no accurate statistics on the proportion of Canadian youth that identify as sexual minorities, KHP assumes that these populations are overrepresented in the calls they make to KHP. Further, approximately 10% of users of phone counselling services identity as First Nations, Aboriginal or Métis. This is about twice the representation in Canada’s population.

Summary of Points:

- Significantly more females than males access Kid’s Help Phone Services
- Minorities of various types are over represented in their use of Kid’s Help Phone services. This includes: First Nations, Aboriginals, Métis as well as youth who identify as lesbian, gay, bisexual, transgendered, or questioning
- A large number of users of online chat use this service because it provides more privacy and anonymity than phone services.
While KHP counsellors allow the youth they speak with to define the subjects they would like to speak about, there are four primary areas that youth who contact KHP like to speak about: mental health, suicide and addiction (22%), struggles in peer relationships (21%), struggles in family relationships (15%), and violence and abuse (13%).

The counselling services offered seem to be effective with 87% of phone clients experiencing a reduction in stress, 84% learning new options for dealing with their problems and 71% of live chat users experiencing an increase in clarity on how to move forward with their problems (Kids Help Phone, 2012).

**Live Chat Counselling**

Kids Help Phone began offering real-time Internet based chat counselling in response to feedback that it received from youth and from youth serving organizations Live chat was offered as a way of responding to the changing ways that youth communicate. The available research is based upon the live chat pilot project period.

When asked why they used live chat as opposed to the Kids Help Phone telephone counselling service, 75% of respondents indicated that they felt too nervous or uncomfortable to use the phone service, 62% said they did not have enough privacy to speak on the phone, and 42% said they would rather write than speak about their problems. Overall, 75% of youth who used the chat service stated that the promise of anonymity was their primary reason for choosing Kids Help phone above other services. A high proportion of study participants indicated that their interaction with a KHP counsellor was productive, with 75% indicating a reduction in stress as a rest of counselling and 71% reporting a significant increase in clarity about what to do to cope with their situation (Kids Help Phone, 2012, 33-36).
b. Case study 2: mindyourmind

Mindyourmind is a not-for-profit mental health program that engages youth, adults and the professionals who serve them in the development of relevant, reliable mental health resources with the goal of helping youth to access the right information, in the right format at the right time. The resources produced by mindyourmind are designed to reduce stigma associated with mental illness and to increase access and use of professional and peer-based community support.

Located in London, Ontario and serving youth from across Canada, mindyourmind employs multiple ways of helping youth to connect with mental health information, and of engaging youth in the creation of mental health information that is presented in useful ways. Mindyourmind provides platforms for youth to share their stories and points of view using art, music, video or other creative methods. Through the use of technology and through actively engaging youth in creating and disseminating mental health information, mindyourmind seeks to inspire youth to reach out for help and to develop the skills necessary to help others reach out.

Summary of Points:

- Mindyourmind provides an example of a program which engages youth in the creation of mental health related material (the creation and dissemination of their own artwork) and provides a way of sharing this information with other youth.
- The strategy for engaging youth is based on the recognition that “There is no one right way of engaging youth.” Different tactics for engagement work different for different groups of youth around different subject matter.
- Peer-to-peer information sharing can be beneficial for many youth. It can help to build trust, confer legitimacy and decrease feelings of isolation.
The mindyourmind website is used as a portal through which youth interested in mental health issues can be engaged. This website uses a number of strategies to engage with youth interested in mental health issues. The website provides the following resources:

1. **Interactive tools which allow youth to access information on complex topics in game form.** Topics dealt with include: reducing stress, seeking help, reducing anxiety, planning strategies for being well, planning strategies for reducing potential harm (drugs).

2. **Accessible information on various mental illnesses, symptoms, causes, treatments, myths.**

3. **A space for youth to share poetry, stories and artwork with a wider audience**

4. **A series of interviews with mental health advocates, role models and people who have experience dealing with mental health issues.**

Mindyourmind's activities are premised upon the idea that there is a need for those who provide mental health services in Canada to find new ways to reach young people (Halsall et al., in press). Zinck et al. (2013) propose that "different strategies need to be explored that identify their appropriateness for youth living in different challenging contexts, representing all genders and age categories" (2013, p. 2). Successful strategies for engaging youth vary according to the populations of youth that are to be engaged and the goals to be achieved by their engagement.

The manner in which youth are engaged is based on the principle of “co-creation.” The idea here is to avoid involving youth in tokenistic ways. Rather, relations between adult
professionals and youth are conceptualized using a partnership model, in which the various strengths of adults and youth are recognized and mobilized. In addition to providing the benefit of allowing youth to feel engaged in the work of which they are a part, practical benefits can accrue to all parties involved in the relationship. According to mindyourmind, both youth and adults stand to enjoy practical benefits from engaging in this way. For example, while adults have relevant clinical experience, youth tend to know a lot more about how young people share information using social media. This provides an obvious opportunity for adults and youth to work together.

In addition to helping youth to navigate the formal mental health system, mindyourmind works to provide spaces for youth to share their own stories. The mindyourmind website provides a space for youth to share stories, artwork, dance routines, video, poetry, and a blog in which articles relevant to mental health issues are aggregated.

Providing this space gives youth who chose to share artwork some motivation to work through their own thoughts using artistic forms. In addition to this, encouraging youth to submit their works leads to the creation of material that be seen by other youth who make their way to the website.

The workshop conducted with youth for this report suggested that, for some youth, peer voices lend credibility to information provided, and help to break down feeling of distrust, self-stigma and isolation. The role that peer involvement plays in mediating mental health stigma was also present in the literature (Moses, 2010). Further, providing this information anonymously "contributes to the youth preference for youth driven information" (Halsall et al., 2014).
The example provided by mindyourmind provides several points for reflection. First mindyourmind’s programming illustrates the value of using diverse strategies to engage youth in mental health related programming. In doing this, the organization shows that peer-to-peer information sharing can be an important component in the info-seeking strategies of youth. Finally, the programming of mindyourmind serves to challenge assumptions about the role of expert adult knowledge in youth info-seeking. While clinical information and the support of adults is important in the model created by mindyourmind, youth who are engaged in the creation and delivery of programming bring a unique set of assets and experiences which lie at the heart of programming.
Section 5: Discussion and Conclusions

I. Informational Preferences

Young adults in Canada experience relatively high rates of mental health concerns, but access mental health service at relative low rates (Marcus et al., 2012). As discussed earlier in the report, the reasons that young people do not seek information related to mental health are complex and appear to be primarily related to issues of stigma, shame and gender concerns (Pasiciel et al., 2013; Marcus et al., 2012). Further, young people who do access formal mental health services may experience long wait times which frustrate their efforts to access assistance when they need it. The evidence on wait times across Canada is fragmented - it is not clear who is waiting for what, from whom and for how long (Davidson et al., 2006). The available evidence however suggests that the needs of many youth go unmet.

Marcus et al.’s (2012) study of the mental health informational preferences of young people suggests that young people differ significantly from adults in terms of the manner in which they would like to receive mental health information. Young adults were less likely to seek out professional care, or to believe that medication or psychotherapy could be helpful. Canadian young adults were more likely to seek support for mental health through informal sources, such as friends and family. More particularly, male participants showed more interest in dealing with mental health challenges in an individual manner (Marcus et al., 2012).

The study conducted by Cunningham et al. (2013) provides support for this argument, and provides additional nuance to conclusions reached regarding the information preferences
of Canadian youth. This study found that 30.1% of young people sampled prefer to receive information through conventional means (books or pamphlets recommended by doctors), while 28.7% preferred to work independently on the Internet in their search for information. Perhaps most importantly, this study found that receiving information in brief snippets was preferred by low-interest participants. In addition, it suggested that maximizing the uptake of information requires a mixture of active and passive approaches to sharing both new and old media.

A number of characteristics of the forms of information preferred by youth have been identified in the literature. In a focus group based study conducted with Canadian youth from across the country, youth stated that mental health related websites should: provide digestible chunks of information in multiple formats, be factually and ethically sound, be concise and interesting. In addition, they stated that websites should include short videos, user ratings, offer quizzes and be easy to search (Rasmussen-Pennington et al., 2013).

In addition, the literature identified a preference for information that is constantly available (ie. websites) and which allowed anonymous access to information (Rasmussen-Pennington et al., 2013). The same study identified a preference for learning about the lived experiences of others with mental health challenges as both a way of increasingly credibility and decreasing feelings of isolation among youth with mental health concerns (Rasmussen-Pennington et al., 2013).

The use of blogs has created a unique opportunity for many youth to share their mental health experiences with wider audiences (Marcus et al., 2012). One study which analyzed the blogs of 18-25 year olds who experienced mental illness. Many of the writers of these blogs reported feeling lonely, alienated and having a lack of connection with others. Many also
reported having experienced mental health professionals as unresponsive and unapproachable. For some of these youth, writing blogs provided an opportunity to share their experiences with others, and to feel empowered by virtue of developing this connection (Marcus et al., 2012).

Evidence gathered from both Kids Help Phone and mindyourmind can also be used to inform an understanding of the preferences of youth with regard to the kinds of mental health information they receive. Discussions with mindyourmind staff members provided an overview of the diverse methods that this organization uses to connect with youth. “Getting the right information, in the right format, to the right youth, at the right time” is a focus of mindyourmind’s activates (Contursi, personal conversation, September 12, 2014).

Aspiring to this has given rise to the diverse offerings provided by the organization. As detailed in the case study above, mindyourmind provides a diverse set of interactive online tools that youth can use to learn about mental health and illness. mindyourmind has identified a preference for peer-to-peer information sharing that is shared by some youth with whom it works. These youth find value in receiving information that is conveyed in the form of the stories, artwork and poetry of other youth. This feeling was partially reflected in the workshop held with youth for the purposes of this report. While some youth did report finding it helpful to know that other young people shared their experiences, others felt that this was not always helpful. One member of workshop group noted that, while at times it was helpful to know that other people experienced similar challenges, at other times it felt better to feel that the problems one faced are individually difficult, and unique to the person experiencing them.

The methods employed by Kids Help Phone to connect with Canadian youth also provide insight into the power of providing information in diverse formats. As the information
presented above shows, Kids Help Phone began by offering a confidential phone in service that youth can use to connect with counsellors who can offer information and guidance. As Kids Help Phone’s own evaluation shows, some youth are reticent to speak on the phone and find it significantly more difficult than communicating over the Internet or using text messaging. In this sense, for some youth offering services exclusively by phone constitutes an additional barrier that separates them from mental health information.

Recognizing that some youth find talking on the phone to strangers to be difficult, Kid’s Help Phone has begun to offer online chat services. Similar to the phone service, youth can use this online messaging service to connect and communicate with counsellors. In support of evidence given in the 2012 Kid’s Help Phone Impact Report, one staff counsellor is quoted as saying:

“On Live Chat, I often connect with teens who otherwise would not have reached out for help. This is particularly true for young people coping with self-harm or eating disorders, who often see Live Chat as a first ‘easier’ step to getting help.” (Kids Help Phone Impact Report, 2012 p. 30).

II. Youth Engagement

Youth engagement has been conceptualized as meaningful and sustained involvement of a young person in an activity, with a focus outside of himself or herself (Zinck, Ungar, Whitman, Exenberger, LeVert-Chaisson, Liebenberg, Ung & Forshner, 2013). The content of youth engagement can vary widely: youth might be engaged in music, activism, the arts, politics or community life. Key to successful youth engagement, in the way the concept is used within
the mental health literature, is that the individual experiences “enjoyed absorption” in the activity that is sustained over time, that the activity provides a link between the individual and the outside world and that the activity is made to feel meaningful and significant (Zinck et al. 2013).

There is a substantial evidence base that supports arguments that engaging youth can have positive mental health impacts (Armstrong & Manion, 2013). Youth engagement has also been found to be an effective strategy in preventing youth suicide and decreasing suicidal ideation (Armstrong & Manion, 2013). In a study which involved 813 Canadian secondary students, Armstrong and Manion (2013) found that youth engagement activities which were personally meaningful to youth were found to moderate the relationships between depressive symptoms, high risk behaviours, self-esteem, and social support in the prediction of suicidal ideation (Armstrong & Manion, 2013, p. 1). Interestingly, as the meaning found in engagement increased, the likelihood that youth reported suicidal thoughts decreased in spite of risk factors.

More directly related to information seeking, Rasmussen-Pennington et al. (2013) argue that youth participation in the development of spaces for mental health knowledge transfer is important (Rasmussen-Pennington et al., 2013, p.15). Youth are more likely to benefit when they feel invested in projects related to mental health, and when they are given the power to influence decision-making.

a. Peer-to-Peer Approaches to Engaging Youth in Information

A previous report authored by the CYCC outlined a number of recommendations related to youth engagement and mental health. This report, based on an extensive review of the literature offers specific ideas for using youth engagement to contribute to efforts to address
youth mental health issues (Zinck et al. 2013). The CYCC report recommends promoting youth engagement to make services more effective. By taking steps toward engaging youth in research, program design and implementation, products that are more relevant to the concerns of youth can be created. Further to this, the report identifies a need for meaningfully including young people in organizational decision-making in cases where an organization is involved with providing services to youth. Finally, the CYCC report recommends that encouraging youth to become engaged in their own communities through doing volunteer activities or political activities could help to reduce feelings of social isolation often experienced by young people with mental health challenges (Zinck et al., 2013).

III. The Role of Social Media in Mental Health Promotion

The Internet provides a set of interesting, although not uncomplicated, ways of providing information related to mental health. The literature search gathered a large amount of information related to the use of the Internet for mental-health intervention. In order to reduce this discussion to a manageable size, this report has broken it down into a number of themes below. In addition, this report discusses several of the limitations of relying on the Internet for mental health related purposes, as well as discussion of some of the negative effects that the proliferation of the Internet may have for youth mental health.

First, the Internet provides a powerful tool for disseminating knowledge related to mental health. It can be used to circumvent several challenges. Stigma is a factor that prevents many young people from seeking mental health information. Using the Internet allows them to search for information anonymously and thus avoid being stigmatized (Rasmussen-Pennington
et al., 2013). The Internet also allows mental health information to be accessed by youth in rural areas that have Internet access which are underserved by traditional services (Griffiths, 2007). The plethora of information available to youth on the Internet provides an opportunity for youth to select information in a format that they find to be accessible (Marcus, Westra, Eastwood & Barnes, 2012). While the Internet does provide powerful opportunities, it has a number of limitations which deserve attention. One limitation that has received attention within the literature is the credibility of online information. Online information, as opposed to information that comes from a physician, may not be credible. It is often necessary for youth to differentiate high quality, accurate information and low quality information (Eysenbach, 2002; Eysenbach, 2007; Rasmussen-Pennington et al., 2013). It has been shown that the overall quality of mental health information available on the Internet is mixed; while some sources provide accurate information, the information provided by other sources is unreliable (Eysenbach, 2002).

The problem of information credibility is closely linked to mental health literacy, or the ability to distinguish between good and bad information. The extent to which youth are literate in issues of mental health has a significant impact on their abilities to discern helpful from unhelpful mental health information. Mental health literacy is important for several other reasons. Perhaps most importantly, a high level of mental health literacy provides the ability to recognize the presence of a mental disorder in oneself or in an acquaintance (Canadian Alliance on Mental Illness and Mental Health, 2007). The base level of mental health literacy in Canada is low among many populations, with many people unable to identify mental health disorders,
not able to understand causal factors and having fearful attitudes toward those who do have mental health difficulties (Canadian Alliance on Mental Illness and Mental Health, 2007).

a. Cyber Bullying and Communities of Negative Identity

Although the Internet does have great potential for use in mental health information sharing, there are several other factors related to mental health which should be taken into account. First, the widespread use of the Internet has created the possibility for the formation of communities of identity that can have negative implications for youth mental health. There are several notable examples of this. One study, provided by Whitlock and Eckenrode (2007), shows that Internet message boards are used to share information about self-injurious behaviour. The literature search also returned academic studies which address the impacts of pro-eating disorder websites (Wilson, 2006).

A second concern is cyber bullying which is enabled by both social media and mobile technology. There is some disagreement over the frequency of cyber bullying, with some studies claiming that it is limited in frequency and inaccurately represented by a small number of high profile cases (Media Smarts, 2012), other studies claim that it is a common experience (Rasmussen-Pennington et al., 2013, 191). Whatever the frequency of cyber bullying, it is clear from cases such as that of Rehteah Parsons (Pepler and Milton, 2013) that cyber bullying can have a severe impact on the mental health of those who experience it.
IV. Mental Health Literacy

The concept of mental health literacy is important to understanding why people seek help or information related to mental health disorders, as well as understanding the way in which stigma operates (MHCC, 2012). The concept of mental health literacy is derived from the term health literacy, which was originally defined as a functional capacity related to basic literacy skills and how these affect the ability of people to access and use health information. Over time the definition of health literacy was expanded to include the development of increasingly complex cognitive and social skills, which are related to personal and collective empowerment for health promotion. Similarly, mental health literacy has been defined as “knowledge and beliefs about mental disorders which aid their recognition, management or prevention” (Canadian Alliance on Mental Illness and Mental Health, 2007, p. 1).

Mental health literacy has been defined as consisting of the following elements (Canadian Alliance on Mental Illness and Mental Health, 2007):

- the ability to recognize specific disorders or different types of psychological distress;
- knowledge and beliefs about risk factors and causes;
- knowledge and beliefs about self-help interventions;
- knowledge and beliefs about professional help available;
- attitudes which facilitate recognition and appropriate help-seeking;
- knowledge of how to seek mental health information.

Much of the available literature argues that the general population has a poor understanding of mental health and illness. There is evidence to suggest that many people are not able to correctly identify mental disorders, fear those who do have mental disorders, have
an incorrect conception of the effectiveness of mental health interventions and are hesitant to seek help for themselves or encourage others to do so (Canadian Alliance on Mental Illness and Mental Health, 2007, p. 2).

A CAMIMH study found that about two-thirds of respondents estimate the prevalence of mental disorders as between one in 10 and one in five Canadians. However, about a third believes that one in 50 Canadians or fewer will experience a mental health disorder. The prevalence of mental health disorders in Canada is approximately 20%. Perhaps most relevant to the present report, the study found that estimations of the prevalence of mental health conditions were slightly more accurate among Canadian youth (Canadian Alliance on Mental Illness and Mental Health, 2007, p. 16).

The same survey inquired into reasons for not seeking help. Respondents identified several factors. These factors included denial or not being able to recognize mental health problems. Shame or discomfort associated with seeking help was also cited. Responses given by men suggested that shame, denial and lack of recognition are higher among men, suggesting that men are perceived as having a harder time asking for help (Canadian Alliance on Mental Illness and Mental Health, 2007, p. 26).

The Mobilizing Minds Research Group conducted an environmental scan that identified activities and initiatives related to mental health literacy, knowledge translation and policy/system change initiatives. This scan identified programs and initiatives that are targeted within provinces, nationally (within Canada) and internationally. While this environmental scan does not comment upon the quality of mental health promotion initiatives, it does establish the breadth of the network which offers such services, as well as indicates that a significant amount
of diversity found within this network. This report also suggests that future scans might investigate the level of coordination across knowledge translation initiatives, mental health literacy initiatives and policy/systems initiatives (Cunningham et al., p. 8).
Section 6: Recommendations

1. **Diverse experiences of mental health**: Researchers, practitioners, and organizations should develop mechanisms that document how youth from diverse backgrounds seek information about mental health and mental health services.

   In particular, it is important to document the experiences of youth from the following populations: a) young males; b) Aboriginal youth; and c) immigrant and refugees.

2. **Youth Engagement**: There is a need for young people and practitioners to develop processes that acknowledge and validate the views and experiences of youth from diverse backgrounds.

   Human services organizations should engage youth from diverse backgrounds in order to develop processes that will enable young people to access information on mental health and mental health services.

3. **Stigma Reduction**: Reducing personal and public mental health stigma related to youth requires widespread awareness and educational initiatives.

   Awareness and educational initiatives should target youth experiencing mental health concerns, the supportive networks in these young people’s lives, and the general youth population.

4. **Mental Health Literacy**: Raising awareness about youth mental health and stigma needs to involve dialogue and collaboration between multiple stakeholders. These stakeholders include: young people and their families, community members, service providers, and policy makers/policy influencers.

   Efforts to increase mental health literacy should be implemented through various systems including: the educational system, health care system, justice system, recreational systems, and faith-based systems.
5. **Evidence and Info-Seeking:** It is important to acknowledge different types of local, practice-based, and evidence-based knowledge as credible sources for youth who seek information on mental health and mental health services.

   It is imperative to recognize that each form of knowledge has merits and limitations; programming that promotes mental health information seeking should incorporate all three types of information.

6. **Information Credibility:** Service providers and organizations must engage youth in the creation of information resources. This approach will result in the creation of resources that are credible for youth who are seeking information on mental health and mental health services. Co-creation of information resources and dissemination strategies can be beneficial to youth and to service professionals.

7. **Social Media and Info-Seeking:** There are few evidence-informed insights about the ways in which young people access mental health information and services through social media and the Internet.

   Researchers, service providers, practitioners, and policy makers should build on existing work and further develop efforts to evaluate the effectiveness of social media and the Internet as mental health info dissemination strategies.

8. **Social Media and Info-Seeking:** Youth, service providers, practitioners, and policy makers need to have an understanding of the both the positive and potential negative impacts of accessing mental health information through different forms of social media.


Cheung, A. (2007). Mental Health Service Use Among Adolescents and Young Adults With Major Depressive Disorder and Suicidality. La Revue Canadienne de Psychiatrie, 54(2).


Mental Health Commission of Canada. (2009). Understanding the issues, best practice and options for service development to meet the needs of ethno-cultural groups, immigrants, refugees, and racialized groups. Retrieved from:
http://www.mentalhealthcommission.ca/English/system/files/private/diversity_issues_options_consultation_eng_0.pdf


Mobilizing Minds. Knowledge Translation, Mental Health Literacy and Policy/System Change Initiatives Aimed at Improving the Mental Health of Youth and Young Adults in Canada: An Environmental Scan


## Appendix A: Glossary of Terms

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Aboriginal</td>
<td>The descendants of the original inhabitants of North America. The Canadian Constitution of 1982 recognizes three groups of Aboriginal people – Indians, Métis and Inuit. These are three separate peoples with unique heritages, languages, cultural practices and spiritual beliefs [PHAC-FNCIS]. However, all shared the common history of colonialism and attempted assimilation.</td>
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<tr>
<td>Adolescence</td>
<td>“Adolescence begins with the onset of physiologically normal puberty, and ends when an adult identity and behaviour are accepted. This period of development corresponds roughly to the period between the ages of 10 and 19 years.” (‘WHO</td>
</tr>
<tr>
<td>Alternative Care</td>
<td>“Alternative care is defined as care for orphans and other vulnerable children who are not under the custody of their biological parents. It includes adoption, foster families, guardianship, kinship care, residential care and other community-based arrangements to care for children in need of special protection, particularly children without primary caregivers.” (UNICEF, 2006, p. 15)</td>
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<tr>
<td>Best Practice</td>
<td>“Best Practices are interventions that incorporate evidence-informed practice, identify and employ the right combination of program elements to ensure targeted outcomes, and match these interventions to the local needs and assets of communities. This definition of best practices thus prioritizes the evidence garnered from researchers, practitioners, and indigenous knowledge, depending on the question being asked” (CYCC-Violence, p. 70)</td>
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<tr>
<td>Bullying</td>
<td>“A form of aggression (physical, verbal, or psychological attack or intimidation) by one or more children that is intended to cause fear, distress, or harm to another child who is perceived as being unable to defend himself or herself. A power imbalance typically exists between the bully and the victim, with the bully being either physically or psychologically more powerful, resulting in repeated incidents between the same children over a prolonged period.” (Farrington, Baldry, Kyvsgaard, &amp; Ttofi, 2010, p. 9; Smokowski &amp; Kopasz, 2005, p. 101)</td>
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<tr>
<td>Child/Children</td>
<td>“Every human being below the age of eighteen years unless under the law applicable to the child, majority is attained earlier” (United Nations General Assembly, 1989, art. 1)</td>
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<td>Child Maltreatment</td>
<td>There are five classifications of maltreatment: physical abuse, sexual abuse, neglect, emotional maltreatment, exposure to intimate partner violence (PHAC-CIS 2008).</td>
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<tr>
<td><strong>Children and Youth in Organized Armed Violence</strong></td>
<td>“Children and youth employed or otherwise participating in Organised Armed Violence where there are elements of a command structure and power over territory, local population or resources” (Dowdney, 2006, p. 13)</td>
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<tr>
<td><strong>Child Soldier</strong></td>
<td>“A Child soldier is any person under age 18 who is part if any kind of regular or irregular armed force or group in any capacity, including but not limited to cooks, porters, messengers and those accompanying such groups, other than purely as family members. This definition includes girls recruited for sexual purposes and for forced marriage. It does not, therefore, only refer to a child who is carrying or has carried arms.” (“UNICEF - UNICEF in emergencies - Children and armed conflict,” 1997)</td>
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<td><strong>Child trafficking</strong></td>
<td>“The recruitment, transportation, transfer, harbouring or receipt of a child for the purpose of exploitation ... even if this does not involve any of the means set forth in [the definition of Trafficking in persons] (“the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs”) [United Nations, 2004]</td>
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<tr>
<td><strong>Community of Practice</strong></td>
<td>The translation of best practices and the mastery of knowledge and skill through participation in the sociocultural practices and relations of a community (Lave &amp; Wenger, 1991, p. 29). A community of practice defines itself along three dimensions:</td>
</tr>
<tr>
<td></td>
<td>• What it is about – its joint enterprise as understood and continually renegotiated by its members</td>
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<td></td>
<td>• How it functions mutual engagement that bind members together into a social entity</td>
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<td></td>
<td>• What capability it has produced – the shared repertoire of communal resources (routines, sensibilities, artifacts, vocabulary, styles, etc.) that members have developed over time. (Wenger, 1998)</td>
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<tr>
<td><strong>CYCCs (Children and Youth in Challenging Contexts)</strong></td>
<td>By CYCCs, this report refers to children and youth who face particular challenges and risks that increase their vulnerability and threaten their safety and development. This definition is not place or culture-specific and refers to CYCCs world-wide. CYCC populations specific to the knowledge syntheses will be defined in the reports.</td>
</tr>
</tbody>
</table>
| **Chronic Illness/ Disease** | “The word ‘chronic’ is typically used for conditions, illnesses, and diseases lasting three months or more. Often, chronic conditions are characterized by lasting symptoms and/or pain that persists, sometimes even despite treatment.” (‘What Is Chronic Illness?’ http://carly-
<table>
<thead>
<tr>
<th>Civic Engagement</th>
<th>“Individual and collective actions designed to identify and address issues of public concern. Civic engagement can take many forms, from individual voluntarism to organizational involvement to electoral participation. It can include efforts to directly address an issue, work with others in a community to solve a problem or interact with the institutions of representative democracy” (American Psychological Association, 2012).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Youth Development</td>
<td>“Community Youth Development is an approach that espouses the principle that when youth are enlisted as active agents of community building, it contributes positively to both youth development and community development. Community Youth Development assumes the involvement of young people in their own development and that of the community - in partnership with adults - to make use of their talents and increase their investment in the community.” (‘Heartwood Centre for Community Youth Development’)</td>
</tr>
<tr>
<td>Engagement</td>
<td>“The meaningful and sustained involvement of a young person in an activity focusing outside the self. Full engagement consists of a cognitive component, an affective component, and a behavioural component- Heart, Head, and Feet.” (‘Centres of Excellence for Children’s Well-Being- Youth Engagement’)</td>
</tr>
<tr>
<td>Environmental Scan</td>
<td>A surveying approach that was used to capture resources and programs that exist outside of the academic, peer-reviewed literature (Chrusciel 2011)</td>
</tr>
<tr>
<td>Evidence-based practice (EBP)</td>
<td>“Interventions based on empirical, research-based support which are used to inform the judgements of practitioners in accordance with the particular priorities, needs, contexts and other factors of both service users and service providers (ie. What research shows is effective).”</td>
</tr>
<tr>
<td>Evidence-informed practice (EIP)</td>
<td>Interventions based on empirical, research-based support, which are employed in accordance with the particular priorities, needs, contexts and other factors of both service users and service providers (Chalmers, 2003; Proctor &amp; Rosen, 2006)</td>
</tr>
<tr>
<td>External validity / generalizability</td>
<td>“The extent to which the claims/arguments are generalizable to, or applicable in, contexts different from the specific context in which they were generated (ie. transferability).”</td>
</tr>
<tr>
<td>Family</td>
<td>“The fundamental group of society and the natural environment for the growth and well-being of all its members and particularly children, should be afforded the necessary protection and assistance so that it can fully assume its responsibilities within the community” (United Nations General Assembly, 1989)</td>
</tr>
<tr>
<td>Generalizability</td>
<td>The ability to for general principles or conclusions from detailed fact, information, or experiences (<a href="http://www.thefreedictionary.com/generalizability">http://www.thefreedictionary.com/generalizability</a>)</td>
</tr>
</tbody>
</table>
| Grey literature | “Information produced on all levels of government, academia, business and industry in electronic and print formats not controlled by commercial
<table>
<thead>
<tr>
<th>High quality information</th>
<th>“Authoritative, high quality information is any peer-reviewed source that is reliable, objective, and internally and externally valid.”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homeless Youth</td>
<td>“Definitions of the term ‘homeless’ of ‘street youth’ are numerous and varied, as are the social realities of different countries. However, one constant found among all street youth is their precarious living conditions, which include poverty, residential instability and emotional and psychological vulnerability. These conditions may lead to behaviour that exposes street youth to physical, mental, emotional and psychological risks.” (“Street Youth in Canada: Findings from Enhanced Surveillance of Canadian Street Youth, 1999-2003”, 2006)</td>
</tr>
<tr>
<td>Indigenous knowledge</td>
<td>“The local knowledge generated within a community, which is contextually dependent on the cultural beliefs and practices of the community and undergoing constant modification in response to its changing needs.” (Agrawal, 1995; Smylie et al., 2004; Warren, 1991)</td>
</tr>
<tr>
<td>Institutional Review Board (IRB)</td>
<td>See Research Ethics Board</td>
</tr>
<tr>
<td>Internal validity</td>
<td>“The extent to which the evidence put forward actually relates to the claims / arguments being put forward (ie. truth value).”</td>
</tr>
<tr>
<td>Intervention</td>
<td>In this report, an intervention refers to the program, project, strategy, etc, employed by a government agency or organization that aims to introduce new ideas, activities and information intended to improve their target audience’s quality of life.</td>
</tr>
<tr>
<td>Knowledge Mobilization</td>
<td>In our context- it is mobilizing knowledge about best practices for NGOs</td>
</tr>
<tr>
<td>Maltreatment</td>
<td>“Physical abuse, sexual abuse, emotional maltreatment, neglect, and exposure to intimate partner violence, all of which pose significant risk of harm to a child’s physical or emotional development. Accordingly, situations classified as maltreatment may range from those in which a caregiver intentionally inflicts severe physical or emotional harm on a child, to situations in which a child is placed at risk of harm as a result of a caregiver’s clear failure to supervise or care for a child, to situations in which living conditions would make it extremely difficult for any caregiver to ensure a child’s safety.” (Trocme et al., 2008, p. ix)</td>
</tr>
<tr>
<td>Neglect</td>
<td>“The failure of parents or carers to meet a child’s physical and emotional needs when they have the means, knowledge and access to services to do so; or failure to protect her or him from exposure to danger. In many settings the line between what is caused deliberately and what is caused by ignorance or lack of care possibilities may be difficult to draw.” (Pinheiro, 2006, p. 54)</td>
</tr>
<tr>
<td>Non-physical violence</td>
<td>“Degrading and potentially damaging forms of psychological violence, including persistent threats, insults, name-calling or other forms of verbal...”</td>
</tr>
</tbody>
</table>
abuse, belittling, isolation or rejection. In violent settings, there is constant fear and anxiety caused by the anticipation of violence; pain, humiliation and fear during its enactment; and loneliness, rejection, distrust, and self-disgust. In addition to direct violence, witnessing violence between family members or in the community can itself pose serious consequences.”

(Pinheiro, 2006, pp. 47, 61)

<table>
<thead>
<tr>
<th>Objectivity</th>
<th>“The extent to which the evidence is unbiased (ie. neutrality).”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peer-reviewed information</td>
<td>“Books, journals, and conference proceedings published by scholarly publishers or professional organizations, and thus subject to independent review by experts. The credibility and authority of the information is determined by <em>extrinsic</em> criteria (ie. based on the reputation of the author, publisher, etc).”</td>
</tr>
<tr>
<td>Physical violence</td>
<td>“The intentional use of physical force against a child that either results in or has a high likelihood of resulting in harm to the child’s health, survival, development or dignity. In extreme cases, this violence can result in a child’s death, in disability, or in severe physical injury. In all instances, however, physical violence has a negative impact on a child’s psychological health and development. Includes homicide, sexual violence, corporal punishment beating, kicking, biting, choking, burning, scalding, or forced ingestion”</td>
</tr>
</tbody>
</table>


<p>| Positive Youth Development | “Youth development views youth both as partners and central figures in interventions. These interventions systematically seek to identify and utilize youth capacities and meet youth’s needs. They actively seek to involve youth as decision makers and tap their creativity, energy, and drive; and they also acknowledge that youth are not superhuman – that they therefore have needs that require a marshalling of resources targeted at youth and at changing environmental circumstances (family and community)” (Mafile’o &amp; Api, 2009). |
| Practice-based evidence (PBE) | “The practice employed by practitioners that has proven to be effective, arising from the contingent conditions and characteristics that facilitate program success.” (Barkham &amp; Mellor-Clark, 2003; Fox, 2003) |
| Receptor Communities (RC) | These are community organizations within the CYCC Network |
| Refugee | “any person, who owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his/her nationality and is unable or, owing to such fear, is unwilling to avail himself/ herself of the protection of that country; or who, not having a nationality and being outside the country of his/her former habitual residence as a result of such events, is unable, or owing to such fear, is unwilling to return to it” (United Nations, 1951) |</p>
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reliability</td>
<td>“The extent to which the evidence is stable (i.e. would be the same if measured at different times and / or by different observers; consistency of analysis).”</td>
</tr>
<tr>
<td>Research Ethics Board (REB)</td>
<td>An REB is a committee, usually within a university or other research institution, that is meant to ensure that research with humans is conducted in an ethical manner.</td>
</tr>
<tr>
<td>Resilience</td>
<td>“In the context of exposure to significant adversity, resilience is both the capacity of individuals to <strong>navigate</strong> their way to the psychological, social, cultural, and physical resources that sustain their well-being, and their capacity individually and collectively to <strong>negotiate</strong> for these resources to be provided in culturally <strong>meaningful</strong> ways.” (Ungar, 2005, p. 225)</td>
</tr>
<tr>
<td>Scoping Review</td>
<td>A review intended to “map’ or identify the extent and nature of the literature that currently exists in the field of interest” (Arksey 2003; p336; Mays et al 2001).</td>
</tr>
<tr>
<td>Service User</td>
<td>For the purpose of this report, we will use the term ‘service user’ to refer to any group or individual who can affect or is affected by the achievement of the organization’s objectives (Freeman 1984; 46). Synonyms include ‘Stakeholder’, ‘Beneficiary’, ‘Consumer’, &amp; ‘Participant’.</td>
</tr>
<tr>
<td>Sexual Violence</td>
<td>“Includes sexual touching, abuse or rape, forced sex within forced and early marriage, spousal abuse (physical and psychological), honour killings and intimidation within the family, or harmful traditional practices (eg. female genital mutilation / cutting, uvulectomy). The shame, secrecy and denial associated with sexual violence against children foster a pervasive culture of silence, where children cannot speak about sexual abuse they have suffered, adults do not speak about the risk of sexual violence or do not know what to do or say if they suspect someone they know is sexually abusing a child.” (Pinheiro, 2006, pp. 54–55)</td>
</tr>
<tr>
<td>Technology</td>
<td>“How different innovations in technology (i.e. mobile phones, the Internet, social networking) are used to help children and youth in the most challenging of contexts. Emphasis will be placed on those innovations which have been used with these young people to prevent violence and promote well-being.”</td>
</tr>
<tr>
<td>Unaccompanied Refugee Children</td>
<td>“Unaccompanied children are those who are separated from both parents and are not being cared for by an adult who, by law or custom, is responsible to do so.” (United Nations High Commissioner for Refugees, 1994, p. 121)</td>
</tr>
<tr>
<td>Validity</td>
<td>The extent to which a concept, conclusion or measurement is well-founded and corresponds accurately to the real world. (<a href="http://encyclopedia.thefreedictionary.com/Validity+%5Bstatistics">http://encyclopedia.thefreedictionary.com/Validity+[statistics</a>] )</td>
</tr>
<tr>
<td>Violence (Direct)</td>
<td>“The intentional or threatened use of physical force or power, involving both a perpetrator and a victim and occurring within the home, school, workplace, community or other settings, which either results in or has a high likelihood of resulting in physical or psychological harm,</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
</tr>
<tr>
<td>----------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Violence (Indirect)</td>
<td>“The intentional or unintentional physical or psychological harm derived from structural inequalities and power imbalances inherent in social, economic, and political institutions, which may not involve a direct perpetrator yet nonetheless prevent victims from meeting their basic needs.” (Farmer, 1996; Galtung, 1969)</td>
</tr>
<tr>
<td>Young People</td>
<td>This is a broad term used to refer to children, adolescents and youth as one, general group.</td>
</tr>
<tr>
<td>Youth</td>
<td>“Youth are defined as persons between the age of 15 and 24.” ('Youth</td>
</tr>
<tr>
<td>Youth Community</td>
<td>“A youth community can be defined as a population of youth who share backgrounds, situations, or lifestyles with common concerns, i.e. ethnic background, socioeconomic background, geographical area (rural, for example), lesbian or gay youth, etc.” (Halifax Regional Municipality)</td>
</tr>
</tbody>
</table>
## Appendix B: Evaluation Grid for Scoping Review

<table>
<thead>
<tr>
<th>Article Citation:</th>
<th>Weak (1-2)</th>
<th>Moderate (3-4)</th>
<th>Strong (5-6)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Relevance</strong></td>
<td>The article was not directly relevant, addressing only one of the key concepts related to the research question</td>
<td>The article was somewhat relevant, addressing some of the key concepts related to the research question</td>
<td>The article was directly relevant, addressing all of the key concepts related to the research question</td>
</tr>
<tr>
<td><strong>Peer Reviewed</strong></td>
<td>The article was not evaluated by one or more people of similar competence to the producers of the work.</td>
<td>The article was evaluated by one person of similar competence to the producers of the work.</td>
<td>The article was evaluated by more than one person of similar competence to the producers of the work (e.g., through a journal).</td>
</tr>
<tr>
<td><strong>Citation #</strong></td>
<td>Cited by 1-3 articles.</td>
<td>Cited by 3-10 articles.</td>
<td>Cited by 10+ articles.</td>
</tr>
<tr>
<td><strong>Rigorous Methodology (qualitative, quantitative, or mixed methods)</strong></td>
<td>There was not sufficient evidence to show that a rigorous methodology was followed. Methods were not clearly presented, lacking context and coherence.</td>
<td>There was some evidence provided that the methodology used was thorough but with room for more rigour. Methods were coherent and relevant to context.</td>
<td>Methods were coherent and relevant to context. Evidence presented illustrates that rigorous methodology followed.</td>
</tr>
<tr>
<td><strong>Appropriate Sample Size</strong></td>
<td>The number of participants in this research is not adequate for answering the research question (either too large or too small)</td>
<td>The number of participants in this research are marginally acceptable to answer the research question</td>
<td>The number of participants in this research is adequate for answering the research question</td>
</tr>
<tr>
<td><strong>Internal Validity</strong></td>
<td>A causal relationship between intervention and outcome was not established.</td>
<td>A causal relationship was somewhat established. There was some evidence that the intervention caused the intended and unintended results</td>
<td>A causal relationship was established. There was evidence that what was done in this study caused the intended and unintended results</td>
</tr>
</tbody>
</table>
**External Validity**

<table>
<thead>
<tr>
<th></th>
<th>The quantitative results are not generalizable (i.e. not applicable to other cases, contexts, people); qualitative results are not transferable.</th>
<th>It was not clear if results are widely generalizable or transferable.</th>
<th>The results are generalizable (i.e. applicable to other cases, contexts, people) and transferable.</th>
</tr>
</thead>
</table>

**Final Score:**
## Appendix C: Search Terms

<table>
<thead>
<tr>
<th></th>
<th>Term(s)</th>
<th>Source/ Location of Search</th>
<th>Number of Search Results</th>
<th>Number of Relevant Search Results</th>
<th>Date of Search</th>
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</thead>
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<td>Young people mental health</td>
<td>Proquest Social Services Abstracts</td>
<td>219</td>
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<td>02/01/2014</td>
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112 CYCC Network · 2014 · http://cyccnetwork.org/info-seeking
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