Ontario Youth Mental Health Literacy & Social Determinants

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Abstract

Mental health literacy includes: recognizing mental health problems and illnesses; knowing how to locate accurate mental health information and professional help; risk factors and causes of mental health problems or illnesses; self-help techniques; promoting help-seeking; and the ability to build and maintain good mental health (Jorm et al., 1997; Kutcher & Wei, 2015; Kutcher et al., 2016; Marinucci, Grové & Allen, 2022). Currently, the Ontario Health and Physical Education curriculum requires the introduction of mental health literacy topics however, students are only required to take one credit in Health and Physical Education, therefore, they are not receiving most of the mental health curriculum. Therefore, what do Ontario youth know about mental health and how do they obtain mental health information? What do Ontario youth want to know about mental and how would they like that information disseminated? What gaps currently exist in mental health literacy programs? Methods: An online survey with demographic and open-ended questions about mental health, mental illness and the social determinants of health. Results: Ontario youth are not satisfied with the education they received about mental health, and mental health problems or illnesses. They also believe that school is a good place to learn about mental health, and would like interactive workshops to disseminate the information.

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Chapter One: Introduction

My thesis addresses the importance and limitations of mental health literacy in Ontario youth. Youths' self reported mental health status has been steadily decreasing with a severe decline since the beginning of the COVID-19 pandemic (Garriguet, 2021). The *Portrait of Youth in Canada* report combines and analyzes different data sources to better understand how Canadian youth with each chapter exploring different areas of their lives (Statistics Canada, n.d.). Garriguet (2021) explored youth mental and physical health utilizing data from Statistics Canada (p. 3). The number of youth, defined by Garriguet as individuals 15 to 30 years old, who reported excellent mental health plummeted by 20% from 2019 to 2020 (p. 8). Armstrong and Young (2015) found that youth in Ontario struggle to identify common mental illnesses other than depression (p. 86). The lack of recognition is concerning as a majority of individuals living with mental health problems and illnesses asserted that their symptoms started before the age of 18 (Mental Health Commission of Canada, n.d., paragraph 1). The average onset of various mental illnesses is adolescence or early adulthood, thus it is concerning that these participants were unable to recognize signs of mental illness. Therefore, mental health literacy must be addressed in Ontario youth for prevention and early intervention. Additionally, from a postmodern feminist psychology perspective, it is important to move away from a strictly individualized approach to mental health problems and illnesses; therefore, it is essential to consider the social determinants of health. For youth to have a complete understanding of mental health and mental health problems and illnesses, they need to be provided with accurate information about how factors external to them can increase risk of developing a mental health problem or illness. I will explore Ontario youth's mental health literacy, where they current

obtain mental health information, preferred methods of information dissemination, and what they know about the social determinants of health.

Definitions

Prior to exploring the literature, I will define mental health, mental illness, mental health literacy and mental illness stigma. *Changing Directions, Changing Lives* is the first ever national strategy for mental health in Canada. The strategy aims to improve mental health outcomes for Canadians by recognizing that treatment alone is insufficient and that, as a country, we must pay greater attention to the promotion of mental health (Mental Health Commission of Canada, 2012, p. 9). I adopted Canadian-devised definitions for the purpose of my thesis work as I have focussed on Ontario youth. I chose the definitions included in *Changing Directions, Changing Lives* as they were developed in consultation with thousands of individuals with mental health problems or illnesses (p. 8). The Commission defines mental health as, "a state of well-being in which the individual realizes [their] own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to [their] own community" (Mental Health Commission of Canada, 2012, p. 14). This definition was chosen as it incorporates many aspects of good mental health, including confidence, resilience and the ability to function. Additionally, it defines mental health as more than being happy, and the absence of illness. Similarly, for the purposes of my thesis, it is important to define mental illness.

The Mental Health Commission of Canada's strategy employs the phrase "mental health problems and illness" in place of mental illness (p. 14). I chose to utilize this phrase, as it allows for the inclusion of multiple experiences and the full continuum of mental distress. Thus, the phrase "mental health problems and illnesses" will be used in my thesis to refer to, "the full range of patterns of behaviour, thinking or emotions that bring some level of distress, suffering

or impairment in areas such as school, work, social and family interactions or the ability to live independently" (Mental Health Commission of Canada, 2012, p. 14). This definition frames mental health problems and illnesses as more than an internal process (thinking or emotions) to include behaviour, and focusses on impairment in various areas of life. However, it could become over-generalized as it does not provide any temporal considerations to the definition. The *Diagnostic Statistical Manual of Mental Disorders* (2013) 5th edition (DSM-5) provide temporal criteria to be met in order to provide an official diagnosis many mental health problems or illnesses (i.e., attention deficit hyperactivity disorder requires symptoms to persist for a minimum of six months, p. 59). Temporal criteria can range in the DSM-5 from two weeks to six months (American Psychiatric Association, 2013). Therefore, it is necessary to add that "symptoms persist for a minimum of one month" to the definition of mental health problems and illnesses, as the DSM-5 defines one month as a "substantial period of time" that is utilized in a number of disorder diagnostic criteria (pp. 110, 142, 175, 226, 256, 414, 446). This temporal consideration aids in differentiating normal human suffering from mental health problems and illnesses (p. 5). The ability to differentiate mental health and mental health problems or illnesses is essential in order to identify when to seek help, and this is called mental health literacy.

Health literacy is the ability to obtain access to, understand, and utilize information that encourages and builds health (Jorm et al., 1997, p. 182). Jorm et al. (1997) stated that therefore "mental health literacy includes the ability to recognize specific disorders; knowing how to seek mental health information; knowledge of risk factors and causes; of self-treatments, and professional help available; and attitudes that promote the recognition and appropriate help-seeking" (p. 182), and thus, according to Sampaio, Goncalves and Sequeira (2022), the term "mental health literacy" was coined. Since the inception of mental health literacy, the definition

has expanded to include the ability to build and maintain good mental health (Kutcher & Wei, 2015, p. 580; Kutcher et al., 2016, p. 567; Marinucci, Grové & Allen, 2022, p. 1). There are numerous positive effects improving mental health literacy (See: Bjørnsen et al., 2019; Lam, 2014; Lindow et al., 2020; Nobre et al. 2022; Wei et al., 2013) which will be discussed in more detail in a later section. Additionally, I will define stigma.

There are many definitions of stigma, however. Some note that stigma "includes the perception that individuals with mental health disorders are weak, flawed, dangerous or incompetent", and often use the words "shame" or "disgrace" (Chandra & Minkovitz, 2007, p. 764). Essentially, stigma is a negative stereotype (Canadian Mental Health Association, n.d.) that can affect how people live their lives. Scholarly analysis of stigma is not new. Erving Goffman (1963) discussed the implication of social stigma many decades ago. He explored how stigma affects how the stigmatized individual is forced to manage stigma through information given that mental health problems and illnesses are an invisible stigma. Goffman describes stigma as a characteristic that is "discrediting" however, he also argues that stigma is relational rather than the characteristic itself. Therefore, stigma is socially constructed, and individualizes mental health when that may not provide a complete understanding of mental health problems and illnesses. Stigma can create an immense barrier for youth in help-seeking, therefore it is imperative that mental health literacy be included in education to reduce stigma.

A Feminist Approach

I have chosen to adopt a postmodern feminist psychology approach to my research. Feminist psychology allows for the move away from a medicalized and individualistic perspective which is typical of traditional psychology, and exposes power inequalities and hegemonic theories in psychology that are based in individualism (Lips, 2006; Mattos, 2015;

Unger & Crawford, 1996). Postmodernism aims to weaken fundamental categories by asserting that they are socially constructed via discourse (Lorber, 2011, p. 285). To my knowledge, a postmodern feminist psychology perspective has not been utilized in mental health literacy. In utilizing this perspective, I aim to deconstruct dominant narratives around mental health and mental health problems and illnesses to move away from a strictly individualistic perspective and acknowledge the environmental, and social influences in mental health, mental health problems and illnesses, and mental health literacy. Discourse deconstruction suggests that these categories are situational, time-bound and culturally shaped, and in doing so it moves away from binary ways of thinking and allows for complexity (Cosgrove, 2000; Lorber, 2011; Ringer & Holen, 2016; Wallin, 2001; Wiggington & Lafrance, 2019). I will employ a discourse analysis to deconstruct dominant narratives that exist within participant responses. Additionally, I argue that mental health literacy is incomplete without acknowledging the social determinants of health, and their can impact on mental health problems and illnesses, and providing that information to youth (Viner et al., 2012). Adopting a postmodern feminist psychology approach allows for a move away from the individualistic perspective typical of traditional psychology, and acknowledge how power and oppression influence mental health. An essential part of a feminist research process is to practice reflexivity, which is when the researcher situates themselves within their research (Hesse-Bieber, 2014, p. 3).

Researcher Positionality

Feminist researchers acknowledge that "it is unrealistic to assume emotions and values will not affect the data" (Jagger, 1997, as summarized in Hesse-Bieber, 2014, p. 5). Therefore, it is necessary for me as a feminist researcher to "practice reflexivity, a process by which they recognize, examine and understand how [my] social background, location and assumptions affect

the research" (Hesse-Bieber, 2014, p. 3). From a young age, I struggled with my own mental health. However, I was never provided the language or concepts to understand my experience, and growing up, I did not know how to find accurate information about mental health problems or illnesses. It was only when I began my undergraduate degree in 2014, that I began to understand what I had been experiencing was not 'normal' and finally sough help. I hoped that this lack of knowledge was generational, and that the increase in awareness and information freely available on the internet would be different for youth today. However, after graduating and working in mental health and addictions for four years, I now believe that there is a general lack of understanding about mental health and mental health problems and illnesses.

From my professional experience, I know that my clients would seek information on the internet; however, they would come to incorrect conclusions, or struggle to make sense of what they read (see also: Boutemen & Miller, 2023, p. 7; Grohol, Slimowicz & Granda, 2014, p. 5). I grew concerned about their lack of knowledge and understanding about mental health. I realized that I wanted to explore mental health literacy in depth. I entered the MEd program with the intention to create a mental health literacy program that would be integrated into the Ontario high school curriculum, in hopes I could help a new generation avoid the struggles my (and previous) generations. However, through the literature review process I located a number of excellent resources, including one already specifically designed to be integrated into the Ontario high school curriculum. Therefore, I chose to survey youth to better understand what they know about mental health literacy, how they felt about their mental health education, and their preferred methods of information dissemination. I enter this work as a white cisgender woman who comes from a working-class family. I come from a place of lived experience with mental health and addiction, as well as a physical disability. I acknowledge that my lived experience

with a mental illness, as well as professional experience treating mental health problems and illnesses, provides a unique perspective to this research.

Research Questions

My thesis is guided by the following research questions: What do Ontario youth know about mental health and how do they obtain mental health information? What do Ontario youth want to know about mental health and how would they like that information disseminated? What gaps currently exist in mental health literacy programs? To answer these questions, I review existing mental health literacy education within the Ontario curriculum, as well as existing mental health literacy programs for gaps. The Ontario Curriculum, within Health and Physical Education, allows for mental health literacy topics to be covered in elementary school; however, it is not a mandatory requirement in high school. Though, there are programs that could be integrated into high school curriculum and are designed to increase mental health literacy (See: Campos et al., 2018; Cilar et al., 2020; Kutcher & Wei, 2017; Lindlow et al., 2020; Skre et al., 2013; Wei et al., 2013). Upon review of the content included in the mental health literacy programming currently available, through a postmodern feminist psychology lens, these programs fail to consider social norms and construction, such as racism, compulsory heterosexuality, and prescribed gender norms. The mental health literacy programs I reviewed cover topics such as: signs of mental illness; risk factors; mental illness myths; mental illness stigma; self-help options; help-seeking options; the stress process; and crisis (Campos et al., 2018, p. 4; Lindlow et al., 2020, p. 102; Skre et al., 2013, p. 4): social norms and social construction were notably absent. Mental health and mental illness problems and illnesses do not exist separate from the social or cultural, and thus it is imperative that “all dimensions of life need to be considered when coming up with strategies to build mental health” (Agteren &

Iasiello, 2019, p. 312). I will explore Ontario youth's mental health literacy, as well as their knowledge of the social determinants of mental health from a postmodern feminist perspective. I then intend on utilizing an online survey to investigate how Ontario youth define mental health, mental health problems and illnesses, how they feel about their mental health education, and their preferred methods of information dissemination.

Plan for the Thesis

In Chapter Two, I will outline the existing literature related to Ontario mental health education curriculum, mental health literacy effects, existing mental health literacy programs, and the social determinants of mental health. Additionally, through the literature review, I identify current gaps in the Ontario Health and Physical Education curriculum regarding mental health literacy, as well as gaps in the existing mental health literacy programming. In Chapter Three, I outline the methods used, including: details of the survey; participants inclusion and exclusion criteria, as well as their demographics; and my approach to data analysis and framework used. Chapter four includes the results from the participants, which includes: mental health education is presently inadequate; a gendered analysis of mental health literacy; participants view on methods of information dissemination, and of mental health education being included in school. Finally, in Chapter Five, I summarize and outline the importance of these results, address limitations of the research and provide suggestions for future research.

Chapter Two: Literature Review

The aim of my thesis is to explore Ontario youth's perspectives on mental health education, mental health literacy and the social determinants of mental health utilizing a postmodern feminist perspective. Utilizing a postmodern feminist approach to my literature review, I will outline concerns about existing mental health education, with particular attention to the Ontario Health and Physical Education curriculum. Additionally, I will explore programs designed to increase mental health literacy to identify potential gaps. This approach allowed me to identify that the social determinants of health, their social construction and the subsequent affects on mental health has not been included in mental health literacy programming and education. Therefore, I will also discuss the social determinants of health, and their importance regarding mental health, mental health problems and illnesses, and mental health literacy. Lastly, I discuss the importance of mental health literacy, and the numerous positive effects good mental health literacy includes.

Mental Health and Education

Students' mental health status influences academic performance (Duncan, Patte & Leatherdale, 2021). Duncan, Patte and Leatherdale (2021) conducted a study in Canada to discover whether mental health factors "are associated with course grades and education behaviours" (p. 337). Education behaviours refer to classes skipped, classes missed due to health and frequently incomplete homework (Duncan, Patte & Leatherdale, 2021). Using data collected from a Canada-wide survey of fifty-seven thousand students, the research team explored the association between depression, anxiety, psychosocial wellbeing, self-reported academic performance, and self-reported education behaviours (Duncan, Patte & Leatherdale, 2021). Duncan, Patte and Leatherdale (2021) found that lower depression scores resulted in better

academic performance and lower frequency of negative education behaviours (p. 349). Additionally, they found that worse anxiety resulted in poor academic performance and more of the education behaviours described above. Students' mental health is integral to their ability to succeed in their education and therefore should be a concern for the public education system. The Ontario Ministry of Education recognized this and implemented new expectations within their curriculums in 2015 and 2019, for the high school and elementary level respectively.

In 2019, the elementary school (grades 1 through 8) implemented new expectations regarding mental health, and new learning requirements for mental health literacy (Ontario Ministry of Education, 2019, p. 6). Throughout elementary school, students are expected to learn that: mental health is distinct from mental health problems and illnesses; everyone has mental health and that it contributes to overall health; thoughts, emotions and actions affect mental health; the stress response; how and when to get help; limits of helping others; and the role of professional help (Ontario Ministry of Education, 2019, p. 44). While it is important and necessary for children to learn about mental health, as one scholar noted, "these are ambitious goals at the elementary level" (Ryan, 2020, p. 1259). Given the complexity of mental health, and mental health problems and illnesses it is important that mental health literacy is continuously taught throughout a child's education. According to the curriculum requirements, mental health and mental health literacy are primarily taught at the elementary level, and not included as a requirement within the high school curriculum. This is concerning, as many mental health problems and illnesses tend to develop in adolescence (Mental Health Commission of Canada, n.d., paragraph 1).

Contrasting the elementary curriculum, the Ontario Health and Physical Education Curriculum for grades 9 through 12 (high school) does not outline specific learning goals for

mental health literacy; however, mental health topics are included within the Healthy Living strand of Physical Education. The curriculum states: "Learning about mental health and emotional well-being can be part of learning related to all these health topics" (Ontario Ministry of Education, 2015, p. 26), which implies that the teacher may choose to teach more than the outlined learning goals. Further explained, "the concepts tied to mental health and emotional wellbeing are woven throughout all the content areas across all grades" (Ontario Ministry of Education, 2015, p. 26), and the focus "is on promoting and maintaining mental health, building an understanding of mental illness, and reducing stigma and stereotypes" (Ontario Ministry of Education, 2015, p. 42). The introduction to the Health and Physical Education curriculum provides the impression that the same level of importance is placed on mental health literacy and education in high school as in the elementary curriculum. However, upon further examination of the high school curriculum it is misleading.

The Ontario Health and Physical Education curriculum grades 9 through 12 (high school) outlines learning requirements for mental health within all Physical Education courses. However, students are only required to complete one credit in Health and Physical Education to graduate from high school (Government of Ontario, n.d.). consequently, Ontario students are only required to take a Health and Physical Education course once out of the 4 years they attend, and each grade level and course has different learning goals for mental health and mental health problems and illnesses. For example, in the grade 9 Healthy Living course, students are required to learn "signs and symptoms that could b related to mental health concerns… and describe a variety of coping strategies", as well as how to respond to mental health concerns in oneself or others (Ontario Ministry of Education, 2015, p. 107). However, how to build and maintain good mental health is not learned until the grade ten *Living Skills* course (p. 110), and Healthy Living

Strand (p. 121). Accordingly, it is very likely that a majority of students are not educated on all facets of mental health literacy. Canadian mental health literacy experts state the importance of integrating mental health literacy into schools (Kutcher et al., 2016, p. 568). Currently, the Ontario Curriculum fails to address mental health literacy in its entirety during these formative years.

Marinucci, Grové and Rozendorn (2022) found that their participants believed that schools should be more proactive in their approach to mental health (rather than reactive – triggered by an event) and include mental health in all year levels. These results emphasize the need to include mental health literacy in schools, and that simply including it in optional courses, as in the Ontario High School Curriculum, is insufficient. Mental health literacy is essential for prevention, early intervention, and reduction of stigma, and thus it is integral it be included throughout a student's education. Furthermore, teachers agree that mental health education is currently insufficient.

Teacher Perspectives

By implementing a Canada-wide survey, Froese-Germain and Reil (2012) found that teachers believe mental health problems are a pressing concern for their schools (p. 11). Furthermore, teachers stated that as many as 10% of students requiring mental health help had yet to be identified and that lack of mental health education was a barrier for help-seeking (p. 12). Thus, teachers agree that currently, mental health literacy in students is insufficient. Furthermore, teachers identified lack of staff training in children's mental health and lack of funding for school-based mental health services as a barrier (Froese-Germain & Reil, 2012, p. 12). Teachers agree that mental health education is important for both students and faculty, which indicates the importance of a standardized way of improving mental health literacy.

However, teachers' lack of confidence in mental health makes them ineffective at educating youth on the subject, while lack of funding creates a barrier for outsourcing this task. These barriers are a concern for the implementation of mental health literacy programming in schools and could contribute to mental health literacy levels in Ontario youth.

Mental Health Literacy

As previously noted, mental health literacy is "the ability to recognize specific disorders; knowing how to seek mental health information; knowledge of risk factors and causes; of self-treatments, and professional help available; attitudes that promote the recognition and appropriate help-seeking" (Jorm et al., 1997, p. 182) and has since expanded to include the ability to build and maintain good mental health (Kutcher & Wei, 2015, p. 580; Kutcher et al., 2016, p. 567; Marinucci, Grové & Allen, 2022, p. 1). There are numerous programs developed to improve mental health literacy, and several have been designed to be integrated within the existing curriculum (Campos, et al., 2018; Cilar, et al., 2020; Kutcher, & Wei, 2017; Lindow, et al., 2020; Skre, et al., 2013; & Wei, et al., 2013).

The aim of this study is to explore mental health literacy in Ontario youth; therefore it is necessary to examine programs designed to improve mental health literacy to identify potential gaps. Campos et al. (2018) tested the efficacy of the mental health literacy program *Finding Space* in Portugal. This program consists of two ninety-minute sessions conducted by a psychologist (Campos et al., 2018, p. 3). *Finding Space* includes topics such as: "signs of mental health problems and their can impact"; risk factors; signs and symptoms of five mental illnesses; destigmatizing behaviours and the importance of including those with mental health problems or illnesses; myths of mental health problems or illnesses; can impact of mental health problems; formal and informal help-seeking options; mental health first aid; and self-help strategies

(Campos et al., 2018, p. 4). To measure the effectiveness of *Finding Space*, the researchers utilized the Mental Health Literacy Questionnaire (MHLq) pre and post intervention. Additionally, Campos et al. (2018) utilized a control group to ensure reliability. The researchers found that the program increased mental health knowledge, decreased negative stereotypes, and increased help-seeking (Campos et al., 2018, p. 8). Furthermore, Campos et al. (2018) found that the intervention was successful at increasing the global score on the MHLq compared to the control group (p. 8). Therefore, *Finding Space* was successful at increasing mental health literacy.

Skre et al. (2013) tested the efficacy of the program *Mental Health is for Everyone* in Norway. Mental Health is for Everyone is a three-day program that is readily available online at no cost, and aimed at secondary schools (age 13 to 15 years-old) (Skre et al., 2013, p. 3). *Mental Health is for Everyone* aims to: prevent mental illness; challenge stigma against those with mental health problem or illnesses; promote confidence and openness about mental health issues; and increase awareness of mental health services (Skre et al., 2013, p. 3). The program focuses on positive mental health, however, it does include "lectures on the most common or well-known mental disorders" (Skre et al., 2013, p. 4). Skre et al. (2013) conducted a cluster control trial to test the efficacy of *Mental Health is for Everyone* at improving mental health literacy (p. 4). They found that Mental Health is for Everyone was effective at improving symptom recognition and knowledge of avenues for help seeking, both of which are essential in mental health literacy. Additionally, the program reduced prejudice beliefs regarding mental health problems and illnesses (Skre et al., 2013, p. 13).

Lindlow et al. (2020) explored the effectiveness of *Youth Aware of Mental Health,* a school-based program that is delivered by certified facilitators in United States schools (p. 102).

Youth Aware of Mental Health consists of five fifty-minute sessions and covers themes such as: awareness of mental health; self-help advice; stress and crisis; and help seeking (Lindow, et al., 2020, p. 102). To measure the efficacy, Lindow et al. (2020) used questions from several sources, including: the General Help Seeking Questionnaire; questions by the originators of YAM; Reported and Intended Behaviour scale; and a few 5-point Likert scale questions about a vignette (p. 103-104). They found that *Youth Aware of Mental Health* was effective at improving general mental health knowledge, and stigma; however, it did not improve help-seeking intent (p. 104). Lindlow et al. (2020) explained that post-intervention, more participants spoke with friends about depression; however, the number of participants who stated they would not seek professional help did not change. Although *Youth Aware of Mental Health* was successful at increasing mental health knowledge, it did not increase help-seeking intent.

Finding Space, *Mental Health is for Everyone*, and *Youth Aware of Mental Health* were all successful at increasing mental health literacy. However, according to reviews of the literature, mental health literacy programs are not entirely effective (Cilar et al., 2020; & Wei et al., 2013). In 2013, Wei et al. conducted a review of the literature, and found that despite reports of positive results from most of the studies "major methodological issues embedded in the studies make it challenging to conclude that current school-based mental health literacy interventions" are effective (p. 116-117). They explained that due to the variability in intent, duration of interventions, and participant age, cross-study analysis is impossible (Wei et al., 2013, p. 118). Wei et al. (2013) concluded that "at the current state of knowledge, there is little substantive evidence for the effectiveness of the current school-based mental health literacy programs" (p. 119). Wei et al. (2013) suggest that future research "address the complexities of the school setting" and suggest using qualitative approaches to explore learning further (p. 118).

Wei et al.'s research indicates a need to explore mental health literacy's complexity, particularly in the school environment, and has helped inform my thesis. Utilizing Wei et al.'s suggestion, I employed a qualitative approach to explore youth's perspectives on their mental health education.

Cilar et al. conducted a more recent systemic review in 2020 with the goal to identify school-based interventions designed to improve mental health and wellbeing in adolescents (p. 2025). The researchers found that more than half of the programs included in the study were effective, and identified 3 key areas to the programs, which included: psychological wellbeing, subjective wellbeing, and psychosocial wellbeing (Cilar et al., 2020, p. 2028). Cilar et al. (2020) suggest that future school-based programs incorporate these concepts into a new evidence-based intervention for youth mental wellbeing (p. 2027). Additionally, Cilar et al. (2020) state "Some interventions are already implemented in the school environment, which are not supported with evidence, or their impact has not been evaluated", and that there is a need for "unique multidimensional intervention" (p. 2025). Cilar et al. suggest that school-based programming is being implemented without evidence indicates that although mental health literacy is included within curriculum or with various programming, it may not be effective. While these programs and systemic reviews are helpful, in that they provide insight into existing mental health literacy educational resources, my study focuses on the Canadian context, therefore it is necessary to explore mental health literacy and mental health literacy programming within this geographical context.

Mental Health Literacy in Ontario

Mental Health & High School Curriculum Guide: Understanding Mental Health and Mental Illness (The Guide) is a mental health literacy program designed in Canada to be

integrated into existing high school curricula, is evidence based, and available online for free (Kutcher, Morgan & Wei, 2015; Kutcher & Wei, 2017; McLuckie, Kutcher, Wei & Weaver, 2014; Milin et al., 2016). Canadian mental health professionals Stan Kutcher and Yifeng Wei (2017) developed *The Guide* in consultation with educators, and designed it to improve mental health literacy for youth and teachers (p. 5). *The Guide* is to be taught by usual classroom teachers following one-day training, which is available online and is free to access; however, to obtain certification a fifty-dollar fee is required at the time of registration ("Teach Mental Health Literacy", n.d.). *The Guide* consists of six modules and includes a complete lesson plan with all relevant core and supplementary materials (p. 6). The modules include topics such as: stigma of mental illness (impact, myths, overcoming, etc.); understanding mental health and mental health problems and illness (brain function, brain's role, etc.); specific mental health problems and illnesses (signs and symptoms); experiences of mental health problems and illnesses (how it affects life, importance of help and communication); where and when to seek help (normal response versus need help, etc.); and importance of positive mental health (stress reduction, resilience, etc.) (Kutcher & Wei, 2017, pp. 8-9). Additionally, *The Guide* includes a Student Evaluation tool that allows "for a robust determination of student learning by comparing scores" pre and post intervention (pp. 5-6). The Student Evaluation tool allowed *The Guide*'s effectiveness to be explored in three studies (Kutcher, Morgan & Wei, 2015; McLuckie et al., 2014; Milin et al., 2016, p. 388).

Alan Mcluckie, Stan Kutcher, Yifeng Wei, and Cynthia Weaver (2014) aimed to explore the effectiveness of The Guide. In February and June of 2012, The Guide was implemented in grade 9 health classes across 4 school boards in Durnham and Peterborough, and the Student Evaluation tool implemented by school personnel prior to the intervention, after and at a two-

month follow-up, for the purposes of program evaluation (Mcluckie et al., 2014, p. 3). Mcluckie et al. (2014) utilized this anonymous survey data to conduct a secondary analysis (p. 3). Four hundred and nine students participated in pre and post measures, while only two hundred and sixty-five were available for the two-month follow-up (Mcluckie et al., 2014, p. 3). Mcluckie et al. (2014) found that *The Guide* "significantly and substantively" improved student mental health knowledge (p. 3) and reduced stigmatizing attitudes (p. 4). Therefore, this study indicates that *The Guide*, taught by usual classroom teachers, can be effective at improving mental health literacy. However, Mcluckie et al. (2014) identified that the lack of a control group is a limitation to this study.

Kutcher, Wei and Catherine Morgan (2015) sought to see if the above results could be replicated in a different population. In January and December of 2013, The Guide was implemented in three schools in the Toronto District School Board within a grade 9 health class (Kutcher, Wei & Morgan, 2015, p. 582), and mirroring the previous study Kutcher, Wei and Morgan utilized the data collected from the pre, post and two month follow-up assessments and conducted a secondary analysis on one hundred and seventy-five participants. Kutcher, Wei and Morgan (2015) found that the implementation of The Guide "demonstrated statistically significant, substantial and sustained improvements in student's knowledge and attitudes" regarding mental health, and mental health problems and illnesses (p. 583). Like Mcluckie et al., Kutcher, Wei and Morgan noted that lack of randomization and control are limitations to this study, which was rectified in a follow-up study.

A team of researchers lead by Robert Milin, and including *The Guide* developers Kutcher and Wei, conducted the first randomized controlled trial for *The Guide*. Twenty-four schools across Ottawa Ontario participated in the study and those randomized to *The Guide* were

expected to implement it within the grade 11 and 12 Healthy Living courses (Milin et al., 2016, p. 385). Teachers in the intervention group received the required training to implement *The Guide*, while those in the control received no such instruction and were expected to teach current curriculum (Milin et al., 2016). They found that *The Guide* significantly improved mental health knowledge and reduced stigmatizing attitudes (p. 388). While these initial findings indicate that *The Guide* is effective, the question remains whether these results are lasting.

Wei, Jeremy Church and Kutcher identified the issue of longevity and recently published a longitudinal study. Three hundred and thirty-two grade 9 students in Vancouver, British Columbia volunteered to participate in their study. In 2017, teachers who had completed the requisite training implemented *The Guide* with the assistance of school mental health professionals over one semester. The participants were provided with pre-test, post-test immediately following the intervention, and a follow-up after one year (p. 372). Of the over three hundred students who received The Guide, only one hundred and thirty completed the pre and post test, while only sixty-seven were available for the one-year follow-up (p. 372). Wei, Church and Kutcher (2023) found that both improvements in mental health literacy and stigmatizing attitudes were sustained at the one-year follow-up (p. 373). These results "suggest that the implementation of *The Guide* delivered by trained teachers may demonstrate long-term persistent positive results in improving [mental health] knowledge and decreasing stigma" (p. 373). The success of *The Guide* indicates that it is possible to improve mental health literacy via the school system.

However, Milin et al. (2016) noted that students in the university stream had "more robust improvements in knowledge and stigma" than those in the college stream (p. 388). Milin et al. (2016) also excluded one school from participating in this study due to low reading levels.

This indicates that the material in *The Guide* may currently be inaccessible to those with learning difficulties or differences (p. 385). Milin et al. (2016) suggest that further adaptation of *The Guide* may be necessary. Despite this potential barrier, the ease of access, minimal financial commitment, and efficacy of *The Guide*, it is interesting that it is not more widely known and implemented. Additionally, *The Guide* improves teacher mental health knowledge as well (Kutcher et al., 2013, p. 88; Wei, Church & Kutcher, 2023, p. 372), providing them with the information they feel they are lacking (Froese-Germain & Reil, 2012). Additionally, *The Guide* does not consider youth perspectives about desired mental health information, or preferred methods of information dissemination, nor does it include reference to the social determinants of mental health. To my knowledge, there have has only been one peer-reviewed study that investigated Ontario youth mental health literacy.

Namely, Laura Lynne Armstrong and Kaitlyn Young (2015) conducted a study at the University of Ottawa to assess mental health literacy in Ontario youth, as well as investigating youth perspectives on desired mental health education, and preferred methods of information dissemination (p. 85). They surveyed two-hundred and seventy-one students utilizing *The Mental Illness Awareness and Transfer of Information Survey*, which was designed collaboratively with youth (p. 85). The survey used vignettes that outlined individuals who met the diagnostic criteria for depression, an anxiety disorder, eating disorder, and psychosis (p. 85). They found that generally, their participants were unable to identify common mental illness with the exception of depressive symptoms (p. 86). Additionally, they found that the participants did not have an interest in learning about mental health resources or self-help strategies, and were not in favour of self or others seeking help (p. 86). They posit that this could be due to the participants believing that these services are not directed at them, or helpful (p. 86). However, I argue that the

first step to seeking help is identifying a problem, and if one is unable to identify a problem (symptoms of mental illness) or holds inaccurate beliefs (i.e., those with mental illness are dangerous, worthless, or somehow 'broken') then that would likely prevent someone from believing they require help and therefore prevent them from seeking help. Armstrong and Young (2015) argue that prior to learning about mental health services youth need to learn about symptoms of common mental illness (p. 86). Their participants also suggest "that they would prefer information be shared with them through both traditional and non-traditional methods", such as classroom presentations, as well as via the internet or other media (p. 86). While this study was conducted in Ontario, the primary focus was knowledge of mental health services and preferred methods of information dissemination. My thesis explores methods of information dissemination, and fill the gap by also exploring Ontario mental health curriculum as well as youth knowledge of the social determinants of mental health. Research indicates that there are numerous positive effects of mental health literacy (see Bjørnsen et al., 2019; Lam, 2014; Lindow et al., 2020; Nobre et al., 2022; & Wei et al., 2013). My thesis will explore methods of information dissemination, and fill the gap by also exploring Ontario mental health curriculum as well as youth knowledge of the social determinants of mental health.

Social Determinants of Mental Health

The social determinants of health are defined, by the Canadian Federal Government (n.d), as "the broad range of personal, social, economic and environmental factors that determine individual and population health". Social determinants of health "refer to a specific group of social and economic factors" which include: socioeconomic status; education; employment; gender identity; sexual orientation; race/racism; culture; childhood experiences; physical

environment; healthcare access; genetics/biology; historical trauma and social support (Government of Canada, n.d.). As Michael Compton and Ruth Shim (2015) wrote,

> Those of us concerned with the social determinants of health equity cannot ignore mental illness because it has such an important effect… Those of us concerned primarily with mental illness cannot ignore social determinants because therein lies the prospect of improving mental health and preventing mental illness (p. xiii).

As Agteren and Iasiello (2019) state "mental illness does not operate in a silo from positive mental health… and psychological techniques alone will not be reliably effective if someone's environment or physical health is severely impaired" (p. 313). Furthermore, Compton and Shim (2015) state that "those concerned primarily with mental illness cannot ignore social determinants because therein lies the prospect of improving mental health and preventing mental illness" (p. xii). Failure to consider social determinants in mental health literacy neglects to educate youth on risk factors that exist external to them. Furthermore, Compton and Shim (2015) argue for attention to social determinants, as mental illnesses "are initially caused by complex interactions between biological, social and environmental factors," and attention to social factors could ultimately lead to the prevention of illnesses (p. 6). Therefore, it is imperative that social determinants of health be included within mental health literacy for youth to better understand mental health problems and illnesses.

Mental Health Literacy Effects

Evidence suggests that mental health literacy can mitigate stigmatizing beliefs and attitudes (see Chandra & Minkovitz, 2007; Lindlow, Hughes & South et al., 2020; Wei et al., 2013). Chandra and Minkovitz (2007) conducted study with youth in Australia, and found that "a few participants explained how their views [about mental illness] changed after they gained more

knowledge" (p. 760), which indicates that increasing mental health literacy can improve youth's attitudes towards those with mental health problems or illnesses. Additionally, Lindlow et al. (2020) found that a mental health literacy program reduced stigmatizing beliefs, and that those results were sustained after three months (p. 104). Wei et al. (2013) also conducted a review of the effectiveness of mental health literacy programs and found that many of them improved stigmatizing beliefs (p. 117). Stigma can create a barrier for youth in help-seeking, therefore it is imperative that mental health literacy be included in education to reduce stigma.

Adrien Furnham and Viren Swami (2017) conducted a review of mental health literacy literature "to provide academics, policymakers, and practitioners an understanding of the field" (p. 240). They found that lay individuals' concept of mental health problems and illnesses; ability to identify symptoms; and lack of confidence in treatment efficacy, all contribute to avoidance of help-seeking. Thus, poor mental health literacy is a barrier to individuals seeking help for mental health problems or illnesses. Furnam and Swami (2017) asserted, "such findings are more worrying among children and adolescents, who frequently report not knowing what to recommend to a friend with mental health difficulties" (p. 247). Therefore, youth need to be provided with accurate mental health literacy to allow them to seek help, and aid in helping their peers locate the assistance they need. Additionally, improved mental health literacy may improve help-seeking.

There is evidence to suggest that increasing mental health literacy improved willingness to seek help (such as Lindlow, et al., 2020; Wei, et al., 2012). However, there have been mixed results in this finding (such as Ratnayake, & Hyde, 2019; Wei, et al. 2012). Ratnayake, & Hyde (2019) did find a connection between help-seeking and overall wellbeing, while there is indications that mental health literacy improves wellbeing (Bjørnsen, et al., 2019; Lam, 2014; &

Nobre, et al., 2022). Therefore, it is impossible that while mental health literacy may not directly affect help-seeking, it may indirectly do so by increasing wellbeing.

Lawrence Lam (2014) conducted a study in China exploring the relationship between mental health literacy and mental health status. After surveying over one thousand students, Lam (2014) found that an "inadequate mental health literacy level is significantly associated with moderate to severe depression" (p. 4). A different study conducted in Portugal explored the relationship between aspects of mental health literacy and mental health with youth (Nobre et al., 2022). Nobre et al. (2022) found that as mental health literacy levels increased, so did positive mental health factors. This is further supported by Bjørnsen et al. (2019) who found that positive mental health literacy was significantly associated with mental well-being. However, one study indicated that there was no connection between mental health literacy and wellbeing (Ratnayake & Hyde, 2019). However, Ratnayake and Hyde (2019) suggest that this discrepancy in findings may be due to their small, homogenous sample, in which there was little variance in mental health literacy levels. As previously noted, mental health is vital to academic performance, and given the possible positive effects mental health literacy can have on mental health status, it is imperative youth be provided with the information required to build and maintain good mental health.

Mental health literacy can mitigate stigmatizing beliefs and attitudes (Chandra & Minkovitz, 2007; Lindlow et al., 2020; Wei et al., 2013). Chandra, and Minkovitz's (2007) participants shared that their perspective about mental health changed after increasing their mental health knowledge (p. 760), indicating that increasing mental health literacy can improve youths' attitudes towards those with mental health problems or illnesses. Lindlow et al. (2020) found that a mental health literacy program reduced stigmatizing beliefs, and those results were

sustained after three months (p. 104). Furthermore, Wei et al. (2013) also conducted a review of the effectiveness of mental health literacy programs and found that many of them improved stigmatizing beliefs (p. 117).

Moses (2010) found that youth with mental illness experienced stigmatizing attitudes from peers, teachers and other school staff (pp. 988-991). Ferrie, Miller and Hunter (2020), in a review of the literature, found that youth rejected mental health problems or illnesses labels specifically due to stigma (p. 13). Clearly, stigma should be a concern for schools. Chandra and Minkovitz (2006; 2007) conducted two studies with eighth graders and found that most of their participants held stigmatizing beliefs about mental illness. Furthermore, they found that those participants were less likely to seek help and had limited knowledge about mental illness (Chandra & Minkovitz, 2007, p. 768; Chandra, & Minkovitz, 2006, p. 4-5). Therefore, educating youth on mental health problems and illnesses is important because "mental health-related stigma stems from a lack of knowledge about mental illnesses and the help needed for those suffering" (Lindlow et. al., 2020, p. 102), and connects to mental health wellbeing, as well as help-seeking. Additionally, youth understand the implications of stigma and the importance of mental health education.

Stigma and Youth Perspectives

Youth are more apt to learn if their opinions are considered (Armstrong & Young, 2015, p. 84). Therefore, mental health literacy programming and mental health education should consider youth perspectives about mental health curriculum, what they would like to know, and how they would like that information disseminated. Youth with mental health problems or illnesses experience stigma from family, peers, and school staff (including teachers) (Chandra & Minkovitz, 2007, p. 769; Moses, 2010, p. 991). For example, a participant from Moses's (2010)

study shared, “yeah, most of them [peers] are real cruel. I’ve had rocks thrown at me, padlocks shot at me, darts shot at me, a fork threw at me, an air freshener can that split my head open in front of my brother” (p. 990). A participant from Chandra and Minkovitz (2007) provided insight into youths’ experience with stigma within their family, “I guess if parents don’t want you to go [get help] or they think you’re fine [they will say] just smile more and you’ll be happy” (p. 770).

Additionally, participants in another study indicated that stigma was a barrier to seeking help (McMahon et al., 2020). However, Chandra and Mikovitz (2007) stated their participants recognized that their attitudes and opinions of mental health problems and illnesses shifted upon further education (p. 769). Furthermore, youth understand that the way to combat stigma is through normalization by developing an understanding of mental health (Marinucci, Grové, & Rozendorn, 2022, p. 5).

More importantly, youth want to know more about mental health (Marinucci, Grové, & Rozendorn, 2022, p. 4). Alexandra Marinucci, Christina Grové and Goldie Rozendorn conducted a study in Australia that aimed “to understand youth perspectives on mental health education and mental health literacy in school settings” (p. 2). They conducted semi-structured online discussion groups with thirteen youth aged eleven to eighteen years old (p. 3). Their results indicated that the youth thought they did not receive enough information about mental health, and that the education they received was too vague (p. 4). One participant in their study noted, “[teachers] don’t really explain it well enough so you don’t understand” (p. 4). The participants also identified various sources of help; however, they favoured informal networks (friends and family) over formal sources (counselors). The participants also identified barriers to help-seeking which included stigma and an unwillingness to talk about mental illness (p. 5). Additionally, Marinucci, Grové and Rozendorn (2022) identified that their participants wanted to understand

and identify symptoms of mental health problems and illnesses within themselves and others, as well as methods of coping with symptoms practically (p. 6). Marinucci, Grové and Rozendorn's study took place in Australia, consequently, may not be applicable to Ontario youth. Thus, I aimed to explore Ontario youth perspectives on desired mental health education, regarding their experiences with mental health education in the Ontario curriculum, and if it differs. While Armstrong and Young's (2015) study was conducted with Ontario youth, they primarily focussed on learning about mental health services, and youth preferences for information dissemination methods. My study expands on Armstrong and Young's work by including inspired by Marinucci, Grové and Rozendorn's study.

Additionally, Marinucci, Grové and Rozendorn (2022) identified youths' perspectives about the school's part in discussing mental health, including when the school should do so, and how mental health education should be disseminated. Their participants believe that schools have an important role to play with mental health education, and believe that it should be taught in schools during regular class time (p. 7). One participant was quoted, "I think school is a place where they feel, you know, comfortable with their friends and their teachers and I think that makes for (a) good environment to talk about things like mental health" (Marinucci, Grové, & Rozendorn, 2022, p. 7). Armstrong and Young (2015) had similar findings in which their participants identified class presentations as a preferred method of information dissemination. McMahon et al. (2020) also found that, "students expressed the need for comprehensive education concerning mental health" (p. 678). Additionally, participants expressed a desire to be part of the planning of programming and future research. Therefore, my research contributes, in a small way, to the existing literature that center's youth's perspectives on mental health education.

Chapter 3: Methods

Method

I utilized a qualitative internet-based survey. The survey consists of 5 demographic questions and 11 open-ended questions (See Appendix B). I chose to utilize an online survey to reach a wider audience, due to the time constraints of a master's program, and this method was used in mental health literacy previously (Armstrong & Young, 2015). Prior to entering the survey, participants were provided with an Information and Consent Letter (See Appendix A). The demographic questions sought such information as: high school location; whether they attended the high school for the full 4 years; gender identity; race/ethnicity; and sexual orientation. The demographic questions were open-ended as well. I chose to include demographic information for two reasons. First, to help ensure participants attended high school in Ontario, and had the opportunity to receive the entire Mental Health curriculum. Second, to identify if there are differences based on geographical location or identity markers, as this is essential in completing an analysis utilizing a postmodern feminist psychology perspective (Archer Mann, 2012; Ward & Archer Mann, 2012).

The 11 qualitative questions were modified from Marinucci, Grové and Rozendorn's (2022) study as their study also explored youth perspectives about mental health literacy and mental health education. They also utilized focus groups to collect their data. However, I opted to utilize an online survey like Armstrong and Young (2015), in part due to the time constrains in completing a master's thesis. Armstrong and Young (2015) utilized an online survey with both open and closed, forced response questions about Ontario youths' mental health literacy regarding mental health services and preferred methods of information dissemination. Marinucci,

Grové and Rozendorn's (2022) questions included: "What is mental health?; What do you want to learn about in terms of mental health?; Do you think school would be a good place to learn about mental health and where can you go for help if you develop symptoms?" (p. 3).

These questions were revised to better reflect the goals of my study, which is to focus on the Ontario high school curriculum instead of the youth's knowledge more generally. Additionally, I developed questions inspired by Armstrong and Young's (2015) work regarding methods of information dissemination. The qualitative questions cover topics such as: mental health education in Ontario high schools; defining mental health; identifying mental health problems or illnesses; experienced and preferred methods of mental health information dissemination; outside sources of information sought; and social determinants of health.

Previous studies on mental health literacy relied on vignettes or scales; however, both have been criticized (Ferlatte et al., 2021, p. 886; Furnham & Swami, 2018, p. 243; Furnham, Gee & Weis, 2016; p. 363; Sai & Furnham, 2013, p. 360). Ferlatte et al. (2021) stated that identifying symptoms of mental illness is complex, and thus using scales, such as the Depression Literacy Scale or Literacy of Suicide Scale may not translate into real-life situations (p. 886). Also, I argue that scales tend to be jargon-heavy which makes them inaccessible, and believe that a measure should be written in a way that is accessible to all education levels (Ferlatte et al., 2021, p. 885). For these reasons, I am not utilizing scales to measure mental health literacy in this study.

Ferlatte et al. (2021) suggest the use of vignettes in place of scales (p. 886). However, previous studies have criticized the use of vignettes (See: Furnham & Swami, 2018, p. 243; Furnham, Gee & Weis, 2016; p. 363; Sai & Furnham, 2013, p. 360). Sai and Furnham (2013) found that minor changes in the vignette can alter a participant's ability to recognize the disorder,

and therefore argued that the use of vignettes could affect the research (p. 360). For this reason, I have decided not to use vignettes to measure mental health literacy. Therefore, I asked participants to define mental health in their own words; to share how they would know if they (or someone else) were experiencing a mental health problem or illness; and what they had learned about the social determinants of health. I evaluated how well participants' responses and understanding of mental health or mental health problems or illnesses aligned with the definitions themselves.

Data Analysis

To explore my participants' mental health literacy, I analyzed two of the open-end survey questions, which are: "Based on what you learned about mental health via the Ontario curriculum, how would you define mental health?" and "Based on what you learned about mental health via the Ontario curriculum, how would you recognize whether or not someone was experiencing a mental health problem or illness." I analyzed these responses for accuracy by utilizing the chosen definitions from *Changing Directions, Changing Lives*, and utilizing the *Diagnostic and Statistical Manual of Mental Disorders* (DSM 5-TR) (2011). Additionally, I employed a postmodern feminist psychology perspective, attending to the ways that multiple perspectives can impact on grand narratives of mental health, to explore the participants thoughts and perspectives.

I employed a thematic analysis "using a data-driven approach in which no priori categories were established; rather, emerging thematic categories were examined" (Gagnon, Gelinas & Friesen, 2017, p. 649). Additionally, I utilized feminist discourse analysis that aligns with postmodernism in that it assumes multiple truths, and that it "aims to effect change in perception and action of and against women" (Frost & Elichaoff, 2014, p. 46). Furthermore, as

Nollaig Frost and Frauke Elichaoff (2014) explain, "discourse analysists look for sense-making practices formed by the cohesion of clusters of terms and phrases" (p. 47). Discourse analysis allows me to pay particular attention to the language, including the specific words and phrases used by the participants, to understand their experiences through the concepts they construct. It "offers ways of challenging accepted norms through the exploration of language and its role in creating, maintaining, and reinforcing discourse" (Frost & Elichaoff, 2014, p. 47, 51). Furthermore, discourse analysis works in conjunction with feminist postmodern analysis which allows for "dialogue that values and counts all women's experiences within their cultural and societal contexts" (Frost & Elichaoff, 2014, p. 47; See also: Lazar, 2007; Mullet, 2018).

Postmodern Feminist Psychology

Feminist psychology allows for the move away from a medicalized and individualistic perspective which is typical of psychology and can be reductionist, and exposes power inequalities and hegemonic tendences (Lips, 2006; Mattos, 2015; Unger & Crawford, 1996). Postmodern feminism incorporates a social constructionist and phenomenological perspective while identifying power relations within power social structures (Archer Mann, 2012; Cosgrove, 2000; Ringer & Holen, 2016; Wallin, 2001; Ward & Archer Mann, 2012; Wiggington & Lafrance, 2019). Additionally, postmodern epistemology works to deconstruct discourse and challenge dominant narratives (Archer Mann, 2012; Ward & Archer Mann, 2012), and allows for a move away from binary reductive notions, providing room for nuance and complexity (Cosgrove, 2000; Tseris, 2015). Integrating a postmodern perspective with feminist psychology I explore the social determinants of mental health from a social constructionist perspective. Additionally, a postmodern feminist psychology perspective allows me to avoid individualized and medicalized traditional psychology, and center youth lived experience and perspectives as

valid epistemology while highlighting the effects of power dynamics existing in mental health and mental health literacy.

Feminist psychology's goal is to be, as Mattos (2015) states, "a permanent critique of epistemological postulates that (re)produce hierarchies and sexism in psychological knowledge and practices" (p. 335). Feminist psychology focusses on the deconstruction of hegemonic notions within traditional psychology by centering women's lived experiences and examining power inequalities to expose sexist, racist and colonizing rhetoric within the discipline (Hesse-Biber, 2014; Lips, 2006: Mattos, 2015; Unger & Crawford, 1996), while postmodernism works to deconstruct dominant narratives to bring about social change (Archer Mann, 2012, pp. 19, 27; Frost & Elichaoff, 2014, p. 43; Ward & Archer Mann, 2012, p. 216). I will deconstruct dominant narratives regarding mental health literacy and the social determinants of mental health to expose the power within the discourse using participant responses (Archer Mann, 2012, p. 27).

Deconstructing dominant narratives surrounding mental health and mental health literacy is important because postmodern feminism argues that "reality is discourse dependent. Words do not represent or mirror reality; rather they create and order our sense of reality" (Ward & Archer Mann, 2012, p. 216). Postmodern feminism postulates that much of our social reality, including gender and personality, is constructed through discourse and that "what can be known is only known through subjectivities, interpretations, and narratives of diverse social actors" (Ward & Archer Mann, 2012, p. 218; Wiggington & Lafrance, 2019, p. 9). Furthermore, as Judith Lorber (2012) explains, "Postmodernism undermines foundational categories by insisting that bodies, identities and statuses are contingent-timebound, situational, and culturally shaped" (p. 285). Therefore, all perspectives are incomplete and restricted and "no one viewpoint can be given epistemic privilege" (Ward & Archer Mann, 2012, p. 218). Considering these partial

perspectives, postmodernists believe that "the very notion of truth becomes multiple and suspect. There is no single truth, but many different truths situated within different discourses" (Archer Mann, 2012, p. 27). In accepting that there are multiple truths, postmodernism allows for the centering of lived experiences as valid epistemology (Frost & Elichaoff, 2014, p. 43).

Additionally, combining a phenomenological and social constructionist lens simultaneously will lend to the inclusion of lived experience as valid epistemology while unpacking patriarchal, androcentric and racist notions (Cosgrove, 2000, p. 263; Wallin, 2001, p. 28; Wigginton, & Lafrance, 2019, p. 5). To my knowledge, a postmodern feminist psychology approach has not been taken in the field of mental health literacy. In employing this perspective in the analysis of my data, I aim to deconstruct my participants' narratives to expose the shortcomings of the Ontario Curriculum in relation to mental health literacy, and identify gaps within their current knowledge of mental health and mental health problems and illnesses, while exploring the potential impacts of social construction on individual mental health and mental heath literacy.

Recruitment, Sampling and Participants

First-year university students were recruited at Lakehead University utilizing nonprobability convenience sampling, "in which respondents are chosen based on their convenience and availability" (Creswell & Creswell, 2018, p. 150). I chose to target first-year university students as they were more likely to have completed high school within the last 4 years, which meant they would have received the most recent curriculum. Posters were placed around the Thunder Bay, Ontario campus (see Appendix C). The recruitment poster was also forwarded via email to students registered in the first year, online, Gender and Women's Studies course. Additionally, I presented my study to the in-person first-year Gender and Women's

Studies course (See Appendix D). A secure URL and QR code were included on the recruitment poster to access the online survey. Inclusion criteria included restrictions based on geographical location of their high school, and length of time since graduation. Participants must have graduated from an Ontario high school recently. For the purposes of this study, recently was means within the last four years. Participants must have graduated from an Ontario high school, as they will be able to speak directly to the Ontario curriculum. Additionally, participants who graduated recently allowed for the data to reflect students who (potentially) received the most recent mental health curriculum. Given that discussions around mental health can be difficult, participants were required to be at least 18 years-old to ensure capacity to consent (Tri-Council Policy Statement, 2022). My thesis focusses exclusively on Ontario, and therefore participants from out of province or international were disqualified.

Data Collection

Chapter 4: Results

Sixteen individuals responded to my survey. One survey had to be discarded as they attended high school internationally and therefore did not meet the requirements to participate in this study. Three participants answered the demographic questions, however, did not respond to the rest of the survey, therefore have not been included in the results. Thus, twelve participants were included in this study. The group was reasonably diverse, and these preliminary results indicate that youth have not received adequate education regarding mental health and mental health problems and illnesses. All 12 participants attended high school in Northwestern Ontario for the entirety of their education. One participant identified as Métis, one as Indigenous, and the other ten as Caucasian. Six participants identified as a woman, three identified as men, one as gender queer, one as genderfluid, and one as non-binary. Three participants identified as heterosexual, four identified as bisexual, one as lesbian, one as gay, one as queer, and one was unsure of their sexual orientation.

Mental Health Literacy

Defining Mental Health

Out of the twelve participants, eight participants provided their definition of mental health. However, one participant replied with their personal experience with mental health and therefore their response was not included in this analysis. Ahead of the analysis section below, I reiterate the definition for mental health, and mental health problems and illnesses for the purposes of this thesis. The national strategy defines mental health as “a state of well-being in which the individual realizes [their] own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to [their] own community” (Mental Health Commission of Canada, 2012, p. 14). Additionally, the Commission defines

mental health problems and illnesses as, “the full range of patterns of behaviour, thinking or emotions that bring some level of distress, suffering or impairment in areas such as school, work, social and family interactions or the ability to live independently” (Mental Health Commission of Canada, 2012, p. 14). Utilizing these definitions as a frame of reference, I analyzed the participants’ discourse to assess their understanding of mental health and mental health problems and illnesses.

A few of the participants’ responses were tautological in their description of mental health. For example, one participant wrote “mental health is the way you maintain a healthy lifestyle mentally” (female, Caucasian (white), I don’t know). This participant understands mental health as being mentally healthy, which does not describe what “mentally healthy” means, and thus the description is circular, and somewhat meaningless. Another participant defined mental health as, “mental health is the wellbeing of your mind” (non-binary, white, bisexual). While these definitions are not necessarily inaccurate, they are vague and are not as specific as the Commission’s definition. Another participant provided a somewhat insubstantial definition of mental health, when they wrote, “from what I learned, I would define mental health as the state of your mental/emotional well-being” (woman, Métis, lesbian). These vague responses indicate that the participants in this study have a tenuous or only very general grasp on mental health as a concept.

However, three participants were more specific in their responses, and their views aligned better with the Commission’s definition. For example, one participant wrote, “I would define mental health as a combination of how stressed you feel, what emotions you feel on a continuous basis, and how you feel about yourself and your body/physical identity” (genderfluid, Caucasian, gay). This participant’s response connects mental health with the ability to manage stress, as well

as the individual's ability to "realize their own potential" (Mental Health Commission of Canada, 2012, p. 14), as an individual's ability to perceive their own potential is inherently tied to their perception of themselves (Barbaranelli et al., 2018, p. 717; Greco et al., 2022, p. 12). Another participant responded stating "taking care of yourself mentally, they made it sound more like so you can perform tasks expected of you instead of your own well-being and happiness" (1 male, white, bisexual?). This participant's definition draws on the Commission's definition which outlines "the ability to work productively and fruitfully". While the ability to continue work is an important determination of mental health, the tone of this participant's response indicates that productive work was the primary focus of their education and that the other aspects of mental health were neglected.

Another participant vaguely defined mental health as "the way in which someone perceives the world and themselves, positive views would be good mental health" (female, white, heterosexual). Centering mental health around positivity is complicated and requires nuance. Positive views have been shown to be a protective factor for depression and anxiety (Thartori et al., 2021, p. 13); however, a recent push for positivity has led to what is now known as toxic positivity. Toxic positivity is a push to remain positive despite adverse events, and encourages individuals to suppress any negative emotion (Lew & Flanagin, 2023, p. 5; Putra et al., 2023, p. 17). Toxic positivity leads individuals to suppress their true emotions (Putra et al., 2023, p. 15). Emotional suppression can cause mental health problems and illnesses (Beblo et al., 2012, p. 477; Pastuszak-Draxler & Gierowski, 2017, p. 18). Some participants have a tenuous grasp of mental health, using a circular and somewhat meaningless definition, while others have narrow and somewhat problematic definitions of mental health. Additionally, the participants

had a narrow understanding of how to identify someone struggling with mental health problems or illnesses.

Identifying Mental Health Problems or Illnesses

Out of the 16 respondents, only seven responded to the question regarding identifying an individual struggling with mental health problems or illnesses. Most participants who responded accurately described how to identify someone struggling with depression. For example, one participant wrote, "the main topic of discussion in our class was depression. Because of this, we were taught to identify traits such as: changes in mood, changes in appetite, changes in participation in class or activities" (woman, Métis, lesbian). According to the Diagnostic Statistical Manual V (DSM-V) Major Depressive Disorder diagnostic criteria includes: "depressed mood most of the day nearly everyday" (which would be viewed as changes in mood by others); and decrease or increase in appetite (p. 161). Additionally, the diagnostic criteria include fatigue or loss of energy, "diminished interest or pleasure in all, or almost all, activities", and difficulties in concentration, all of which could appear to others as changes in class participation.

Another participant wrote, "they look sad, pull away from others, stop trying, feel guilty" (genderqueer, white, queer) which aligns with the diagnostic criteria of depressed mood and lack of interest and concentration. Equating mental illness with depression is further indicated by another participants response, who wrote "being distant, increased general sensitivity, lower mood" (female, Caucasian (white), I don't know), and "if the person suddenly changes, if they become disinterested in things, if they start missing school" (non-binary, white, bisexual). These results align with the current literature that individuals are able to identify depression. However they struggle to identify other mental illness (Armstrong & Young, 2015, p. 86; Gibbons,

Thorsteinsson & Loi, 2015, p. 9). While the identification of depression is advantageous, depression is not the only mental health problem or illness that youth are susceptible to and therefore it is concerning that youth do not seem to understand how to identify other potential issues.

A couple other participants did provide less singularly focussed responses; however, one was tautological in their response. For example, "if they seem off or different than they usually are, and if they are going through any different symptoms than usually. I usually just ask them if they are doing okay" (genderfluid, Caucasian, gay). While this participant is not necessarily incorrect in determining that an individual struggling with mental health would seem "different" the response is vague and would require knowing the individual well enough to determine if the behaviour or attitudes are markedly different than their baseline. Furthermore, looking for changes in the individual negates the possibility that the other person may had been struggling for longer than the time the participant knew them. Additionally, another participant indicated that identifying mental health problems or illnesses depends on the individual; they wrote "really depends on the person and how the reaction to poor mental health/stressful situations" (1 male, white, bisexual?). These participants seem to understand that to identify those with mental health problems or illnesses you must understand the individual's baseline attitudes and behaviours. People have their own baseline for different diagnostic criteria, for example, individuals differ on their affect and what may be "normal" to one, may be "disordered" to another. Therefore, it is beneficial that the participants understand that it is necessary to consider an individual's baseline.

Gendered Lens

There were some notable differences based on gender identity of the participants. Only one of three self-identified men provided a definition of mental health and provided a method of

identifying mental health problems or illnesses. Furthermore, his definition of mental health focussed on productivity rather than well-being. As seen in his response, his understanding of mental health was: "taking care of yourself mentally, they [the instructors delivering the mental health curriculum] made it sound more like so you can perform tasks expected of you instead of for your own well-being and happiness" (1 male, white, bisexual?). Additionally, this participant stated that it "really depends on the person and how they react to poor mental health/stressful situations," instead of providing symptoms or warning signs of mental health problems or illnesses as requested. These responses (and lack of response) indicate a lack of mental health literacy. The self-identified women participants also struggled to define mental health.

Three out of six women participants provided their definition of mental health; however, they were tautological in their definition as discussed above. The self-identified women did provide accurate descriptions for identifying depression in contrast to the self-identified men. This result is consistent with current literature regarding gender differences with mental health literacy (Armstrong & Young, 2015, p. 85; Furnham, Annis & Cleridou, 2014, p. 285; Gibbons, Thorsteinsson & Loi, 2015, p. 10; McGuirk & Frazer, 2021, p. 251), which remarks that women tend to have better mental health literacy than men. This difference is concerning, as men are more likely than women to complete suicide (Statistics Canada, 2023), a trend which has been amplified as a result of the COVID-19 pandemic (Mental Health Commission of Canda, 2022, p. 2). The Mental Health Commission of Canada (2022) has connected the increase in suicide risk, as well as the poorer mental health literacy on prescribed and rigid gendered expectations for men (pp. 5-6; See also: Garfield et al., 2008; King et al., 2020; Milner et al., 2019). Additionally, I would argue that women tend to have better mental health literacy due to prescribed gender norms as well. Women are prescribed to be "more emotional" and therefore, may be more

inclined to be in touch with their mental life. Many studies use a binary notion of gender, only exploring the differences between men and women (See: Furnham, Annis & Cleridou, 2014; Gibbons, Thorsteinsson & Loi, 2015; McGuirk & Frazer, 2021). The use of the gender binary is problematic as it erases the experience of transgender or gender non-conforming individuals, therefore, it was necessary to explore those who identify as a gender minority's mental health literacy.

Those who identify as a gender minority (such as trans, non-binary, or genderqueer) are more likely to self-report mental health problems or illnesses (Brandt et al., 2023, p. 98). Considering gender minorities' additional risk factors, it is necessary to explore their knowledge of mental health. Three participants identified as a gender minority however, one participant provided their personal experience with mental health rather than their definition of mental health, and another provided a circular response, they wrote "mental health is the wellbeing of your mind" (nonbinary, white, bisexual). As previously discussed, one gender minority participant provided a more accurate response that included reference to perception of self, and capability of managing stress. While gender minority participants struggled to define mental health as much as self identified women or men participants, they seemed to have a better understanding about how to identify mental health problems or illnesses.

Gender minority participants provided accurate descriptions about how to identify someone with depression. For example, one participant wrote, "they look sad, pull away from others, stop trying, feel guilty" (genderqueer, white, queer). "Looking sad" aligns with the diagnostic criteria that the individual be in a low mood, "pull away from others" and "stop trying" could be an indication of lack of interest or pleasure, while feeling guilty is in itself a diagnostic criterion for depression (American Psychological Association, 2013, pp. 160-161).

Additionally, two other participants drew on the same diagnostic criteria; for example, they wrote "if they become disinterested in things" (non-binary, white, bisexual) and "if they seem different than usual" (genderfluid, Caucasian, gay). Considering all three gender minority participants were able to provide accurate descriptions for identifying depression, they are better at identifying these issues compared to their women and men counterparts, which is consistent with existing results (Brandt et al., 2023, p. 99; Ferlatte et al., 2021, p. 882). Ferlatte et al. (2021) hypothesized that this difference may be due to gender minority individuals' tendency to develop psychological disorders as they experience social prejudice more than their cisgender counterparts (p. 884; See also: Brandt et al., 2023, p. 98).

Mental Health Education is Insufficient

The lack of mental health literacy in the small survey sample is apparent; however, the participants also felt as though their mental health education was insufficient.

No Education

Half of the participants did not recall mental health being part of the curriculum during their tenure in high school. Four participants responded with simply "not really" when asked if mental health was covered in their curriculum, indicating that if it was covered it was not sufficient or memorable. As further indicated by another participant who wrote, "it [mental health] wasn't [covered], or at least, I do not remember it being so (which indicates that if it was part of the curriculum it wasn't memorable or helpful" (ciswoman, white/Caucasian, bisexual/asexual). Another participant wrote "I'm not sure" in response to the same question, further indicating that if mental health was covered by the curriculum, it was not memorable. Another participant believes that although mental health was spoken about, it was not part of the curriculum. She wrote mental health was "somewhat [included in the curriculum], [however] it

seemed as though teachers taught it on their own, not as part of the curriculum" (female, white, heterosexual). This participant highlighted that whether mental health is taught is up to the teacher which aligns with the Ministry guidelines (Ontario Ministry of Education, 2015, p. 26). These results indicate that if mental health was included in the participants' education, it certainly was not memorable. Those who did indicate that mental health was discussed, indicated that it was not particularly helpful.

Insufficient Mental Health Education

Participants who did recall mental health being spoken about, did not feel that it was helpful, or covered sufficiently. For example, one participant wrote that it was covered "a little bit in health class" (genderqueer, white, queer); while another seemed to agree with this statement, when they wrote "mental health was covered briefly in grade 9 health, then it wasn't ever talked about again" (woman, Métis, lesbian). These participants highlight the concerns I discussed previously about the Ontario Curriculum: that mental health is only covered in the Health and Physical Education curriculum, and that students are only required to take this course once throughout their high school tenure, in grade 9 (Government of Ontario, n.d.). These results also align with previous research (Marinucci et al., 2022, p.4). Other participants did not comment on the frequency in which mental health was discussed; however, they did indicate that the information they received was less than what they would have liked.

Participants indicated that they did not receive enough information regarding different mental health problems or illness. For example, one participant wrote "I don't remember much, it was mostly about managing depression and anxiety by managing stress, nothing about other mental health issues" (genderqueer, white, queer). This participant indicated that there was a lack of coverage on other mental health problems and illnesses, which was a sentiment expressed by

others as well. Another participant wrote, “The only disorder that they mention is depression and while that was helpful there are many others that people could be experiencing and need help with” (non-binary, white, bisexual). Two others also stated a desire to learn about more mental health problems and illnesses, one noted that “teaching about different kinds of mental illness” would have helped (ciswoman, white/Caucasian, bisexual/asexual), and another wrote “more about other mental illnesses like schizophrenia or autism or adhd [sic]” (genderqueer, white, queer) as a way that their education could have been improved. Therefore, these participants clearly indicate a need for more information about mental health problems and illnesses, thus indicating that what they did receive is insufficient. Participants also indicated a desire to learn more about how to help or access help for mental health problems and illnesses.

In contrast to Armstrong and Young’s (2015) findings, participants indicated a need for more information about how to help those struggling with mental health problems or illness, or where to seek help for themselves. One participant indicated that mental health resources were discussed, but they felt it was insufficient. They wrote, “discussion focused on where to get help without going into detail” (non-binary, white, bisexual). Other participants were more straightforward in expressing their need for a better understanding of how to locate mental health resources. One wrote that they wanted to learn “how to recognize it [mental health problem or illness] in myself and where to go for help” (female, white, heterosexual), while another wrote “how to realistically communicate and seek help/accommodations” (2 male, white, bisexual?).

Others wanted to know more about how to help someone struggling with their mental health. For example, one participant wrote “what an outsider can do to help a friend” (genderqueer, white, queer), and another wrote “at the time, I really wanted to learn how to help someone who is experiences [sic] mental illness/distress. It was mostly because it runs in my

family and I myself have been experiencing problems as well" (woman, Métis, lesbian). With the steady decline in self-reported youth mental health status, as well as a decline in reporting amongst those with lived experience of mental health problems and illnesses indicating their symptoms began before 18 years of age, youth are likely to come into contact with, or they struggle with, mental health problems and illnesses; therefore it is necessary to provide youth with accurate information in order for them to help a peer in distress (Garriguet, 2021; Mental Health Commission of Canada, n.d.).

This is further indicated by another participant's request: they wrote that they would like to know "how to approach someone who is struggling very much with mental health or mental illness and is in a bad mental state, how to try to calm the person down until help can come assist the situation" (genderfluid, Caucasian, gay). This participant indicates that they have come into contact with someone struggling with a mental health crisis. According to a recent study that investigated the prevalence of suicide ideation and self-harm among adolescents in Canada, 44% of the 809 participants indicated that they experienced suicidal ideation since the COVID-19 pandemic began, while 32% reported they had engaged in deliberate self-harm (Turner et al., 2021). This means that nearly half of adolescents experience suicidal ideation, therefore youth are likely to experience suicide ideation themselves or know someone who does. Providing youth with helpful steps for how to help (or get help themselves) has the potential to prevent suicide, and youth believe that such sensitive topics should not be avoided (Marinucci, Grové & Rozendorn, 2022, p. 6). The participants in this study indicate a strong desire for more mental health education, and that it should be framed differently then for productivity.

Mental Health for Production

An emerging theme was that mental health was often framed for the sake of productivity, rather than well-being or happiness. For example, one participant indicated that the discussion focused on grades and time-management, she wrote "we talked about time management a lot, reaching out for support, that one mark isn't make or break" (female, white, heterosexual). This participant's response indicates that the discussion about mental health was centered around the student's ability to effectively manage their never-ending to-do lists, rather than their own well-being. Her sentiment was mirrored by another participant. He wrote, "taking care of yourself mentally, they [teachers, school staff] made it sound more like so you can perform tasks expected of you instead of for your own well-being and happiness" (1 male, white, bisexual?). Another participant indicated that discussions about mental health were held for the students' ability to perform, she wrote "there wasn't [mental health] information delivered for the most part, except for occasionally by teachers of their own accord when there were exams or tests coming up, they would talk about stress" (ciswoman, white, bisexual/asexual). Even in the latter example, I would argue that centering the mental health discussion around stress management in and of itself forces it to be about production rather than well-being.

Many other participants indicated that stress was part of the mental health education. For example, one participant wrote "I would define mental health as a combination of how stressed you feel…" (genderfluid, Caucasian, gay), while another wrote "I don't remember much, it was mostly about managing depression and anxiety by managing stress" (genderqueer, white, queer). While the ability to manage stress is important to overall well being, mental health is about more than managing stress and therefore should be discussed more holistically. Another participant outlined this capitalist approach to mental health when they wrote, "they were like 'take care of yourself!' but only if it fits in with what society still expects of you/you don't need too much

help" (2 male, white, bisexual?). Participants clearly thought that the conversation around mental health was not for the well-being. Additionally, participants felt that the methods chosen to teach mental health trivialized the topic.

Information Dissemination

Participants were largely not satisfied with the methods in which mental health was discussed, and furthermore, some felt it was trivialized. For example, one participant wrote, "I recall one mental health day, where there were rocks to paint, lizards to pet, and fruit on sticks. There was also dog therapy at our school occasionally. There wasn't information delivered for the most part" (ciswoman, white, bisexual/asexual). The fact that relevant information was not covered on a mental health day is concerning; and the types of activities the student described indicate that the day was not taken seriously by those who planned the event. Another participant indicated that although mental health was discussed it was not taken seriously by teachers. He wrote "teachers said it was important but didn't do anything to accommodate" (1 male, white, bisexual). The trivialization of mental health was made further evident by another participant who wrote that mental health was covered "by silly posters mainly" (2 male, white, bisexual). While a common theme was that mental health was trivialized, even those who did not share this sentiment were not satisfied with the methods of information dissemination, and had thoughts about how mental health discussions could be improved.

Many participants felt that they would have benefited from a more interactive approach. Participants indicated that mental health information was disseminated via presentations and/or regular lectures However, they would have preferred that the information be relayed in a more interactive style. For example, one participant wrote "I would have preferred there was more discussion and engagement rather than just listening to the information" (nonbinary, white,

bisexual). This is a sentiment expressed by others as well: “more group discussions and sharing” (female, white, heterosexual); “more personal, as a conversation or with personal activities” (genderqueer, white, queer); and “I definitely would have appreciated more information, preferably delivered hands-on workshop style” (ciswoman, white/Caucasian, bisexual/asexual). Their responses align with Armstrong and Young (2015), whose participants identified small interactive groups as their preferred method of information mobilization (p. 86). An additional participant indicated the same notion, while further explaining their reasoning: she wrote, “in my opinion, I feel like I learned best when the information was delivered through workshops. It allowed me to truly absorb the information because I was actively working with different things instead of someone just talking at me for an hour” (woman, Métis, lesbian). Participants believe that interactive workshops are the most beneficial, and that it would be best for these mental health workshops to be included as part of the curriculum.

Seeking Mental Health Information

Most participants did identify alternative sources of mental health information. The internet was the primary sources identified; however, the locations online did vary. For example, one participant wrote, “lots of information about mental health that I learned outside of school was through YouTube from the ‘psych2go’ channel or websites like mayo clinic” (woman, Métis, lesbian). Another participant also identified medical websites as a valid source, they wrote “I used the internet. The websites were Cleveland clinic, mayo clinic and healthline” (non-binary, white, bisexual). Another participant was unsure which websites but did identify medical ones as possibilities, she wrote “I don’t recall what kinds of websites, but I often used medical ones, probably mayo clinic and those types” (ciswoman, white/Caucasian, bisexual/asexual). These participants utilized reliable sources, but not all internet sources are reliable. For instance,

one participant identified social media as a helpful source, she wrote “I think social media provided a lot of awareness around mental health and finding ways to cope was much easier online then in school” (woman, white, straight). This is concerning as research suggests that youth “express concerns about their ability to assess the credibility of online” mental health information (Scott et al., 2021, p. 305). Additionally, other studies indicate that mental health information found on social media is not always credible (Milton et al., 2023; Yeung, Ng & Abi-Jaoude, 2022). Unfortunately, the internet is not the only unreliable source participants identified.

One participant noted that the only information they received about mental health was from fiction. They wrote, “I only knew about it [mental health or mental health problems or illnesses] from mostly fictional stories (tv, books, magazines)” (female, white, heterosexual). Learning from fiction sources is problematic as they may or may not be based in fact, and can be overdramatized for effect. Additionally, a few participants stated that they would speak with their parents about mental health. For example, one participant wrote, “I would ask my parents about mental health and mental illness” (female, Caucasian (white), I don’t know). Early research indicates adult Canadian’s can identify common mental illness (Gallagher & Watt, 2019); however, there is insufficient evidence to state unequivocally that parents would be an acceptable source for mental health information. An exception to this would be if the parent was a mental health professional. One participant indicated this was their experience, she wrote “my mother is a therapist, and so I occasionally would ask her questions” (ciswoman, white/Caucasian, bisexual/asexual). She was also not the only participant that indicated they sought information from professionals.

A few participants stated that they sought mental health information from professionals. For example, one participant wrote, “therapy through my dads work (was awful LOL) through my doctor” (1 male, white, bisexual? [sic]). This notion was mirrored by another participant, who wrote that they obtained information about mental health from a “personal therapist” (male, Indigenous, bisexual). Another participant wrote that they sought mental health information “through the hospital, the school guidance counsellors, the thunder bay counselling center, children’s center, my doctor” (genderqueer, white, queer). While participants identified some helpful sources for mental health information, they acknowledge and believe that school would be a good place to introduce mental health and mental health problems and illness information.

Mental Health Should be Covered in School

Many participants believe that mental health and mental health problems or illnesses should be covered in school; however, two participants did express hesitation as to whether it was currently a good place to cover such topics. For example, one participant wrote “right now, no [mental health should not be covered] but ideally, yes” (1 male, white, bisexual), while another mirrored a similar sentiment, stating “ideally it would be but currently no” (2 male, white, bisexual). These participants believe that school could be a good place to learn about mental health, however, feel that in the current school climate, it is not a safe place for such education. Unfortunately, these participants did not elaborate as to why they believe that school is not currently a good place to discuss mental health, other participants’ responses may shed light on the issue. One participant wrote, “yea [mental health should be covered] if done right” (male, indigenous, bisexual), and another agreed, stating that “it [mental health] definitely can be if taught correctly” (female, Caucasian (white), I don’t know). These participants could be indicating that since mental health is not covered completely, or with the correct intent (for

wellbeing and not for production), that school is not presently a safe place to discuss mental health. However, another participant indicated there may be other concerns. They stated mental health could be discussed in school "when treated right within the curriculum I do believe that it is. However schools often misinterpret or give misinformation on purpose to convey certain messages about mental health especially within the school board I attended" (genderfluid, Caucasian, gay). This participant suggests that they felt the school had an ulterior motive that allowed educators to manipulate mental health information. This is particularly concerning, as this participant was the only one who indicated they had a satisfactory mental health education; therefore, it raises various questions about what they believe occurred during their mental health education. While these participants have concerns about mental health discussions in school, they ultimately believe that school is a good place for the discussion, which many other participants agreed with.

Most participants agree that mental health should be discussed in school. One participant wrote:

> I think it [school] absolutely is [a safe place to learn about mental health]! It's important to learn about as soon as possible, and to teach kids not only about mental health but to give them some basic strategies for if they struggle with it. Obviously, for many people, that wouldn't be enough, but it might at least get them thinking about it. They'd be more likely to recognize signs in themselves and others if struggles, and catch it early (ciswoman, white/Caucasian, bisexual/asexual).

Another participant also felt that early recognition of symptoms is important, stating that "it [school] is a good place to introduce mental health to help kids identify symptoms they may have due to mental health issues" (genderqueer, white, queer). An additional participant reiterated this

notion: she wrote, “I think school is a great place to learn about mental health. Since kids and teens are required to attend, I feel like incorporating information that could help them into the curriculum is very important. That way, they know about what they or friends may be struggling with and feel more equipped to deal with such issues” (woman, Métis, lesbian).

In sum, these participants believe that mental health literacy should be included in the school curriculum but current mental health literacy programming and curriculum are currently missing a key component of mental health.

Social Determinants of Mental Health

As discussed above, the currently available mental health literacy programs are missing educational materials regarding the social determinants of mental health. The participants in this study also noted that they had not learned of the social determinants of health prior to entering university and most stated they did not recall learning of them at all. One participant wrote that he “learned about them in my first year of nursing” (male, Indigenous, bisexual). Another participant mirrored this statement, she wrote, “unfortunately we did not learn about the social determinants of health in high school” (woman, Métis, lesbian). Furthermore, this participant highlighted why the social determinants were not included: she wrote, “In my experience, we were simply taught that you were born like that, and it was a problem you had to deal with” (woman, Métis, lesbian). We do not exist separate from our environment and neither does our mental health (Agteren & Iasiello, 2020). It is imperative to learn about the social determinants of health to have a holistic understanding of mental health and mental health problems and illnesses.

Discussion

These results of this preliminary study suggest that Northwestern Ontario youth are not receiving adequate mental health education. The participants struggled to define mental health, and often provided circular and somewhat meaningless definitions. While they were able to provide depression symptoms to identify, they did not provide any markers for other mental health problems or illnesses. Considering the hundreds of conditions in the DSM-V, it is noticeably insufficient to only be able to accurately identify one. Furthermore, since the average age of onset of mental health problems and illnesses occurs prior to the age of 18-years-old, it is necessary that youth understand how to identify warning signs in both them and others (Mental Health Commission of Canada, n.d., paragraph 1). Furthermore, there are noticeably differences in mental health literacy based on gender identity.

Women provided more accurate definitions of mental health and identification than their male counterparts. These results are consistent with current research (such as Armstrong & Young, 2015, p. 85; Furnham, Annis & Cleridou, 2014, p. 285; Gibbons, Thorsteinsson & Loi, 2015, p. 10; McGuirk & Frazer, 2021, p. 251). Additionally, Gibbons, Thorsteinsson and Loi's (2015) study of sex differences in mental health literacy found that males were more likely to perceive symptoms as less serious and that they had personal control (p. 10). Gender norms tend to teach men that they should not have emotions and should be in control. These enforced norms could be leading to the misconceptions regarding mental health problems and illnesses. Milner, Shields and King (2019) explored the relationship between masculine norms and mental health literacy. They found that men who endorsed masculine norms, based on their responses to the Conformity to Masculine Norms Inventory, held lower levels of mental health literacy (p. 4). Therefore, the enforced hegemonic masculine norms are adversely affecting young men's mental

health literacy and thus, creating a barrier for them to seek the appropriate care when needed. This is particularly concerning as young men are more likely to complete suicide or struggle with substance abuse than their female counterparts (Mental Health Commission of Canada, 2022; Statistics Canada, 2023). Additionally, there is evidence to suggest that conforming to masculine norms can have an adverse effect on men's mental health (King et al., 2020). In addition to gender norms affecting mental health education, capitalism seems too as well.

Many participants stated that they believed the discussion about mental health was only discussed so the students would be able to carry out their expected tasks. Marinucci, Grové and Rozendorn's (2021) participants also felt that their mental health education was centered around completion of academic expectation, such as exams. These results suggest that much of the mental health conversation was around productivity and managing stress to be productive. Capitalism suggests that "private ownership by means of production" with a focus on profits, asserts that individual wellbeing is dependent on their ability to work (Ventriglio & Bhugra, 2023, p. 1301) and "represents the evaluative social order in which the merits of human actions are assessed by their market value" (Ziera, 2022, p. 206). In framing mental health education around a student's ability to be productive it only reinforces that their value exists solely in their capacity to work and not in their inherent worth as a human being. So far, capitalism has only increased economic prosperity in the elite few, and instead been harmful to those who fall outside that category (Ziera, 2022, p. 207). Additionally, capitalism reinforces wealth inequality, and there has been a rise in mental health problems and illnesses. Framing mental health education around production feeds capitalist notions of self worth while simultaneously worsening mental health and making it an individual problem when it is structural. This is further evident by the fact that the mental health discussion was centered as an individual issue.

Participants identified that mental health was framed as an individual issue that one was born with and that they should take care of themselves as long as it does not affect anyone else. The individualistic perspective further evident by the lack of education on the social determinants of mental health. This individualistic perspective negates how our environment and social lives affect our mental health. This is particularly concerning as it goes against human need, as Zeira (2022) wrote, "neoliberalism encourages individualism, which has decreased emphasis on the need for community and social fulfillment" (p. 208). Additionally, centering mental health as an individual issue erases the effects of the social determinants of mental health. For example, discrimination, education, employment status, socioeconomic status, and access to healthcare have all been indicators of poor mental health (Alegria et al., 2018; Compton & Shim, 2015; Henderson et al., 2022; Zeira, 2022). It is concerning that mental health continues to be framed as an individual issue as this rhetoric is missing key components to the development of mental health problems or illnesses. Framing mental health problems and illnesses as strictly an individual issue forces an individual to believe they have complete control over the issue, when in fact they do not. This mirrors how capitalism centers the individual as at fault for their own financial circumstances when there are structural issues that affect that as well. Additionally, the participants wanted to learn more about mental health.

In alignment with Armstrong and Young (2015), the participants agreed that they would like more information about mental health. Participants identified that they recalled learning about depression and anxiety, but would like to learn more about other mental health problems and illnesses. While participants agreed that the information about depression is helpful, it is vague. The DSM-5 (2013) has an entire section dedicated to outlining anxiety disorders, and anxiety is also a normal, common, and necessary emotion. Therefore, teaching generally about

anxiety is not helpful as students may believe that experiencing anxiety at all means that they have a mental health problem or illness when they are simply experiencing a normal emotion. The ability to differentiate between normal human experiences and mental health problems or illnesses is integral to mental health literacy. Additionally, there are hundreds of mental health problems or illnesses outlined in the DSM-5, and only teaching students about two vague illnesses does them a severe disservice and prevents them from identifying other potential issues. Furthermore, if students cannot identify warning signs, they will not know when to seek help and they want to learn more about how to help those struggling and where to locate help for themselves or others.

In contrast to Armstrong and Young's (2015) findings, participants in this study agreed that they would like to learn more about avenues for help for mental health problems or illnesses as well as how to support someone that is experiencing a mental health crisis. Considering the prevalence of suicide ideation, self-harm, decline in youth mental health, and that symptoms often begin before the age of 18-years-old, it is highly likely that youth will be in contact with someone experiencing a mental health problem or illness, or experience it themselves (Garriguet, 2021; Mental Health Commission of Canada, n.d.; Turner et al., 2021). According to the Mental Health Commission of Canada (2017), 1.2 million children and youth experience mental health problems or illnesses, and as previously discussed, that number has since risen with the COVID-19 pandemic (Garriguet, 2021). Youth are already struggling with mental health problems or illnesses; thus, it is imperative that they be provided accurate information to seek help to prevent further suffering or worse, suicide. Additionally, it is important that mental health education not be trivialized in its delivery and be engaging and helpful for the youth.

Participants felt that the mental health education provided in schools was insufficient, which aligns with Marinucci, Grové and Rozendorn (2021). Like the participants in this study, their participants also felt that their mental health education was vague and only covered in briefly in one year. Additionally, both studies suggest that youth feel the most effective method of information dissemination for mental health is interactive. While Marinucci, Grové and Rozendorn's (2021) participants suggested group discussions, the participants in this study suggested workshops, which also aligns with Armstrong and Young's (2015) participants that suggested small interactive groups. Additionally, Armstrong and Young (2015), Marinucci, Grové and Rozendorn (2021), as well as this study all found that youth believe that school is a good place to learn about mental health.

Limitations and Future Research

This study does have limitations. All the participants were from Northwestern Ontario, thus the findings may not be applicable in other areas of the province. Despite the small sample size, however, there were trends I could identify which suggest that there is, at least in Northwestern Ontario schools, insufficient mental health training for youth. Future research should look at expanding this study to a larger sample of youth across the province. This would allow for analysis of whether the lack of mental health education is jurisdictional or due to the Ontario curriculum. Additionally, a larger study would provide a more holistic understanding of what youth would prefer in regard to methods of information dissemination.

Conclusion

The present study suggests that youth have limited mental health literacy. Particularly, that they are unable to provide a holistic and helpful definition of mental health, nor are they able to identify signs and symptoms of mental health problems or illnesses outside of depression. These results suggest that the mental health education currently implemented in the Ontario curriculum is insufficient, and youth agree that their education was insufficient. Additionally, the results from this study indicate youth want to learn more about mental health and this is supported by previous research (Armstrong & Young, 2015). Youth also believe school to be a helpful place to learn about mental health and would prefer small interactive workshops to deliver mental health education (Armstrong & Young, 2015; Marinucci, Grové & Rozendorn, 2021).

Furthermore, there are numerous mental health literacy programs that could be provided to youth, and one that is specifically designed to be integrated into the existing Ontario curriculum and taught by usual classroom teachers (Kutcher & Wei, 2014). Integrating this program into the existing curriculum could vastly improve Ontario youth's mental health literacy, while simultaneously increasing teacher mental health literacy (Wei, Church & Kutcher, 2023; Kutcher, Morgan & Wei, 2015; Kutcher & Wei, 2017; McLuckie, Kutcher, Wei & Weaver, 2014, Milin et al., 2016). However, the preliminary results here suggest that discussions around mental health need to be less individualistic and need to include reference to the social determinants of mental health.

In conclusion, integrating mental health literacy programming in the Ontario curriculum should be a priority, and reflect the preferred methods of information dissemination of Ontario youth. Future endeavors need to prioritize youth perspectives and voices by incorporating mental

health literacy into high school education in ways they would find beneficial. The effective use of mental health literacy programming in education could improve help-seeking behaviour, thus avoiding further suffering and possible suicide. Additionally, it is imperative that future studies explore Ontario youth mental health literacy on a larger scale to provide evidence for the need to overhaul the Ontario Health and Physical Education curriculum to include better mental health education.

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Appendix A: Information and Consent for Participants

Letter of Information & Consent for Potential Participants
Ontario Youth Mental Health Literacy & Social Determinants

October 26 2023

Thank you for your interest in participating in this exploration of young peoples' mental health literacy in Ontario. The study is for a Lakehead University Master of Education Thesis (MEd), conducted by me, Veronica Malinoski, supervised by Dr. Jenny Roth. Participation is voluntary. Please read this letter carefully to understand what is involved. If you have any questions, please email me at vmalinos@lakeheadu.ca

Purpose The study's purpose is to explore your mental health knowledge: what information you received in high school, and what you would have liked to receive. Your information will allow me to identify gaps in the high school curriculum for my MEd.

Information Collected The anonymous online survey has 5 demographic questions and 11 open ended questions. You are asked your high school's region, your sexual orientation, gender identity, and race/ethnicity. These questions help identify difference due to social location. None can be traced directly back to you. The survey then asks about your high school mental health education, what you would have liked to learn, where you went for information, delivery method, and the social determinants of health.

Participant Expectations The online anonymous survey should take 30-45 minutes to complete.

Participant Rights Participation is voluntary. You may withdraw without penalty by exiting SurveyMonkey prior to submission. You will be unable to withdraw after you submit the survey. Your decision to participate will have no effect on your academics. You can provide as detail as you wish, and you can choose not to answer questions. Submitting the survey indicates you consent to the collection of your information.

Risks & Benefits Your reflection on mental health education will be beneficially used to critically examine mental health curricula. I do not anticipate any risks. Reflecting on mental health may be distressing; however, you are asked to reflect on mental health education, not your own mental health. If you do require free support, please contact:

Good2Talk: 24/7 post-secondary student helpline, (ph) 1-866-925-5454 or (txt) GOOD2TALKON to 686868

Lakehead Student Health & Wellness: book at https://www.lakeheadu.ca/students/wellness-recreation/student-health-and-wellness/counselling-services/make-an-appointment. Call 807-343-8361 for same or next day appointments.

Confidentiality Due to collection and storage of data online, we cannot absolutely guarantee the confidentially of your data. With your consent to participate, you

acknowledge this. To protect confidentiality, the online tool is not linked to your email, and your name will not appear anywhere on the survey. When you submit you are anonymous to the researchers, and there is no way to link your responses to you by the researchers. Data is therefore anonymized from the outset.

Data Use The data will be used to complete an MEd. Results may be shared in conferences, publications, or speaker series. Email Veronica if you would like a short summary of the results.

Researcher Contact Information
Principal Investigator: Dr. Jenny Roth jroth@lakeheadu.ca
Student Researcher: Veronica Malinoski vmalinos@lakeheadu.ca

RESEARCH ETHICS BOARD REVIEW AND APPROVAL This research study has been reviewed and approved by the Lakehead University Research Ethics Board. If you have any questions related to the ethics of the research & would like to speak to someone outside of the research team, please contact Sue Wright at the Research Ethics Board at 807-343-8010 ext. 8283 or research@lakeheadu.ca.

Appendix B: Survey Questions

Part One – Demographic Questions

1. Where (city, province) did you attend high school?
2. What year did you graduate high school?
3. What is your gender?
4. What is your race/ethnicity?
5. What is your sexual orientation?

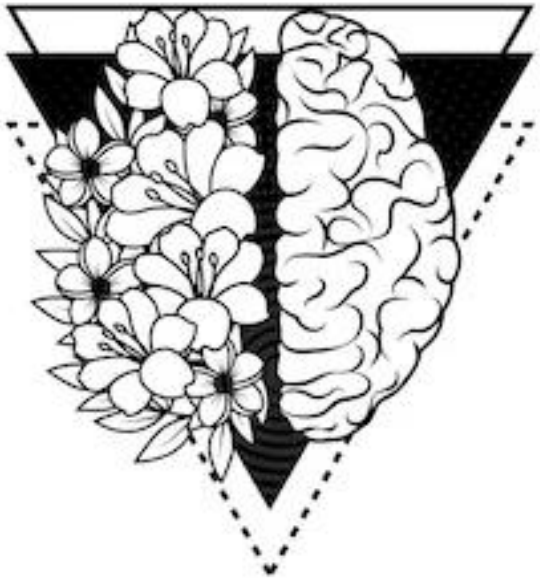
Part Two – Mental Health Questions

1. Based on what you learned, how would you define mental health, and how would you recognize whether or not someone was experiencing a mental health problem or illness?
2. Was mental health discussed in your high school(s)? If so, what do you remember about the discussions?
3. What do (did) you want to learn about mental health and mental illness in high school, if anything?
4. How was information about mental health delivered to you (for example, in a presentation, hands-on workshop, a media presentation such as film or online tutorial, etc)? In your opinion, was that form of delivery the best for you, or would you have preferred it a different way?
5. If you sought mental health information outside of school, what process did you use to obtain it? Please provide details (such as website, organization or specific people).
6. Do you think school is a good place to learn about mental health?

7. Did you learn about the social determinants of health? If you did, describe some of them here.

Appendix C: Recruitment Poster

What do you know about mental health?



Participate in a survey about mental health education in Ontario.

To participate you: Must be at least 18 years old, have graduated from an Ontario high school within the last 4 years, and attended high school in Ontario for most of Grades 9 through 12.

surveymonkey.com/r/D8TKM23

RESEARCH ETHICS BOARD REVIEW AND APPROVAL This research study has been reviewed and approved by the Lakehead University Research Ethics Board. If you have any questions related to the ethics of the research & would like to speak to someone outside of the research team, please contact Sue Wright at the Research Ethics Board at 807-343-8010 ext. 8283 or research@lakeheadu.ca.

Appendix D: Class Presentation

Hello. My name is Veronica Malinoski, and I am Master of Education student here at Lakehead. I am completing an original thesis entitled: Ontario Youth Mental Health Literacy and the Social Determinants of Health. My study aims to explore young peoples' mental health literacy in Ontario, paying particular attention to any differences people experienced based on their social location. The purpose of this study is to use young adults' perspectives about how and what they would have liked to learn in high school regarding mental health, mental health problems and illnesses, and the social determinants of mental health to identify gaps in the current mental health curriculum in Ontario. I am looking for volunteers to complete my online survey.

The survey consists of five demographic questions, and eleven open ended questions on the topics of mental health understanding, mental health education, and social determinants of health. I ask demographic questions in order to explore any differences in responses based on these markers (your social location). None of the demographical information you provide will be linked to you. The survey is completely anonymous, even to myself and my thesis supervisor, Dr Roth. After answering the demographic questions, you will be asked to describe your experience with mental health education in high school, what you would have liked to learn about mental health, where you received the best information, in your opinion, about mental health, how you think mental health education should be delivered, and about the social determinants of health.

I, and this study, is in no way affiliated with this course and participation is completely voluntary, whether you choose to participate or not is completely up to you and is not connected to your performance in this course in any way. If you would like to participate the information to do so is here [I will have recruitment poster and my email under document camera] and I will

leave copies of the information [copies of the recruitment poster and my email] with [professor's name]. Thank you [Professor's name] for allowing me to present in your class.