

**“What’s Gender/ Sex Got to do with it?”
Health Research, Policy and Practice in Nova Scotia**

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Case Study: Mental health, addictions and youth

Atlantic Centre of Excellence for Women’s Health

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Acknowledgements

The introductory pages of this case study, defining gender and gender-based analysis, are adapted with permission, from: Donner, Lissa. (2005).

Including Gender in Health Planning: A Guide for Regional Health Authorities. Winnipeg: Prairie Women's Health Centre of Excellence. We gratefully acknowledge the work of the author, Lissa Donner and the project lead, Margaret Haworth-Brockman, Executive Director of the Prairie Women's Health Centre of Excellence.

We would also like to acknowledge the work of Patty Thile, who undertook much of the background research for the case study.

1. Introduction: What is gender-based analysis

Gender-based analysis (GBA) is a tool to help understand how the experiences of women and men are different, and how they are the same. In the case of health, GBA illuminates the differences in health status, health care utilization and health needs of men and women.

Health Canada defines gender-based analysis as:

“...an analytical tool applied to research, policies, program design, and evaluations to ensure that appropriate questions about both men and women yield sensitive and accurate analyses and programs.”¹

“Gender-based analysis helps to ensure that the differential economic, political, social and biological circumstances of both girls and boys, and women and men are taken into account. Gender-based analysis will render transparent issues such as the under-representation of women in decision-making or the absence of women in research. It may similarly highlight imbalances in addressing men’s health issues.”²

GBA flows from a **population health** perspective. Gender is an important determinant of population health. Other determinants of health accepted by Health Canada are:

- income and social status
- social support networks
- education
- employment and working conditions
- social environments
- physical environments
- biology and genetic endowment
- personal health practices and coping skills
- healthy child development
- health services
- culture

¹ Status of Women Canada 1997, cited in Health Canada. 2003. Exploring Concepts of Gender and Health. Ottawa: Minister of Public Works and Government Services Canada., pg.1

² Health Canada. 1999. Women’s Health Strategy. Ottawa: Minister of Public Works and Government Services.

Why gender-based analysis?

When it comes to health, sex and gender matter. Research is increasingly alerting us to the ways that sex and gender interact to “create health conditions, situations and problems that are unique, more prevalent, more serious, or have different risk factors or interventions”³ for women and men. ...Tailoring the health care system to meet the particular needs of women (and men) should lead to better use of resources⁴.

GBA allows us to consider the ways in which gender interacts with these other determinants of health to influence the well-being of women and men, boys and girls.

This is important because women and men are not all the same. We differ because of age, education, socio-economic status, culture, physical environments, etc. Including GBA can be part of on-going programming and planning for health care delivery. Using GBA provides an idea of the wider breadth of the health issues that affect a regional population.

Gender can act in two ways to influence health.

Firstly, gender acts on its own. The most obvious example of this is reproductive health. But gender acts in other ways, which may not always be considered. For example the same drug can cause different reactions and different side effects in women and men.⁵

Secondly, gender works along with other determinants of health. For example, income is linked to health. Those with lowest incomes are at the greatest risk of ill health.

GBA also includes an analysis of the diversity among people, recognizing that all women and all men are not the same. For example, senior women, especially senior women living on their own, women with disabilities and Aboriginal women of all ages are at even greater risk of poverty than their male counterparts.⁶

³ Greaves, et al. quoted in Health Canada, 1999, pg.35.

⁴ Health Canada, 1999, pg.35.

⁵ Health Canada. 2003. pg..6.

⁶ Donner, L. 2002. Women, Income and Health in Manitoba. Winnipeg: Women’s Health Clinic.

GBA is a powerful tool for health planners and decision-makers who must allocate resources. GBA contributes to “evidence-based” decision making, because it broadens the scope of “evidence” used in the decisions.

Isn’t Gender Just a Polite Way of Saying “Sex”?

In order to undertake GBA, it is important to understand the concepts “sex” and “gender”.

Sex refers to the biological differences between females and males. The health sector has focussed largely on reproductive differences, particularly maternity care, but physical distinctions between females and males shape a much broader range of health issues.

Gender refers to the array of socially constructed roles and relationships, personality traits, attitudes, behaviours, values, relative power and influence that society ascribes to the two sexes on a differential basis. Gender is relational - gender roles and characteristics do not exist in isolation, but are defined in relation to one another...

Gender roles and responsibilities are rarely evenly balanced in any society. Women and men generally do not have equal access to resources such as money, information, power and influence...⁸

Did You Know...

Women and men do not receive the same (or similar) care, even for the same conditions. American studies show women are less likely to receive high-tech services, and tend to receive less aggressive care for conditions such as heart disease and cancer.⁷

Without GBA, women and men may be treated the same way, when it is inappropriate to do so. Alternatively, they may be treated differently when it is inappropriate to do so, based on traditional, long-standing stereotypes. GBA helps to uncover both of these types of problems.

- It is well-known that young men commit suicide much more frequently than young women. Looking at gender - and understanding the differences in the lives of young women and young men - will

⁷ Grant, K. 2002. *GBA: Beyond the Red Queen Syndrome*. www.cewh-cesf.ca/bulletin.

⁸ Health Canada. 2000. *Gender Based Analysis Policy*. Ottawa: Minister of Public Works and Government Services, pg. 14.

help in the development of prevention and intervention strategies to reduce suicides among both young women and young men. The first case study in this guide deals with this issue, as well as the related problem of self-inflicted injuries among women. In this example, treating women and men the same way is not appropriate.

- Canadian women live, on average, longer than Canadian men do. DHAs will therefore see more elderly women than men in hospital. Considering gender, and its many influences on the lives of senior women, will help to provide services that better meet the needs of these women. For example, their lower incomes mean that they are less able to purchase non-insured treatments such as certain prescription drugs, medical supplies and physiotherapy. Their caregiving roles may mean that senior women are themselves responsible for caring for others who are chronically ill. Again, in this case, treating women and men the same way is not appropriate.
- Health education messages designed to prevent unwanted pregnancies have primarily focussed on young women. This has reinforced the stereotype that places most of the burden of responsibility for birth control on women. In this case, it would be more appropriate and effective to target both women and men.

What About Men's Health?

A gender inclusive approach includes men and women. When women's health is emphasized, it is often because women's roles in society create additional and /or invisible burdens. At the same time, more is known about certain aspects of men's health, such as symptoms of disease and reactions to medication. Most health research in the past was conducted on men and by men. The results may then be applied to women, leading to inappropriate or ineffective interventions.

Gender-based analysis gives us an opportunity to ask questions based on health data which is already available. It also helps point out information which may be missing from current data.

Why is Gender Important in Research, Policy and Health Planning?

GBA is about more than identifying and analyzing issues specific to women (like hysterectomy rates and Caesarean section rates) or men (like prostate cancer) or issues more common to women (like breast cancer). GBA is a tool to apply when analyzing all aspects of health, and all parts of the health care system, because gender affects all aspects of the lives of women and men - everything from income and education to family responsibilities, and social supports to occupational health.

Good research, planning and programs are about using the available resources to help obtain the best possible health outcomes for all. However, asking the same research questions or providing the same programs and treatments for everyone in a region (that is, treating them equally), may not produce results which are equitable. Different programs or treatments may be necessary for women and men, boys and girls, in order to achieve the best possible results. GBA will help to identify and give priority to those areas where gender-sensitive interventions will lead to improved health.

2. Case Study: Outline and Objectives

The following case study deals with mental health, addictions and wellness among youth in Nova Scotia, and provides researchers, policy makers, community workers and others with an opportunity to:

- a) reach a deeper understanding of the terms “sex” and “gender”;
- b) appreciate the overlapping and discrete impacts of sex and gender on health and well-being
- c) recognize sex and gender differences that may affect health and wellness, broadly defined;
- d) gain a basic understanding of gender-based analysis (GBA) and practice using it.

The case study is divided into three sections – each with its own set of assumptions, questions and evidence. Together, these sections build an awareness of the importance of sex and gender as determinants of health and provide participants with an opportunity to practice GBA.

For the duration of the case study group work, you are asked to adopt a specific role and/or persona as you are provided with evidence, questions, and tasks around the health and well-being of youth in Nova Scotia.

Facilitators at each table will guide you through the process.

Part One: One way to look at your work

Your role:

Imagine that you work in a provincial agency that deals with research and analysis as well as the design and delivery of regional programs and services across Nova Scotia. You have just been promoted to a management level within this agency, with a hefty raise in pay and much more responsibility.

Your supervisor tells you that it has recently come to her/his attention that the youth of Nova Scotia, girls and boys in their teens especially, are not doing well. Mental health concerns, addictions and risk-taking are a growing problem for youth in the areas served by the agency.

Your supervisor provides you with some standard data, about which no other details are available, and asks for your recommendations on research, policies and programs. For the duration of the case study group work, you are asked to adopt a specific role to help you respond to evidence, questions, and tasks around the health and well-being of youth in Nova Scotia.

Instructions:

As a group, spend some time reviewing the data and come up with recommendations.

A. Rates of Alcohol and Substance Use

Alcohol and Drug Use, 12-15 year-olds, Canada

At some time, tried:	Age			
	12	13	14	15
Alcohol				
At least one drink	17	29*	53*	66*
Intoxicated	4	10*	29*	44*
Marijuana	3	9*	25*	38*
Hallucinogens			9	13
Glue-sniffing	1	3	3	2
Non-medical use of prescription drugs			4	4
Other drugs (+)			3	5

Related Information

* denotes statistical significance from estimate for previous age ($p < 0.05$)

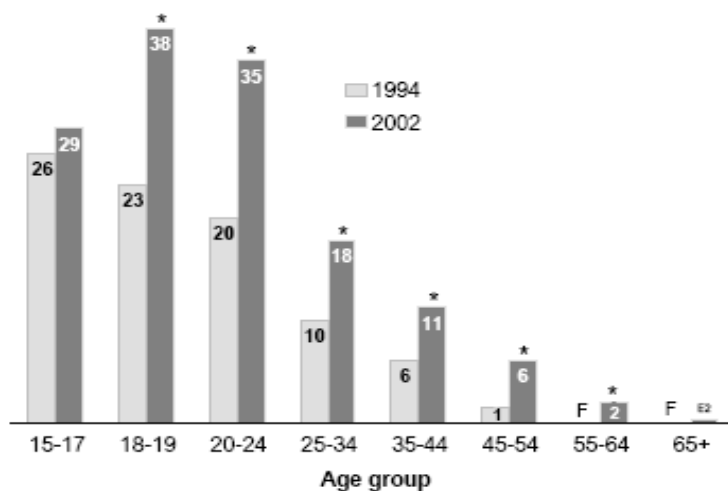
(+) For example, heroin, speed, PCP, crack/cocaine

Source: National Longitudinal Study of Children and Youth, 1998/99 cycle

Based on the National Longitudinal Study of Children and Youth, 1998/99, Hotton and Haans (2004) reported:

- Average age of first drink was 12.4 years, and first intoxication was 13.2
- The average age for first use for marijuana and other drugs was slightly older, ranging from 13.1 to 13.8
- Students doing poorly or very poorly in school were more than twice as likely to have consumed alcohol to intoxication.

Percentage of population aged 15 or older who used cannabis in past year, by age group, 1994 and 2002

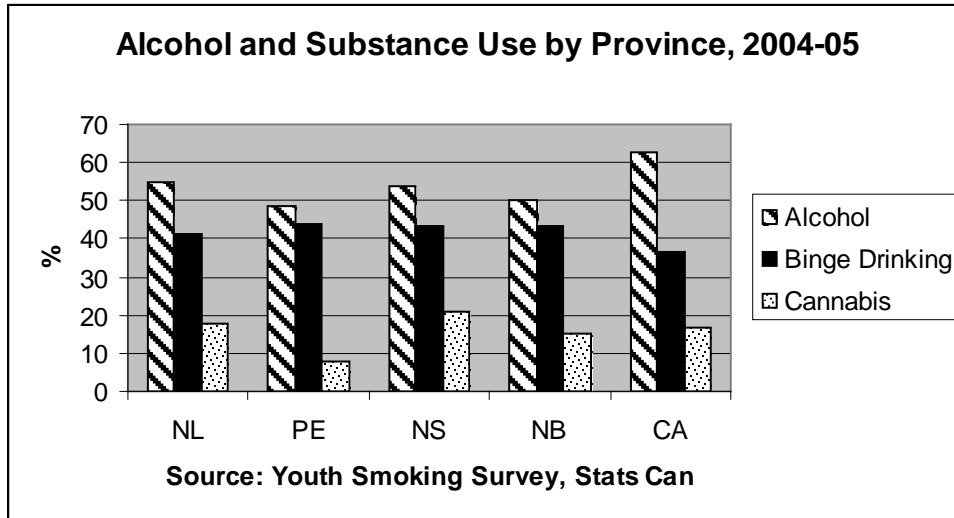


Data sources: 2002 Canadian Community Health Survey; 1994 Canada's Alcohol and Other Drugs Survey

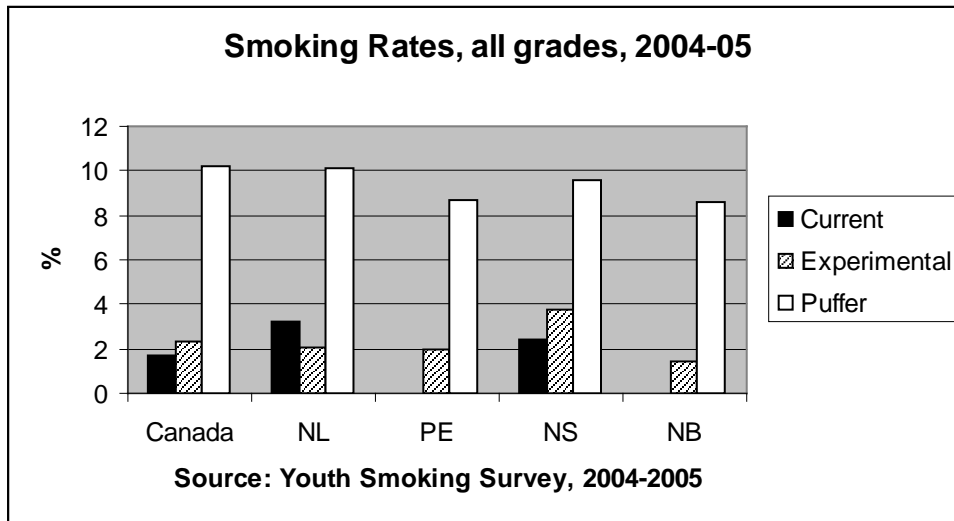
Related Information

Thomas (2004) found that in Canada in 2002, the adult age cohort with the highest current drinking rate alcohol was 24-29 year olds (90.9 – 91.1%), followed by young adults aged 19-24 years (89.2-92.3%).

Source Canadian Community Health Survey, 2002



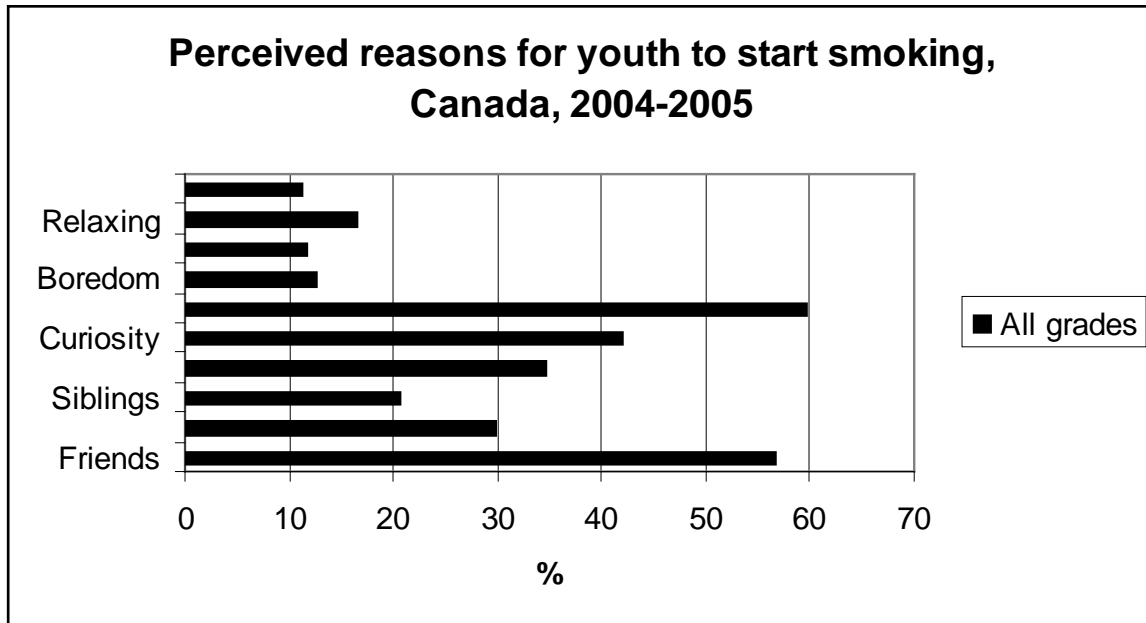
* Note: Binge drinking rates among those who have ever tried alcohol



* Note: Experimental smoker refers to those who have tried smoking; Puffer refers to those who smoke occasionally

* Note: High variability in current smoker status in PE and NB led to suppression of the data

B. Explanations for Alcohol and Substance Use



Source: Youth Smoking Survey, 2004-2005

- Peer group is a strong predictor of alcohol and substance use: The majority of those who consumed alcohol or tried drugs reported that most or all of their peers had done so as well while the opposite was true for those who did not consume alcohol or use other
- According to the Nova Scotia Alcohol Indicators report (Graham, 2005) young adults, 19-24 years, who currently drink are most likely to drink to excess (49.1%), followed by 15-18 year old drinkers (26.8%). Among students, heavy drinking and drunkenness were associated with older age, lower grade point average and friends' use of alcohol.
- Adolescents from families with problems related to alcohol use were no more or less likely to consume alcohol, but youth who had 'hostile' relationships with their parental figures were more likely to consume alcohol and use drugs.
- Youth 12-15 years old who attended a religious service weekly were less likely to have consumed alcohol or drugs.

C. Impacts of Alcohol and Substance Use

Alcohol-Related Hospitalizations:

Alcohol-related external causes of hospitalizations are most prevalent in young persons. External causes include acute toxicity/poisoning, falls, and attempted suicide.

Injuries:

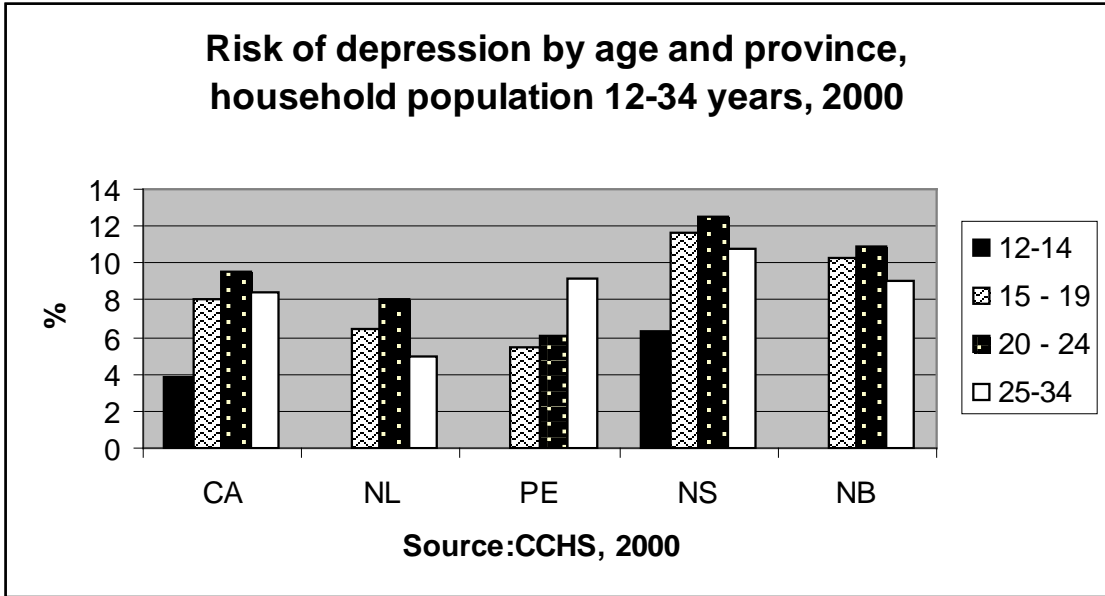
- Victims of accidental and violent injuries were more likely than their non-injury counterparts to be young (ie, 15-24 vs 25 and older), to consume alcohol, to consume more than five alcohol beverages on one occasion, and to have experienced harm from alcohol. They were also more likely to use a range of drugs than those who had not experienced injuries.
- Those people who had experienced injuries from violence were significantly more likely to attribute the injury to another person's alcohol or drug use, when compared with those who reported accidental injuries.

Fatalities:

- An estimated 33% of all fatalities from car crashes were related to alcohol consumption, with higher proportions noted in young drivers.
- In 2001, 25.3% of driver fatalities among those under 19 years, and 42.6% of the same for those aged 20-25 had positive blood alcohol levels.
- In NS, the three leading causes of death from acute use of alcohol between 1999 and 2003 were motor vehicle crashes, suicide and accidental falls.

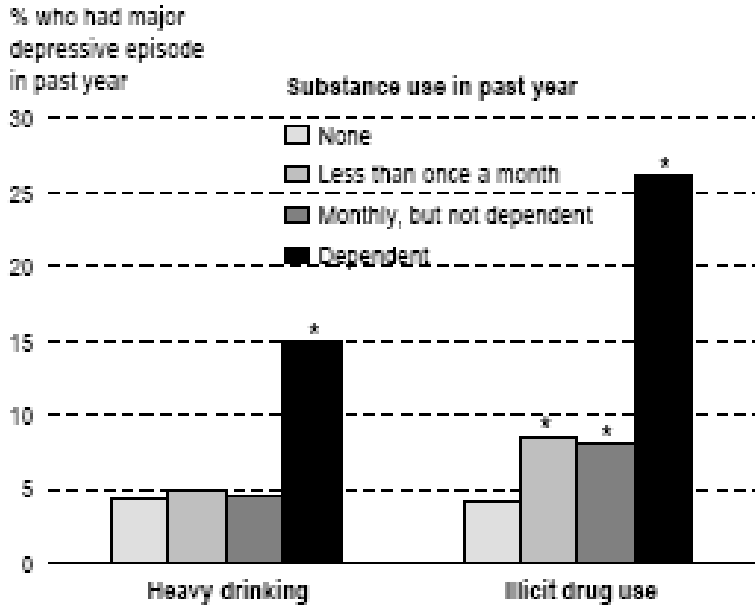
Risk taking behaviours:

- According to the NS Student Drug Use Survey (NS Department of Health, 2002), 31% of students reported having one of ten alcohol-related problems in the previous year; 11% had at least three of the ten.
- The most commonly reported consequences of alcohol consumption were property damage, self-injury, unplanned sexual intercourse, and disagreements or tension with family or friends.
- 64% of students surveyed reported using a condom during most recent sexual intercourse, but the three most common reasons for not using one were: not having a condom at the time, the feeling that condoms interfere with sex, and being under the influence of a substance.



* Note: Rates for 12-14 year olds in NL, PEI, NB were suppressed due to reliability issues

Prevalence of depression, by frequency of heavy drinking and illicit drug use in past year, household population aged 15 or older, Canada excluding territories, 2002



Data source: 2002 Canadian Community Health Survey: Mental Health and Well-being

* Significantly different from estimates for "none" ($p < 0.05$)

Binge eating and substance use

- Ross & Ivis (1999) reported those who have binged – eating unusually large quantities of food in a short time and feeling a loss of control – at least once in their life were twice as likely as non-bingers to report problematic substance use.
- Compensatory purging behaviours – self-induced vomiting, diarrhea, etc. – were linked to the use of drugs other than tobacco, alcohol and cannabis.

Part 2: A different lens

What's happening at work:

Well, you've not had much luck devising strategies for dealing with the wellness of youth in Nova Scotia – at least according to your supervisor who says that nothing has changed. Despite this lack of progress, you've managed to hang on to your job. And a new researcher recently joined the staff of your agency and provided you with new data that you can add to the data you already have. With luck this new data will help you to develop an effective strategy that will keep your boss happy and you in your job.

Instructions:

Review the new data as well as the old data. Does this new data change how you view the issues or solutions for them? What effect, if any, does this information have on your recommendations? Be prepared to justify your new recommendations or your decision to stick to your existing recommendations to the rest of your department.

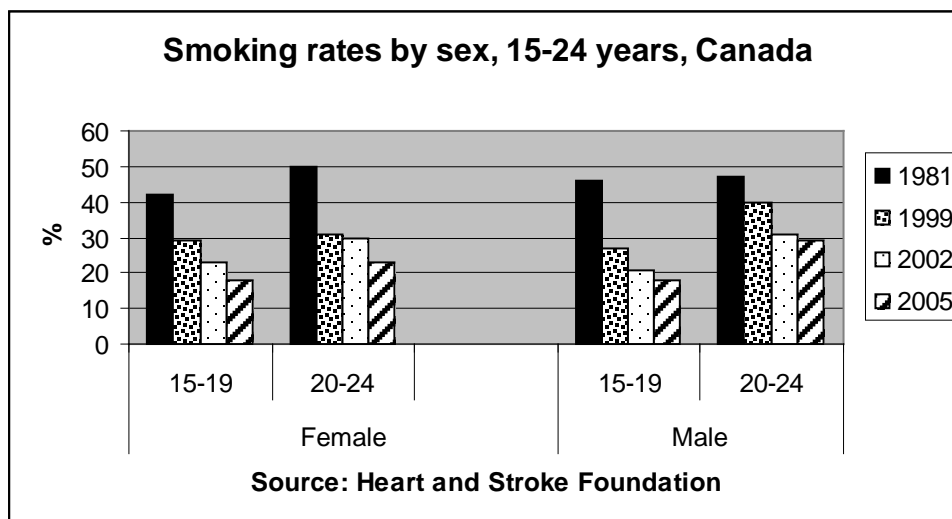
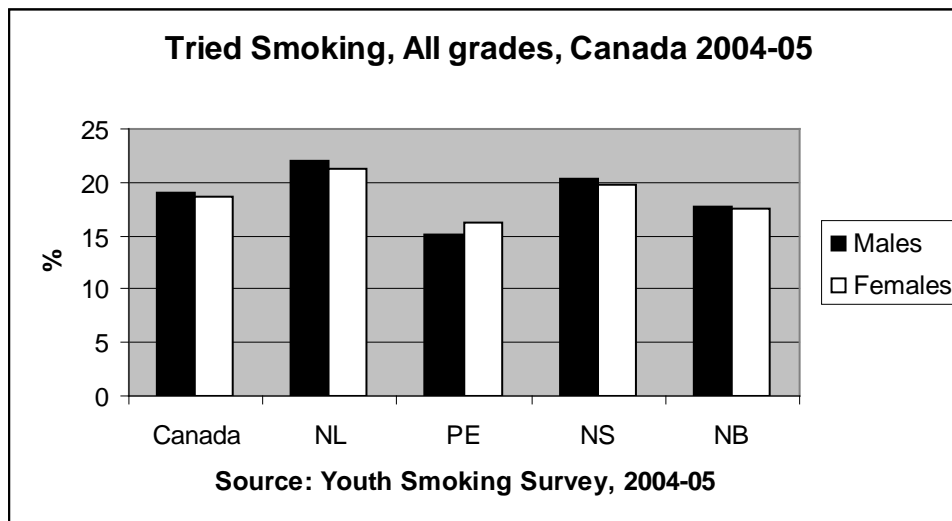
A. Rates of Alcohol and Substance Use

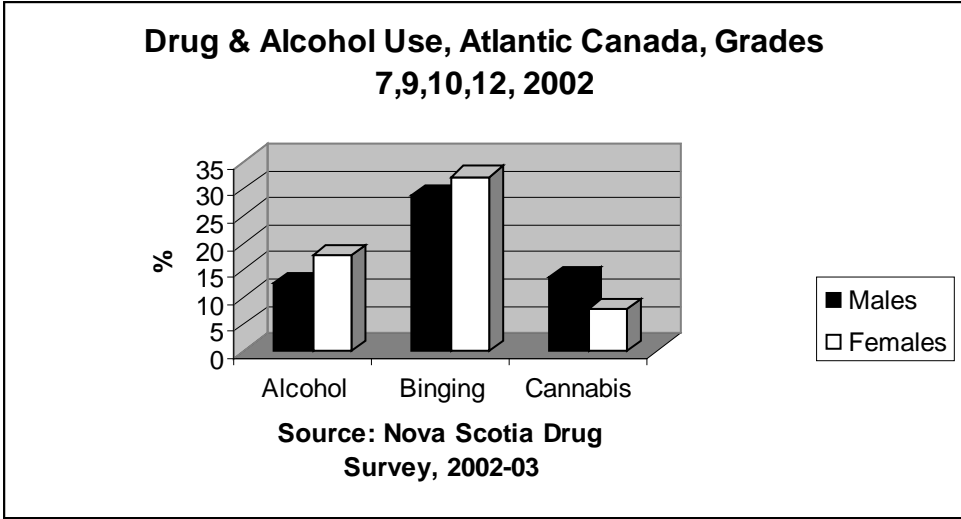
	Sex	
	Males	Females
At some time, tried:		
Alcohol		
At least one drink	44	39
Intoxicated	20	24
Marijuana	20	19
Hallucinogens	10	12
Glue-sniffing	2	2
Non-medical use of prescription drugs	3	5
Other drugs *	3	5

➔ Related Information

Among 12-15 year olds, males were more likely to have tried alcohol, while females were slightly more likely to have consumed alcohol to intoxication or tried other drugs.

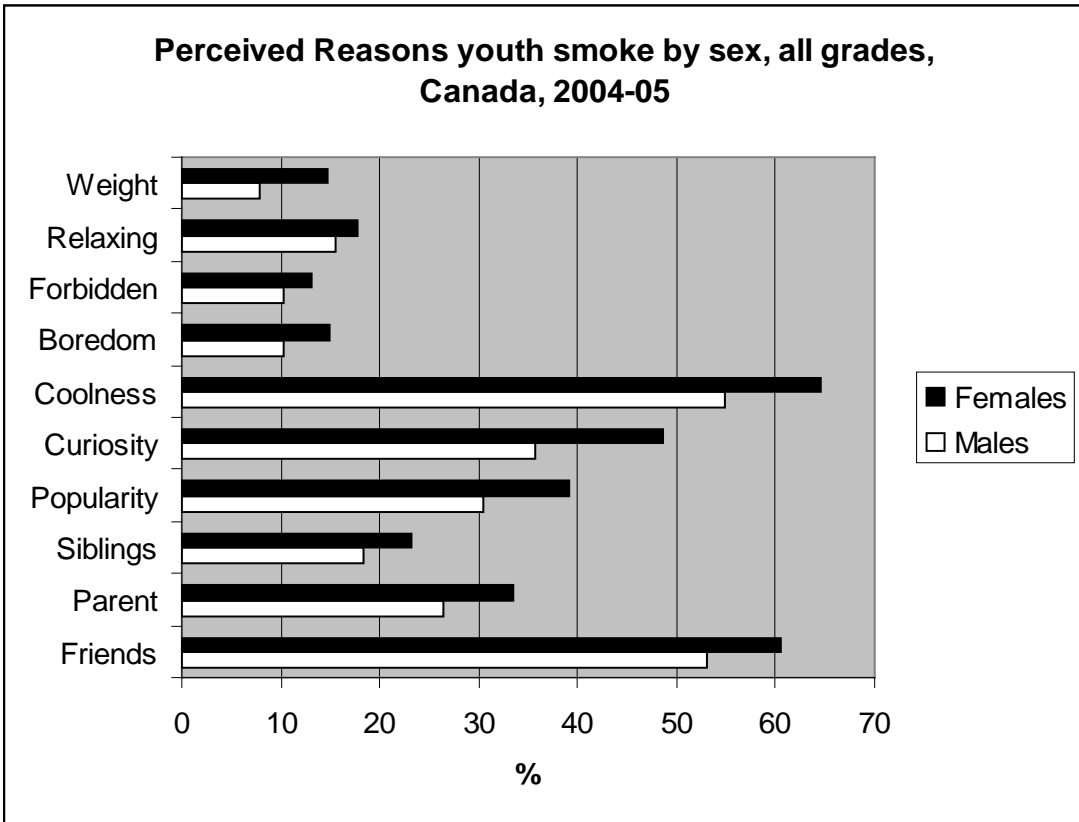
Source: National Longitudinal Study of Children and Youth, 1998/99 cycle





* Note: Binging refers to the proportion of students using alcohol

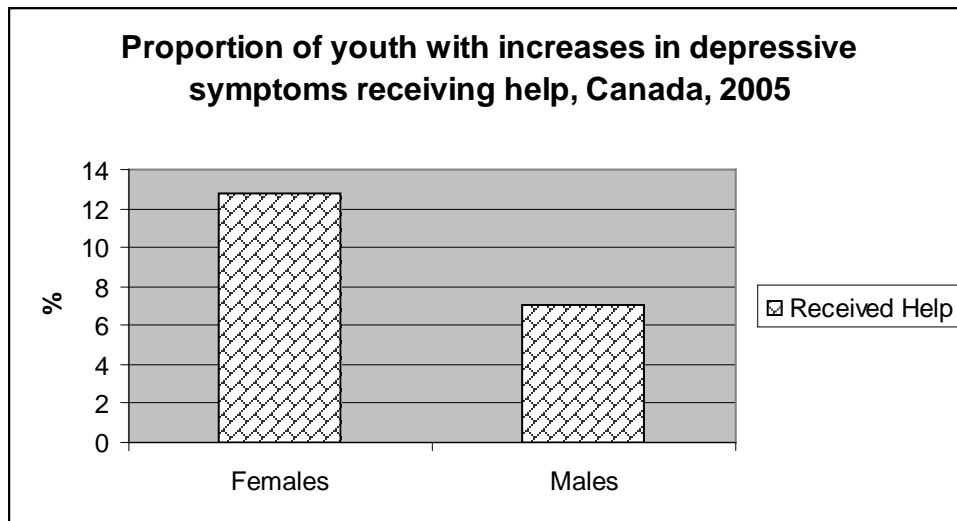
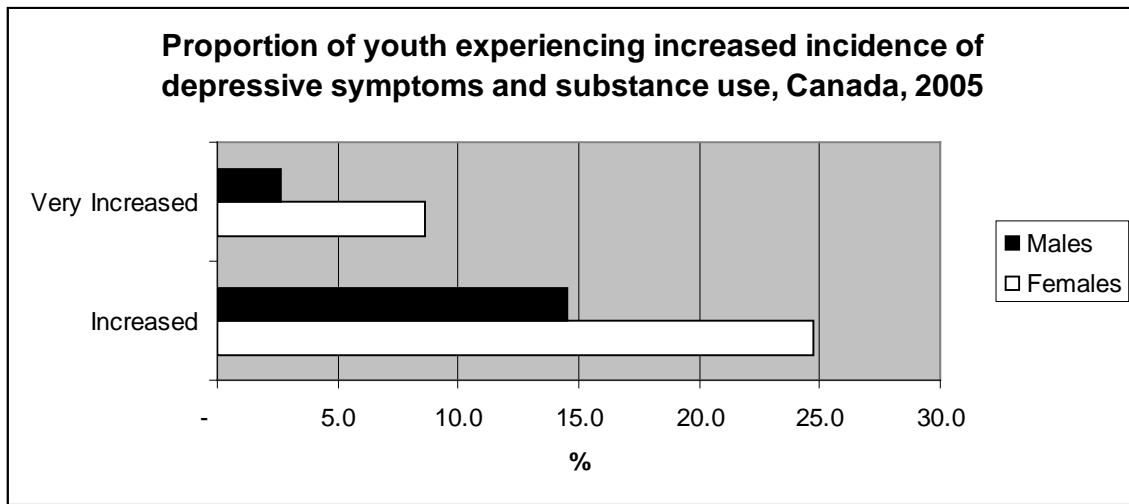
B. Explanations for Alcohol and Substance Use



- Source: Youth Smoking Survey, 2004-05

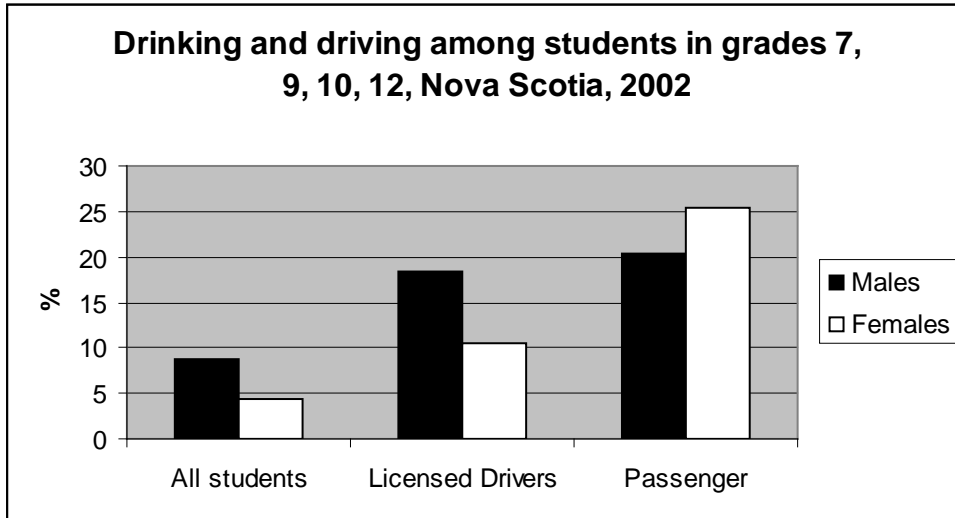
C. Impacts of Alcohol and Substance Use

Depression: Poulin and colleagues (2005) studied the substance use as a predictor of depressive symptoms for males and females. Females using substances were more likely than their male counterparts to report increases in depressive symptoms. Females were also more likely than males to ask for and receive help with their symptoms.



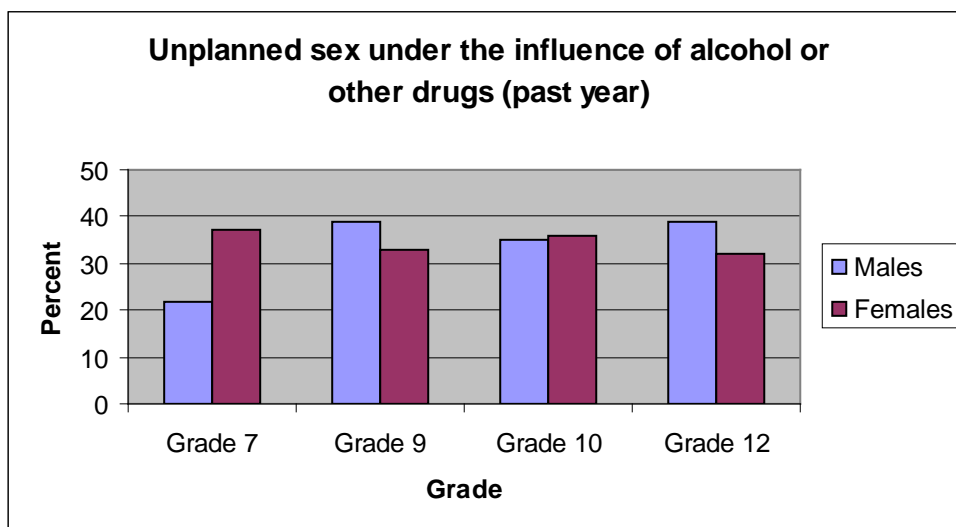
Driving and substance use in Nova Scotia

From the NS Student Drug Use Survey (Nova Scotia Department of Health, 2002):



- Male students were more likely than female students to drive within one hour of alcohol or cannabis consumption.
- Female students were more likely to be passengers with alcohol-impaired drivers than males.

Safe sex and substance use in Nova Scotia



* Source: Nova Scotia Student Drug Use Survey, 2002 Note: Both graphs derived from Poulin et al, 2005.

From the NS Student Drug Use Survey (Nova Scotia Department of Health, 2002): 64% of students reported using a condom during most recent sexual intercourse. Females were less likely to have done so than males.

Depression and Suicide

Rates for four northern NS high schools, participants aged 14-20, 2003

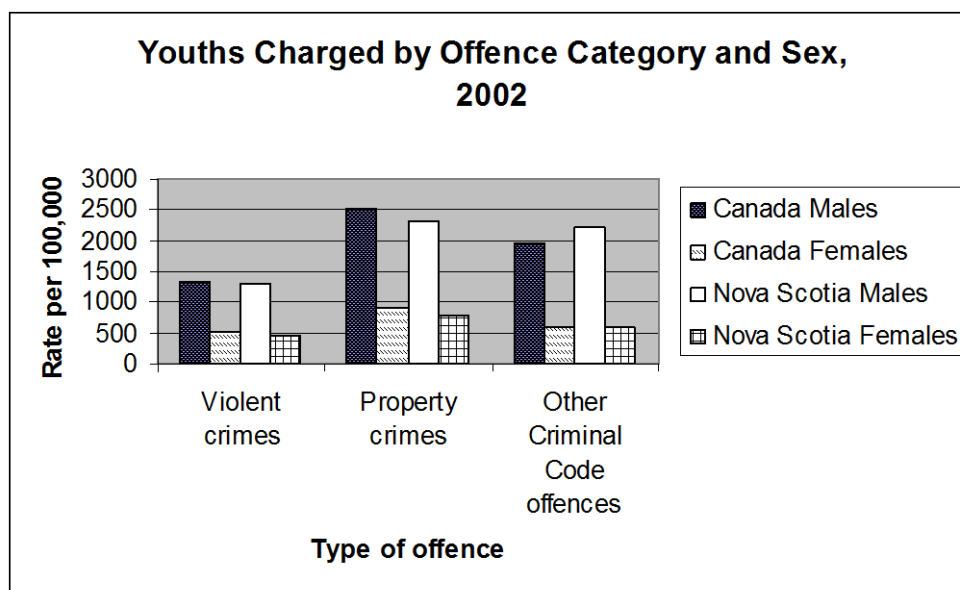
TABLE I

The 12-month Prevalence of Suicidal Behaviours (Overall and by Gender)

	Overall N=2353 N (%)	Boys n=1132 N (%)	Girls n=1219 N (%)	Fisher's Exact Test p Value
Suicidal ideation	16.6	12.8	19.9	<0.005
Suicide planning	11.8	9.4	13.9	<0.005
Suicide attempts	5.1	3.0	6.8	<0.005
Injurious suicide attempts	1.2	1.1	1.3	not significant
Any suicidal behaviours	19.3	15.3	22.8	<0.005

- Drug use, but not alcohol use, among female students positively correlated with thoughts of and planning for suicide – no correlation among males
- Data from the Canadian Community Health Survey, Cycle 1.1 (n=17,557, ages 12-19) showed that factors correlating with depression for both female and male teens included fair or poor self-rated health, smoking, alcohol dependence (using DSM IV criteria), food allergies, migraine headaches, chronic bronchitis, and having physical health problems.

Crime:



Binge eating and substance use

- Ross & Ivis (1999) reported those who have binged – eating unusually large quantities of food in a short time and feeling a loss of control – at least once in their life were twice as likely as non-bingers to report problematic substance use.
- Compensatory purging behaviours were linked to the use of drugs other than tobacco, alcohol and cannabis.

Part 3: The whole enchilada

What's happening at work:

Well, your recommendations for policy and program changes seem to be making some differences. Smoking rates are down across the province. But there are still many problems facing the youth in Nova Scotia: crime rates are up, drunk driving remains an issue, and depression and continues to plague children and youth.

On top of all that, things are getting tense in the agency because your supervisor is taking heat from upper administrators and politicians who are being questioned closely by the opposition and the public.

You and your team are eager to find more data that will help them devise more effective solutions. Some new research reports have been released in the last few weeks and they are excerpted here. How does this new data affect your recommendations and/or your understanding of addictions?

Instructions:

Review the new data as well as the old data and make new, revised, and/or identical recommendations. Be prepared to justify these recommendations to the rest of your department – as well as to your boss, the Minister and your mother.

More things to think about, ...

A. Quantitative/statistical data on related topics

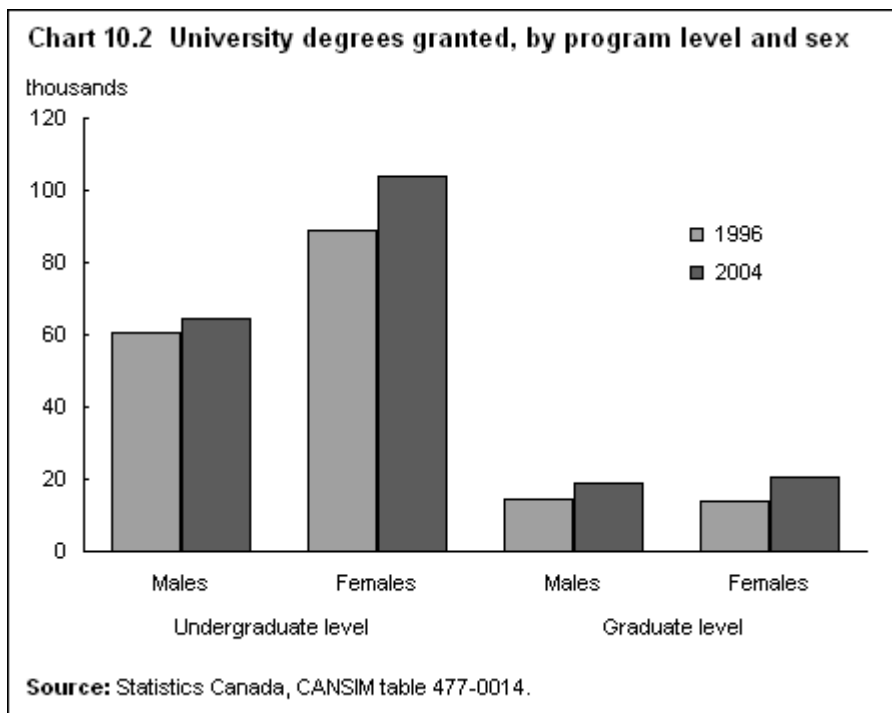
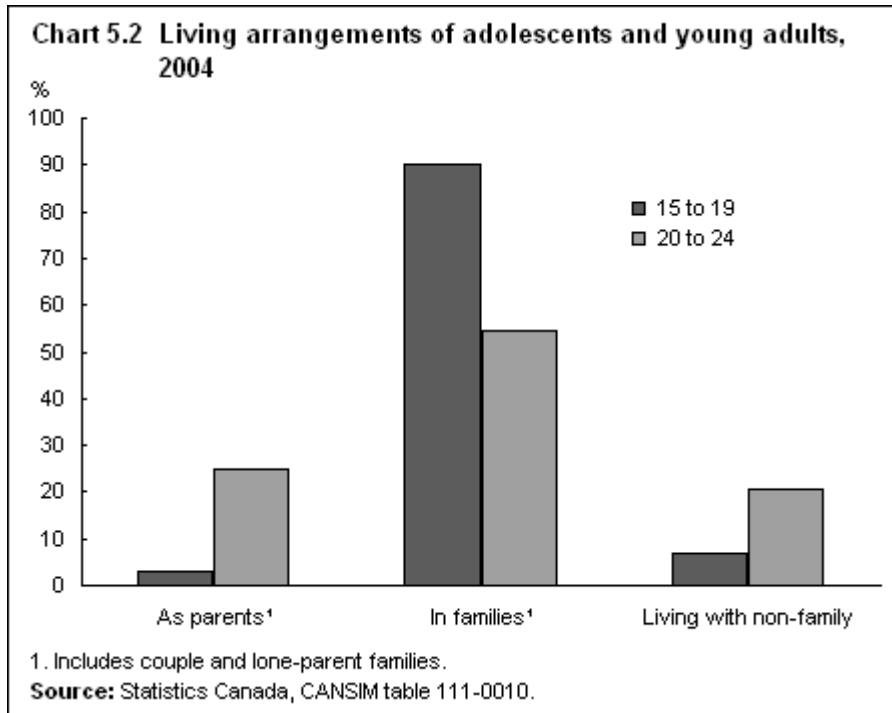
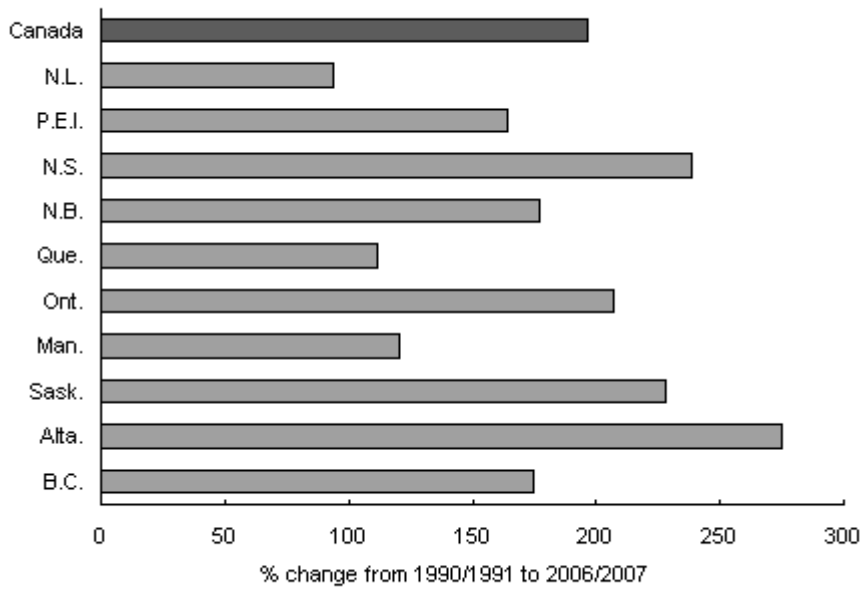
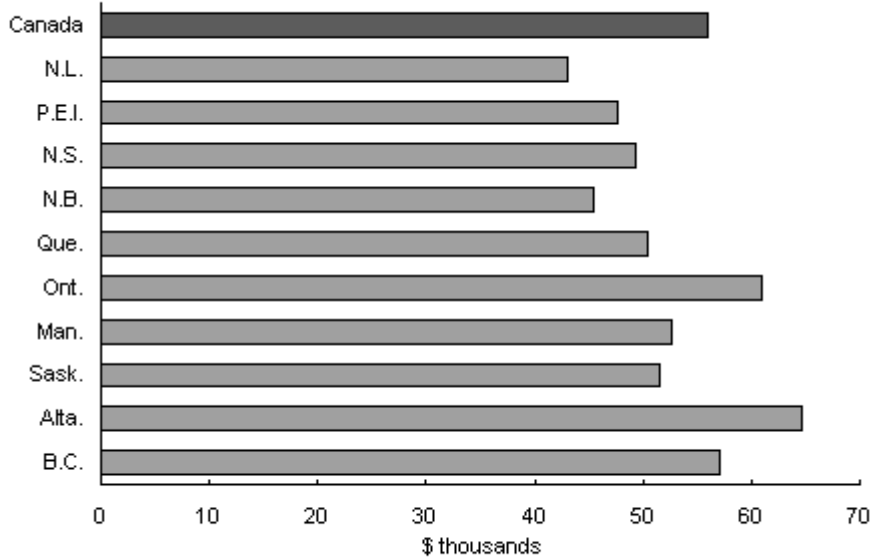


Chart 10.3 University tuition fees



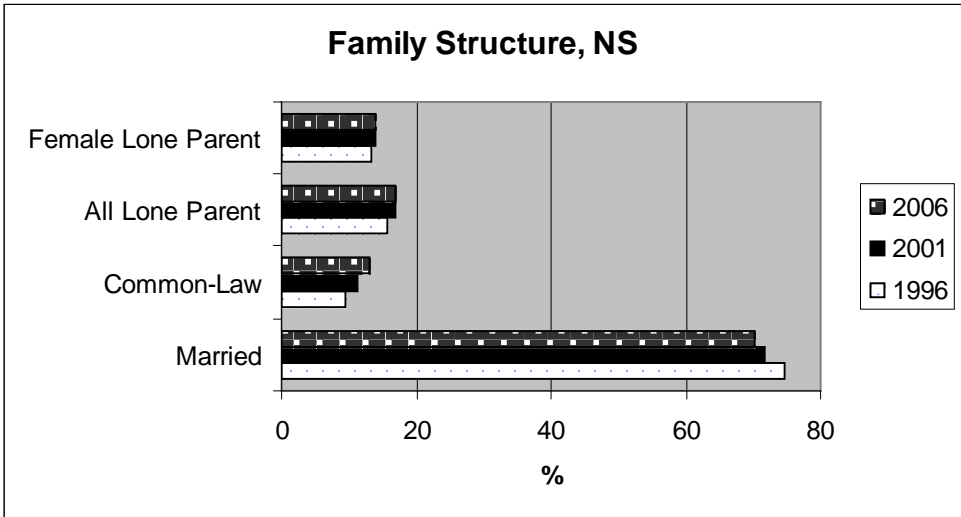
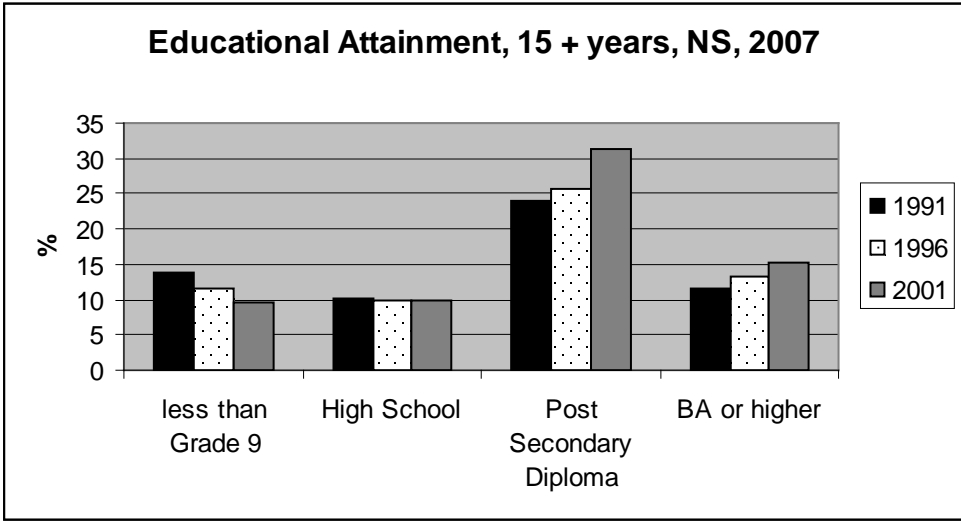
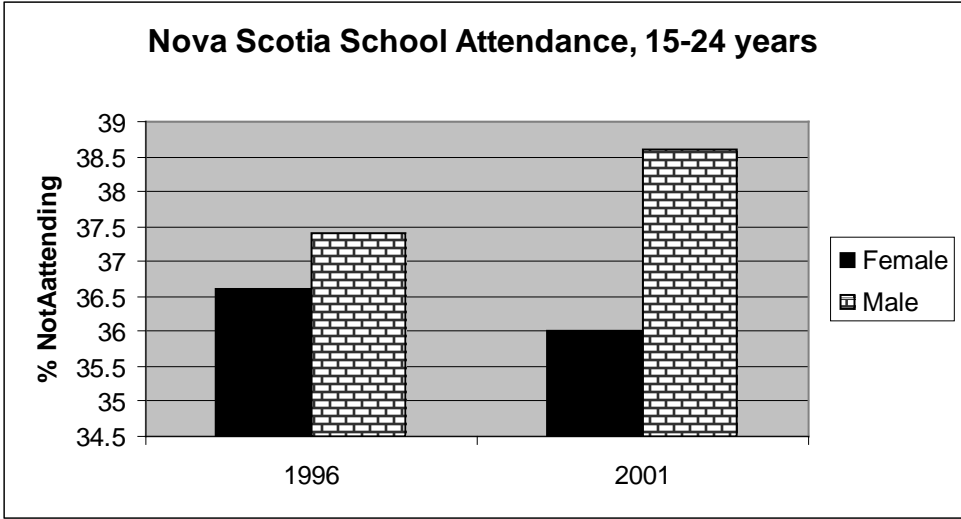
Source: Statistics Canada, Tuition and Living Accommodation survey.

Chart 18.2 Family median after-tax income, by province, 2005



Note: Measured in 2005 constant dollars; economic families of two or more people.

Source: Statistics Canada, Catalogue no. 75-202-XIE.



B. Qualitative Data

What youth say about:

Why they use substances, ...

- “Me [sic] and my friends drink a lot because when your [sic] in a small town there’s truly nothing else to do on the weekend but drink/smoke pot. Don’t get me wrong we don’t every day but we usually do” (Female, grade 10)
- “I have had the urge a few times to get drunk because my friends were” (Female, grade 7)
- “I think it is possible to use drugs/alcohol responsibly and not let it interfere with school or anything else. I don’t think using marijuana has in anyway affected my grades or my mental health. I am not at all an addict, I just use alcohol/marijuana for entertainment”. (Female, grade 10)
- “Marijuana helps relax people so they can do things like study for tests, play instruments and sing. It helps you concentrate on what you are doing. It makes you appreciate every good thing in life. Everyone thinks it’s bad but that is when they haven’t tried it before. Only idiots do more than that, like the harder drugs that ruin their lives. I’ve been smoking it for 4 years, my grades are good and I feel good about who I am”. (Male, grade 10)
- Young men with an established or prospective intimate female partner consumed less alcohol, to avoid embarrassment or to “*protect*” their partner. “*When you go to a bar with your girlfriend, you’re not going to drink and behave the same way as if you go with your friends.*” (male) while young women in such situations were more likely to increase alcohol consumption, to “*loosen inhibitions*” or garner more attention: “*guys pay attention to you*”. Alcohol lets them relinquish some control; “*lets you do things you wouldn’t normally say or do*”.
- Young men in one study were reported as encouraging increased consumption of alcohol by young women: “*Guys know this*” and were described by both women and men using predatory language: “*The guys would get together the day before and choose which girls they were going for, once they were drunk.*” (male)

The relationship between sex and substance use, ...

- “I have been forced to have sex due to my partner being on drugs also he was drinking, but he used a condom. I have also been beat by him when he was on drugs or drinking”. (Female, grade 10)
- “When I had sexual intercourse without a condom, I didn’t think it was going to happen. It just did...” (Male, grade 10)
- “I feel that a lot of teen use drugs, alcohol and smoke. I have tried drinking and drugs but I don’t use them...But a lot of teens do other sexual acts such as, oral sex etc. We should spend more time talking in school about this and what can happen etc”(Female, grade 10)

The impact of alcohol and substance use, ...

- young men drinking larger quantities, “*drinking to get drunk*”, and reportedly experienced more frequent injuries, blackouts, or alcohol-related memory loss
- Young women spoke about unplanned intoxication, with no or few precautions taken to prevent negative consequences of overdrinking.
- Alcohol poisoning, once described, was familiar to many on a first-hand basis. Youth also reported other common physical and social consequences of alcohol consumptions, including vomiting, passing out, injury, school suspensions, parental discipline, accessing medical care, and contact with police
- The legal consequences of drinking and driving were not seen as a deterrent:
 - “*Last weekend I had a buzz on, drove two houses down, got caught by the police, failed the breathalyzer and the cop ended up giving me his phone number, I could have driven away.*” (female)
 - “*After being in the bars, I’ll go to Pizza Corner and everybody is standing around. Some go and get into their cars – the cops are more concerned with the people hanging out on the corner for fights and stuff than the people who go and drive drunk.*” (male)
- Young men recognized a number of negative consequences of over drinking (such as unsafe sex, driving under influence charges, and fights) but they also reported a social acceptance of high-risk alcohol behaviours and consequences for males

One youth, sex unknown, commented on the impact of substance use on her/his life: “*A few years ago I was unsure about life and didn’t care about choices I made. Because of my actions I failed a grade twice,*

and now I have to stay back with younger people whom are more immature than me. All of this was because of alcohol and marijuana. I have now cut back and do well in school. I still smoke and drink, but these things no longer affect my school work because of my self control”.

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