

HOUSING

6 Service Preferences of Homeless Youth with Mental Illness: Housing First, Treatment First, or Both Together

Cheryl Forchuk, Jan Richardson, Karen Laverty, Mirella Bryant, Abraham Rudnick, Rick Csiernik, Betty Edwards, Sandra Fisman, Beth Mitchell, Martha Connoy, Mark S. Dolson, Chandell Kelly

Introduction

Homelessness in Canada has been on the rise since the 1980s, growing to the point of being declared a “national disaster” in 2006 (United Nations, 2006). Municipalities across Canada struggle with how to best address the related issues of homelessness, mental health and addiction – particularly among youth. Youth make up anywhere from 7.6 to 44 percent of the homeless population in North America (Community and Neighbourhood Services Policy and Planning, 2006; Edmonton Homelessness Count Committee, 2002; Casavant, 1999; Cauce et al., 2000; Ringwalt et al., 1998). Although the needs of homeless youth are different from those of other homeless groups (Haldenby et.al., 2007; Reid et al., 2005), few Canadian studies have addressed housing-first approaches (i.e. providing housing before requiring that someone deal with their mental health or addictions issues) for youth in particular, leaving decision makers without much information on promising solutions.

Youth Matters in London: Mental Health, Addiction and Homelessness – Treatment and Service Preference

Project Description

The main objective of the *Youth Matters in London* project is to investigate and better understand youth participants' *choices* regarding treatment and service options over a three-year period (as of the writing of this chapter, the study is still on-going). The study is following 187 homeless youth who are also living with mental illness and/or an addiction. Participating youth are being followed over three years in order to better understand their housing and mental health treatment preferences. The study provides participants with a choice between three treatment and service options: 1) *housing first*; 2) *mental health and addiction treatment first*; or, 3) *both housing and mental health and addiction treatment together*, and then tracks the outcomes and results for the youth. As such, the study team is interested in understanding why youth participants might choose one of the above-mentioned options rather than another. Participants are interviewed individually every 6 months over the course of 3 years, for a total of four interviews. By focusing on the choices and experiences of youth (and the potential changes in their choices over the 3 year time frame), the ultimate goal of the project is to develop effective options that can help street youth stabilize their lives and get off the streets.

This project is firmly grounded in the principles of Participatory Action Research (PAR). As understood by the research team and community partners in our research context, these principles include the following: 1) the recognition of invested members of the community as key decision makers so as to solidify community capacity building; 2) promotion of a research environment wherein learning and empowerment are equally distributed, and therefore to the benefit of all research partners; and, 3) following suit, the dissemination of knowledge involves and is directed to the entire community wherein the research is conducted (McTaggart, 1991). To this end, the research team is comprised of university-based researchers, community stakeholders, and members of the municipal government. Representatives from the City of London, community agencies, and individuals with lived experience of mental health, addiction and homelessness meet regularly to discuss the project in all of its aspects.

Approach to Providing Housing and Services

Homeless youth experience extremely high levels of depression, stress and emotional distress (Yates et al., 1988; Smart et al., 1993; Ayerst, 1999; McCay et al., 2006). Mental illness may either be a major cause of homelessness, or a

response to the stress of life on the streets (e.g., exposure to violence and the peer-related pressures to participate in the sex/drug trade [McCay, 2006]).

Understanding the need for mental-health/addiction treatment and services among homeless and street-involved youth, the research team has been working closely with existing service providers in London (including a broad spectrum of community-based services including youth-focused, peer-supported shelters, drop-in services, mental health programs, addiction programs and treatment facilities). The focus of the research team and the service providers is on testing and evaluating three approaches that might be of benefit to homeless youth who have a mental illness (which may or may not have been previously diagnosed) and/or addiction (to narcotics, marijuana, alcohol, or tobacco, for instance).

The three approaches are:

1. Housing First

Housing first initiatives focus first and foremost on moving individuals to appropriate and available housing and providing the ongoing supports necessary to keep individuals housed. As described in the Mental Health Commission of Canada's 'At Home/Chez Soi' project, "Housing First creates a recovery oriented culture that puts the individual's choice at the centre of all its considerations with respect to the provision of housing and support services. It operates on the principle that individuals experiencing homelessness living with mental illness and/ or addiction should be offered the opportunity to live in permanent housing of varying types that is otherwise available to people without psychiatric or other disabilities" (MHCC, 2008:5).

The housing first model is very different from the general service delivery model, called the Continuum of Care approach – a model that assumes that individuals with mental illness cannot maintain independent housing before their mental illness is under control (Tsemberis et al., 2004).

Much in line with our findings, Tsemberis et al., (2004) and Padgett et al., (2006) found that the housing first approach was the most effective service option for homeless adults and adults living with mental illness and substance abuse/addiction.

The housing first model was designed by *Pathways to Housing, Inc.*, a not-for-profit, social service organization in New York City that serves persons who are homeless and have both mental health problems and addiction issues (Tsemberis & Asmussen, 1999). The model is based on the belief that hous-

ing is a basic right, and that people receiving mental health services have a right to make their own life decisions.

2. Treatment First

Treatment first initiatives seek to provide mental health supports and treatment solutions to the individual. This approach puts an emphasis on recovery, and the individual's choice is at the centre of treatment and support options. It operates on the principle that the symptoms and mental health/addiction concerns of the individual need to be addressed immediately.

In this study, service providers (primarily at the Youth Action Centre) provided treatment first options by facilitating appointments – where possible – with health professionals, such as nurses, physicians, psychiatrists or addiction counsellors through Ontario Works and the Addiction Services of Thames Valley.

3. Attention to Both Housing and Treatment Together

Providing housing and treatment together creates a recovery-oriented culture (one that is aimed at fostering hope, healing and individual empowerment, as well as using the individual's experience of care to inform improvements to services) that puts the individual's choice at the centre by offering simultaneous housing, mental health, addiction, and support services. It operates on the principle that mental health/addiction concerns and the need for housing both need to be addressed immediately. Housing first and treatment first approaches are offered at the same time.

Sample and Inclusion Criteria

The *Youth Matters in London* project works with youth aged 16–25. This range is the cut-off used by most youth services in London, Ontario, Canada. We use the same definition of *homeless* as the At Home/Chez Soi study (MHCC, 2008), which includes: *Absolute homeless* – having no fixed place to stay for more than seven nights and little likelihood of finding accommodation in the next month, or leaving an institution, prison, jail, or hospital with no fixed address; and, *precariously housed* – those whose main residence is a Single Room Occupancy (SROs, or a single room rented within a building), rooming house, or hotel/motel, or who in the past year have twice been absolutely homeless, as defined above (Tolomiczenkoa & Goering, 2001).

Study participants must also be experiencing a serious mental disorder, as defined by the Diagnostic and Statistical Manual IV, Text Revision (DSM-

IV TR), with or without also having a substance use issue; formal diagnosis at the time of entry into the project was not required. The focus is on those youth who are not formally participating in existing mental health treatment services or programs related to finding housing.

Our study includes homeless youth staying in shelters and those who use alternatives, such as living on the street or “couch surfing” (moving between friends’ and families’ places without their own address). Because homeless and street-oriented youth are particularly difficult to engage in treatment and service programs (particularly due to placing a low priority on health-related concerns), a clearer understanding of their preferences and choices will be essential for establishing appropriate services. It is recognized that some youth will choose none of the options as the study progresses. We will attempt to understand the reasons for youth’s choices as they evolve throughout the study.

Data Analysis: Initial Treatment and Service Preferences of Male and Female Study Participants

From the first round of interviews, youths’ responses to the following two questions were analyzed:

- 1. Which service model did you choose? (housing first, treatment first, both together, or none of these options)*
- 2. Tell me why you chose that particular service model (what did you like best about it? What were your concerns about other choices?)*

Participants answered these questions during the initial interview that took place at the beginning of the study (recruitment began in July of 2010). While enrolling in the study, all 187 youth study participants were told that there was no guarantee that they would receive the housing or treatment option they chose. It was explained that each participant would work closely with a service provider towards their treatment/housing preference. Participants worked individually with a service provider from one of the community partners (Youth Opportunities Unlimited) to find acceptable and affordable housing and/or referral to treatment.

Since the goal of the study is to better understand youth’s treatment/service choices, it is important that the youth be allowed to choose the treatment/service option they actually want. A controlled, randomized study would not allow youth to make this choice.

Table 1

Youth matters in London: Participants choosing each treatment and service option						
	Male	Female	Other	Transgender	TOTAL	
Housing First	50	23	2		75	40%
Treatment First	39	18			57	31%
Housing and treatment combined	18	19		1	38	20%
No Selection/ Other	15	2			17	9%
TOTAL	122	62	2	1	187	100%

Participants’ responses were sorted by gender, and then grouped according to treatment/service option preference (i.e., “housing first,” “treatment first,” “both together,” and “other” preferences were analyzed separately). After careful deliberation, the team found that the naming/listing of gender identities is troublesome and obviously open to debate. The terms “male” and “female”, though scientific-sounding, best capture the main gender categories of the participants involved in the study. The use of terms such as “men” and “women” is troublesome, too, in that many participants – for example, those who are 16 years old – may not identify as a “man” or a “woman,” seeing themselves as “kids”, “children”, or simply “youth”. One youth identifying as transgendered participated in the study; and two identified as “other” (such a choice reflects a potential discomfort with the other listed gender identities) Participants’ statements were analyzed by two separate members of the research team, who read and re-read the responses in order to establish broad themes related to youth’s preferences. Coding was open at first in order to identify, name and categorize recurring themes from the answers to the open-ended questions. A selective coding approach was then used to refine themes by either eliminating previous themes, or combining certain themes (for instance, if there was an overlap between two themes one of them was combined with the other). Through selective coding, one category was chosen to be the “core” category or key theme; other categories are then related to this core category or key theme. Youth’s responses to each of the open-ended questions were taken down, word for word, by trained research assistants. Once themes specific to each treatment/service preference were established, responses were then re-read and coded according to these themes. However, some responses were very brief (sometimes limited only to a few words), and therefore difficult to code. Since there were 187 open-ended interviews conducted at the beginning of the study, a large amount of qualitative (narrative) data was gathered.

As well, many participants gave the same reasons for choosing a specific treatment/service option. For this reason we have chosen three of the most

common responses – in the form of example quotations – for each of the treatment/service options offered.

Housing First: Females

Getting Away From Bad Environments, and Providing for Children

Female responses were coded according to two major themes evident in the data. The core categories were: 1) *getting away from negative influences*, and 2) *providing a stable environment for children*. Typical responses included under the first theme described a desire to remove oneself from negative environments – often associated with alcohol or drugs. Such a desire is expressed in the following three sample quotations:

“Cuz that’s my basic need. I’m in a bad environment that I can’t be in”.

“I don’t know, it just made sense in order to get away from the alcohol and drugs. I need to get out of the shelters and away from the streets to remove myself from the temptations”.

“Because I can’t live with my parents, they show me a bad example all the time, they’re hypocritical. They tell me if I want to do what I want I have to get my own house and pay my own rent. So that’s what I want to do”.

Responses were also coded and grouped under the second theme, which centred on the practical and moral pressure for pregnant youth to get off the streets and into a place of their own. Having a place of one’s own was also understood as a condition to keeping or getting back custody of one’s children, as well as being necessary in order to provide basic shelter for a child. The following sample quotations indicate this urgency.

“Because I have a baby on the way and I’m on the streets”.

“Mainly my child, I need to take care of her first, then myself. Plus CAS [Children’s Aid Society] is involved and it will look good if I actually have a house”.

“I’ve been trying to fight for my son, between me and my mom. The only way I can get him is if I have my own place. The place where I’m at is not good – I can’t even go there”.

Housing First: Males

In Need of a Stable Living Environment to Decrease Social Stressors

Much like the female participants' responses, the males expressed an urgent need for a more stable living environment; however, a key difference was the underlying reason for wanting stability. For the male participants, the need for stability was a strategy of resilience: stable housing removed the stress of survival on the streets and made it possible to focus on other problems. The harmful effects of both addictions and mental illness, as was revealed by youth's repeated mention of their harmful and negative effects, could be avoided through stable housing. It was found that housing provided a stable base from which to set one's life in order.

Lack of housing was also described as a cause of mental health issues and substance abuse – which, ultimately, could be understood as a form of coping with the stress of life on the streets. As such, responses were coded according to the following theme: *attaining a more stable environment to decrease environmental/psycho-social stressors*. The following quotes describe housing as important to explaining and hopefully avoiding mental illness and substance misuse:

“Basically, with lack of housing I became really depressed and then I started drinking to deal. But if I had a place it probably wouldn't have worked out that way”.

“I feel like that my drug addiction is because I don't have a house. I feel like if you don't have a stable environment, you're bound to try to occupy your mind with something else”.

“Because, when you're on the streets your mental health problems can affect you more. Because you're more under more stress because you're homeless”.

Treatment First: Females

The Need for Mental Health and Addiction Treatment

With regard to the female participants who chose treatment first, the main themes that arose from the data, and under which responses were coded, were: *need treatment* and *need treatment, but already have housing*. These themes indicate an urgent need to deal with issues relating to addiction and mental health before seeking stable housing, especially in those cases where participants did not have permanent or stable housing (many of the youth were concerned that housing would provide a stable place in which to use drugs). The quotations below indicate this urgency,

firstly for those who need treatment but do not have housing; secondly for those who explained that they have housing, but expressed that it may only be semi-stable or temporary – what is often referred to as “couch surfing”.

“Because I’ve had psychological problems before, but they were never diagnosed. I’ve had depression but I’ve never seeked help before”.

“Because, like, the other day I woke up at 6:00 in the morning puking all over some girl, and I’m getting pill sick”.

“Well, I have a place I’m living in right now, and OW [Ontario Works] says it’s better for me to not be on my own. I’m in addiction counselling but I still want someone to talk to”.

Treatment First: Males

Housing is Not an Issue, or Housing Would Serve as an Enabling Environment

The situation was much the same for male participants in that many who chose the treatment first option already had housing. A key underlying difference for choosing treatment first for the males – as well as females – was that many saw housing as an enabling environment for continued addiction and mental health problems. The two themes under which responses were grouped show this reasoning: *already have housing* or *housing would provide an enabling environment for addiction/mental health problems*.

“I have a drug addiction. It would be more fair to get treatment first. It makes more sense to me. I’d rather be more comfortable physically before I have my own place. I’m just tired of being an addict”.

“I just think people need to help themselves. You gotta be clean before you can be housed. Because if you can’t take care of yourself, how are you supposed to take care of the things around you”?

“Because I’m a drug addict. Cause I know it’s not realistic to have housing and treatment for me, because I will turn my house into a chop-house”.

The living situations of both male and female participants were quite varied. Some participants’ had stable or semi-stable housing, while some lived with a parent.

“At the moment, I have semi-stable housing, and I find it’s hard to keep housing when you’re not mentally/emotionally stable”.

“Housing I already have, and my mom has mental health issues and I’m not sure if I have it because I have a lot of the same symptoms”.

“Because I already have housing and that’s the biggest problem right now. We do need stuff for housing, we don’t have much money because of our addiction.”

Both Housing and Treatment: Females

For the housing and treatment together preference, the main themes for participants were: 1) *both are easier when done at the same time*, and 2) *both are top priorities*. For those participants with mental health and substance abuse problems, and who are also homeless or unstably housed, making both options a top priority was logical.

“Cause I don’t have a place to live and I’m addicted to oxy’s; and I want to get off of them. They are both really important things”.

“Because they’re both top priorities. I’ve had a huge problem with addictions, I’ve been on pills since 15 and needles, a lot of health problems. And my daughter, I want to prove to her that I want to do more than what my mom did for me. And housing, oh god, I’ve just been bouncin’ around, and my boyfriend is out in 44 days, so I need a place for me and him, and I’m banned from St. Thomas”.

“I don’t know, because it made it easier to do both together. I guess the people I surround myself with – those are the two most important topics. They are equal”.

Both Housing and Treatment: Males

As with the female participants, the following quotations reveal that both treatment and housing were a top priority for males.

“Both, ‘cause right now I’m living in the (homeless shelter) and I have drug problems. It’s easier to take out two birds with one stone”.

“Because if you do treatment first, then if they’re homeless the treatment is pointless. If you give them housing first it sets up to give them

all that they need to do drugs. If you do both it isolates them so they can start treatment from there”.

“I want to figure out how to get an apartment. How to budget the treatment, I want to become a better person, to fix myself”.

Neither Housing nor Treatment: Other

A number of participants were grouped under the “other” category regarding treatment/service preference. This category was used for responses that either indicated a perceived inability to participate in the treatment/service options offered, or an inability to receive the treatment/service options offered through the project. Examples of some of the responses grouped under the “other” category are as follows:

“I chose employment”.

“I’m not on any drugs right now, and I’m living with my boyfriend”.

“Right now I’m court-ordered to live with my mom, so when that’s over I’ll need help with housing”.

Discussion

Responses from the initial interview questions suggest that participants’ choice of treatment/service option depends on whether they have an addiction, together with an understanding that the addiction is a problem and a desire for treatment. If this is the case, participants will most likely choose the “treatment first” option. Part of the rationale driving such a choice is that housing represents a potentially negative consequence: a stable place to use drugs.

Based on the responses, the “housing first” option seems to be the most preferred treatment/service option for both females and males. This preference indicates – at least at this point in the study – that housing is a very important concern for participants. This is a result of the view that housing (a permanent home) will add stability to one’s life – which fits with the values and social norms of Western (particularly North American) culture. And, from the perspective of homeless youth, without the stability of permanent housing one is more vulnerable to stress and anxiety due to environmental (i.e., poor weather) and psycho-social stressors (i.e., peer pressure to use drugs or engage in criminal activities), and a lack of private space. It follows that lack of housing or unstable housing can – according to project participants – ultimately trigger a mental health issue (for instance depression, as described in the example quotations above), or lead to substance

use to cope with the stress of homelessness. It must be recognized that substance abuse or mental health issues can also lead to homelessness or street involvement. Homelessness can be a cause of mental illness and addictions, or vice versa.

According to Tsemberis et al., (2004) and Padgett et al., (2006), individuals who are homeless and suffering from mental illness and addictions see housing as an immediate need; however, access to housing – under the Continuum of Care model – is only given when individuals first complete mental health and/or addictions treatment. The treatment first model is, according to Tsemberis et al., (2004), incompatible with the individual's priorities. This model excludes those individuals who are unable or unwilling to follow treatment programs.

The results of the Tsemberis et al., (2004), and Padgett et al., (2006) studies indicate that the housing first approach is effective in keeping individuals with a history of homelessness, mental illness, and addictions housed. In the studies mentioned above, approximately 80% of individuals given the housing first option remained housed. This can be contrasted with the At Home/Chez Soi project, wherein 72% of participants remained housed throughout the project (MHCC 2012). Participants' responses show that those who were given housing first had a greater sense of choice and independence than those who were given the treatment first approach.

Although the results from the studies mentioned above indicate that most participants prefer housing first, as did 40% of participants in our study, the picture is complicated by the fact that, due to mental health and addiction issues, not all participants were comfortable with the choice and independence that the housing first model provides.

Considering the diversity of responses and needs of youth in our study it is clear that a "one size fits all" approach to treatment and service provision is not enough. The social, cultural, financial and existential (i.e., the perceived meaning of one's existence and place in the world, as well as how this meaning may influence the decisions one makes) situations of the study's participants are very different.

For instance, at one moment a youth may find him/herself precariously housed by staying at friends' places, while taking advantage of the benefits of the social support network provided by friends (such as having access to a group in which to discuss difficult situations; having people to share stories and similar experiences with; and, ultimately, having access to a group that can provide emotional support). However, the next moment (due to a variety of circumstances beyond their control) that same youth may find him/herself at a homeless shelter, an urban camp, or on the streets with no place to stay. He/she may not know where to seek help, or fear the stigma of seeking care in

the event of a mental health or addiction crisis. To this end, homeless or street-oriented youth with addiction and mental health problems are anything but a “single group” with similar and stable needs and preferences.

The life-context of each youth is unique, and as such, a “one size fits all” approach cannot address and treat youth’s many complex and constantly evolving issues. A variety of housing, mental health and addiction treatment and service options are needed. Although our study may be limited in that it focuses on one city, we think the relatively large number and diversity of participants allows us to at least suggest solutions for similar youth elsewhere.

Conclusion

The purpose of this chapter was to report on youth’s initial preference of service options for the *Youth Matters in London study*. We have shown how this choice is complicated by the fact that, due to mental health and addiction issues, not all participants are comfortable with the independence the housing first model provides. Some youth indicated in the open-ended answers that living in an apartment alone may be too isolating. Since many youth see their peer group as an extended family and support network, the thought of living alone may be quite painful for some youth – hence the potential discomfort with the independence the housing first model provides.

The sheer diversity of responses and needs of participants in our study shows that a “one size fits all” approach to providing treatment and services is not enough to capture the full spectrum of needs of street-involved youth. These needs include social and financial difficulties; issues related to teen pregnancy; and the demands of parenting on street youth with children.

Many housing first options assume that youth do not have children of their own, and therefore provide accommodation designed for individuals. However, families need to be taken into consideration when designing housing first options so that youth with children can be housed rapidly, well and safely.

With respect to youth experiencing ongoing addiction issues, access to treatment needs to be immediate, and may also need to occur before providing housing – since housing may actually serve as an enabling environment for continued drug use. A related issue is that since the major goal in housing first approaches is to remove individuals from the negative influences of street life such as the sex and drug trade, we need to find affordable housing in neighbourhoods located outside the downtown core of cities to truly make a difference in providing better, safer options for youth.

With respect to housing first models, it may be assumed that youth, like adults, have the experience and necessary skills for independent living and household management. Since youth typically have very limited independent living experience (or perhaps none at all), many may find it more acceptable and less threatening if housing first models included a life and living skills development component adapted from transitional housing approaches.

Coupled with this is the reality that many youth prefer to focus on one goal at a time (especially with respect to either treatment or service goals). As seen in some of the open-ended answers, when faced with competing priorities and peer pressures, many street-oriented youth seem more comfortable working on one goal at a time. In many cases, the decision making abilities of an individual can be influenced by the greater social and cultural context he/she belongs to. This may also affect whether or not an individual will choose housing first; if an individual feels that such a choice will take him/her away from his/her social group, then he/she may avoid the housing first option entirely. Also, many youth seem to have difficulty prioritizing health concerns owing to the competing demands of street survival (i.e., what to eat and when; where to sleep; avoiding confrontations and “drama” on the street). Housing first approaches often expect youth to transition to housing and address mental health and addiction issues at the same time. Along with peer pressure, gender identity is another factor that should be taken seriously in understanding decision making processes among street-oriented and homeless youth with mental health and addiction issues. Someone who identifies as male or female may have different concerns compared to someone who identifies as transgendered. As such, treatment and service options should also take into consideration the gender identity of each participant. Complicating matters is the notion that gender identities can be fluid, (i.e., a person could move between male, female and genderless identities over the course of months and years). The consideration of gender identity, then, along with the pressures, priorities, and anxieties associated with such identities, whether they be male, female, two-spirited, tri-gendered, transgendered or androgyne or ambigendered (i.e., a person who identifies as neither male nor female, but something perhaps in between), can help focus our understanding on sustainable interventions for street-oriented and homeless youth. Therefore, by centring on participants’ lived experiences and realities of choice-making, the ultimate goal of the *Youth Matters in London* project will be to develop effective “in the moment” responses and interventions that fit individuals’ treatment and service preferences.

The ongoing collection of data for the *Youth Matters in London* project will allow the research team to understand how youths’ treatment and service preferences may change and evolve over time. To this end, the *Youth Matters in London* study will be in a unique position to explore the relationship between

participants' social and financial situations, addictions, and mental health.

As well, following participants over time will make it possible to gain a better understanding of how youth's perceptions of their own social, psychological, financial and housing-related situations may or may not affect their help-seeking behaviours.

References

- Ayrest, S. L. (1999). Depression and stress in street youth. *Adolescence*, 34(135), 567-575.
- Casavant, L. (1999). *Composition of the homeless population*. Retrieved from Government of Canada website: <http://publications.gc.ca/Collection-R/LoPBdP/modules/prb99-1-homelessness/composition-e.htm>
- Cauce, A. M., Pradise, M., Ginzler, J. A., Embry, L., Morgan, C. J., Lohr, Y., & Theofelis, J. (2000). The characteristics and mental health of homeless adolescents: Age and gender differences. *Journal of Emotional and Behavioral Disorders*, 8(4), 230-239.
- Community and Neighbourhood Services Policy and Planning. (2006). *Count of Homeless Persons in Calgary*. Retrieved from http://intraspec.ca/2006_calgary_homeless_count.pdf
- Edmonton Homelessness Count Committee. (2002). *A count of homeless persons in Edmonton*. Retrieved from <http://www.homelesshub.ca/Library/View.aspx?id=34829>
- Haldenby, A., Berman H., & Forchuk, C. (2007). Homelessness and health in adolescents. *Qualitative Health Research*, 17(9), 1232-1244. doi:10.1177/1049732307307550
- McCay, E., Langley, J., Beanlands, H., Cooper, L., Robinson, P., Howes, C., . . . Rigatti, M. (2006, July). *Qualitative and quantitative approaches to understanding the mental health needs of transitional street youth*. Poster session presented at the meeting of the International Research Congress Focusing on Evidence-Based Practice, Montreal.
- McTaggart, R. (1991). Principles of participatory action research. *Adult Education Quarterly*, 41(3), 168-187.
- Mental Health Commission of Canada. (2008). *MHCC research demonstration projects in mental health and homelessness*. Retrieved from www.mentalhealthcommission.ca
- Mental Health Commission of Canada. (2012). *MHCC Research Report*. Retrieved October 3, 2012, from www.mentalhealthcommission.ca
- Padgett, D., Gulcur, L., & Tsemberis, S. (2006). Housing First services for people who are homeless, with co-occurring mental illness and substance abuse. *Research On Social Work Practice*, 16(1), 74-83.
- Reid, S., Berman, H., & Forchuk, C. (2005). Living on the streets: A feminist narrative study of girls and young women. *Issues in Comprehensive Pediatric Nursing*, 28(4), 237-256.
- Ringwalt, C. L., Greene, J. M., Robertson, M., & McPheeters, M. (1998). The prevalence of homelessness among adolescents in the United States. *American Journal of Public Health*, 88(9), 1325-1329.
- Smart, R., & Walsh, G. (1993). Predictors of depression in street youth. *Adolescence*, 28(109), 41-54.
- Tolomiczenkoa, G., & Goering, P. (2001). Gender differences in legal involvement among homeless shelter users. *International Journal of Law and Psychiatry*, 24(6), 583-593.
- Tsemberis, S., & Asmussen, S. (1999). From streets to homes: An innovative approach to supported housing for homeless adults with psychiatric disabilities. *Journal of Community Psychology*, 27(2), 225-241.
- Tsemberis, S., Gulcur, L., & Nakae, M. (2004). Housing First, consumer choice, and harm reduction for homeless individuals with a dual diagnosis. *American Journal of Public Health*, 94(4), 651-656.
- United Nations Committee on Economic, Social and Cultural Rights (UNCESCR). (2006, May). *Consideration of reports submitted by states parties under Articles 16 and 17 of the Covenant, concluding observations of the Committee on Economic, Social and Cultural Rights: Canada*. Retrieved from United Nations High Commissioner for Refugees website: <http://www.unhcr.org/ref-world/docid/45377fa30.html>
- Vingilis, E., & State, S. (2011). *Applied research and evaluation in community mental health services: An update of key research domains*. Montreal: McGill-Queen's Press.
- Yates, G. L., Mackenzie, R., Pennbridge, J., & Cohen, E. (1988). A risk profile comparison of runaway and non-runaway youth. *American Journal of Public Health*, 78(37), 820-821.

