

Bridging the Gap: A Needs Assessment of Vulnerable Male Youth in Fredericton

A Report to: Youth in Transition

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Executive Summary

Homeless youth have a variety of needs and are a tremendously underserved population in Canada (Calgary Homeless Foundation, 2011). In responses to an apparent “service gap” between the child and adult service systems, particularly for 16- to 18-year-old male youth (Coates & McKenzie-Mohr, 2010; Coates & Neate, 2000; Richard, 2008), a comprehensive needs assessment was conducted with homeless or vulnerable male youth in the Fredericton area. The three main goals of the needs assessment were to: 1) identify the needs of male youth who have experienced homelessness or who are vulnerable to homelessness; 2) assess the services typically used by this population; and 3) identify whether additional services may be beneficial. Consistent with Bronfenbrenner’s ecological systems theory (1979, 2005), several factors were examined: individual adjustment (i.e., psychological problems, self-esteem, satisfaction with life, self-reported delinquency, and substance use), family relationships, peer relationships, social support, traumatic experiences, school performance, and use of services in the community.

Homeless or vulnerable male youth between the ages of 16 and 18 who lived in the Fredericton area were recruited to participate in the current study. A participatory research methodology was used, whereby three members of the study population were hired and trained as youth research assistants to recruit participants and collect data. Participants ($n = 187$) were mainly recruited through the youth research assistants, either through their social networks or by public solicitation. Five participants were also recruited through community organizations and advertisements. Participants completed a series of standardized questionnaires and a semi-structured interview to assess the aforementioned factors.

Participants were clearly vulnerable based on their reported range of experiences. Although many were still living at home, over half had been, or currently were, homeless.

Moreover, consistent with some previous research with homeless youth, participants reported significant concerns in regards to mental health, self-esteem, delinquency, substance use, family relationships, traumatic experiences, and academic achievement. Youth reported using from zero to four different services in Fredericton, although approximately one-third of participants reported no service use (despite endorsing a variety of needs). The most common type of service used was therapy or counselling, particularly for those individuals who had been on probation. A significant number of participants indicated that they had experienced difficulty in trying to access services. The service that participants most frequently indicated as necessary in Fredericton was a youth shelter, but other suggestions included improving access to mental health and alternative education programs and creating a teen drop-in centre.

Based on the needs of this population and the available literature on prevention and intervention efforts for vulnerable or homeless youth, several recommendations have been made. First, to provide a long-term solution to complex problems, it is recommended that sustainable funding be obtained from governmental agencies and private foundations to support a comprehensive array of services. Second, it is recommended that a central advocate be available to assist youth and their families in expediting access to services. Third, it is recommended that an integrated service delivery model be implemented across multiple sectors and agencies to facilitate a comprehensive array of services without duplication. This model would include ongoing communication among relevant agencies. Furthermore, because the services only have the opportunity to be effective if youth access them, it is important that any approaches include engagement and empowerment strategies with youth, their families, and the broader community.

Additional recommendations are made in regards to specific services to be implemented. First, family-based services are critical to prevent homelessness in vulnerable youth residing at

home. Second, front-line professionals (e.g., law enforcement, school officials) should be provided ongoing training on effective engagement practices with vulnerable youth. Third, although services should be provided in schools for youth who are able and willing to access services in this setting, youth who are not in the school system should be able to access similar services elsewhere. Furthermore, providing alternative education and occupational programs to youth who have dropped out of school or who are at risk for dropping out may facilitate positive outcomes. Fourth, it is also recommended that both a youth shelter and a youth drop-in centre be developed in Fredericton. These two services could be connected to provide an array of services to youth, both for youth residing at home and to those who are currently experiencing homelessness. Finally, regardless of the services that are implemented, ongoing evaluations should be conducted to examine effectiveness, identify barriers, and facilitate modifications (i.e., improvements) of programming. These evaluations should optimally go beyond maintaining records of the overall number of people in contact with the program and include standardized and unstandardized measures.

Bridging the Gap: A Needs Assessment of Vulnerable Male Youth in Fredericton

It has been estimated that at some point each year, approximately 65,000 youth are homeless (Raising the Roof, 2009). This is likely an underestimate, as it is often challenging to identify individuals who may not be on the streets or in a shelter at any single point in time but who otherwise do not have a safe or stable living situation. Although youth might “choose” to become homeless as a form of coping with difficult life circumstances (Coates & McKenzie-Mohr, 2010; Hyde, 2005), a significant segment of homeless youth may have been asked to leave home, referred to as being “thrownaway” by Ringwalt, Greene, and Robertson (1998). Youth homelessness is increasingly being recognized as a significant concern across Canada and as unique to homelessness among adults (Calgary Homeless Foundation, 2011). As highlighted in Calgary’s *“Plan to End Youth Homelessness”*, youth are often still at a crucial (and precarious) developmental stage when they become homeless, often not having completed their formal education or the opportunity to learn essential independent living skills (e.g., work skills, cooking, money management) and, as a consequence, often having unique difficulties and unaddressed needs (Calgary Homeless Foundation, 2011).

Factors that have consistently been identified as leading to homelessness or increasing the risk of youth becoming homeless are mental health problems, substance use, family problems, and abuse or other trauma (Edidin, Ganim, Hunter, & Karnick, 2012; Hyde, 2005; Mallett, Rosenthal, & Keys, 2005; Martijn & Sharpe, 2006). In adolescence, experience of victimization, as well as family relationship difficulties and problems in academic performance, were found to predict homelessness in late adolescence and emerging adulthood (van den Bree et al., 2009). Furthermore, youth at risk for homelessness have also been found to have high rates of contact with the criminal justice system (Cameron, Racine, Offord, & Cairney, 2004). Edidin and

colleagues also emphasized that individuals who “age out” of the foster care system may be a specific at-risk group for experiencing homelessness, often due to a lack of both financial and social supports in place to help them live independently.

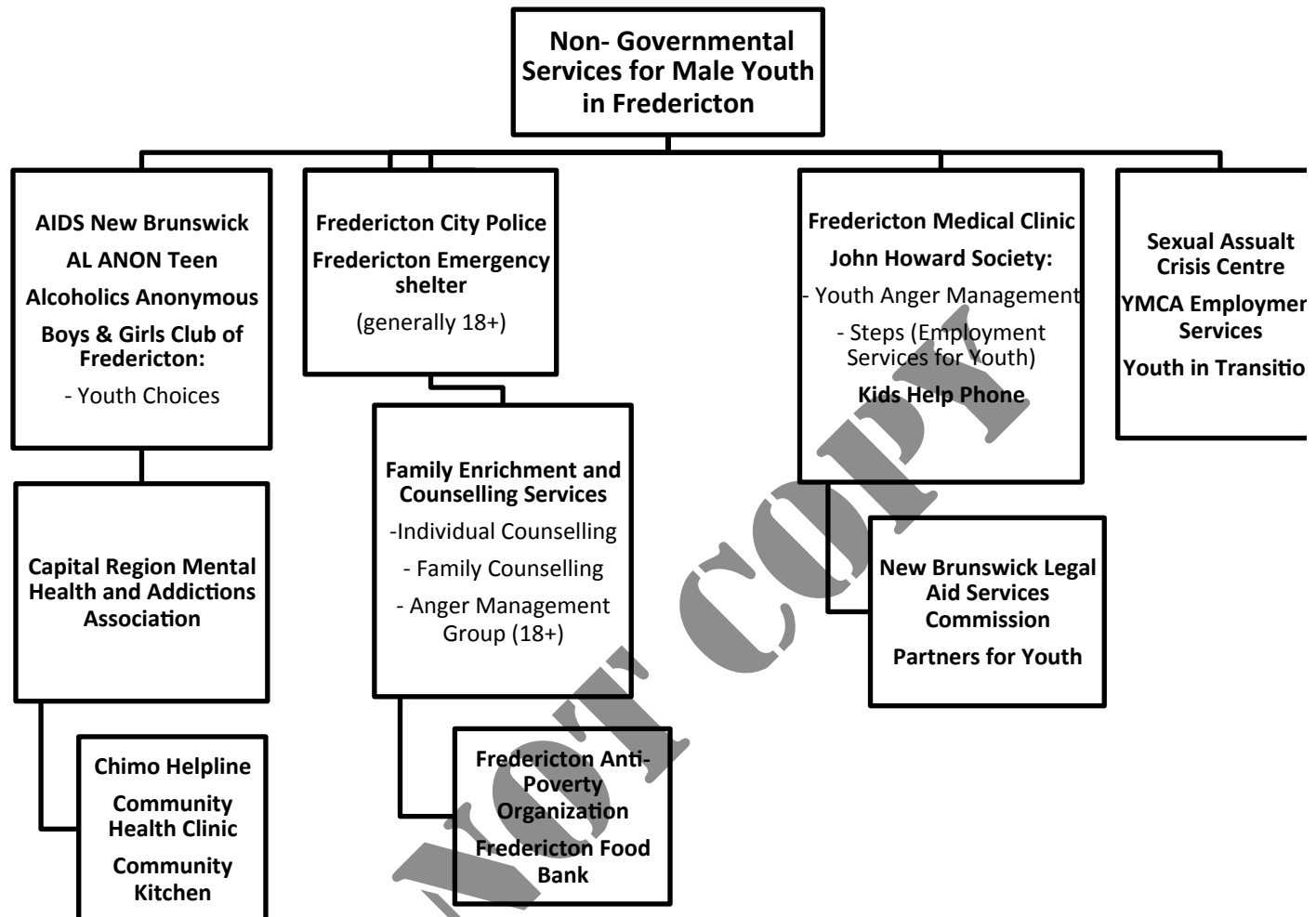
Youth homelessness can have a wide range of significant negative outcomes beyond having unstable living situations, including poor academic achievement, cognitive functioning deficits, substance use, poor physical health (e.g., sexually transmitted infections), and mental health disorders (Edidin et al., 2012). Homeless youth report significantly more behavioral and emotional problems and less emotional support from their parents than do non-homeless youth (Dadds, Braddock, Cuers, Elliott, & Kelly, 1993). In addition, homeless youth have been found to experience high rates of trauma (Coates & McKenzie-Mohr, 2010; Edidin et al., 2012; Keeshin & Campbell, 2011; Martijn & Sharpe, 2006). Although some of these difficulties may be resolved once the youth are no longer homeless, there are frequently long-term residual impacts, which are compounded by the fact that few homeless youth seek help for their concerns (Edidin et al., 2012). This provides further rationale for targeting risk factors in adolescence, that is, to prevent vulnerable youth from becoming homeless as adults.

Bronfenbrenner’s ecological systems theory (1979) and revised bioecological systems theory (2005) have commonly been used to explain influences on child and adolescent behavior in general and are valuable in understanding the experience of vulnerable youth in particular. These theories highlight the importance of considering not only individual factors, but the context in which youth are embedded to gain a more complete understanding of individual experiences. Bronfenbrenner (2005) proposes that youths’ behavior is influenced by the reciprocal interaction between individual factors (e.g., genetics, personality, individual adjustment) and environmental factors (e.g., family relations, peer relations, academic

performance, social and cultural norms, governmental policies). Consistent with the bioecological systems theory, youth homelessness is most likely to occur when both individual and environmental risk factors are present. It is also critically important to consider community and social policy factors when examining the issue of homelessness because these factors at least indirectly influence the experience of the youth and the services available to them.

Relevant Services in the Fredericton Area

Although it is outside the scope of this project to provide an exhaustive evaluation of specific agencies and services (for reviews, see Coates & Neate, 2000; Richard, 2008), it is important to understand the most relevant services that are officially available to youth in the Fredericton area. Information about available services is often not made readily public (e.g., through the Internet), thus making it difficult to identify the scope, limitations, and duplication of such services. As shown in Figure 1, there is an array of relevant governmental and nongovernmental agencies that have been working with youth in some capacity. However, it is not clear whether these agencies sufficiently meet the needs of male youth.



Primary prevention agencies. Primary prevention encapsulates services that are universally provided to youth (usually at early ages) to decrease the likelihood of potential future problems (e.g., delinquency, school drop-outs, homelessness). The scope of primary prevention would include the Boys and Girls Club and YMCA as well as programming in schools and in the larger community. Although primary prevention is relatively inexpensive and quite effective overall, it does not eliminate the need for more intensive services.

Secondary prevention agencies. Secondary prevention (early intervention) targets services toward youth who are considered at risk based on identifiable risk factors (e.g., low socioeconomic status, family on social assistance). Relevant programs and agencies include AL ANON, Community Health Clinic, Community Kitchen, Fredericton Anti-Poverty Organization, and Kids Help Phone.

Tertiary prevention (intervention) agencies. The most intensive services are provided to select youth who have had histories of serious problems (e.g., delinquency, homelessness) to attempt to ameliorate such problems or other related issues. Although some agencies deliver both secondary and tertiary services, much of the attention is focused on the latter. Public and municipal agencies such as Fredericton police, Department of Public Safety, various mental health agencies, emergency shelters, John Howard Society, and Youth in Transition usually have the most interaction with youth with serious problems.

Current Circumstances in New Brunswick

Although not unique to New Brunswick, a “service gap” for 16- to 18-year-old male youth has been identified between the child and adult service systems (Coates & McKenzie-Mohr, 2010; Coates & Neate, 2000; Richard, 2008). This literature has highlighted that arbitrary age cut-offs prevent many youths from receiving a variety of different services (Richard, 2008).

Despite the fact that this gap has been identified as a critical need for over a decade, it still remains to be addressed. Although changes to the Family Services Act in New Brunswick in 2010¹ clearly placed responsibility for care of individuals in this age group on the child protective services system, the changes to service provisions appear to be minimal. In addition, there is still no assistance for those in transitioning from the child to adult service systems, as the types of services and the criteria do not necessarily correspond. As noted by one community agency representative who has worked with such youth, many of whom had histories of abuse, “[w]hen they age out, they are chronologically 18, but intellectually and emotionally they are certainly much younger.”

Specific concerns that have been identified for homeless youth include lack of services, poor access to services (e.g., long waiting lists, lack of knowledge/information about available services), limited appropriate housing, and lack of employable skills (Coates & Neate, 2000). There are currently no shelter or transitional beds designated for male youth in the Fredericton area. Despite specific recommendations made by Coates and Neate to deal with the youth homelessness issue, these concerns have not been directly targeted.

The Present Study

To investigate the “service gap” and unmet needs of male youth 16 to 18 years old who have been or who are vulnerable to homelessness, a comprehensive needs assessment was conducted. The three main goals of the needs assessment were to: 1) identify the needs of male youth who have experienced homelessness or who are vulnerable to homelessness; 2) assess the services typically used by this population; and 3) identify whether there are any additional

¹ The relevant statute of Family Services Act (2010, c.8, s.5) now states:

29.2 In this Part, a child who has reached 16 years of age, unless the child is a disabled person, may refuse any protection service established in this Part or by virtue of any regulation created under this Part, unless otherwise ordered by a court.

services that may be beneficial. Secondary aims for the present study will be to describe general characteristics of vulnerable male youth in Fredericton and to investigate the use of participatory research with this population. In following from Bronfenbrenner's model, individual factors (e.g., psychological problems, substance use), family relationships, peer relationships, social support, traumatic experiences, school performance, and use of services in the community were investigated.

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Method

Participants

The focus of this project was to identify service needs of homeless or otherwise vulnerable male youth, ages 16 to 18 years, who lived in the Fredericton, New Brunswick area. Consistent with the United States Department of Education (2000) guidelines on youth homelessness, we recruited youth who were: living in shelters, on the streets, or in abandoned buildings or in other facilities unfit for human habitation; without an adequate home base (stable, with appropriate shelter and amenities) that serves as a permanent home; or living with friends or relatives because they cannot stay at home. In addition, consistent with the research literature on youth homelessness (e.g., Cameron et al., 2004; Coates & McKenzie-Mohr, 2010; Keeshin & Campbell, 2011), youth who were considered to be vulnerable to homelessness were recruited if they were previously homeless or had a history of running away from home; had a history of abuse; or were involved in delinquent or criminal activity.

Procedure

Participatory research. This study utilized an approach known as participatory (action) research, which focuses on involving members of the target population (i.e., vulnerable male youth) in the research process. In the present study, members of the study population helped recruit participants and collect the data. The rationale behind this approach is that more informed research can be conducted when those who will be affected by the results are involved in its design and implementation (Dallape, 1996). The benefits of participatory research include allowing participants to develop critical thinking skills, learn about a particular area, and contribute to the community (Foster-Fishman, Law, Lichty, & Aoun, 2010). Previous research has shown that this approach can be effectively implemented with socially marginalized groups

who may be less likely to seek help (Power, 2002), and can help empower youth (Kefyalew, 2007).

In this study, three male youth who fit the criteria for participation in the study were hired as youth Research Assistants (RAs) and were involved in recruitment, data collection, and data entry. They were recruited through community organizations and completed one week of training (i.e., 20 hours) in basic research methods and interviewing skills prior to beginning data collection. In addition, ongoing supervision and training was provided in the field on a daily basis. RAs worked for 16 weeks, primarily recruiting participants and collecting data from them. Towards the end of the study, the RAs assisted with data entry.

Recruitment. The original aim of the study was to recruit 200 participants. Four primary recruitment strategies were utilized: (1) advertisement through posters placed in various locations around Fredericton and on the Internet (e.g., kijiji, Facebook); (2) informing community organizations (e.g., Department of Public Safety, Department of Social Development, John Howard Society) that work with vulnerable male youth about our study and asking them to pass on information about the study; (3) word of mouth through our research assistants and study participants; and (4) solicitation of qualified youth in public.

The overwhelming majority of participants were recruited through word of mouth (mainly through the research assistants) or by public solicitation. Many participants were solicited during business and early evening hours in the downtown area (e.g., Kings Place Mall, Victoria Health Centre), although other areas of recruitment included the Northside, along Prospect Street, and the Regent Mall. Few youth contacted the researchers through advertisements or referrals from community organizations. Of the few who contacted research staff, only five ultimately participated in the study.

Once potential participants were identified, they were screened by either the co-investigator (for participants recruited through the advertisements or community organizations) or one of the research assistants (for participants approached in the community) to verify that they met the study inclusion criteria. If an individual was deemed eligible to participate, he was informed about the study protocol. Individuals who were interested in participating provided informed consent. Although parental consent is typically required for individuals under 18 years of age, we recognized that this would not be appropriate for all members of our study population. We anticipated that because some of the participants would be estranged from their family or have highly conflictual relationships with them, it would not be appropriate to require parental consent. Therefore, although all participants were asked if we could seek parental consent, individuals were able to provide their own consent.

Data collection. This study utilized both self-report questionnaires and a semi-structured interview to collect information from participants. Specifically, consistent with an ecological model of youth development (Bronfenbrenner, 2005), participants completed a series of standardized questionnaires assessing individual adjustment, family relations, peer relations, and academic performance. These questionnaires were completed anonymously to encourage honest reporting of sensitive variables such as substance use, delinquency, and trauma experiences. After completing the questionnaires, participants were interviewed by the research assistants to learn about their vulnerability factors, service use and experiences, desired services, and social support. Participation took approximately 45 minutes, and participants each received a \$15 gift card in exchange for their time.

Measures

Demographic information. Participants provided information about their age, race, primary language, location of present residence, and employment status. During the interview, participants were asked to identify their status related to vulnerability (e.g., previous or current homelessness, involvement with the juvenile justice system, involvement with Child Protective Services). They were also asked about their biological parents' marital status and parental employment.

Individual adjustment.

Conners Clinical Index (Conners, 2008). The Conners Clinical Index (Conners CI) is a 24-item screening measure of mental health concerns in child and adolescent populations. Items were rated on a 4-point scale ranging from 0 (*Not at all true*) to 3 (*Very much true*), and item scores were summed for one of five subscales: Disruptive Behavior Index, Mood Disorder Index, Anxiety Disorder Index, Attention Deficit-Hyperactivity Index, and Language and Learning Disorder Index. Each subscale consists of five items, and scores range from 0 to 15, with higher scores indicating greater levels of concern in a particular area. Norms based on age and sex are provided for each subscale (Conners, 2008). Although the Conners CI cannot be used to diagnose psychiatric disorders, scores can be used to classify individuals into one of five levels: low, average, high average, elevated, and very elevated.

Rosenberg Self-Esteem Scale (RSES; Rosenberg, 1965). The RSES is a 10-item questionnaire that assesses respondents' global self-esteem. Participants responded to items on a 4-point scale ranging from 1 (*Strongly disagree*) to 4 (*Strongly agree*), with higher summed scores indicating greater self-esteem. Total scores range from 10 to 40. The RSES has been

found to have high internal consistency ($\alpha = .85$ to $.86$) for adolescent male samples (Bagley, Bolitho, & Bertrand, 1997; Bagley & Mallick, 2001).

The Satisfaction with Life Scale (SWLS; Diener, Emmons, Larsen, & Griffin, 1985).

The SWLS is a 5-item questionnaire that assesses individuals about their current overall satisfaction with life. Each item was rated on a 7-point scale ranging from 1 (*Strongly disagree*) to 7 (*Strongly agree*), with total (summed) scores ranging from 5 to 35. Higher scores indicate greater satisfaction with life. Scores can be classified into one of six categories: extremely dissatisfied, dissatisfied, slightly below average, average, high, and highly satisfied. The SWLS has high internal consistency ($\alpha = .87$) and two-month test-retest ($r = .82$) reliabilities (Diener et al., 1985).

Self-Report Delinquency Scale – Revised (SRD-R; Piquero, MacIntosh, & Hickman, 2002). The SRD-R is a 9-item questionnaire used to determine the frequency of various delinquent behaviors (e.g., running away from home, disorderly conduct) in the past year. Each item was rated from 0 (*Never*) to 9 (*2 to 3 times a day*), for a total (summed) score ranging from 0 to 81, with higher scores indicating more delinquent activity.

Substance Use Scale. The Substance Use Scale was created for the purposes of this study and assessed participants' lifetime and monthly use of 14 different substances (e.g., alcohol, marijuana, cocaine). In addition, the scale assessed participants' age at which they first used each substance as well as reasons for beginning substance use.

Family relations.

Family Adaptability and Cohesion Evaluation Scales (FACES-IV; Olson, Gorall, & Tiesel, 2006): ***Family Satisfaction Scale (FSS)*** and ***Family Communication Scale (FCS)***. The FSS and FCS are each composed of 10 items, and are part of the larger FACES-IV. The FSS

assesses individuals' overall satisfaction with their family, including with the family's levels of cohesion and flexibility. Items were rated on a 5-point scale from 1 (*Very dissatisfied*) to 5 (*Very satisfied*). Total scores range from 5 to 50, with higher scores indicating greater levels of satisfaction. The FCS relates to how openly individuals believe their family communicates with each other. Items are responded to on a 5-point scale from 1 (*Strongly disagree*) to 5 (*Strongly agree*), with total scores ranging from 5 to 50. Higher scores indicate more open family communication. Scores on both the FSS and FCS can be classified into one of five categories: very low, low, moderate, high, and very high. The FCS and FSS were normed on a national sample of over 2,400. The FSS has very high internal consistency ($\alpha = .92$) and test-retest reliability ($r = .85$). The FCS also has high internal consistency ($\alpha = .90$) and test-retest reliability ($r = .86$).

Peer relations. Participants were asked how many close friends they currently had. They were also asked two items to indicate their perceived satisfaction with their peer relationships (from *very unsatisfied* to *very satisfied*) and perceived value of their peer relationships (from *not at all important* to *very important*).

Social support. During the semi-structured interview, participants were asked if they had any individuals that they could go to for support, and if so, whom. In addition, if not already mentioned, participants were specifically asked if they had any *adults* that they could go to for support, and if so, whom. Finally, participants were asked if they were satisfied with their current amount of social support.

Trauma experiences.

Trauma Experiences Questionnaire. This questionnaire is composed of questions from the National Longitudinal Study of Adolescent Health (Add Health). It includes items about the

occurrence and frequency of different types of victimization (e.g., bullying, assault, physical abuse, neglect, emotional abuse, and sexual abuse) committed by peers, adult caregivers, and other adults. It also asks about past involvement with Child Protective Services and if the participant has ever been removed from their home.

Academic achievement. Participants completed three items about their current academic achievement. They were asked about the highest year that they had completed at the time of the study. Participants also were asked how often they were currently attending school (or had attended the last time that they were in school). Finally, participants reported their current (or most recent) grades in school.

Service use. During the interview, participants were asked in an open-ended format the services that they had ever used in Fredericton. They were prompted to consider housing or shelter services, food services, therapy or counselling, and specific programs (e.g., anger management, Youth Choices), and they were then asked if there were other services not already mentioned that they had used. Participants were subsequently asked whether or not they had experienced any difficulties accessing services and, if so, the specific details regarding such difficulties. Finally, participants were asked to identify services they felt would be beneficial to have in Fredericton.

Results

Demographic Information

Data were collected from 197 participants. However, 10 of these individuals did not meet the age criteria for the study (i.e., were younger than 16 or older than 18 years old) and thus were removed from analyses. In total, 187 participants were included in the results (see Table 1). Our sample included over two times the expected percentage of First Nations or Metis in the population of New Brunswick (Statistics Canada, 2006). Regarding primary language, our sample seems representative of recent census data (2011), which noted that Fredericton is represented 86.7% by Anglophones, 7.0% by Francophones, and 5.1% by others.

Table 1. Demographic Information

Characteristic	%
Ethnicity	
Caucasian/White	70.7
First Nations/Metis	13.8
Black	3.7
Hispanic	3.2
Asian	2.1
Middle Eastern	1.1
Multiracial	2.1
Language	
English Only	81.3
Bilingual (English & French)	10.2
Bilingual (English & Other*)	5.3

(continued)

Characteristic	%
Primary Residence	
Northside Fredericton	36.9
Downtown Fredericton	31.0
Southside Fredericton	18.7
Outside Fredericton	8.0
Variable Locations	1.6
Employment Status	
Currently Unemployed, but Looking	32.6
Employed Part-time	29.4
Currently Unemployed, but Not Looking	21.4
Employed Full-time	8.0
Vulnerability Factors	
Ever Run Away From Home	64.3
Ever Been on Probation	59.8
Ever Been Homeless	50.5
Ever Been Involved with Child Protective Services	18.2
Dropped Out of School	11.8
* Other included Maliseet, Mandarin, and Mi'kmaq	

In comparison to the general population of New Brunswick, our sample was much more representative of children in need. For example, only 1% of New Brunswick youth are in probationary services, whereas our sample includes a much higher percentage. In 2011, 5,060 youth were in Child Protective Services, which represents a very small percentage of the overall child population. Furthermore, the school drop-out rate is 2% province-wide. Again, these rates are much different than what was found in our sample.

Participants were asked to provide select demographic information on their biological parents (see Table 2). According to census data for Fredericton (2011), 50.2% of the population

were married (not separated) and 8.1% of the population was divorced or separated. With regard to unemployment, the recent official rate in New Brunswick is 9.5% (Statistics Canada, 2011).

Table 2. Parental Demographic Information

Characteristic	%
Biological Parent Relationship Status	
Married	35.3
Divorced/Separated	22.5
Never Married	21.9
Widowed	6.4
Cohabiting/Common-law	2.1
Maternal Current Unemployment	32.6
Paternal Current Unemployment	19.8

Individual Adjustment

Mental health problems. Five symptom areas were assessed using the Conners CI: (1) disruptive behavior disorders, (2) mood disorders, (3) anxiety disorders, (4) attention deficit-hyperactivity disorders, and (5) language and learning disorders. Participant responses were compared to standardized population norms to determine how the symptoms of our sample relative to the general adolescent male population. See Table 3 for descriptive information for the Conners CI symptom areas.

Table 3. Conners Clinical Index Symptom Areas

Symptom Area	Subscale Score	Average
	<i>M (SD)</i>	Symptom Level*
Disruptive Behavior Disorders	4.71 (3.47)	High Average
Mood Disorders	4.14 (3.90)	High Average
Anxiety Disorders	5.16 (3.53)	High Average
Attention Deficit-Hyperactivity Disorder	4.50 (3.41)	Average
Language & Learning Disorders	5.13 (3.83)	Average

*As compared to the general population

The symptom levels of disruptive behavior disorders, mood disorders, and anxiety disorders were all higher in our sample than expected norms in the general adolescent male population. The present sample reported levels of attention deficit-hyperactivity disorder symptoms and language and learning disorder symptoms similar to those of adolescent males in general. Figures 2 to 6 show the sample distributions across severity levels for the five symptom areas relative to population norms.

Figure 2. Percentage of Participants at Each Symptom Level for Disruptive Behavior

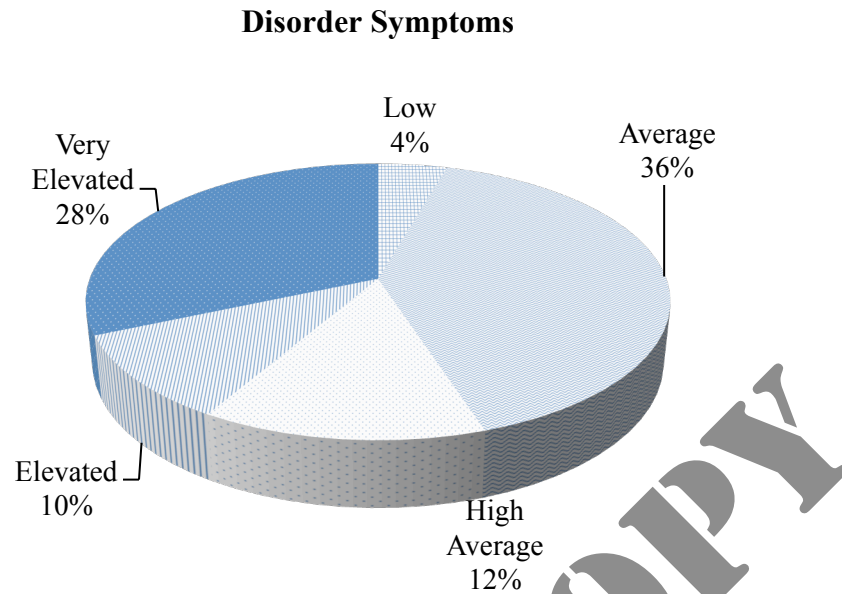


Figure 3. Percentage of Participants at Each Symptom Level for Mood Disorder Symptoms

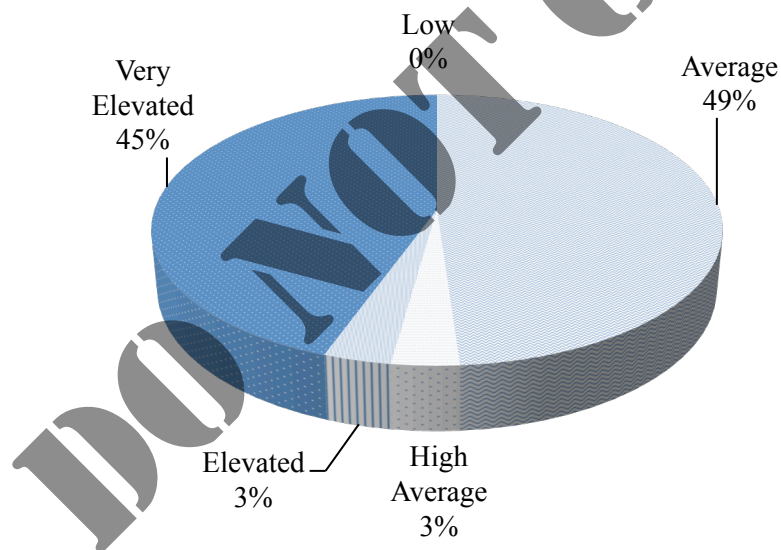


Figure 4. Percentage of Participants at Each Symptom Level for Anxiety Disorder

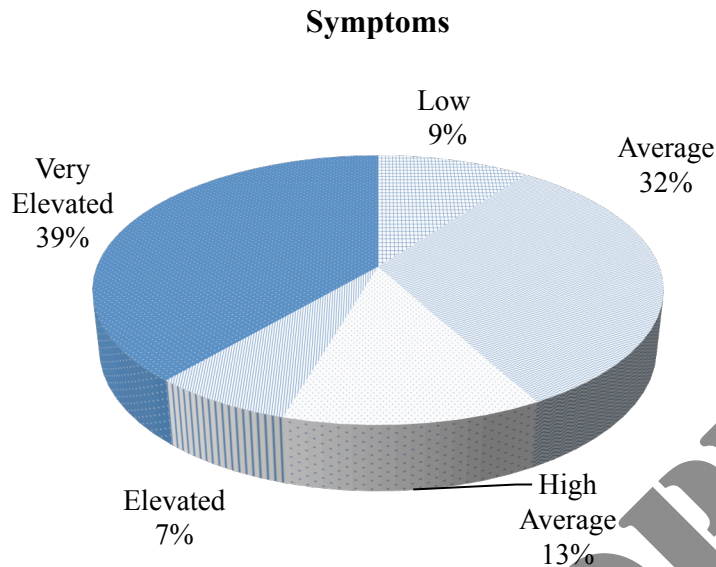


Figure 5. Percentage of Participants at Each Symptom Level for Attention Deficit-Hyperactivity Disorder Symptoms

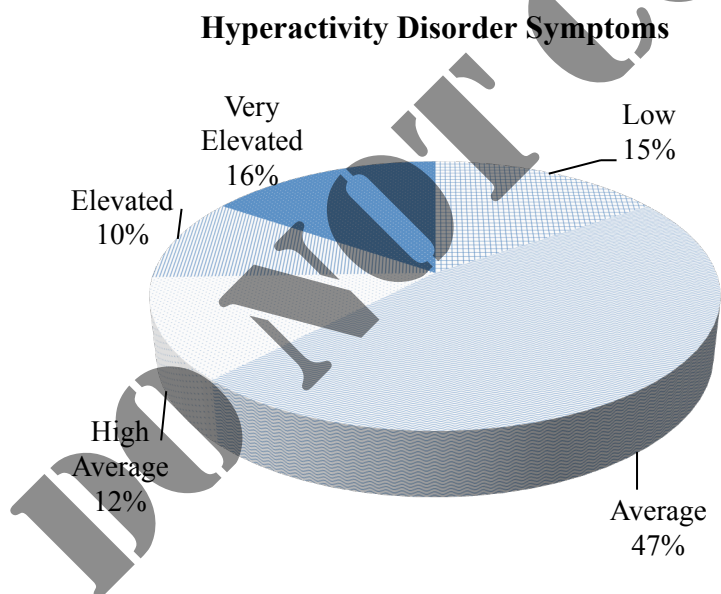
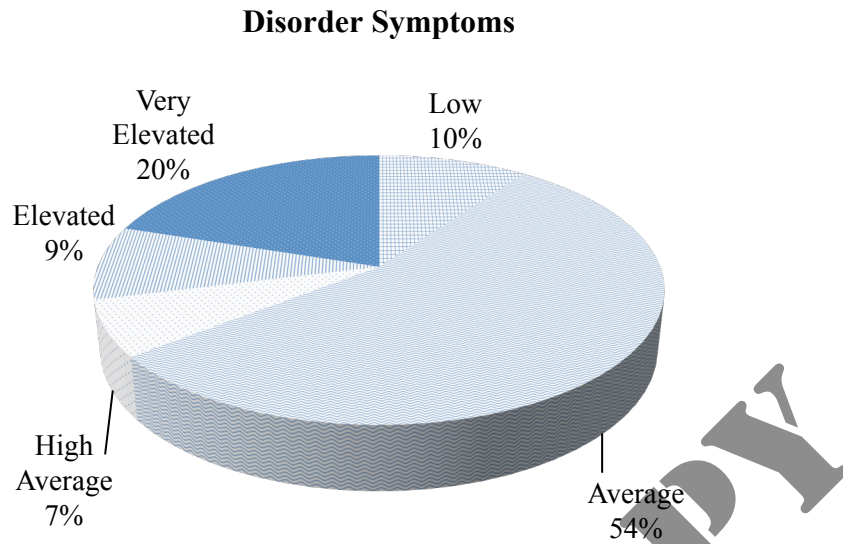


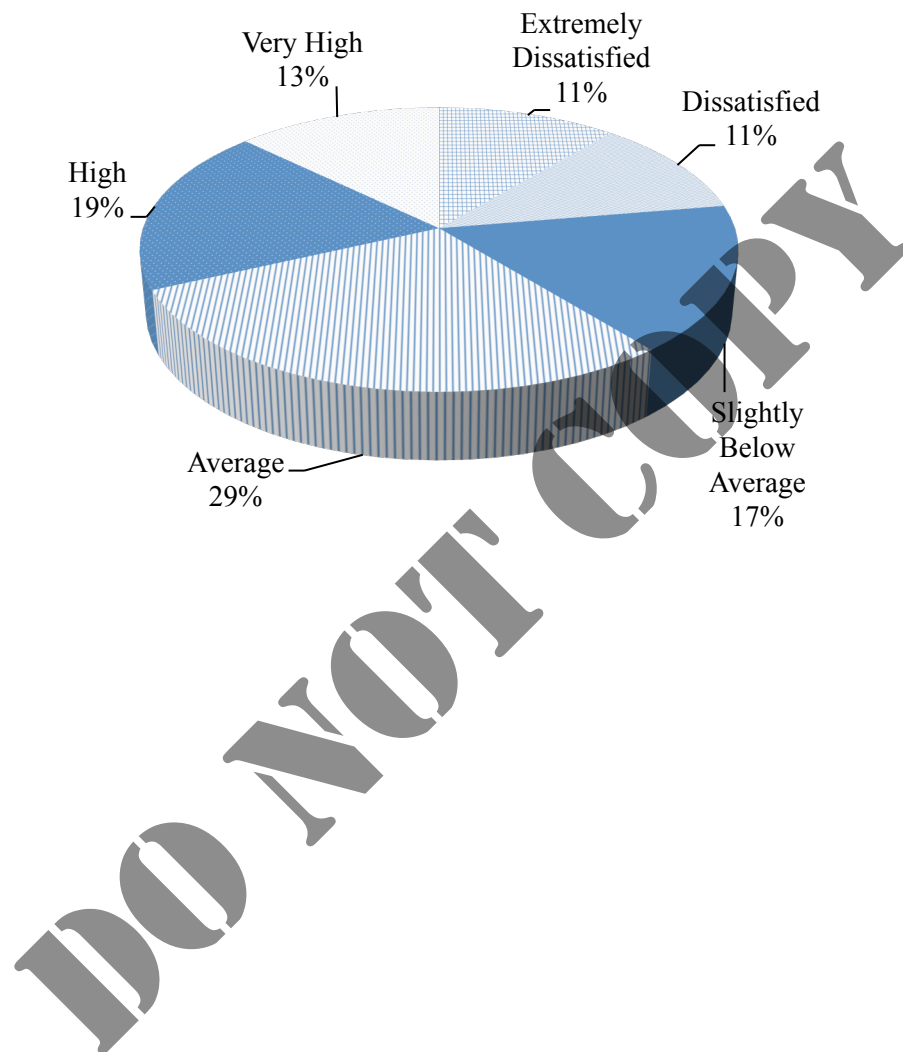
Figure 6. Percentage of Participants at Each Symptom Level for Language & Learning



Self-esteem. The mean score reported for self-esteem was 27.73 ($SD = 5.18$), which is lower than the mean level reported for male high school students in the general population ($M = 30.88$ for 16- and 17-year-olds, $M = 31.59$ for 18- and 19-year olds; Bagley et al., 1997). In addition, 7.1% of the present sample reported “very low” self-esteem, which is defined by Bagley and colleagues as a score lower than 21.

Satisfaction with life. Overall, participants reported an “average” level of satisfaction with their lives ($M = 20.34$, $SD = 7.75$) compared to ratings in the general population. The distribution of participants across different levels of satisfaction is shown in Figure 7.

Figure 7. Distribution of Participants Across Different Levels of Satisfaction with Life



Self-report delinquency. Participants reported engagement in a variety of delinquent behaviors over the past year ($M = 9.62$, $SD = 10.87$). The percent of participants engaging in each delinquent act and the frequency in which youth engaged in these acts can be found in Table 4.

Table 4. Frequency of Delinquent Behaviors Engaged in During Past Year

Delinquent Act	Never	Less Than Once per Month	Once per Month or More	Once a Week or More
Run Away from Home	61.0%	31.7%	2.8%	4.6%
Stealing	37.9%	20.4%	16.9%	24.9%
Assault with Intent to Cause Serious Harm	59.2%	27.4%	10.1%	3.4%
Involved in Gang Fights	73.0%	19.7%	5.6%	1.8%
Hit (or Threatened to Hit) a Parent	72.1%	21.8%	2.8%	3.3%
Disorderly Conduct	43.3%	21.9%	23.6%	11.2%
Taking a Car for a Ride Without Permission	58.1%	31.8%	6.7%	3.4%
Use of Force to Get Things From an Adult	75.8%	15.7%	4.4%	3.9%
Begged for Money From Strangers	71.3%	14.7%	6.7%	7.3%

Substance use. Substance use was very common among the youth who participated in the study. Specifically, the average number of substances EVER used was 4.72 ($SD = 3.02$), with responses ranging from no substances used to 14 distinct substances used. The vast majority of the sample (86.7%) had used at least two substances in the past month, and nearly half of participants (49.7%) had used at least two substances other than alcohol and tobacco in the past month. Lifetime and past month use for the most common substances are presented in Table 5. Youth were also asked about the reasons why they began using drugs. The most common responses were because of curiosity (68.8%), to get “high” (46.5%), or they were encouraged by friends (36.9%).

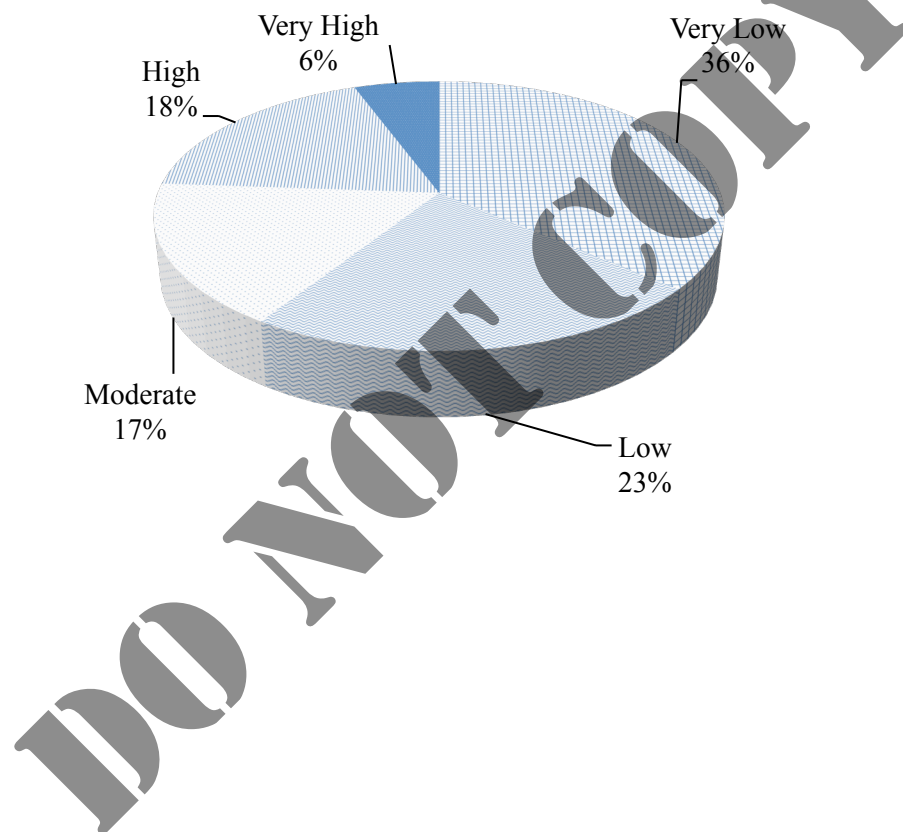
Table 5. Most Common Substances Used

Substance	% Ever Used	Age When First Used <i>M (SD)</i>	% Used At Least Once Per Week (In Past Month)	% Used Daily (In Past Month)
Marijuana	89.4	13.25 (1.61)	79.8	53.8
Alcohol	35.3	13.13 (1.65)	40.7	5.2
Tobacco	22.5	13.19 (1.69)	69.0	61.4
Mushrooms	21.9	14.87 (1.17)	9.6	-
Ecstasy	6.4	14.85 (1.16)	10.3	-

Family Relations

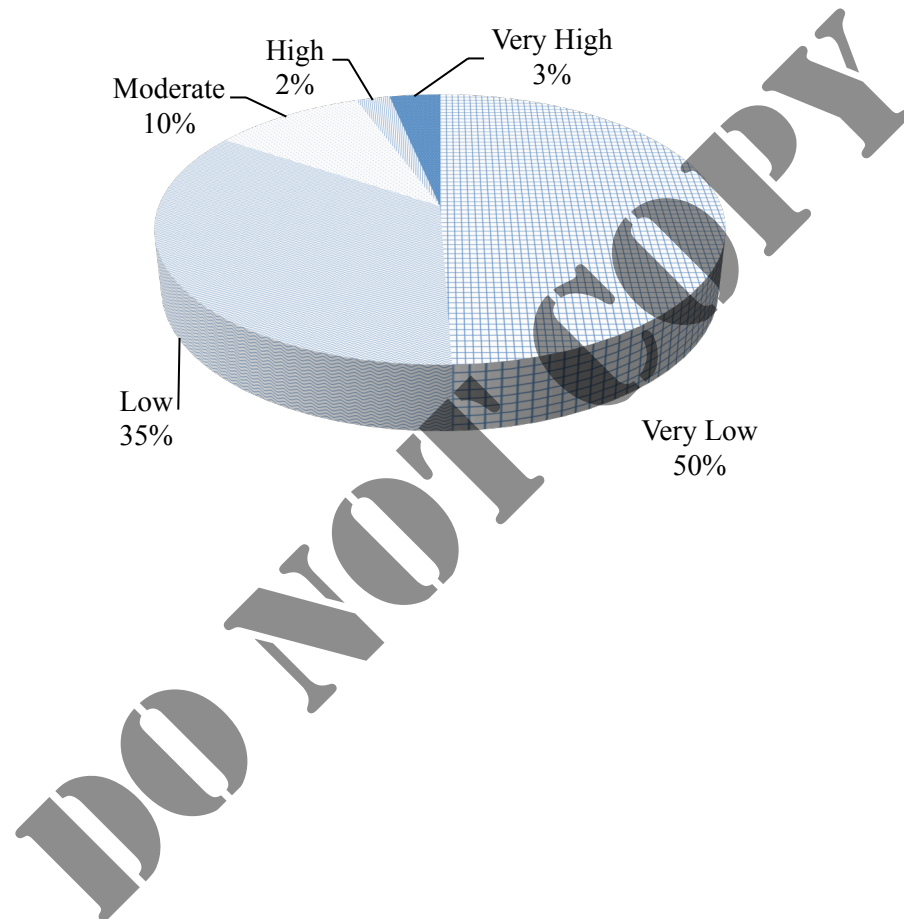
Participants were asked about their family's *communication* patterns and their *satisfaction* with their family relationships. Participants reported that, on average, their families had “*low*” levels of open communication, compared to families in the general population ($M = 30.32$, $SD = 9.36$). Figure 8 shows the breakdown of the samples' communication levels relative to norms in the general population.

Figure 8. Percentage of Participants Reporting Each Level of Family Communication



Participants were also asked about their *satisfaction* with their family relationships, specifically in terms of cohesion (i.e., emotional warmth) and flexibility (i.e., ability to handle stressors). Overall, participants reported “*very low*” levels of satisfaction, compared to the general population ($M = 27.68$, $SD = 9.06$). Figure 9 displays the percentage of the sample that reported each level of satisfaction relative to norms in the general population.

Figure 9. Percentage of Participants Reporting Each Level of Family Satisfaction



Peer Relations

Over half of the participants (57.5%) indicated that they were either “*satisfied*” or “*very satisfied*” with their current relationships with friends, and an additional 21.5% were “*somewhat satisfied*”. Participants also reported that friendships were quite important to them; 21.5% indicated “*somewhat important*”, 32.6% said “*important*”, and 26.2% chose “*very important*”. There was wide variety in the number of close friendships participants reported having; results are shown in Table 6.

Table 6. Number of Close Friendships Reported

	%
None	11.5
1 or 2	25.5
3 to 5	29.0
6 to 9	9.6
10+	20.5

Note. Percentages do not sum to 100% because some respondents provided only descriptive labels (e.g., a lot, few).

Social Support

Most participants (83.2%) reported that they had at least one person in their life that they could go to for support and 76.4% had at least one supportive adult in their life. However, only 68.6% of participants indicated that they felt that they currently had enough support. As noted in Table 7, participants were most likely to report friends as their source of social support.

Table 7. Supportive Individuals in Participants' Lives

	%*
Friends	42.6
Family (in general)	27.6
Father	10.8
Mother	9.6
Girlfriend	9.0
Grandparent(s)	6.0
Brother	5.4
Other Adult ⁺	4.8
Friend's Parent	1.8

* Participants could endorse multiple categories

⁺ Included family friend, coach, teachers, and staff

Traumatic Experiences

Participants reported experiencing a range of traumatic experiences involving caregivers, peers, and others. As demonstrated in Table 8, most youth reported at least some peer rejection or violence. Furthermore, although physical maltreatment by caregivers was uncommon, the majority of youth reported at least some emotional abuse by caregivers.

Table 8. Lifetime Frequency of Traumatic Experiences

Experience	Never	1 to 2 Times	3 to 5 Times	6 to 10 Times	More Than 10 Times
Peer Rejection or Exclusion	24.0%	28.5%	14.0%	10.1%	23.5%
Peer Physical Violence	27.9%	30.1%	18.4%	10.6%	12.8%
Emotional Abuse by Parent/Caregiver	43.6%	28.5%	10.1%	7.3%	10.6%
Physical Abuse by Parent/Caregiver	70.2%	20.8%	5.1%	1.7%	2.2%
Neglect by Parent/Caregiver	75.8%	15.8%	5.1%	1.1%	2.2%
Sexual Abuse by Parent/Caregiver	87.0%	7.9%	2.3%	1.7%	1.1%
Sexual Abuse by Other Individual	83.8%	8.4%	2.8%	3.4%	1.7%

Academic Performance

The highest year on average that participants had completed at the time of participation was grade 10 ($M = 10.17$, $SD = 1.24$). Responses ranged from a low of grade six to completion of high school. Participants reported a wide range both in terms of how often they attended school or an alternative education program (i.e., Enterprise) as well as their current or most recent academic performance (see Table 9).

Table 9. Participant School Attendance and Academic Performance

	%
Current School Attendance*	
Most Days	24.1
Almost Every Day, for the Whole Day	17.1
About Half of the Time	15.5
Dropped Out	11.8
Almost Every Day, but for Only Part of the Day	11.2
Grades	
80% - 90%	7.5
70% - 80%	18.7
60% - 70%	30.5
50% - 60%	14.4
Below 50%	19.3

*Note. These are the most common responses.

Previous Service Use

When asked about services used in Fredericton, participants reported an average of 1.12 services ($SD = 1.03$, range 0-4). Almost one-third of participants had never used any services (30.4%). Therapy or counselling was the most common type of service accessed (44% of participants). Specifically, respondents reported receiving such services from Addictions Services, Community Mental Health, Family Enrichment, and through private practitioners. Participants who had been on probation were more likely than participants who had not been on probation to have received therapy or counselling, $\chi^2(2) = 6.75, p = .009$.

The specific program that had been identified as being attended by the most participants was anger management (13.4% of participants). Other programs participants reported completing included Youth Choices, Youth Options, Enterprise, job preparation, and social skills training. Overall, 6% of the sample reported using the Men's Shelter. In addition, respondents reported receiving food services through the Community Kitchen (16.5%), the Fredericton Food Bank (7.5%), and the John Howard Society (3.1%).

An important finding was that one-quarter of participants had experienced some degree of difficulty in gaining access to services in Fredericton. Long waiting lists was mentioned for several different services, including Community Mental Health, Addiction Services, and Enterprise. The most common specific difficulty, reported by 7.8% of the sample, was being denied access to the Men's Shelter due to being too young. Other participants noted that they had experienced difficulty getting on social assistance and had not been able to get food from the food bank as often as they would have liked. It should also be noted that of the participants who had never used services, some reported never attempting to use services, either because they did

not think that they needed any services or because they did not know what services were available, whereas others reported being unsuccessful when attempting to access services.

Alternative Services Requested by Participants

Participants were asked about the types of new services they would like to see in Fredericton. They were asked about the broad categories of housing/shelter, education or work, and mental health, and then were asked about other ideas for services that had not already been mentioned. In terms of housing/shelter, 39.2% indicated that they believe new services are needed. Specifically, participants discussed creating a teen shelter, or allowing teens to stay at the adult shelter and making sure there is enough room for them. In addition, some mentioned free or low-rent housing that teenagers could access. Overall, participants put more emphasis on more transient housing that they could access if they did not have somewhere else to go on a particular night, rather than longer-term options.

When asked about new education or work services, 19.8% of participants indicated that new services are needed. No specific novel education services were reported, but participants desired more access to existing alternative education programs, such as room for more students in Enterprise, or another location at Leo Hayes High School. In addition, participants reported that it would be helpful to have access to more resources or help in the regular school system so that they would be better able to succeed. Having smaller class sizes was the only specific example given in terms of what would be helpful to them. Suggestions for new work services were employment counsellors for teenagers and programs that can help youth obtain jobs or work skills training.

Eleven percent of participants reported that new mental health services would be beneficial. Specifically, suggestions of another location for mental health or addictions services

(on the “Northside”) or more staff at existing locations were made. There were also suggestions made for more drop-in or casual counselling services that youth could access as needed. Finally, 16.5% of participants indicated other services that they would like to have in Fredericton. These suggestions varied widely, including cheaper transportation, mentoring services, and another food bank. Several related suggestions concerned a teen drop-in or recreation centre; participants mentioned a free gym, a place to meet new people, some place where one could “drop in and hang out”, and a new skate park.

Discussion

Male youth in the Fredericton area who were homeless or vulnerable to homelessness ($n = 187$) completed standardized questionnaires and a semi-structured interview as part of a comprehensive needs assessment. As previously mentioned, the three main goals of the needs assessment were to identify: 1) the needs of male youth who have experienced homelessness or who are vulnerable to homelessness; 2) services typically used by vulnerable male youth in Fredericton; and 3) alternative services that may be beneficial to this population. A secondary aim for the present study was to describe relevant characteristics of vulnerable male youth in Fredericton using a participatory research design. Consistent with Bronfenbrenner’s (1979, 2005) ecological systems theory, individual youth adjustment, family relations, peer relations, academic performance, and experience with accessing and using services in the community were all examined.

Participants were clearly vulnerable based on their reported range of experiences. Nearly two-thirds of the youth reported previously running away from home, over one half had been on probation, and approximately one half had been or currently were homeless. Moreover, nearly 20% had been involved with Child Protective Services, and 12% had dropped out of school.

Overall, youth in the present study seemed to represent the “fringe” of the general youth population, with many of them experiencing varying degrees of homelessness. Furthermore, we found what has been referred to as “hidden” homelessness (Canadian Alliance to End Homelessness, 2012): youth who were not living on the street or in a shelter but who had left or been forced to leave home and were “couch surfing” or staying with friends or extended family.

In accordance with our first main goal, we found that participants reported a wide range of difficulties that could be addressed with interventions. Consistent with findings in previous research (e.g., Dadds et al., 1993; Edidin et al., 2012), youth in the present study endorsed more mental health problems (i.e., disruptive behavior, depression, anxiety) than what is exhibited by male adolescents in the general population. In addition, youth in our study evaluated themselves more negatively compared to male youth in general population studies (e.g., Bagley et al., 1997); approximately 7% of participants reported “very low” self-esteem. However, participants reported average levels of overall satisfaction with life. Participants recounted a variety of delinquent activities over the previous year, with the most prevalent being stealing, disorderly conduct, taking a car without permission, and assault. Substance use was also very common; participants reported using an average of four different substances, most commonly marijuana, tobacco, alcohol, mushrooms, and ecstasy. This is consistent with previous research identifying both delinquency and substance use as significant problems among homeless or at-risk youth (e.g., Cameron et al., 2004; Edidin et al., 2012; Votta & Manion, 2004).

Because experiences with family, peers, and school can have a large effect on youth adjustment, it was important to examine youths’ reports of these experiences. Consistent with previous research (e.g., Dadds et al., 1993; Hyde 2005), participants reported poor family relationships (i.e., limited open communication and very low satisfaction). In the present study,

youth generally reported higher levels of satisfaction with their peers than with their families, and peer relationships were considered to be important by the majority of participants. There was wide variability in the number of close friendships reported, but the vast majority of participants reported having at least one close friend. Similarly, 83% of participants indicated that they had at least one person in their life to whom they could go for support, most commonly friends or family members. Approximately three-quarters of participants reported that they had a supportive adult in their life, and two-thirds of participants felt that they currently had enough support. Similar to what has been found in previous research (e.g., Coates & McKenzie-Mohr, 2010; Keeshin & Campbell, 2011), traumatic experiences were quite common in our sample; rejection or physical violence committed by peers were most common and had been experienced by the majority of participants. Furthermore, a substantial number of participants reported experiencing some form of maltreatment by parents or adult caregivers, including emotional abuse (most common), as well as sexual abuse perpetrated by someone other than a parent or caregiver. Rates of maltreatment in the present study were slightly lower than in some previous reports, although this is likely due to our sample including youth who were not presently living on the street or in a shelter. Finally, many participants indicated that they do not consistently attend school and are achieving low levels of academic performance, an issue that has been highlighted in previous research (Edidin et al., 2012).

To achieve the second main aim of the study, participants were asked about their use of relevant services in Fredericton. The number of different services used ranged from zero to four, with approximately one-third of participants indicating that they had never used any services. Of those individuals who had accessed services, therapy or counselling was the most common type of service received, particularly for participants who had been on probation. Participants also

reported attending specific programs (e.g., anger management, Enterprise), using food services (e.g., Community Kitchen, Food Bank), and the shelter. The pattern of service use among youth in our study differed from other research with homeless youth, in that our sample had lower service use than what has been reported previously (Carlson, Sugano, Millstein, & Auerswald, 2006). However, unlike research that has been done with youth who were currently homeless, much of our sample was currently still living at home. As such, our sample typically would not have had to use services to meet basic needs (i.e., food, shelter). Nevertheless, it is important to remember that the needs of youth shift quite suddenly when situations change. Overall, our sample may very easily experience situational stressors in which they would seek (or want) services. Indeed, research focusing exclusively on youth who were currently homeless was examining individuals who were under acute stress and thus more likely to access services. In contrast to the relatively low usage rates of services designed to address basic needs, the percentage of our sample that had received therapy or counselling is comparable to or higher than in previous reports (DeRosa et al., 1999; Pergamit & Ernst, 2010).

Service use also depends upon the type of services available in the community in which an investigation is being conducted. A recent study of homeless youth in three large cities found that street outreach services and food services were the most commonly used (Kort-Butler & Tyler, 2012). Previous research has also identified shelters and drop-in centres as being commonly utilized services (DeRosa et al., 1999; Pergamit & Ernst, 2010), but Fredericton does not have either a youth shelter or an official drop-in centre. There are places in Fredericton (e.g., Boys & Girls Club, YMCA, John Howard Society) where youth can access programs and resources consistent with some of those provided in drop-in centres. However, none of these organizations offer a combination of recreational activities and resources/services that youth can

access. What is consistent with the present study is that vulnerable youth do not often receive enough services to adequately address all of their needs (Kort-Butler & Tyler, 2012; Tyler, Akinyemi, & Kort-Butler, 2012).

One-quarter of participants reported some degree of difficulty in accessing services, including long waiting lists or being denied entry into places like the shelter because of age or other criteria. Although this level of difficulty is not consistent across locations (e.g., DeRosa and colleagues (1999) found that youth did not experience difficulty accessing services), this issue has been previously identified in Fredericton (Coates & Neate, 2000). Many of the same needs and issues reported by the present sample, including limited available services, poor access to services (e.g., long waiting lists, lack of knowledge/information about available services), lack of appropriate housing, and deficiencies in employable skills, were previously identified for homeless youth in Fredericton (Coates & Neate, 2000). Although we cannot provide specific details from the present study about why youth did not access services, other research (Pergamit & Ernst, 2010) found that homeless youth who are not accessing services are often not aware about the services that exist or know how to access them. It seems likely that low rates of service utilization in the present study are also due to lack of knowledge.

The third goal of the needs assessment was to identify alternative services that may be useful in Fredericton, which was determined by examining the results of the questionnaires as well as responses in the semi-structured interviews. Over one-third of participants felt it was imperative to have some type of shelter, either exclusively for teenagers or by allowing teenagers to access the existing one. Although low-rent housing was mentioned by a few participants, the majority mentioned more transitory housing solutions. In regards to other types of services, participants mainly commented on increasing access to the types of services that currently exist,

such as Enterprise (an alternative education program) or those from the Department of Mental Health, perhaps by having multiple locations or more staff. Another theme that arose from participant responses was some kind of youth recreation/drop-in centre. A substantial number of participants wanted recreation activities and a place to “hang out”, but some also mentioned services such as drop-in counselling or a mentoring program.

Use of Participatory Research

All three of the hired youth research assistants were successful in fulfilling their responsibilities for the project. They were highly beneficial in terms of recruiting a relatively large sample of vulnerable male youth, one that we do not believe would have been otherwise accessible. This is highlighted by the fact that although referrals were solicited through multiple community organizations that work with youth (e.g., John Howard Society, Enterprise, Youth Choices, Youth Probation Services) and through advertisements on posters and kijiji, only five participants were recruited via these methods. The vast majority of study participants were recruited either through the research assistants’ social networks or by directly approaching youth in the community.

Because of the participatory research design’s recruitment advantages relative to strategies typically employed by researchers, we were able to assess a significant number of participants who had not used services. Indeed, by utilizing the research assistants, a more “hidden” vulnerable population was included. This is especially important considering that Fredericton does not have a large apparent youth homeless population—those who are actually living on the street or the shelter. A final significant advantage of a participatory research design was that youth would likely not have been as receptive to researchers approaching them in the community to participate as they were to individuals their own age.

It is important to consider the benefits of the use of participatory research unrelated to the actual findings. All three youth had limited prior work experience, but through their participation in the project they gained valuable work skills and were able to help with a project that will likely make a difference in their community. Following completion of the project, one of the research assistants explicitly noted that he valued the opportunity to be given the responsibility and independence associated with the position, as there are not many opportunities like this for vulnerable youth.

Considerations for Interventions with Homeless or Vulnerable Youth

Vulnerable male youth represent a heterogeneous group with various needs (DeRosa et al., 1999). Kort-Butler and Tyler (2012) identified multiple clusters of homeless youth, based on different risk factors and patterns of service utilization. Due to this variability among the homeless youth population, they highlight that “a one-size-fits-all approach to meeting the needs of homeless youth is not efficient” (p. 621). As such, interventions should be tiered to address individual needs. For example, youth who are living at home may require family-based interventions to prevent homelessness from occurring, whereas youth who have run away and cannot return due to factors such as abuse may require individualized services to address basic needs of shelter and food, basic living skills, and mental health needs. Therefore, a continuum of services should be available, both in terms of the type of services and the intensity and duration of delivery. To be most efficient, youth should be assessed and directed to the type and level of service provision most relevant to their current needs. The concept of taking into account the individual circumstances of the youth and the reasons that they are homeless has been highlighted by youth themselves in a qualitative evaluation of their experiences with services (DeRosa et al., 1999). It is also necessary to have both prevention services, to address the needs

of youth that are vulnerable but not yet homeless, and intervention services, to assist youth who are homeless transition back home or into independent living or another appropriate living situation.

Prevention services that target known risk factors for homelessness should be available to vulnerable youth to address their needs before they escalate to a point when the youth may become homeless. The Canadian Alliance to End Homelessness has emphasized that “[t]he most cost-effective way to end homelessness for people is to stop it before it begins” (2012, p. 4). There is quite an extensive literature on the risk factors for homelessness that should be addressed as soon as they are identified to prevent youth from becoming homeless. As previously mentioned, abuse or other trauma, substance use, mental health concerns, academic difficulties, and poor family relationships are all associated with an increased risk of future homelessness (Cameron et al., 2004; Edidin et al., 2012; Hyde, 2005; Mallett et al., 2005; Martijn & Sharpe, 2006; van den Bree et al., 2009). There are also specific groups of individuals that are at particular risk for homelessness. Gay, lesbian, bisexual, and transgendered (GLBT) youth have higher rates of homelessness than youth in the general population (Gattis, 2009; Rosario, Schrimshaw, & Hunter, 2012), particularly for those individuals who either complete sexual identity development at an earlier age or experience sexual abuse (Rosario et al., 2012). Youth who have been involved in the foster care system are also a high-risk group, especially if they have not been assisted in transitioning out of the social services system (Edidin et al., 2012). At-risk groups could be targeted through secondary prevention efforts to reduce the likelihood that they will experience further difficulties, including homelessness. In addition, a more general prevention strategy would be to provide assistance to youth in navigating the transition between

the child and adult service systems, which has been identified as a key issue both in New Brunswick (Richard, 2008) and in research from the United States (e.g., DeRosa et al., 1999).

Despite the critical role of prevention, intervention efforts are also necessary to provide assistance to those youth who have become homeless. Intervention approaches must consider that the concerns that were present prior to the youth becoming homeless (e.g., psychological problems, poor family relationships, and substance use) are typically exacerbated by homelessness (Martijn & Sharpe, 2006). In addition, homeless youth experience high rates of trauma or revictimization when living on the streets (Coates & McKenzie-Mohr, 2010), and many youth experience long-term negative effects of trauma (Coates & McKenzie-Mohr, 2010; Keeshin & Campbell, 2011; Thompson, 2005). Rates of risky sexual behaviors are also very high in this population (Tyler et al., 2012), and poor general and sexual health often results from these risky behaviors, substance use, and poor living conditions (Edidin et al., 2012). GLBT homeless youth experience all of the same concerns as heterosexual homeless youth (e.g., substance use, trauma, mental health concerns), but are at increased risk (Gattis, 2009). Of course, negative outcomes are not inevitable, as a significant proportion of youth demonstrate resilience following traumatic experiences (Afifi & MacMillan, 2011). Factors that influence resiliency include positive family environment (Afifi & MacMillan, 2011), high self-esteem (Kidd & Shahar, 2008), and good psychological health (Afifi & MacMillan, 2011; Cleverley & Kidd, 2011). Regardless, any services implemented will have to be prepared to deal with potential negative effects, and counsellors who work with vulnerable youth should be trained to help youth address potential outcomes of traumatic experiences (Coates & McKenzie-Mohr, 2010). Returning to the premise of ecological systems theory, it cannot be forgotten that risk factors or needs do not occur in isolation; addressing a single factor will likely not have a lasting impact unless the broad

maintenance or causal factors are also targeted (Bronfenbrenner, 1979, 2005; Slesnick, Dashora, Letcher, Erdem, & Serovich, 2009).

Aside from targeting current issues that homeless youth may be experiencing, interventions must target those factors that maintain homelessness, which may not necessarily be the same as the risk factors for becoming homeless (Slesnick, Bartle-Haring, Dashora, Kang, & Aukward, 2008). Therefore, intervention programs may need to have targets that are distinct from prevention programs to successfully address current homelessness. Slesnick, Bartle-Haring, and colleagues (2008) found that the most consistent predictor of continued homelessness was limited connections to formal and informal social systems (e.g., schools, medical facilities, places of employment). A strong base of support is critical for youth to transition out of homelessness (Brown & Amundson, 2010; DeRosa et al., 1999). This can initially be provided by service organizations, but efforts should be made to develop sustainable support for the youth to prevent future homelessness. Other barriers to exiting homelessness that have been identified by youth are risky sexual behaviour (Slesnick, Bartle-Haring, et al., 2008), substance use, emotional difficulties, lack of education and skills, and lack of financial resources (Brown & Amundson, 2010). Thus, intervention approaches should focus on increasing the social connections of homeless youth and connecting them with sources of support, in addition to addressing their individual needs and providing them with life skills. Effective interventions for homeless youth are rehabilitation-focused (i.e., help youth get off of the streets), strength-based (i.e., focus on the skills and abilities of the youth, not just his deficits), non-stigmatizing, and involve connecting youth with support (Karabanow & Clement, 2004). It is also necessary to coordinate services to improve access to care and to prevent duplication of services (Edidin et al., 2012). Due to the multiple concerns that must be dealt with and the fact that homeless youth

may be distrustful of service providers and take time to open up, short-term strategies are not feasible; interventions must be available longer-term (Edidin et al., 2012).

Based on previous findings that homeless youth are often not aware of available services (Pergamit & Ernst, 2010), consideration should be given to the issue of how youth learn about any new services implemented. Lack of information is an important barrier to accessing services; youth have reported that even if they become aware that a particular service exists, important information (i.e. requirements to receive service) is often not clear (Pergamit & Ernst, 2010). One of the most consistent ways that youth learn about and access additional services is through drop-in centres and shelters, which can be thought of as “gateway” services (Karabanow & Clement, 2004; Pergamit & Ernst, 2010). Drop-in centres in particular may be useful because a variety of youth, not just those who are currently homeless, could utilize them. Currently in Fredericton, Youth Probation Services appears to be functioning as a gateway to other services, particularly mental health. Thus, by getting youth to access one service, they may be more likely to utilize additional services to address critical needs. Besides drop-in centres and service providers, other important sources of information include “word of mouth” and the Internet (i.e., websites, social media); although not all homeless youth have access to a computer (Pergamit & Ernst, 2010). Suggestions from youth include one list of all services available that is easily accessible (Pergamit & Ernst, 2010). Schools were also indicated as a potential resource in providing information about services (Pergamit & Ernst, 2010).

It is also imperative to consider the elements of services that appeal to youth. Even evidence-based interventions will have little success if youth do not attend and complete them. Although there is limited research on the service preferences and experiences of homeless youth, some previous research has identified youth preferences. Youth often find referral processes

where they are simply transferred from person to person highly frustrating (Pergamit & Ernst, 2010); they would prefer to make contact with one person who, if they cannot provide assistance to the youth, can guide them in seeking an appropriate service. Youth prefer services that are targeted to their personal needs (DeRosa et al., 1999; Pergamit & Ernst, 2010) and are relationship-based (Brown & Amundson, 2010). In addition, homeless and at-risk youth base ratings of satisfaction more on intangible program characteristics, such as program climate, sense of belonging, interpersonal interactions, and opportunities for personal growth, than on the specific number or type of services offered (Heinze, Jozefowicz, & Toro, 2010). In addition, youth prefer services that offer them more flexibility (i.e., can come and go) and fewer rules and restrictions (DeRosa et al., 1999). Youth report that feeling that they are respected is highly important to them, as is establishing trust and rapport with service providers (Slesnick et al., 2009). Youth desire opportunities for recreation, skills training, and mentoring (Pergamit & Ernst, 2010). Alternatively, youth may be discouraged from using services based on negative experiences (e.g., negative interaction with service providers) and encountering barriers (e.g., feeling unsafe, long waiting list) when they do attempt to access services (DeRosa et al., 1999). Requirements to complete paperwork and disclose personal information are frequently viewed as barriers to accessing a particular service (DeRosa et al., 1999; Pergamit & Ernst, 2010).

As highlighted earlier, concerns with current services in Fredericton include the notion that they are often reactive rather than preventative, focused on basic needs rather than on other aspects of well-being, and are professional-driven (Coates & McKenzie-Mohr, 2010). Although housing is a critical need, addressing it on its own is not sufficient to solve the problems experienced by homeless or vulnerable youth. Supports must be in place to assist youth in gaining independent living skills that they often lack. In addition, homelessness was often

temporary for participants in the current study; many returned home at some point. Coates and McKenzie-Mohr (2010) have emphasized that homelessness is often a symptom of more enduring individual and environmental factors. Barriers that are preventing youth from getting off of the street long term must be addressed if solutions are to last (Coates & McKenzie-Mohr, 2010).

Previously Implemented Prevention and Intervention Approaches

There is a general lack of research evaluating prevention and intervention approaches for homeless youth, particularly high-quality research (Altena, Brilleslijper-Kater, & Wolf, 2010; Edidin et al., 2012; Slesnick et al., 2009). Major methodological problems, such as lack of comparison groups, random assignment to conditions, follow-up assessments, and adequate sample sizes, make it difficult to identify approaches that are effective with homeless youth (Altena et al., 2010). Of the studies that have been conducted, the interventions used have generally targeted a single problem (e.g., substance abuse) instead of adequately addressing multiple risk factors or concerns of this population (Edidin et al., 2012). In addition, there is very little information available about the long-term outcomes of various services that are commonly provided (Karabanow & Clement, 2004; Slesnick et al., 2009). Karabanow and Clement (2004) identify four categories of typical services included in programs: 1) those that address the basic needs of food, shelter, and safety; 2) medical services; 3) therapy and counselling; and 4) skill-building services. While programs for homeless youth had originally been established to focus only on addressing basic needs and medical concerns, more recent programs have emphasized psychological interventions (Slesnick et al., 2009).

Shelters and drop-in centres are the most common services accessed by homeless youth to address their basic needs (DeRosa et al., 1999; Karabanow & Clement, 2004); however, the

availability of these types of services for homeless or vulnerable youth is drastically lower than for homeless adults (Slesnick et al., 2009). One of the significant benefits of shelters and drop-in centres is that, in addition to addressing the basic needs of youth, they can incorporate additional services in a single location or can facilitate the referral process to other services (DeRosa et al., 1999; Karabanow & Clement, 2004; Slesnick et al., 2009). This is highlighted by findings that youth who had used shelter services were significantly likely to have accessed additional services than those individuals who had never used a shelter (Berdahl, Hoyt, & Whitbeck, 2005; DeRosa et al., 1999). For example, they can facilitate access to medical care for youth by either having medical services on site or by referring youth to a partnering service. Due to the fact that utilization of formal health care services is generally low among homeless and vulnerable youth, despite higher levels of medical and sexual health problems (Carlson et al., 2006; Karabanow & Clement, 2004; Tyler et al., 2012), this could provide a significant improvement in terms of meeting the medical needs of homeless youth. In addition, youth have reported high levels of satisfaction with drop-in centres (DeRosa et al., 1999). Finally, shelters and drop-in centres provide settings where youth may have the opportunity to develop positive relationships with staff. Once trust is built, youth are likely to be more willing to ask for help to address their additional needs (Slesnick et al., 2009). Shelters that provide services to youth have been found to have at least a short-term positive impact on school and employment problems, number of days on the run, behavioral and emotional problems, and substance use (Slesnick et al., 2009).

Therapy or counselling and skill-building services can also be incorporated into shelters or drop-in centres, or can be stand-alone services. They can be implemented in a variety of styles, including individual, family, peer based, or mentor based (Karabanow & Clement, 2004). The majority of studies evaluating treatment approaches focus predominately on substance abuse

or sexual health problems (Slesnick et al., 2009). The studies that have been conducted vary greatly in terms of the methodology and intervention approaches used, making it challenging to interpret the mixed results reported. However, there are some types of intervention that demonstrate potential effectiveness. Interventions that utilize cognitive-behavioral approaches have been found to improve outcomes in regards to substance abuse, psychological distress, social stability, and maintaining housing (Altena et al., 2010). Family therapy for substance abuse may be a promising approach to address both family and individual functioning, and a combined substance abuse/HIV prevention approach may successfully target both risky sexual health behavior and substance abuse (Slesnick et al., 2009). In addition, a peer-based intervention for substance abuse has demonstrated improvements over and above that of adult-led interventions (Altena et al., 2010). Very minimal research has been conducted evaluating supportive housing programs for youth, but initial evidence indicates that improved health and decreased substance use may be present in comparison to youth who only access a drop-in centre (Altena et al., 2010). In contrast, neither intensive case management nor motivational interventions have been found to be effective when used on their own (Altena et al., 2010; Slesnick et al., 2009).

Prevention and Intervention Service Examples

Crisis intervention teams (CIT). Because police and other law enforcement are often first responders to crisis situations, they are in important positions to affect positive change. CIT programs train law enforcement to effectively deal with mentally ill individuals. The primary goals are to train first responders to recognize individuals who are experiencing psychological problems and to have the skills necessary to de-escalate crisis situations. In addition, responders learn about resources in the community to which they can refer individuals. Furthermore, there

are specific components of CIT that address working with youth. Overall, this prevention model effectively addresses police officers' limited training in mental health and in dealing with vulnerable youth. CITs have been shown to be effective in helping individuals in crisis obtain critical services (e.g., Tyuse, 2012). As a result, this model provides potential cost savings in dealing with at-risk populations relative to other approaches (e.g., incarceration, hospital admission).

Youth drop-in centre. Slesnick, Glassman, and colleagues (2008) provide a comprehensive model of a drop-in centre for homeless youth as well as recommendations for the initial creation and maintenance of the centre. Drop-in centres based on this model have been developed in the United States, and outcomes are forthcoming. The general philosophy of the centre is to provide a strengths-based, wraparound approach, which includes: (a) assessing youths' personal strengths, and (b) creating individualized plans to address youths' needs through interagency communication rather than indirectly referring youth to multiple services. Staffing is a key issue, as they must be able to develop positive, empathetic relationships with youth. Access to a centre is critical; it should be easily accessible by transit and ideally located in an area frequented by youth. Youth should be able to access a centre when they have specific needs; off hours often represent times when youth may need support and a safe place to go.

A drop-in centre should address the basic needs of homeless youth by providing access to food, showers, clothes, and health care. Structured (e.g., GED prep course, interview skills) and unstructured (e.g., job searching, art, homework help) activities as well as recreational opportunities (e.g., television/game room) should be available. Case management and counselling should be offered, and being connected to a youth advocate would be beneficial. To provide structure and privacy, the centre should consist of multiple rooms, rather than a single

open space. The centre will also need to have clear expectations and consequences to ensure a safe environment.

Foyer Model. The Foyer Model, originally developed in France following World War II, is now a well-established approach to providing affordable and appropriate housing and a broad array of services (e.g., skills training, counselling, case management) for youth. Foyers have been adapted and implemented across Europe, Australia, the United States, and, to some extent, Canada (Gaetz & Scott, 2012). Although the Foyer Model is tailored to each community's needs, specific elements typically include: (a) longer-term residency (i.e., up to two years in some cases), (b) case management, (c) youth-driven action plans, (d) life skills (e.g., communication skills, budgeting, health and fitness), and (e) opportunities for education and training. Foyers are generally supported by public and private funding as well as monthly program fees from youth participants (to encourage the practice of saving money and paying rent). Evaluations of the success of Foyers have typically focused on obtaining employment and housing following participation in the program, and have concluded that Foyers improve the outcome of youth in terms of their ability to obtain employment and stable housing (Gaetz & Scott, 2012). For example, 77% of graduates from a New York City Foyer were discharged into stable housing and 75% were currently employed at graduation (Gaetz & Scott, 2012). However, these evaluations are limited due to a lack of comparison to youth who do not receive services and to those who participate in other programs. Therefore, it is currently unknown if Foyers add incremental benefit to other types of interventions. In addition, Gaetz and Scott (2012) highlighted that lack of adherence to the values and policies of the program is a challenge for implementation. Examples of three services based on the Foyer model that have been

implemented in Canada are presented below. It should also be noted that two new projects based on the Foyer model are underway in Halifax, Nova Scotia and Saint John, New Brunswick.

Choices for Youth. This service, located in St. John's, Newfoundland, provides housing and lifestyle development supports to youth. The basis of the program is to develop trusting, healthy relationships with youth so that they have a stable foundation to make positive changes. The program includes a shelter for young men and a supportive housing program that focuses on attaching supports to the individual that can adapt based on changes in their circumstances. In addition, the program permits youth to drop in for basic needs (e.g., food, showers, laundry facilities) and for referrals to other services that address personal difficulties (e.g., substance abuse, mental health issues). There is also a long-term housing project under development that will provide on-site support.

Eva's Phoenix. Based out of Toronto, Ontario, Eva's Phoenix is a transitional housing and training facility providing services to homeless and street-involved youth ages 16 to 24 years. The goal of the program is to provide opportunities for youth to develop life skills, build careers, and live independently. Eva's Phoenix provides housing while youth complete workshops, classes, and either an education or training program. There is also a peer mentorship component to the program and staff can provide counselling to those who need it. Job opportunities are available on-site or through a variety of industry placements.

The Doorway. The Doorway is a program in Calgary, Alberta that focuses on helping youth, ages 17 to 24, transition from life on the streets to mainstream living. This transition occurs through a series of steps towards personal change that are determined by each individual youth in collaboration with community volunteers. One of the unique aspects of this program is that it views a transition into mainstream living as a type of cultural change, as most of the youth

have lived on the streets for several years before entering the program. Another unique feature is the business-planning approach to change; youth compare where they currently are in their life with where they would like to be. Incentives in the form of money are given for each step that is accomplished. The program is designed to last for two years, and is run by three full-time staff and a group of committed volunteers. The objectives of the program are to help youth obtain: 1) reliable problem-solving skills; 2) sustainable independence in housing and employability; and 3) stability in managing variables and challenges in life. The Doorway has been successful in transitioning approximately 70% of the over 900 youth served into mainstream living (Raising the Roof, 2009).

Although all of the programs that reviewed might not be comprehensively implemented in Fredericton, there are aspects of each that would be beneficial. One of the key differences in Fredericton is that the homeless population is more transient and that there is not a large group of visible homeless youth. If a similar intervention was to be implemented in Fredericton, it would have to focus more on addressing risk factors to homelessness and barriers to living at home or independently, rather than transitioning out of an entrenched street culture. However, the model of empowering youth by engaging them in developing their own plan to change is worthwhile, as changes are most likely to be maintained if youth are fully committed to the process.

Study Strengths and Limitations

One of the major strengths of this needs assessment is the use of participatory research. As previously mentioned, by using members of the population of interest to recruit participants and collect data, we were able to capture a sample that would likely have been impossible to find through other means. Other strengths are the broad range of factors that were examined and the

fact that by including vulnerable youth, rather than only those who were currently homeless, we were able to get a picture of the types of factors that might be targeted in prevention efforts.

One major limitation of the study was the lack of detail in the responses of many participants during the interview. This likely stemmed from two main sources: (1) the youth may have been guarded in terms of the information that they were willing to reveal, and (2) the youth research assistants, despite intense training, did not have the experience necessary to determine how to follow up vague responses or to encourage participants to open up about their experiences. Another limitation is that although an ecological perspective was used to examine key factors, it is possible that other variables not assessed in the present study (e.g., individual cognitions, attitudes, motivation for change) may be useful to address with interventions. Furthermore, the present study only assessed these factors from youth self-report; studies that examine needs of this population from multiple vantage points (e.g., parents, teachers, service providers) would provide a more comprehensive perspective. Nevertheless, we were involved in several key inter-agency and community-wide meetings throughout the project and believe that our findings and recommendations accurately depict the realities of vulnerable male youth.

Recommendations

1. Funding should be sustainable, and it is recommended that the model of funding not be based on fee for individual services but rather on a comprehensive array of services. From the federal government, funding should be provided for the development and maintenance of a centre with relevant resources. Although there will be initial start-up costs as well as ongoing expenses, there will likely be a large cost savings in both the short- and long-term relative to alternatives (e.g., medical services, legal and criminal justice). Although there is no cost-effectiveness research specifically for homeless youth,

interventions for mentally ill homeless adults have been shown to be cost-effective (e.g., Jones et al., 2003; McLaughlin, 2011). Outside funding and opportunities from the private sector (e.g., J. D. Irving, McCain Foods) should also be obtained to help prepare youth to become productive citizens in New Brunswick.

2. It is recommended that there be a central advocate who can provide direct support to youth and families in need (but without resources to advocate for themselves). The advocate would ideally be accessible from various agencies as well as directly from youth and families (especially via online communication). The advocate should expedite necessary services and reduce duplication of services, which, in turn, would produce overall cost savings that more than offset any expenditure for this direct-service position. Although it is recognized that the Office of the Child and Youth Advocate has as its mandate to ensure that “children and youth have access to approved services”, it is unclear to what extent it directly facilitates such access on an ongoing basis (rather than at a broader public policy level). We believe it is important that the role of the advocate be advertised and that the advocate is easily accessible by community agencies and the public.
3. Communication and engagement is key for any effective programming. Therefore, it is recommended that an integrated service delivery model be implemented across multiple sectors and agencies to facilitate a comprehensive array of services without duplication. This model would include ongoing communication among relevant agencies. Furthermore, because the services only have the opportunity to be effective if youth access them, it is important that any approaches include engagement and empowerment strategies with youth, their families, and the broader community. Currently, there are two

pilot sites in New Brunswick with formal integrated service delivery models. These models should continue to be evaluated and expanded province-wide.

4. Based on the responses of the youth in the present study as well as on empirical research, it is recommended that Fredericton establish a drop-in centre for youth who are homeless, are vulnerable to homelessness, or otherwise reside in the broader community. Ideally, the drop-in centre would be centrally located in the downtown core (or accessible to public transportation), would be flexible, and have the capacity to operate on a round-the-clock basis. The centre should have recreational opportunities, structured programming (e.g., job skills training, supportive group therapy), and flexible and individualized services (e.g., counselling, advocacy). The drop-in centre should be staffed with trained professionals who can handle a variety of issues. Fredericton is ideally situated with two universities, each with relevant post-graduate training programs (e.g., social work, clinical psychology, education); there is the possibility of inexpensively staffing some positions while providing practical opportunities to students across these programs. To help retain good staff, relevant resources (e.g., ongoing training, flexible scheduling, staff support) should be provided.
5. Based on standardized questionnaire responses and interview data from participants, it is recommended that a shelter for male youth be established in Fredericton. Similar to the recommendations for the drop-in centre mentioned above, the shelter should be centrally located to facilitate access and be flexible in terms of how long youth can stay. Besides providing the basic necessities of shelter, food, clothing, showers, and laundry, the shelter should include daytime programming in which youth can participate (e.g., job skills training, tutoring). This could be facilitated through collaboration with the recommended

drop-in centre (and may be physically connected to the centre to reduce expenses). The shelter should be staffed by individuals experienced in working with vulnerable youth who can provide both supervision and delivery of programming.

6. Because many of the youth identify problems in their families and given that positive family relationships are critical for positive youth adjustment, it is recommended that services be readily available to help families address key issues. These services would be especially important for youth who are presently living at home and who are vulnerable for homelessness. Services should be empirically supported, strength based, and ideally provided in the communities in which youth reside.
7. It is recommended that ongoing training on how to engage with vulnerable youth be provided to law enforcement and school officials. These are professionals who interact with this population on a regular basis and are in the capacity to positively affect youth. Programs, such as the Crisis Intervention Team program, have been shown to be effective in dealing with vulnerable youth in particular and individuals with mental health problems in general.
8. Alternative educational/occupational programs should be provided to youth who have dropped out of school or who are at risk for dropping out. This will likely facilitate successful completion of school and employment afterwards but also prevent negative outcomes (e.g., drug use, homelessness, delinquent behaviour).
9. As part of providing effective services in the broader community, school-based services should be available for youth who are able and willing to access services in this setting. For other youth who do not typically access these services, perhaps because they have dropped out or are reluctant to seek out services, the integration of a drop-in centre,

trained law enforcement and teaching professionals, and alternative community services will likely fill in many gaps.

10. Any programming should include ongoing, objective evaluations of the program's effectiveness. This should go beyond maintaining records of the overall number of people in contact with the program and include standardized and unstandardized measures from multiple vantage points. These evaluations can help provide feedback to identify specific barriers and facilitate modifications (i.e., improvements) to programming. The information obtained from these evaluations could also be useful for providing accountability to funding agencies.

Conclusion

Using a participatory research design, a comprehensive needs assessment was conducted to investigate the previously identified “service gap” for vulnerable male youth aged 16 to 18. A truly vulnerable sample was obtained; youth in the present study seemed to represent the “fringe” of the general youth population, with many of them experiencing varying degrees of homelessness. These youth reported a variety of different needs, including mental health concerns, low self-esteem, delinquent behaviour, substance use, poor family relationships, traumatic experiences, and poor academic achievement. However, a significant number of participants had not utilized any existing services in Fredericton. Of those who had accessed services, they were most likely to report receiving therapy or counselling. Approximately one-quarter of participants reported experiencing difficulty accessing services. When asked about new services to be developed in Fredericton, common responses included a youth shelter and a drop-in centre. Participants also mentioned improving existing services, such as mental health and alternative education programs, by having multiple locations or more staff.

Due to the fact that vulnerable male youth are a diverse group with varying needs, a continuum of services should be available. Youth should be assessed and directed to the type and level of service provision most relevant to their current needs. It is also necessary to have both prevention services, to provide assistance to vulnerable youth while they are still living at home, and intervention services, to address the needs of homeless youth and help them transition out of homelessness. Prevention services should target known risk factors for homelessness (e.g., poor family relationships, substance use) and specific groups who are at-risk (i.e., youth in foster care, GLBT youth), whereas intervention services should focus on common concerns of homeless youth (e.g., mental health, trauma) and factors that maintain homelessness (e.g., lack of social support). It is imperative that the delivery of these services be coordinated to facilitate access and conserve resources through the prevention of service duplication. Any services should consider that youth prefer services that are relationship-based and that the establishment of trust and rapport with service providers is critical for interventions to be effective.

Although there is a general lack of research evaluating prevention and intervention efforts for homeless or vulnerable youth, what is available indicates that there are some promising interventions for this population, such as cognitive-behavioral interventions and family-based therapy. In addition, the value of shelters and drop-in centres in terms of connecting youth with further services, particularly medical care, has been highlighted. In addition, several case examples have been provided to illustrate strategies that have been used with similar populations. Based on the needs reported by our sample and strategies mentioned in the literature, several recommendations have been made regarding prevention and intervention efforts to implement in Fredericton. Key in these recommendations is providing support to families, as well as establishing both a youth shelter and youth drop-in centre. In addition, specifications regarding

how best to develop, fund, and evaluate newly developed services are made. In conclusion, vulnerable youth in Fredericton have significant needs that are not being addressed by existing services, and effectively addressing these needs can both prevent homelessness and help youth transition out of homelessness.

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Figure 1. Relevant Governmental and Nongovernmental Services for Youth in Fredericton

