Université de Montréal

Experiences of Accessing Mental Health Services among Homeless Youth: *Differences between Linguistic Majority and Linguistic Minority Youth*

Par
Camille Arbaud

Programme de sciences biomédicales
Faculté de médecine

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Experiences of Accessing Mental Health Services among Homeless Youth: *Differences between Linguistic Majority and Linguistic Minority Youth*

Présenté par

Camille Arbaud

A été évalué par un jury composé des personnes suivantes

Céline Bellot
Président-Rapporteur

Amal Abdel-Baki
Directrice de recherche

Srividya Iyer
Co-directrice de recherche

Manuela Ferrari
Co-directrice de recherche

Naomi Nichols
Membre du jury

RÉSUMÉ

Contexte: Les problèmes de santé mentale émergent majoritairement chez les adolescents et jeunes adultes. Les jeunes en situation d'itinérance (JSI) ont d'importants besoins non-comblés en lien avec leur santé mentale et ce possiblement davantage pour les jeunes de minorités linguistiques (JML).

Objectifs: Décrire les facteurs associés aux expériences d'accès aux services de santé mentale chez les JSI, en comparant les expériences des jeunes de majorité linguistique (francophones) aux JML (anglophones et allophones).

Méthodes: 22 jeunes de 18 à 25 ans ont participé à la cartographie communautaire, méthode de recherche qualitative utilisant les arts, où les participants ont créé leurs cartes des ressources d'aide en santé mentale. Des groupes de discussion ont permis aux jeunes d'exprimer leurs perceptions de l'accès et des services. Les résultats sont générés par une analyse thématique.

Résultats: Les facteurs liés aux expériences d'accès aux services se regroupent en deux catégories: (1) des soins adaptés à l'individu, et (2) la disponibilité et la structure des services. Les JSI veulent des services adaptés aux besoins spécifiques des JSI et des minorités (incluant les JML), avec une approche centrée sur les besoins de l'individu. Les JML identifient moins de diversité de services et se tournent vers des stratégies alternatives de soins ou des services itinérance adulte.

Conclusion: Des services co-localisés et intégrés, répondant aux besoins de base et de santé mentale, permettraient de diminuer les obstacles à l'accès aux soins pour les JSI. Une attention particulière aux JML est nécessaire puisqu'ils rencontrent davantage d'obstacles que leurs pairs JSI.

Mots-clefs: jeunes en situation d'itinérance, accès aux services de santé mentale, recherche qualitative, cartographie communautaire

ABSTRACT

Background: Most mental illnesses begin in youth. The homeless youth population reports a high level of unmet mental health needs; a situation which is possibly worse for linguistic minority homeless youths

Objectives: To describe the factors associated with homeless youths' experiences of accessing mental health services and to highlight differences in such experiences between linguistic majority (Francophones) and linguistic minority (Anglophones and Allophones) groups.

Methods: 22 youths between 18 to 25 years old participated in community mapping, an arts-based qualitative research method in which participants draw maps of resources they use to receive help with their mental health. Discussion groups enabled youths to express their emotions and perceptions towards access and services. Thematic analysis was user on verbal and visual data.

Results: Factors associated with of access to mental health services were grouped into two categories: (1) care adapted at the individual level, and (2) availability and structure of services. Homeless youths need services that are adapted to the specific needs of homeless youths and minorities (including linguistic minorities), with an approach to care centered on an individual's needs. Linguistic minority homeless youths identify less diversity in services and often turn to informal mental health strategies or to adult-oriented homeless services.

Conclusion: Services that are co-located and integrated with mental health and basic needs services help bypass a lot of identified barriers to care for homeless youths. Particular attention needs to be paid to linguistic minority homeless youths as they experience more barriers than their counterparts.

Keywords: homeless youth, access to mental health services, qualitative research, community mapping

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LIST OF ABBREVIATIONS AND ACRONYMS

CHUM – Centre Hospitalier de l'Université de Montréal

CIUSSSS – Centre Intégré Universitaire de Santé et de Services Sociaux

CLSC – Centre Local de Services Communautaires

JML – Jeunes de Minorités Linguistiques

JSI – Jeunes en Situation d'Itinérance

LGBTQ+ - LGBTQ is an acronym for Lesbian, Gay, Bisexual, Transgender, and Queer; LGBTQ+ is used to include all the communities in the *Queer community* or LGBTTTQQIAA: Lesbian, Gay, Bisexual, Transgender, Transsexual, Two-Spirit, Queer, Questioning, Intersex, Asexual, Ally, etc. (OK2BME, n.d.)

MH – Mental Health

NGO – Non-Governmental Organization

RIPAJ – Réseau d'Intervention de Proximité Auprès des Jeunes de la rue

SUD – Substance Use Disorder

C'est venu à moi tout simplement. Je devais être avec les jeunes, je devais les aider.

Père Emmett Johns « Pops »

—

It just kind of came to me. I should be with the kids, I should help them.

Father Emmett Johns "Pops"

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—

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—

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CHAPTER 1 – INTRODUCTION

In Canada, homeless youths account for about 20% of the homeless population, which means around 35,000 to 40,000 youths every year and about 6,000 per night (Gaetz et al., 2014). It is estimated that, in any given year, over 2 million youths in the United States (Morton et al., 2018), and about 75,000 in the United Kingdom (Quilgars et al., 2008) experience homelessness. Youth homelessness can be defined as "the situation and experience of young people between the ages of 13 and 24 who are living independently of parents and/or caregivers, but do not have the means or ability to acquire a stable, safe or consistent residence" (Gaetz et al., 2014). In the literature, sub-categories of homeless youths may be referenced under such terms as runaways who spend more than one night away from home without parental permission, street youths who live in high risk non-traditional locations, and systems youths who have previously been involved in government systems such as foster care or juvenile justice (Edidin et al., 2012; Greene et al., 1997; Moore, 2005). In Montreal, where this study took place, over 1,000 youths use youth-specific homelessness services per year, with 300-350 of these being first-time users of these services per year (Abdel-Baki et al., 2019).

Since the 1980s, Canada has seen a rapid increase in homelessness, in part due to a decrease in national investment in affordable housing by over 46% (Gaetz et al., 2014). With structural factors, such as discrimination, affecting access to affordable housing, individuals from minority groups, youths, Indigenous people, and newcomers (often linguistic minority immigrants) are increasingly more likely to be homeless (Gaetz et al., 2014). In 2015, the proportion of Indigenous homeless youths (30.6%) was higher than their proportion in the Canadian youth population as a whole (6.6% of Indigenous youth) (Gaetz et al., 2016; Statistics Canada, 2018a). A national shelter study in Canada identified that Indigenous youths use shelter at a rate 6.4 times higher than non-Indigenous youths (Employment and Social Development Canada, 2016). The increasing prevalence of diversity in homelessness has been showing no sign of changing (Abdel-Baki et al., 2019; Gaetz et al., 2014; Latimer et al., 2015), thereby highlighting the

importance of increasing our knowledge of the issues faced by homeless youth minorities, including linguistic minorities.

1.1 Homeless youths and mental health

By age 24, 75% of major lifetime mental health disorders have begun (Kessler et al., 2005). Being a period of significant emotional, physical and social development, mental health problems during the period of adolescence and young adulthood have serious potential short- and long-term consequences (Iyer et al., 2015). A Canadian national survey found that 85.4% of homeless youths expressed high emotional distress (Gaetz et al., 2016), with over half of them struggling with mental disorders, a rate that is 2.5-5 times higher than the national average for youths (National Learning Community on Youth Homelessness, 2012). A 2015 longitudinal study in the UK found that about 88% of homeless youths had a current mental disorder and 93% a lifetime mental disorder (Hodgson et al., 2015). Furthermore, rates of mental health disorders and general emotional distress are more significant in youths who have been homeless for longer (Solorio et al., 2006).

Substance use disorders and depression are significantly more prevalent among homeless youths compared to the general youth population (Aichhorn et al., 2008; Boivin et al., 2005; Edidin et al., 2012). Among homeless youths in two American cities, 40% presented with a substance use disorder (SUD) only, 34% had a mental health diagnosis co-occurring with SUD, and 26% had two or more comorbid diagnosis and an SUD (Slesnick & Prestopnik, 2005). Over 90% of youths in a cohort study of 1013 street youths in Montréal, Canada consumed cannabis or hallucinogens, 81.6% consumed cocaine or crack and 46.2% reported injecting drugs (Roy et al., 2004). In this same study, 44% of youths consumed at least two drug categories in the last month. Similarly, suicidal behavior is significantly higher in homeless youths compared to the general youth population (Cash & Bridge, 2009; Georgiades et al., 2019; Miranda-Mendizabal et al., 2019). Looking at suicidality in over 7,000 homeless youths, a study in the United States found that 66.2% reported suicidal thoughts in their past, 37.5% reported having had serious suicidal thoughts in the last month, and 51.3% reported at least one suicide attempt in their

lifetime, with 8% making such an attempt in the last month (Desai et al., 2003). In Canada, 42% of homeless youths reported at least one suicide attempt in their life (Kidd et al., 2017).

1.2 Access to mental health services

Despite high rates of mental health problems, a large number of Canadian youths with mental health problems do not use requisite services, such as mental health professionals, general practitioners, or other allied mental health services (Kidd et al., 2018; Kort-Butler & Tyler, 2012; Muir-Cochrane et al., 2006; Waddell et al., 2002). Homelessness is known to further exacerbate issues around mental healthcare access among youths (National Learning Community on Youth Homelessness, 2012). In a recent Canadian survey, 84% of homeless youths struggling with mental illness reported needing additional care other than the services currently provided to them (National Learning Community on Youth Homelessness, 2012). Half of 1015 street-involved youths in a major Canadian city attempted to access mental health services: 26% of those were unable to access any services and 15% of all attempts were unsuccessful (Phillips et al., 2014). Further, difficulty accessing services was associated with characteristics such as Aboriginal ancestry, homelessness, and being a recent victim of violence (Phillips et al., 2014). Homeless youths, surveyed in three Midwestern cities in the USA, presented low rates of service utilization with 57% having never used counselling services and 35% having never used street outreach services (Kort-Butler & Tyler, 2012). In addition, homeless youths experiencing mental illness also show low levels of compliance to medication regimens prescribed for their mental disorder, even when they perceived such medication to be beneficial (Muir-Cochrane et al., 2006).

1.2.1 Perception of the services

Homeless youths' perception of services offered to them can have a significant impact on the likelihood that they will reach out to and remain engaged in services. Results from qualitative and quantitative studies have shown that homeless youths often report negative experiences with mental healthcare such as feelings of being exposed, betrayed, antagonized, and labelled (due to their mental health issues) by service providers; and perceiving staff as

lacking in support and respect (Barker et al., 2015; Collins & Barker, 2009; Darbyshire et al., 2006). On the other hand, human contact and establishment of a therapeutic relationship, through a case manager for example, can facilitate access to care, according to a qualitative study (Aviles & Helfrich, 2004). Experiences of empathy, support, and acceptance (Collins & Barker, 2009; Darbyshire et al., 2006; Kozloff et al., 2013; Solorio et al., 2006), as well as explanations offered by service providers, attentive listening, and fostering a of a strong therapeutic relationship (Darbyshire et al., 2006; Kozloff et al., 2013; Solorio et al., 2006), encourage homeless youths to access mental health care.

1.2.2 Structural factors

At a structural level, the organization of mental health services can deter homeless youths from using them. For example, many homeless youths report feelings of being rushed, a lack of coordination between services (e.g., multiple referrals delaying service access, frequent changes in personnel, lack of proper advertising of the services, etc.), limited access to staff, and perceiving staff as being unavailable (Aviles & Helfrich, 2004; Darbyshire et al., 2006). Financial or material barriers to mental health care access for homeless youths are repeatedly identified in the literature. Lack of appropriate documentation such as identity and medical insurance cards is a common barrier, for up to 50% of homeless youths (Busen & Engebretson, 2008; Christiani et al., 2008; Edidin et al., 2012). Additional barriers include an inability to provide a permanent address (Barker et al., 2015), or pay for transportation (e.g., having a bus ticket) to the service (Edidin et al., 2012). Conversely, homeless youths have identified availability of transportation and the ability to locate services as important facilitators to access mental health care (Aviles & Helfrich, 2004).

1.2.3 Sociodemographic factors

Many factors out of the control of youths can impact their access to mental health or allied services. In a Canadian survey, 79% of homeless youths requiring additional mental health services experienced barriers to housing due to their mental illness (National Learning Community on Youth Homelessness, 2012). Such barriers also have the consequence of keeping homeless youths out of employment, which can in itself represent an obstacle to accessing

services, through lack of financial means or lack of accountability (Barker et al., 2015). Low educational achievement by homeless youths has also been linked to lower access to mental health services. In a qualitative study, youths identified their educational achievement and skills as facilitators to their ability to locate and use services(Aviles & Helfrich, 2004). Illegal behavior, such as drug dealing or usage, violence, or a recent police encounter, reduces the probability of access to mental health services and allied services (housing, food, medical) in street youths (Barker et al., 2015). Youths find themselves in a vicious cycle of barriers to care, employment and housing, which is even more important considering that youths identify having their basic needs met as being a strong facilitator to accessing services (Aviles & Helfrich, 2004). Other sociodemographic factors, such as linguistic proficiency, may play a role in access to mental health services.

1.2.4 Linguistic abilities

In a world with increased numbers of migrants (United Nations, 2017), among whom lower language proficiency has been shown to impact integration and to lead to social inequalities (including education, income, and access to central institutions) (Esser, 2006), language proficiency is a factor that could considerably impact mental health access. From a clinician's perspective, language barriers can affect the evaluation/diagnosis of the patient, who could appear more disorganized, withdrawn, or disturbed by not being able to communicate in their native language (Leong & Lau, 2001). Linguistic factors can also influence the length and outcome of the treatment (Leong & Lau, 2001). An important gap exists in understanding linguistic considerations and how they may intersect with other aspects of identity and life situations (e.g., being homeless, newcomer, etc.) to impact mental health care access.

Some studies have been conducted on access to health services amongst immigrant populations in Canada, but their findings are divergent. In a study of Asian adult immigrants in British Columbia, language did not appear to hinder access to mental health services (Chen et al., 2008) – however, the researchers point out that this could be due to a high prevalence of health professionals who are fluent in Asian languages or simply to a higher cultural sensitivity in the province. An American study on adults had similar results for Asian immigrants; however,

Latino immigrants were less likely to use mental health services (Kim et al., 2011). Hispanic Americans with lower verbal English skills have been shown to report lower health care satisfaction, a lack of a physician-patient therapeutic bond, and feelings of being misunderstood (David & Rhee, 1998). Even though these findings are limited to medical settings, the same factors could greatly impact motivation to reach out for mental health care. Nonetheless, literature on immigrant adult populations cannot be generalized to homeless youths who are linguistic minorities, among whom barriers to mental health care extend beyond those contributed by language and ethnic disparities (Chen et al., 2008; David & Rhee, 1998; Kim et al., 2011).

Canada has two official languages (English & French). Most provinces and territories use English as their official language, while Quebec is the only province in which French is the only official language (Ballinger et al., 2020; Charte de la langue française, 1977; Official Languages Act, 1985). In each province or territory, the linguistic minority is composed of individuals who do not speak the provincial official language, speaking either the alternative national official language, or neither French nor English (Allophones). Linguistic minorities represent 0.5-7.5% of each province's population and 14.6% of Quebec's population (Statistics Canada, 2016). There is growing consideration in the Canadian healthcare services research about how linguistic considerations such as being from a linguistic minority group could affect health and social services access and outcomes (Bowen, 2001; Lepage & Lavoie, 2017). The potential difficulties experienced by linguistic minorities may be especially salient in Canada's homeless youth population.

In Quebec, 13.7% of the population consists of immigrants (Statistics Canada, 2018b); only 55.3% of all immigrants welcomed into Quebec speak French (Ministère de l'Immigration, de la Diversité et de l'Inclusion, 2019). Most of them (72.2%) reside in Montreal (Ministère de l'Immigration, de la Francisation et de l'Intégration, 2018). About 10.1% of Canadian homeless youths are immigrants (Gaetz et al., 2016); since this is similar to the rate of immigrant youths in Montreal (Montréal en statistiques, 2020), it would be fair to expect similar or higher rates of immigrants amongst homeless youths in Montreal. Provincial laws require administration,

health and social services to extend any communications (notices, forms, publications, etc.) to the public in French, the official language in Québec (Charte de la langue française, 1977). In Montreal, most services for homeless youths are primarily Francophone organizations. Given the predominance of French communications in the Francophone community organizations serving homeless youths, Anglophone and Allophone youths may experience additional barriers to access information and services.

1.3 Research question

Although there is a fair amount of research on homeless youths' access to support services, few studies focus on mental health services and none, that we could find, addressed the difficulties that linguistic minority youths, who are homeless, face when attempting to access mental health care. This study attempts to address this gap by asking how linguistically diverse homeless youths (linguistic majority vs. minority) perceive access to mental health services in Montreal, Canada. The goals of this study are to describe homeless youths' experiences accessing mental health services by identifying factors influencing their access and to highlight differences in the experiences of access between linguistic majority (Francophones) and linguistic minority (Anglophones and Allophones) groups.

CHAPTER 2 – STUDY DESIGN

2.1 Study context

In the context of the ACCESS Open Minds project (Iyer et al., 2015), which is a research and evaluation project that aims to implement and assess a transformation in the way youths access and use mental health services across Canada in different real-world settings (Malla et al., 2019), the present study focuses on the realities of homeless youths in Montreal, QC. The present project is linked with the ACCESS Open Minds RIPAJ site. The Réseau d'Intervention de Proximité Auprès des Jeunes de la rue (RIPAJ) network is a group of NGOs and governmental institutions (CHUM, CIUSSS Centre-Sud-de-l'Île-de-Montréal CLSC Sainte-Catherine) offering a range of services in engaging and diversified environments for homeless youths or those at risk of homelessness, aged 12 to 30 (Abdel-Baki et al., 2019). The network focuses on improving access to mental health services for youths facing homelessness, street life, or in highly precarious situations putting them at high risk of homelessness. Its main objectives are to offer alternatives to everyday street life and services helping youths stabilize their situation and, for most who wish so, to quit homelessness. Organizations in the RIPAJ network offer a variety of services including basic needs (shelter, food, help for legal problems, sense of security, support, etc.), vocational functioning (educational and employment support, work programs, etc.) and social, physical and mental health services.

2.2 Methodology

Inspired by participatory methodology (Baum et al., 2006), the research question chosen was directly asked by members of the RIPAJ network; this study therefore answers a need from the community and aims to bring positive change to the network. Each homeless youth's path to homelessness and experiences with mental health services are different (Edidin et al., 2012). Keeping in mind the high diversity found within the homeless youth population, this study adopts a social constructivist paradigm (Walker, 2015), influenced by participatory approaches (Baum et al., 2006) and intersectionality (Creswell & Poth, 2016), under the assumption that

understanding individual experiences allows for a more comprehensive description of access to mental health services among homeless youths.

Intersectionality, a term coined by Kimberlé Williams Crenshaw (Crenshaw, 1989), refers to the "critical insight that race, class, gender, sexuality, ethnicity, nation, ability, and age operate not as unitary, mutually exclusive entities, but rather as reciprocally constructing phenomena" (Collins, 2015). The social traits of an individual need to be understood as linked to fully understand the individual. Intersectionality is used to understand power relations and social inequalities. Within the context of this study, intersectionality allows us to explore the individual realities of youths with a complex profile: experiencing homelessness, being part of a linguistic minority, and potentially experiencing other forms of stigmatization.

To achieve the study goals and to address the RIPAJ network's request for informed change, we used arts-based methodology to describe the core nature of access to mental health services in youths of different linguistic groups. Arts-based research is a systematic use of the artistic process as a method of understanding experiences. Visual arts capture emotions and ideas that are difficult to put in words, evoke memories or stories, and highlight new perspectives (Knowles & Cole, 2008). They empower the individual to communicate their present reality (Crampton & Krygier, 2018). Through deliberate inclusion of minorities, visual arts have been regularly used to encourage social action (Parker, 2006). In addressing linguistic differences, a core value of this study is to include youths regardless of their linguistic proficiency in one of the official languages (French and English). Research often omits the voices of people with low levels of literacy, simply because they cannot participate if they cannot sign a consent form or answer a questionnaire (Muir & Lee, 2009). We wished to use research methods that do not require high levels of literacy, which arts-based methodologies provide; thereby allowing homeless youths with low levels of education and allophone homeless youths to participate. To ensure that participants were able to give informed consent, we asked a few questions, approved by the Research Ethics Board (see Appendix A)

The method selected was community mapping, which allows participants to identify services in their communities and indicate their relationship to these services (Amsden &

VanWynsberghe, 2005). A map is given to participants who can then highlight places of their choosing with any level of creativity they desire, which gives full control to the participant on how the information is presented (Amsden & VanWynsberghe, 2005). Looking at access to health care in homeless youths using multiple methods of data collection, one study found community mapping and focus groups to yield the most information, with community mapping emerging as the most enjoyable for the youths (Ensign & Gittelsohn, 1998). This method allows the researchers to know what is available in a community and make connections between the services to generate better care (Amsden & VanWynsberghe, 2005). Community mapping also allows the participants to identify the services they use, to indicate the strengths and weaknesses of the services, and to find a voice in the research process (ACCESS Open Minds, 2017; Amsden & VanWynsberghe, 2005). This method has been used successfully with youth populations, creating active engagement and an open space for communication (Amsden & VanWynsberghe, 2005; Ensign & Gittelsohn, 1998). This method involves discussion groups, which provide a naturalistic setting and have been shown to facilitate the communication of sensitive issues. Youth participants were invited to create individual and group maps, allowing the researchers to highlight any experience where intersectionality played an important role in youths' access to services and to provide a narrative on each linguistic group's experiences.

2.3 Participants: sampling & recruitment

Participants who met the following criteria were invited to participate in this study: (1) aged between 18 to 25, (2) being *homeless* according to the Canadian definition of youth homelessness: "the situation and experience of young people between the ages of 13 and 24 who are living independently of parents and/or caregivers, but do not have the means or ability to acquire a stable, safe or consistent residence" (Gaetz et al., 2014).

This project used a purposeful sampling method (Palinkas et al., 2015), in an effort to represent a variety of specific characteristics of different profiles of homeless youths and those at risk of homelessness. Purposeful sampling aims to identify and select information-rich participants who are knowledgeable and experienced with the phenomenon of interest. This allows for an efficient use of limited resources (Palinkas et al., 2015). Research shows that

minorities can have different experiences in homelessness (Gaetz et al., 2014). As such, we employed a maximum variation strategy of purposeful sampling which attempts to include specific minorities (Palinkas et al., 2015). Maximum variation aims at recruiting participants who have different experiences and profiles to document unique and diverse information on the phenomenon of interest in different conditions (Palinkas et al., 2015). Participants were primarily recruited based on their first language (Francophone, Anglophone and Allophone). Allophones were required to understand/speak sufficient French or English to understand and be able to consent to the study and minimally participate in a discussion. However, they are not categorized as Francophones or Anglophones because of insufficient fluency in those languages, potentially making it difficult to receive mental health services in those languages. We also recruited participants who have used mental health services and participants who know peers who use or try to access mental health services, to gain knowledge on the perspective of these sub-groups according to their experience with issues around accessing mental health services. To be mindful of intersectionality and to represent the perspective of a range of different homeless youths, some efforts were made in including participants following these general characteristics: gender, visible minorities, and various sexual orientation/identities. This sampling procedure aims at including minority youths who can share different experiences of youth homelessness and provide new perspectives to gain information on how minorities may experience access to mental health services differently.

The graduate student who acted as the research coordinator for this project met with organizations and members of the ACCESS Open Minds RIPAJ team to describe the project and share recruitment materials. Recruitment posters and pamphlets were available in most of these organizations (examples are provided in Appendix B). The majority of participants were recruited in face-to-face interactions by organizing a little recruitment booth in one of the organizations during lunch hour. Other participants were identified by clinicians and youth workers from the organizations and met in person or contacted by the graduate student for further information. Some youths were also recruited through social media publications from the participating organization. Five groups of 2 to 9 participants took part in the study, between June and September 2018, divided by dominant language.

2.4 Data Collection Layout

During the study, participants were accompanied by the research facilitation team, composed of:

- An experienced researcher: a female researcher and assistant professor with expertise in qualitative methodologies and art-based approaches who played the role of the facilitation leader during the first focus group (Anglophone).

- The facilitation-leader: a female Masters student trained by the experienced researcher

- A facilitation assistant: a female PhD student with in-depth clinical experience as a social worker with homeless youths with mental health and addiction problems

None of the participants had a previous relationship with any of the team members. The research facilitation team communicated their current role within the study to the participants. The questions and prompts used during the focus groups were reviewed and refined with inputs provided by youth representatives with experience of homelessness and involved in the RIPAJ youth council.

The two- to four-hour community mapping discussions took place, in a youth-community room at Dans la Rue, one of the RIPAJ organizations. Participation was compensated with a 25CAN$ pre-paid credit card. Short breaks were taken about every hour and snacks were provided throughout the activity. Participants filled a socio-demographic self-report questionnaire, provided in Appendix C. Included in the questionnaire were the self-rated health and self-rated mental health measures, two questions, each on a five-point likert scale (from 1 = poor to 5 = excellent), which assess respondents' health and mental health (Ahmad et al., 2014; Schnittker & Bacak, 2014). These measures were validated with youths, as well as minority populations (Ahmad et al., 2014; Chandola & Jenkinson, 2000; Schnittker & Bacak, 2014). Participants were provided with maps of the city and asked to illustrate their

experiences with mental health services, as well as their knowledge of mental health services around the city.

Participants were invited to share information they had on their map. They then created a group map of the mental health services they knew about. All participants contributed to the group maps. They exchanged reactions and thoughts on this group map. Facilitators had a list of suggested questions for the participants, serving as a reminder to guide the discussion if needed (see Appendix D). A summary of the schedule during the community mapping activities is provided in Appendix E.

2.5 Data analysis

I, as the graduate student on this study, transcribed the audio-digital recordings from the focus groups. The transcripts were then analyzed, in their original language, using thematic content analysis: providing key elements of the participants' experiences and a general overview of the content and topics addressed (Braun & Clarke, 2006). Unbound to theoretical frameworks, thematic analysis allows this study to describe the overall phenomenon while still highlighting individual experiences (Braun & Clarke, 2006). This analysis requires identification of the principal themes through regularities in the data and comparative analysis, coding of the identified themes, and organization of the data based on the identified themes (Braun & Clarke, 2006). I carried out the thematic analysis, with regular feedback and discussions with, at least, two senior researchers. Concretely, the following steps for thematic analysis took place (Braun & Clarke, 2006):

1. I familiarized myself with the data: transcribing, reading and re-reading, noting down initial ideas

2. Initial codes—words and short phrases symbolically summarizing the essence of a portion of data (Saldana, 2015)—were generated by reading through the transcriptions and summarizing each idea in a few words. Similar ideas were then homogenized under common codes.

3. Themes were identified by analyzing the frequency, patterns, and commonalities between the codes. The themes were discussed and evaluated with senior researchers over fifteen meetings, including revision of the first versions of manuscript, until an agreement was reached.

4. Themes were reviewed by generating a thematic map and creating relationships between each theme. A total of five thematic maps were created and reviewed with senior researchers to ensure validity and coherence. Some themes were re-organized through the process of finalizing a thematic map. Two final thematic maps were selected: one, Figure 5 in section 2.5.1, organizing the themes as they were generated by the participants, and another, Figure 4 in section 2.5.1, showing the steps of the trajectory of access to mental health services over time. We go into further description of various generated thematic maps in section 2.5.1.

Scripted data analysis was carried out using NVivo 12, a qualitative data analysis software, to organize, analyze and code the scripted. To present the results, I translated the French quotes from the linguistic minority youths, post-analysis. I am fluently bilingual in French and English, having completed higher education degrees in both languages. The quotes were also reviewed and slightly corrected during the revisions of this manuscript by my research directors. Only minor changes were made, such as fixing the spelling or adding words for comprehension (indicated in brackets). The quotes were kept as formulated by the youths.

The visual data analysis was carried out by creating a summary map for each linguistic group as well as a global summary map. Summary maps were created on *Mapz.Com* and combined the group maps created as well as information from the individual maps. This information had to be pertinent to the group maps and consisted of services that were left out of the group maps and hang-out spots that multiple participants identified in their individual maps. Markers were placed on a blank map of Montreal to indicate, approximately, different locations that the youths included in their maps. Various symbols were used to differentiate the type of service or location; a legend is provided with the maps. Further details of the process of generating the community maps are presented in section 2.5.2.

2.5.1 Generating a thematic map

During the process of generating a final thematic map, the themes identified through the data were reorganized multiple times by the research team. At first, I generated a list of all the themes organized into sub-categories (Figure 1). This served mostly as a brainstorming exercise to get a sense of the different themes and how they were related to each other.

Through multiple meetings with at least two senior researchers, the themes were reorganized into two new thematic maps (Figure 2 and Figure 3). These two thematic maps emerged out of discussion sessions aiming to understand and schematize the relationship between the themes. The first (Figure 2) helped visualize factors associated with entering allied services and mental health services separately. In this figure, arrows represent pathways from the streets to services and from allied service to mental health services. Most factors were understood to influence the pathway from allied to mental health service. However, after discussion, the research team agreed that this hypothesis, driven by our literature review, was not true to the data extracted from youths' discussions. Indeed, the youths did not differentiate between mental health specific services and allied services. The second (Figure 3) conceptualized the idea of accessing services through three steps: going, using, and engaging over time. In this figure, shapes are used in a sticky-note fashion – to place each theme in the area it belongs. Larger shapes were used to group themes that were related (homelessness and system factors) or to highlight how some themes impact all three steps of access to services (system factors).

As such, we created two final thematic maps (Figure 4 and Figure 5). The first (Figure 4) was used during the preliminary dissemination of the results as it provides a dynamic idea of access that is useful for service providers. It helps identify where the changes need to happen to help youths' access mental health services. However, the proposed timeline of access to services was not participant-generated. In this figure, the arrows represent the idea of the ongoing influence of the factors on the three steps of access. The second (Figure 5), used for this thesis, groups the various themes into simple categories as presented and discussed by the participants. This way of conceptualizing the themes allow us to re-introduce aspects of the

intersectional perspective on the youth that were lost in Figure 4. We also regrouped and re-named some themes to parallel themes present in previous literature. In the result section, I provide a deeper explanation of each theme presented in Figure 5.

Coding the transcripts lead to the identification of 22 factors influencing homeless youths' access to mental health services. When naming these factors, we chose to reflect youths' needs, as such the names are not based on what the services currently offer but rather what the youths would like in services, whether it currently exists or not. In order to stay in line with youths' realities, I felt that the data would be best illustrated by talking about youths' experiences with access to mental health services through the needs that they expressed. Choosing to name the themes in this manner also provides generalizable results; whereas, discussing what the services currently offer would only apply to the RIPAJ network. We grouped the factors associated with access to mental health services into two broad categories: (1) Care adapted at the individual-level and (2) Availability and structure of the services.

Figure 1 – Initial categorization of the themes

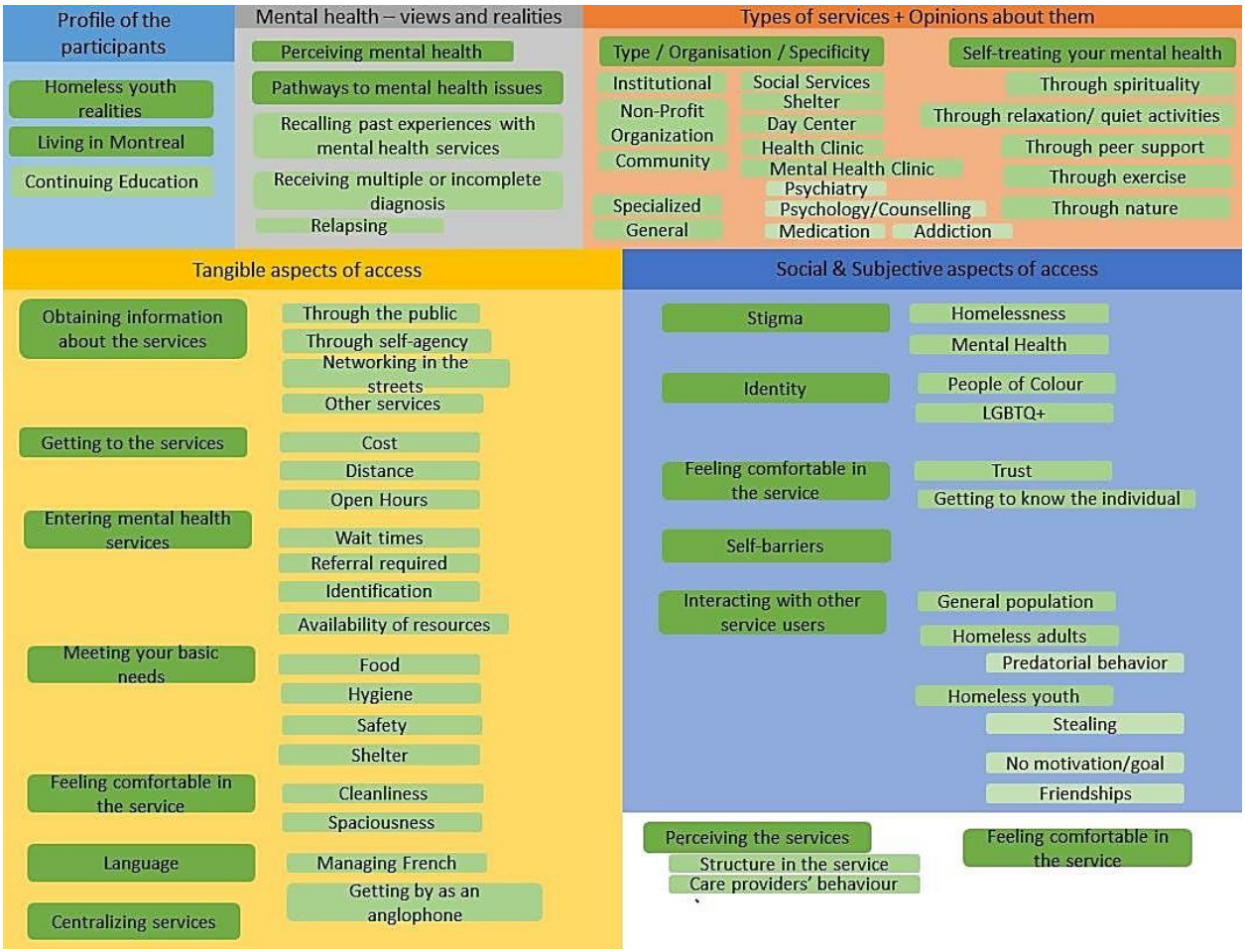


Figure 2 – Preliminary thematic map – Separated mental health and allied services

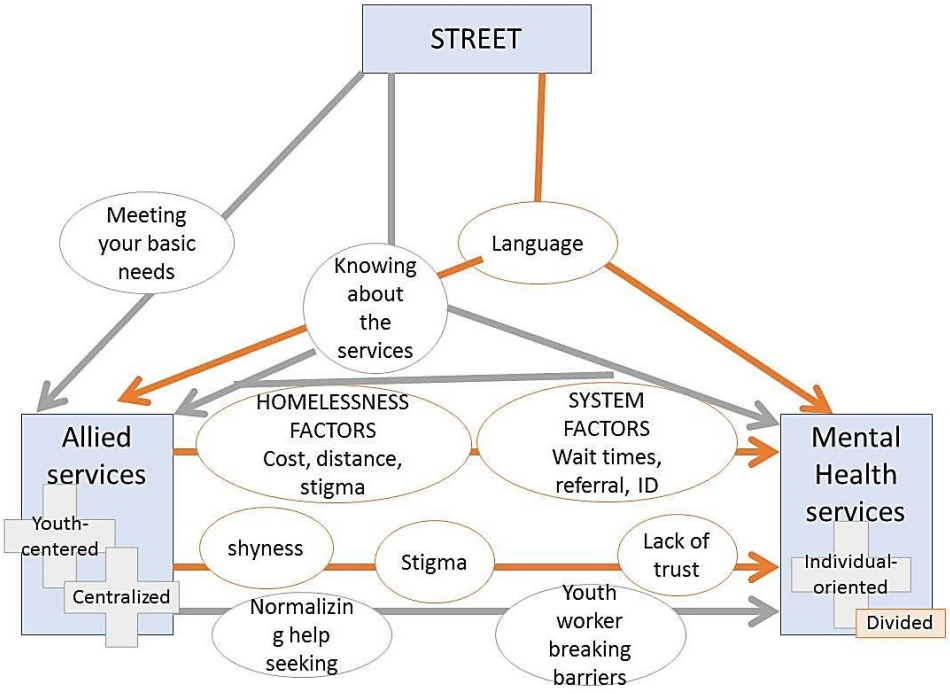


Figure 3 – Preliminary thematic map – Steps to access to services

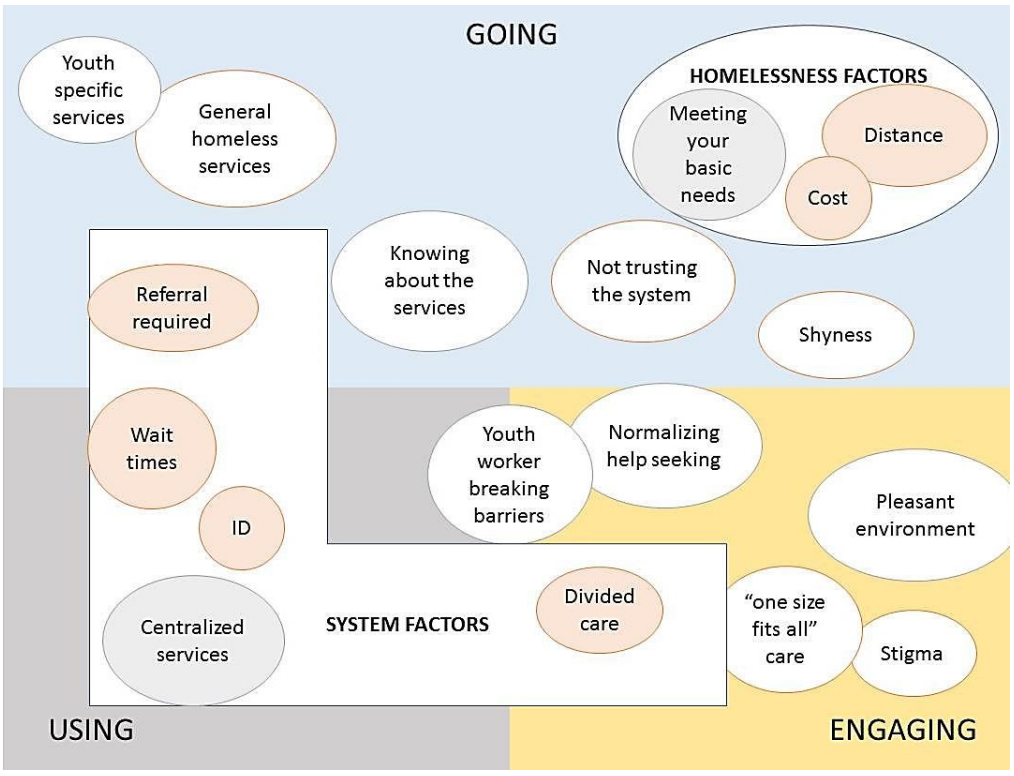


Figure 4 – Dynamic final thematic map

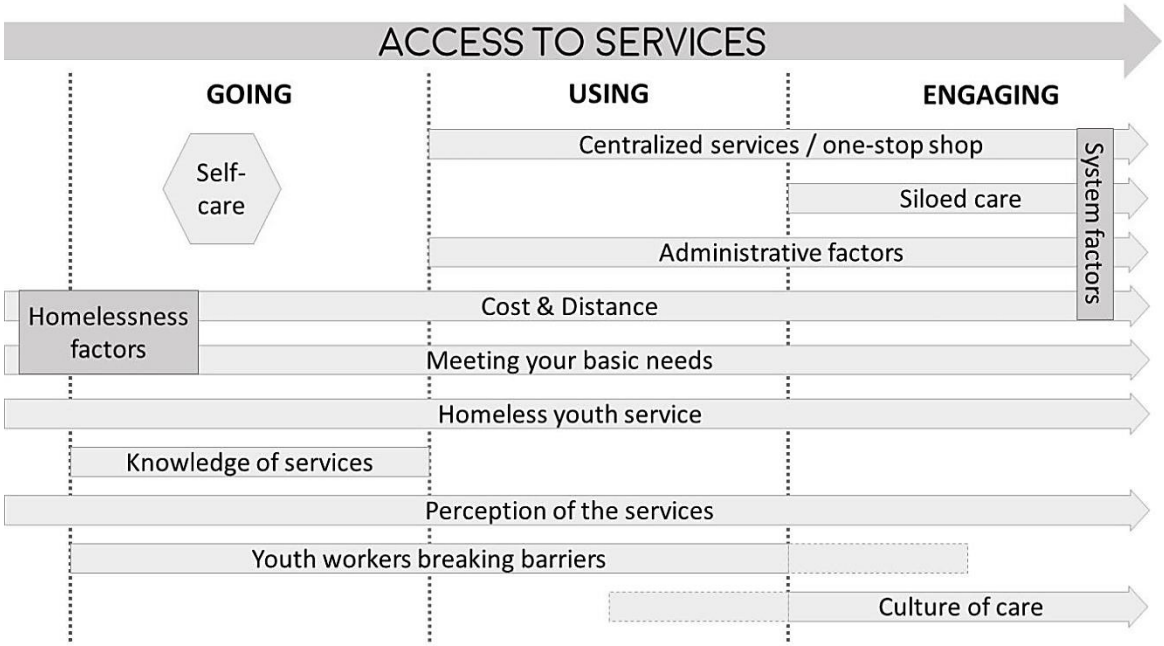
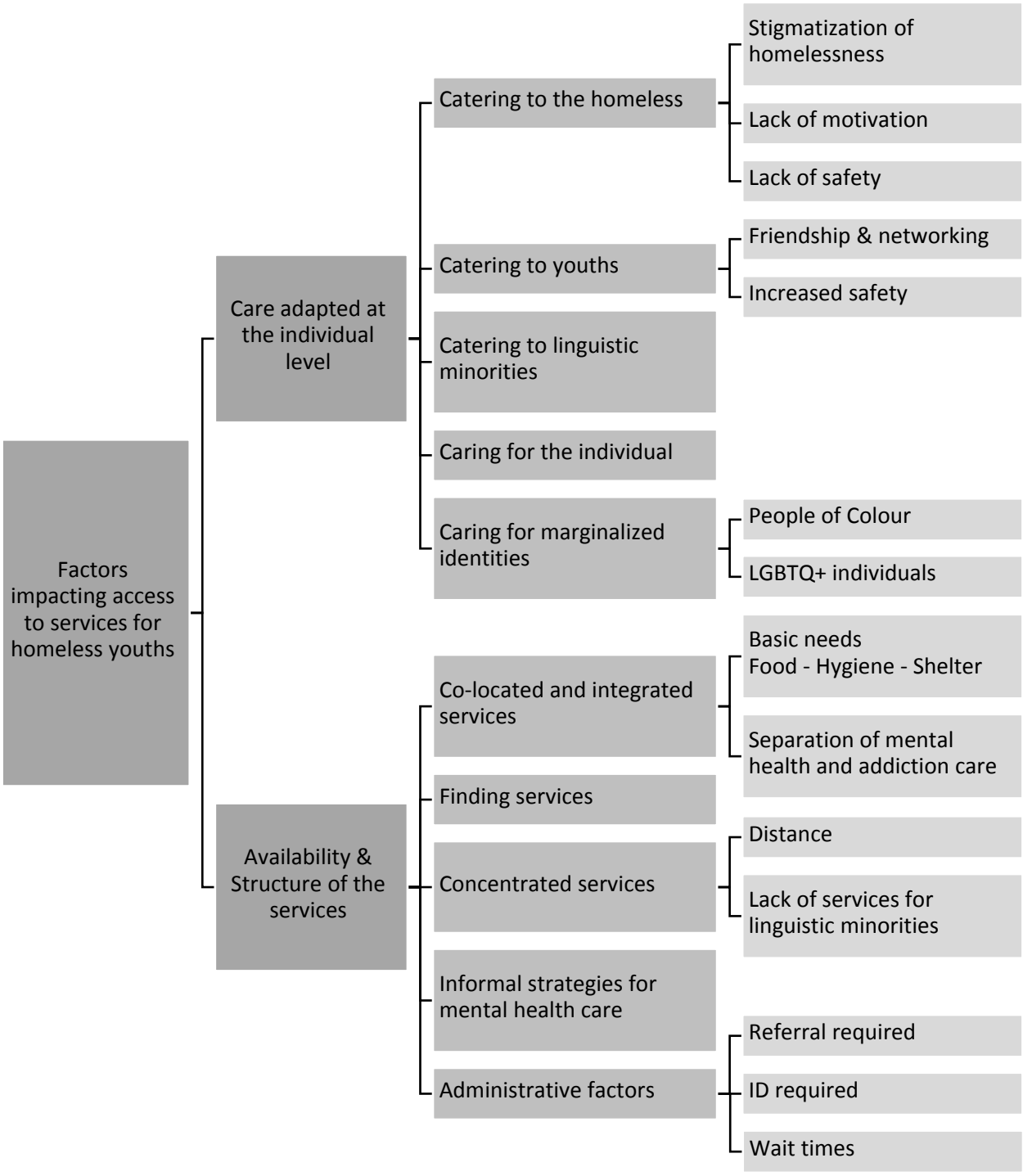


Figure 5 – Final Coding Tree



2.5.2 Generating the final group maps

To create the final maps, all services and hang-out spots from the different community mapping sessions were identified. They were then approximately added to a dynamic mapping software (mapz.com). Some services need to keep their location private and were therefore kept out of the final maps for publications. However, they were added in the maps during the analysis. Symbols and colors were used to differentiate the different services and their relevance to the research question.

Three final maps were created: one for linguistic minority youths (Figure 9 in section 4.3.2), one for linguistic majority youths (Figure 10 in section 4.3.2), and a summary map of all services identified by participants (Figure 11 in section 4.3.2).

CHAPTER 3 – PORTRAITS OF THE YOUTHS – QUANTITATIVE DESCRIPTIVE RESULTS

Twenty-two homeless youths took part in the community mapping activity, ranging between the ages of 18 and 25 years old (mean: 22.91 years old; s.d.: 1.95 yrs). To simplify the presentation of the results, I chose to use *youths* to refer to the participants in our study which were all homeless young people aged between 18-25 years old. Only one approached youth declined to participate in the study, prior to the start, and therefore did not sign the consent form. Eleven youths identified themselves as Francophone (linguistic majority), nine as Anglophone (linguistic minority), and two as Allophone (linguistic minority). The sociodemographic questions asked to the participants are shown in Appendix C. Street youths in Montreal come from all over the province, all over the country, and sometimes from international places. They seem to choose Montreal for its perceived openness to individuality and its ability to provide a range of experiences.

> There is something for everybody here [in Montreal]. Anything and everything. You could be into whatever you want, you can find it here. [sic]
>
> — **Linguistic minority white cis man**

Table 1 – Summary of sociodemographic variables by linguistic group

		All participants (n=22)	Linguistic Majority (n=11)	Linguistic Minority (n=11)
Age		22.91 ± 1.95	22.64 ± 1.86 n.s.	23.18 ± 2.09 n.s.
1=Poor; 5=Excellent	Self-Rated Health	3.24 ± 1.18 (n=21)[1]	3.30 ± 1.27 (n=10)[1] n.s.	3.09 ± 1.14 n.s.
	Self-Rated Mental Health	2.95 ± 1.25	3.09 ± 1.30 n.s.	2.82 ± 1.25 n.s.
Gender	Cis women	14	6	18
	Cis men	5	2	3
	Trans / non-binary youth	3	3	0
Minority status	Visible minority	5 (n=21)[1]	1	4 (n=10)[1]
	Indigenous identity	3	1	2
	Born outside of Quebec	4 (n=16)[1]	0 (n=9)[1]	4 (n=7)[1]
	Born outside of Canada	3	0	3
Spoken languages	French Only	2	2	0
	English Only	4	0	4
	Both French & English	16	9	7
Most used languages	French Only	8	8	0
	English Only	9	0	9
	Both French & English	5	3	2
Current living situation	Apartment	6	3	3
	Group Home	1	0	1
	Supported housing	2	2	0
	Couch surfing	1	1	0
	Someone else's house	1	1	0
	Homeless shelter	8	5	3
	In the streets	7	2	5
Mental health services	Currently or ever received MH services	14	8	6
	Currently think MH services could be helpful	14	6	8
Preferred languages for MH services	French Only	8	8	0
	English Only	9	0	9
	Both French & English	5	3	2

[1] n-values are indicated since some participants left the answer to this question blank

CHAPTER 4 – QUALITATIVE RESULTS

The qualitative results are presented according to the coding tree (Figure 5 in section 2.5.1). First, I present the factors related to *care adapted at the individual level*: catering to the homeless, catering to youths, catering to linguistic minorities, caring for the individual, and caring for marginalized identities. I then follow with the factors related to the *availability and structure of the services*: co-located and integrated services, finding services, concentrated services, informal strategies for mental health care, and administrative factors. Homeless youth services and mental health services accessible to youths are presented together under the term *services*, as participating youths did not distinguish between the two types; rather viewing all services as steps towards better mental health. Finally, I will present and discuss the group maps, for each linguistic group, as generated by the youths.

4.1 Care adapted at the individual level

Participants identified multiple factors that they deemed important for their access to care. These factors were related to the service providers' approach to care and addressed how they cared for various facets of youths' circumstances and personality, including: (1) catering to the homeless; (2) catering to youths; (3) catering to linguistic minorities; (4) caring for the individual; and (5) caring for marginalized identities. The way that youths felt treated by service providers strongly impacted the likelihood that they would engage with the service over time.

4.1.1 Catering to the homeless

For all linguistic groups, services catering specifically to the homeless population seemed to facilitate access to services by allowing participants to avoid feeling stigmatized or judged. However, even these services could negatively impact access by creating an environment where participants could feel unsafe or demotivated. In general, being around youth workers who understood the situation of homeless youths, or peer workers, was positive to the youth.

> [Homeless youth service 1], it's nice. They aren't here trying to bother you and asking you questions like "what are you doing with your life?" and all. They are open; you can talk to the youth workers. [sic]
>
> — **Linguistic majority white cis man** (translated[2])

> I know there are places where they have people who have lived in this situation who are there for the people in the same situation. It allows for more understanding and less judgment. [sic]
>
> — **Linguistic majority white non-binary youth** (translated[3])

When using services which did not cater to homeless people, participants of all linguistic backgrounds experienced stigmatization, which often took the form of being taken for *junkies* or being treated rudely by service providers.

> You may go to some hospitals, when you're homeless, who don't want to serve you that well because they think you are nothing but a piece of sh* [sic]
>
> — **Linguistic minority white cis man**

> It's like me… and my friend who was outside, waiting for people, and a cop keeps bothering him. Or like you who tries to go to a hospital and gets treated like a junkie. Those things don't have a place here. [sic]
>
> — **Linguistic majority white cis man** (translated[4])

[2] Original : «[Service pour jeunes de la rue 1], c'est cool. Ils sont pas là entrain de te faire chier, puis entrain de te poser : "qu'est-ce que tu fais dans la vie? ", puis toute. T'sais, ils sont ouverts; tu as le droit de parler avec les intervenants. » [sic]

[3] Original : «Je sais que y'a des places où y'ont des personnes qui ont vécu la situation qui sont là pour des personnes dans la même situation; fait que ça permet que y'ai plus de compréhension puis moins de jugements. » [sic]

[4] Original : « Moi puis mon ami qui était dehors, qui attendait du monde, puis qui se fait écœurer par un policier. Ou toi qui essayes d'aller dans un hôpital puis qui te fait traiter de junkie. T'sais ça a pas sa place ça. » [sic]

Another experience related to stigmatization that emerged in the linguistic minority group was when participants felt forced into certain areas of town, often told by the police to "get out of the rich people neighbourhood", as said by a linguistic minority youth. In those areas, they also noticed how residents can be bothered by the presence of homeless youths and the presence of the services there to help the youths.

> Everything is really concentrated in one area. It seems like they've relegated people like us into a certain area where they can manage us. And it seems like they are saying: "You better f* off to this part of the city where we put undesirables". [sic]
>
> — **Linguistic minority Indigenous cis man of color**

Salient in all comments around stigmatization of homelessness, there seemed to be a feeling of not being cared for, of being perceived as a nuisance more than a person.

> Homelessness is a concept that will disappear one day. People will realize we are all friendly. We are all the same thing; we are all the same. So, when someone is suffering, we all suffer. It's not by leaving a few people behind that we save the whole pack. Everyone loses. You know… if I wasn't homeless, I would save lives. [sic]
>
> — **Linguistic majority white cis man** (translated[5])

Participants of all linguistic groups also talked about the negative/depressing impact of being surrounded and interacting with homeless people, including other homeless youths, who did not seem motivated to help themselves.

[5] Original : « L'itinérance est un concept qui va être révolu un jour. Les gens vont se rendre compte qu'on est toute sympathique. On est toute la même chose, on est toute pareils. Fait que quand quelqu'un souffre, tout le monde souffre. C'est pas en en laissant quelques-uns derrière qu'on sauve toute le peloton. Tout le monde y perd. T'sais moi si je serais pas itinérant, je sauverai des vies. » [sic]

> For me it's not really about a specific place, it's more about mental strength. No matter where you go, it's about being strong. Every time I go to services, I feel my well-being decrease at least a little bit because of the people that are there. Even if I try to move forward, I can see that there are others who aren't trying to move forward. [sic]
>
> — **Linguistic majority white cis man** (translated[6])

> How does it feel to be surrounded by youths that are not trying to help themselves? // Me? Personally, it has to do with being lazy. That's it. Like you have some of them... Honestly, I'm gonna be rude, because I've been around, I've been homeless. […] so, it's not like I'm better than anybody else. It's just not like… do I want to waste myself and like go into drugs and all that stuff, when I know there is so much resources out there that can help better myself. And they know there is resources there but they just are not willing to try. [sic]
>
> — **Linguistic minority cis woman of color**

Another obstacle to participants' desire to access homeless-oriented services was that they could not trust that their belongings were safe.

> I could say that it's very different, but there are similarities as well. Except at [Women shelter] there are thefts too, yes, we have lockers but…[sic]
>
> — **Linguistic majority white cis woman** (translated[7])

[6] Original : « Moi, c'est pas tant des places en particulier, c'est plus une histoire de force mentale. T'sais peu importe où ce que tu vas aller, c'est une question d'être fort. Moi, à chaque fois que je vais dans des ressources, ça me rabaisse tout le temps un minimum à cause des personnes qui sont là puis toute. Même si j'essaye d'avancer puis que je vois que y'en a qui essayent pas d'avancer. » [sic]

[7] Original : « Je pourrais dire c'est très différent, mais y'a des côtés similaires aussi — beaucoup qui se ressemblent. Sauf que comme à [hébergement pour femmes] aussi y'a des vols. Oui, on a des casiers aussi. » [sic]

> I was on my phone. I stuck my phone on my chest and I woke up and my phone was still there. […] But I was like laying like this, my phone was directly sitting on me. I woke up and I was like "Oh I got my phone". […] No, I'm gonna wake up. I need to take my anger out on something. And that's justified. Don't touch my shit! I'll break your jaw. [sic]
>
> — **Linguistic minority white cis man**

> It sucks because everyone feels free to steal. As soon as there is an opportunity to take something from someone, there are some who will do it. [sic]
>
> — **Linguistic majority white cis man** (translated[8])

4.1.2 Catering to youths

The youth aspect of services was important to the participants of all linguistic groups, as it allowed them to create relationships with other youths. All participants prioritized using services that specifically catered to homeless youths as opposed to general homeless services, which cater to homeless adults, as they felt safer with other youths. Being surrounded by other homeless youths allowed participants to develop friendships and support networks. These networks could help youths find helpful services.

> We can create new friendships, new trusted connections also. [sic]
>
> — **Linguistic majority white cis woman** (translated[9])

> What's the first thing you do? You talk to the homeless people. You go meet the homeless people, and you make friends with them, and you give them weed and cigarettes. Just give them things. [sic]
>
> — **Linguistic minority white cis man**

[8] Original : « Moi je trouve ça poche parce que le monde, ils se permettent avec le vol. Dès que y'a une opportunité de prendre quelque chose à quelqu'un, ben les gens le font. » [sic]

[9] Original : « On peut se faire des nouvelles amitiés, des nouvelles confidences aussi.» [sic]

One youth mentioned that shyness can make it harder to access services. Shy youths have a harder time entering a new environment alone and knowing what to expect from the activities and the services provided.

> I don't really know the LGBTQ organizations but I would like to go. I would like to… I don't know… meet a circle of friends that visit those organizations. But I am so shy. [sic]
>
> — **Linguistic majority white non-binary youth** (translated[10])

Homeless adult services were seen as unpleasant and unsafe, sometimes due to youth-reported predatory behaviour by older service users. Indeed, youths went as far as preferring sleeping in the streets over using a shelter not specifically for homeless youths.

> I've heard the main [shelter] for older men apparently is [General homeless service] and all I can really say about [General homeless service] is horror story. Not even so much that the staff are bad, but the general crowd that goes there. [sic]
>
> — **Linguistic minority Indigenous cis man of color**

> The [Youth shelter 1] is 30 days on and off. When I was on the off month at the [Youth shelter 1], I'd sleep outside because all the other ones would creep me out. [sic]
>
> — **Linguistic minority white cis man**

> That's why they don't like people under 25 because we become targets to these creepy old men. [sic]
>
> — **Linguistic minority white cis man**

[10] Original : « Je connais tellement pas les organismes LGBTQ mais j'aimerais ça y aller. J'aimerais ça… je sais pas… me faire un cercle de gens qui fréquentent ces organismes-là. Mais je suis tellement gêné.e. » [sic]

4.1.3 Catering to linguistic minorities

Linguistic minority youths were asked about their experiences accessing services while not being completely comfortable in French (majority language). Many mentioned working on their French, or understanding French better than they could speak it. In some situations, services would not accept linguistic minority youths, even when they were seeking supports for basic needs due to the staff's lack of ability to communicate in English (main minority language). Youths in these circumstances reported finding themselves forced to sleep in the streets. Linguistic minority youths reported being treated differently and disrespectfully when using services in French-speaking hospitals. They also mentioned how often, even if a worker in the service can help them in English, the paperwork was in French and posed difficulties.

> She doesn't speak any French. The nurse there treat her like shit, they're refusing to help her because she spoke English. [sic]
>
> **— Linguistic minority white cis man**

> The services I use, it's pretty much English. Because I don't really access the French ones. The [Addiction service] is actually 90% French. Most people there don't speak English, but I work on my French. [sic]
>
> **— Linguistic minority white cis man**

> They did it in English. They had the paperwork in English. 80% of the people didn't speak… couldn't really get English. // I hate it when I go somewhere and you need help and they speak to you in your language but they give to you the paperwork in the opposite language. Like how the fuck you supposed to understand that? [sic]
>
> **— Linguistic minority cis man of color**

> I've stayed in shelters too. And I've gotten discriminated at a shelter. Yeah, like one time I called the shelter and they were like: "you can't come here because I only accept French people". And I was like… I can learn because all their activities are in French. But I said I understand that. [sic]
>
> **— Linguistic minority cis woman of color**

> I try to apply for an apartment with them, but places were asking me more. […] I was kinda discriminating with them, because you have to only speak… you have to know really well speaking French. […] you have to speak with the people who work there in French, it's mandatory. That part, I think: discrimination. [sic]
>
> **— Linguistic minority cis man of color (allophone youth)**

Linguistic minority youths were sometimes able to access services that did not typically cater to linguistic minorities by being referred to those services by other service providers who were fluent in French.

> [Youth shelter 2], a long time ago they wouldn't accept me because I didn't speak French. And then I came to [Homeless youth service 1] and spoke to [Youth worker] and [Youth worker] got shit rolling and then I went there. And then, there's another place by like [location]: "Oh sorry, use other resources.". But sorry there's none so what am I supposed to do. [sic]
>
> **— Linguistic minority cis man of color**

4.1.4 Caring for the individual

One repeated frustration that participants of all linguistic groups reported stemmed from perceiving service workers as treating every individual the same way, *one-size-fits-all* approach. Homeless youths preferred an individualized approach, where care is administered differently depending on an individual's needs. Although it may be argued that most people would prefer such an approach, homeless youths' complex backgrounds make it even more relevant to highlight. In order to feel comfortable in services, youths mention a need to be treated as

whole individuals, capable of self-determination. They identified that some services seemed to treat them as fitting a stereotype to which they then applied a particular model of services. Youths preferred to access services that are adapted to their individuality and they expressed more engagement with service providers who take the time to get to know them as a person.

> They don't take the time, it seems, to take the person's profile. [sic]
> — **Linguistic majority white cis woman** (translated[11])

> I think we would need "emotion-ologists", not just professionals that read their books and who think this is what works in life. We need someone who may not have experience but who is, at least, sufficiently open to get to know the individual and why they are unhappy, for example. [sic]
> — **Linguistic majority white cis man** (translated[12])

> It makes me think of self-determination. There are a lot of organizations, like [Homeless youth service 1] for example, that have this principle that if the person can make their own choices for themselves and to know what is good for them, then you encourage them with that, then you trust the person with their choices. [sic]
> — **Linguistic majority white non-binary youth** (translated[13])

[11] Original : « Parce que c'est ça, ils prennent pas la peine, on dirait, de prendre le profil de la personne. » [sic]

[12] Original : « Je trouve qu'il faudrait des *sentiment-ologues*; pas juste des professionnels qui ont lu leurs livres puis qui pensent que c'est ça qui marche dans la vie. Avoir quelqu'un qui a peut-être pas d'expérience mais qu'au moins qui est assez ouvert pour apprendre à connaître la personne, apprendre à connaître pourquoi qu'elle est malheureusement, des trucs du genre. » [sic]

[13] Original : « Ça me fait penser à l'auto-détermination. Y'a pleins d'organismes, comme par exemple [Service pour jeunes de la rue 1], qui ont ce principe là que la personne est capable de faire ces choix pour elle puis savoir qu'est-ce qui est bon pour elle, puis de l'encourager là-dedans, puis de faire confiance à la personne pour ces choix. » [sic]

> They don't know how to deal with our people problems. They just deal with normal people problems. Like, the moment addiction or homelessness gets there, they get lost. […] They'll try to help you but you can see they are not comfortable. The services only go thus far you know. [sic]
>
> — **Linguistic minority white cis man**

Youths also expressed not always trusting service providers, fearing that they may be coerced into a system of care without their explicit consent.

> I don't trust the system. When I get to a hospital, I get scared. Because I always feel they won't let me go. I have this big fear. Once you go to a hospital, they can find a reason and they don't release you until a doctor approves it. That's the thing about a hospital: they can literally just take you in and keep you if they think there is a good reason. [sic]
>
> — **Linguistic minority white cis man**

Participants mentioned allied services as varying in their insistence on discipline and structure, ranging from rigid to lenient. Youths too had varying preferences for these different levels of structure, but mentioned wishing the service would ask them what type of structure they would prefer, and then building an intervention plan fit for each individual, as this would make it more likely each youth to engage with a service and recommend it to others.

> Sincerely, the second [Youth shelter] I used, I stayed not even three weeks. Then I said f* that. I would rather get back in the streets and go to [Youth shelter 1] then to get told how to do things, how to live. [sic]
>
> — **Linguistic majority white cis man** (translated[14])

[14] Original : « Sincèrement, la deuxième [Hébergement pour jeunes] que j'ai fait, je suis resté même pas trois semaines. Puis j'ai dit : "f* that". J'aime mieux retourner dans la rue, et d'aller à [Hébergement pour jeunes 1], plutôt que d'être là puis de me faire dicter comme faire, comme vivre. » [sic]

> No, it's not very strict. Like they explain how is everything and we have to be there. It's like a game… No, not a game…. It's like there is a rule and you follow the rules and if you don't follow the rules you can't stay there and if you stay outside it's really bad for you. So, you want it or you don't want it, you have to stay there anyway — rule of survival. [sic]
>
> — **Linguistic minority cis man of color (allophone youth)**

> When you come to [Homeless youth service 1], they say it clearly in the take-in interview: "you come here when you need a break from the streets". That means you may be intoxicated but if you come here, you don't consume substances, you don't talk about it. That's really what matters to remember: it's a break from the streets. [sic]
>
> — **Linguistic majority white cis man** (translated[15])

4.1.5 Caring for marginalized identities

Participants who identified as people of color, in both linguistic groups, discussed experiencing racism and discrimination regularly from civil servants, such as the police or public transport workers, or even from education providers. They mentioned not feeling treated differently by the RIPAJ network and not seeing racism within these services. They saw this as a positive aspect which encouraged their engagement with these services.

> And I think especially the youth workers there [RIPAJ organization], I like them a lot. They are, I'm saying this, they are not racist. [sic]
>
> — **Linguistic minority cis man of color (allophone youth)**

Participants who identified as part of the LGBTQ+ community (Morisseau-Guillot et al., 2020), expressed that the way they were treated depended on the individual within the service. Some workers were very accepting of the participant's identity while others were not,

[15] Original : « Quand tu viens à [Service pour les jeunes de la rue 1], ça dit très bien quand on fait notre entrevue d'accueil : "Tu viens ici, quand tu veux prendre un break de la rue". Ça veut dire que tu peux être en état de consommation, mais quand tu viens ici, tu en consommes pas, tu en parles pas. C'est vraiment ça qui est important à retenir : c'est un break de rue. » [sic]

sometimes using wrong pronouns or making off-hand comments. They were also aware that not all workers had received training to work with the LGBTQ+ community.

> The trans 101 was given in some organizations // Yes but everyone needs to participate. [sic]
>
> — **Linguistic majority white trans youth** (translated[16])

4.2 Availability and structure of the services

Participants identified multiple factors related to structural aspects of the services. Those factors addressed the general availability of the services, or lack thereof, and the structure within the service, such as (1) the integration of services; (2) finding services; (3) concentrated services; (4) informal strategies for mental health care; (5) administrative factors.

4.2.1 Co-located and integrated services

Youths expressed a preference for the co-location of various services and supports in one location/structure, and saw it as improving access to care. They also talked about the importance of integrated services which communicate amongst themselves and refer youths as needed. Participants of all linguistic backgrounds desired co-location and integration. The way they conceptualized co-location included support for basic needs and a combination of addiction and psychiatry services. Homeless youths have several basic needs (including food, shelter, and hygiene) that may need to be met before or in addition to receiving mental health services. The availability of food, and the palatability of said food, came up regularly in youths' comments about allied services. Services that provided good food and supported young people with personal hygiene seemed to open doors that youths were more likely to go through. Thus, co-located services provided street youths multiple opportunities to get in contact and familiarize themselves with services.

[16] Original : « Y'a le trans 101 qui a été donné dans certains organismes. // Ouais mais faut que tout le monde y participe. » [sic]

> The [Youth service]. All of them. They help me reach my fitness goals, mental health goals, life goals. [Governmental first-line health and social service] for x, y, and z reasons. [sic]
>
> **— Linguistic minority cis man of color**

> If there were really one point in Montreal that I had to pinpoint as a place where I can usually be relied upon to turn up, it's literally right here [Homeless youth service 1]. Even if I'm like, you know, fried on acid, I'll still show up here for lunch. [sic]
>
> **— Linguistic minority white cis man**

> The [Youth shelter 1] is actually… the staff is good; the food is pretty good. [sic]
>
> **— Linguistic minority Indigenous cis man of color**

> I only really started using shelters after I got a job because it gave me somewhere to actually get a solid night sleep and shower before I go to work. [sic]
>
> **— Linguistic minority white cis man**

A recurring theme in relation to youths' basic needs was around access to shelter. All participants, regardless of linguistic group, mentioned negative or positive feelings about various shelters they have used. Shelters themselves do not provide access to mental health services; however, some shelters seemed to provide a schedule and a set of rules that facilitated youths' access to such services.

> I didn't try and access anything because like I don't care. I'm okay with who I am. But like, I stayed in a shelter one night, that entire 6 months, because like some guy was trying to kill me. And they kinda saved me by like giving me coffee and a muffin. But even in Montreal, it's been, I don't know, a couple months. I'd rather stay in the park and not access any services. Listen to music and just do hard things. And just do my own thing like I don't need to be classified as something that I'm not just because I am different than you. [sic]
>
> — **Linguistic minority white cis man**

> Shelter is basically for that. It's basically to get out of the streets.
>
> — **Linguistic majority cis man of color** (translated[17])

> Currently, I'm at the [Youth shelter 3] and, yes, it does take a certain discipline. […] Because before, when we are free, we can do whatever we want: we can sit on our ass all day, 24/7. It's okay but we don't move forward. And here, there are steps to do from 9 to 4. […] Which teaches us, when we get a home, to take care of our stuff, to have good habits. [sic]
>
> — **Linguistic majority white cis man** (translated[18])

Youths expressed a need for more inclusive mental health services and identified that addiction and psychiatry are often treated separately, which can delay access to proper care.

[17] Original : « L'hébergement c'est pas mal pour ça. C'est pas mal pour sortir de la rue. » [sic]

[18] Original : « Présentement, je suis à [Hébergements pour jeunes 3], puis oui c'est sûr ça prend une certaine discipline. […] Parce qu'avant, en liberté, on peut faire c'qu'on veut : rester assis sur notre cul toute la journée 24 sur 24, 7 jours sur 7. C'est correct sauf qu'on avance pas : j'avançais pas plus. Sauf que là, pendant la journée, y'a des démarches à faire de 9 à 4. […] Ce qui nous apprend, mets qu'on arrive chez nous, à faire nos affaires, prendre des bonnes habitudes.» [sic]

> Sometimes, especially like, I find there should be more mental health things. I had a big problem… I had a problem last week where I tried to do something and then no crisis center took me because I'm on suboxone. So, I had to go to and addiction center, it's like "what the f*". [sic]
>
> — **Linguistic minority white cis man**

> What makes it helpful? // Because there are a lot of resources. [sic]
>
> — **Linguistic majority white cis woman** (translated[19])

> Are there shelters for addicts? Does it exist? There's definitely a need for it. [sic]
>
> — **Linguistic majority white non-binary youth** (translated[20])

Other youths mentioned being unable to access mental health services because these services viewed drug consumption as a separate issue that needed to be dealt with first. Homeless youths in this situation often have to go through a detoxification service before being eligible to enter specialized psychiatric services. The detox services are too short, according to the youths. When the addiction services end, the youths are just sent back to their reality: the streets, living in shelters, socializing with other youths going through substance misuse difficulties. They are not directly referred or transferred to the psychiatric services they needed in the first place and they are not provided with social support to address other factors that may have influenced their consumption in the first place.

[19] Original : « Qu'est-ce qui fait que c'est aidant d'abord? // Parce que y'a plusieurs ressources. » [sic]

[20] Original : « Y'a tu des auberges pour les toxicomanes? Ça existe-tu? Y'a un besoin en tout cas. » [sic]

> I've been trying to see a psychiatrist for over 2-3 months. And first I couldn't see one because, you know, they say I party too much; this was stupid, you know. Part of it is, like, I'm sober 53 days. And, you know, it's probably because I have a mental illness, I think I'm bipolar or something but you know when you see a psychiatrist than they say "oh, you need to take care of that, then you can see him". But it makes no sense because they go hand in hand. [sic]
>
> — **Linguistic minority white cis man**

4.2.2 Finding services

Participants of all linguistic groups discussed strategies they used to find services. Homeless youths often seemed to find mental health services by carrying out their own research. While they saw the internet as a useful place to find out about services, they found the websites of services as not being youth-friendly and as being tailored towards donors instead. Many participants wanted to know more about activities that services offered. Indeed, many services still use billboards and in-person calendars to inform the youths of activities; a practice which certainly has its place with many youths relying only on this.

> I really think the information needs to be on the internet for the people who are looking for it. Because sometimes you look for services or organizations, and you don't know. Like for example at [Homeless youth service 1], they always update their schedule late, but I want to know what is going on. [sic]
>
> — **Linguistic majority white non-binary youth** (translated[21])

> Yes, it's often made for donors. But youths are looking for the information on the internet; we are in 2018. [sic]
>
> — **Linguistic majority white non-binary youth** (translated[22])

[21] Original : « Je trouve ça vraiment important que l'information se ramasse sur l'internet pour les gens qui en cherchent. Parce que des fois tu cherches des organismes ou des services, puis tu sais pas. Comme en bas chez [Service pour les jeunes de la rue 1], ils mettent tout le temps leur calendrier en retard, mais moi je veux savoir ce qu'il se passe. » [sic]

Irrespective of linguistic background, youths mentioned networking in the streets, sometimes through a barter-system – exchanging goods, services, and information, as a means of getting information about services and obtaining required help.

> Yes, a lot of people told me “don’t go to this place, don’t go this place, don’t go to this place”. And I’m like “I won’t go”. [sic]
>
> — **Linguistic majority white trans youth** (translated[23])

> I heard from word of mouth to know where the [Homeless youth shelter 1] was. And from that place, I got linked to others, technically. [sic]
>
> — **Linguistic majority white trans youth** (translated[24])

Participants mentioned receiving information about other services by asking a service that they were already using about additional services. However, they often had to take the initiative to ask for such information which was not necessarily offered by default. Linguistic minority youths mentioned being refused at some French-only services, mainly housing services, that did not offer alternatives for linguistic minorities.

> That is true: almost every resource will give you a paper with every single resource. [sic]
>
> — **Linguistic minority cis man of color**

[22] Original : « Oui c’est souvent pour les donateurs. Puis les gens vont chercher l’info sur l’internet; on est en 2018.» [sic]

[23] Original : « Oui, beaucoup de personnes m’ont dit genre : “vas pas à telle place, vas pas à telle place, vas pas à telle place”. Je suis comme : “j’y vais pas”. » [sic]

[24] Original : « Moi j’ai entendu d’oreille en oreille pour savoir le Bunker il était où. Puis le [hébergement d’urgence pour les jeunes de la rue 1], ça m’a relié aux autres, techniquement. » [sic]

> So, if you go somewhere, and they don't accept you because you don't speak French well enough, do they recommend other places you can go to? // [All participants answered] No // Sometimes yeah, sometimes I don't know, maybe I didn't ask, they say no so. [sic]
>
> — **Linguistic minority cis man of color (allophone youth)**

Youths mentioned that some youth workers did not mention all available resources when they were asked for help:

> And then sometime, some of the social workers[25] don't necessarily tell you what is out there. Some of them are just really particular who [they] tell certain things to. So, one of them might tell "oh you can go here or here" but then some other person they are limited in what they can tell you. Like I've been around certain social workers[2525]. Some of the stuff I had to hear from other kids, you know, in the same situation. I didn't hear that from the social worker[25] when they had that, when they had resources. They are willing to tell certain people certain things, but they are not going to tell that person or whatever. Like even if you want to try to better yourself right. They don't tell you the resources that they know that they have. [sic]
>
> — **Linguistic minority cis woman of color**

4.2.3 Concentrated services

Participants of all linguistic backgrounds noticed that services that were accessible, mainly services that catered to homeless youths, were concentrated in the same area of town, which was predominantly a French-speaking (linguistic majority) area. One important consequence of this is that youths who do not live near this area had a harder time accessing services, because of lack of funds for transport or because of simply not knowing about these services. Linguistic minority youths were quick to point out that the Anglophone (linguistic minority) hospitals

[25] The participant used the term *social workers* to refer to youth workers who may not have a diploma in social work.

were far away from this area, thereby making access to mental health services harder for homeless youths who were from a linguistic minority background.

> I find that a lot of the services are grouped together; a lot are in the same area. It's like, if you are not here, if you're not within a certain range, you're not even gonna hear about it. You're not gonna see people. You're out of reach. [sic]
>
> — **Linguistic minority Indigenous cis man of color**

> Because someone who doesn't live in the same place; someone who lives over there and who needs services but doesn't have the money to take the metro or the bus — how will you travel all the way here from all the way over there? It's access to services. I have friends who live over there who are not able to have access to services. [sic]
>
> — **Linguistic majority white cis man youth** (translated[26])

> What we were noticing [...] is that all the services that are accessible, shelters and everything, are separated from the English hospitals. [sic]
>
> — **Facilitator** (providing a summary)

Linguistic minority youths talked more about the general lack of availability of services, commenting on the distance from hospitals and on the lack of services in general. They used services in the area of the city where they were concentrated, but primarily to support their basic needs which did not necessitate proficiency in French (linguistic majority language). The services themselves were not necessarily seen as being able to cater to linguistic minority youths. Linguistic minority youths also identified a lack of mental health services, especially as mental health specialists seemed to be in high demand and unavailable.

[26] Original : « Parce que quelqu'un qui habite pas à la même place; quelqu'un qui habite là-bas et qui a besoin de ressources mais qui a pas d'argent pour prendre le métro, l'autobus — tu vas te déplacer jusqu'ici? de là-bas là, au bout? C'est l'accès aux services. J'ai des amis qui habitent là-bas puis qui sont pas capable d'avoir accès aux services. » [sic]

> There's a lot of social services. There's a shit ton, but there are not really that good. Especially for English people. And I know there is a lot more for French people, like for addiction. They have maybe like 50, and like 3 for English people, you know. [sic]
>
> **— Linguistic minority white cis man**

> I literally have to schedule a good couple week. Because part of the problem is, they go hand in hand. So, I'm on a big waiting list, told me it would take a few months to see a specialist or psychiatrist, and there's only one of them that goes to the doctor's office once a month. And there's a big waiting list, you know, so obviously, not everyone can be seen. [sic]
>
> **— Linguistic minority white cis man**

4.2.4 Informal strategies for mental health care

Only linguistic minority participants mentioned informal strategies such as relaxation, peer support, exercise, quiet activities, and being in nature to increase well-being and mental health. Drug use was talked about as a recreational activity and a form of self-medication.

> My mental health services is my friends, and my parks, and the people I have connections with, and I give a shit about, and I care. So, most of my mapping consists of where my friends live in the city, and which parks I find most of my self-medication at, and my self-therapy, which is really just talking to other people about it. [sic]
>
> **— Linguistic minority white cis man**

> I'm just gonna do my own thing. Through like meditation and reading, I can understand mental illness rather than try to numb it. [sic]
>
> **— Linguistic minority white cis man**

> I got the mountain and on one side it's just, like, where I used to party on the mountain, so I just wrote *party*. And on the way up the mountain, where it actually goes up, I wrote relaxing and reading and exercise. [sic]
>
> — **Linguistic minority white cis man**

One Allophone youth talked about the importance of spirituality to him.

> I like to pray. I like the temple. Because when I have problems, or when someone has problems or when others have problems, I am always there. I go there more. I feel like it's a place that can really appease me. [sic]
>
> — **Linguistic minority cis man of color (allophone youth)**

4.2.5 Administrative factors

A number of tangible factors can affect homeless youths' ability to receive proper mental health care. Even after homeless youths became aware of and knew about mental health services they could use, the process of accessing and receiving mental health service was filled with its own barriers. Some such barriers identified by youths of all linguistic groups included requirements for referrals, IDs or medical insurance, and extended wait-times. Some places required referrals for youths to receive mental health services.

> I recommend you go get your referral from the [Governmental first-line health and social service] before. // You need a referral from an organization. [sic]
>
> — **Linguistic majority white cis woman** (translated[27])

Some participants felt they had to be arrested by police in order to get mental health services that properly took time to help them

[27] Original : « Je te conseille d'aller prendre ta référence au [Service de santé et de services sociaux gouvernemental de première ligne] avant. // Faut que tu ailles une référence d'un organisme. » [sic]

> It kinda sucks that you needed to receive services and that's what you had to do to get them, get charged. It's kinda sad — the system. [sic]
>
> — **Linguistic minority white cis man**

Many services required ID or medical insurance to receive mental health services. The reality for homeless youths is that some may not always have proper identification on them, for a variety of reasons. Amongst homeless youth services, many accepted youths without proper identification or medical insurance, and often helped the youths through the process of acquiring these.

> Like at this [Governmental first-line health and social service] they take you without a medical card, but you know, you go to another [Governmental first-line health and social service] they may not necessarily serve you without a card. [sic]
>
> — **Linguistic minority white cis man**

Another important barrier seemed to be around wait times associated with accessing mental health services. Wait times took different forms, from being on a waiting list before receiving any form of help to waiting in person for a walk-in service. One participant mentioned having received an evaluation within 72-hours of her first request for help. After this evaluation, it was established her demand could wait and it took long before she received any follow-up service. However, she identified this practice of having received an initial assessment of her needs as helpful:

> There was wait. I had to wait a year and a half to connect directly with the [Governmental first-line health and social service], simply to get access to a follow-up and regular care. Yes, but she did give me a first meeting really quickly, to establish my needs. When she saw that it wasn't really urgent, she gave me a longer wait time, but the first evaluation was done in 72 hours. [sic]
> — **Linguistic majority white cis man** (translated[28])

4.3 Community maps

4.3.1 Individual maps

The individual maps created by the youths took on a lot of different perspectives and aesthetics. Some of the youths chose to highlight a few services and indicate different spots in the city that relate to their lives (Figure 6). Others preferred to write-out information about the services they wanted to discuss (Figure 7). Some of the youths simply highlighted various points of the city without communicating their importance or used the map to see which areas of the city they knew (Figure 8). Some participants also chose to keep their individual maps blank: they took the time to think of services that they shared during the discussion. Individual maps were not analysed individually: information from these maps were combined with the group maps for analysis. I chose to present them here as data from the study and as an introduction to the group maps presented in the following section.

[28] Original : « Y'a eu de l'attente je te dirais. Y'a eu un an et demi d'attente pour me connecter avec justement le [Service de santé et de services sociaux gouvernemental de première ligne], juste pour avoir accès à un suivi. Oui elle m'a fait une première rencontre d'évaluation rapidement, pour établir les besoins. Quand elle a vu c'était pas justement urgent, elle a mis le temps d'Attente un petit peu plus long. Mais la première évaluation s'est faite dans les 72hrs. » [sic]

Figure 6 – Examples of individual maps with personal experiences

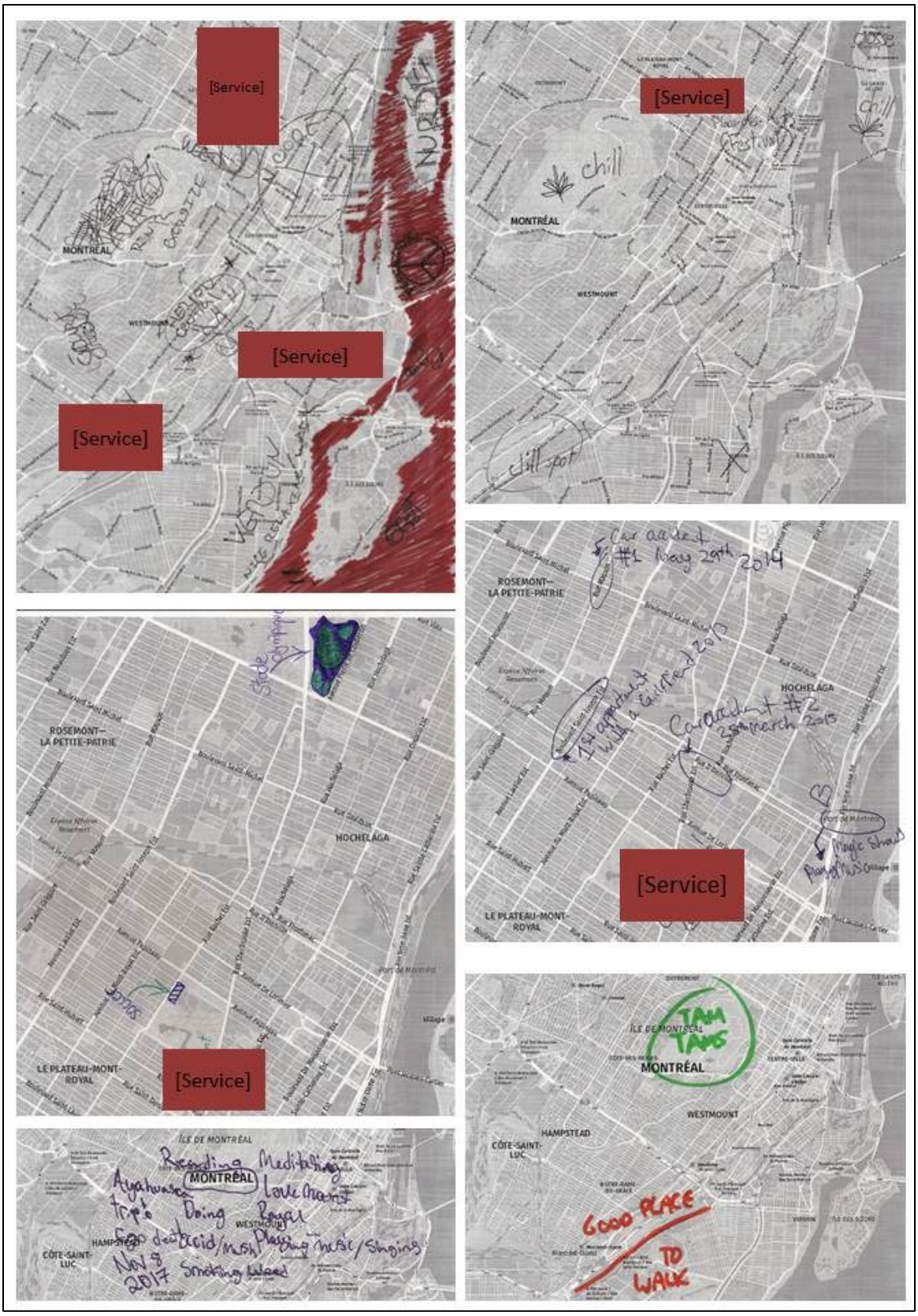


Figure 7 – Examples of individual maps with information about services

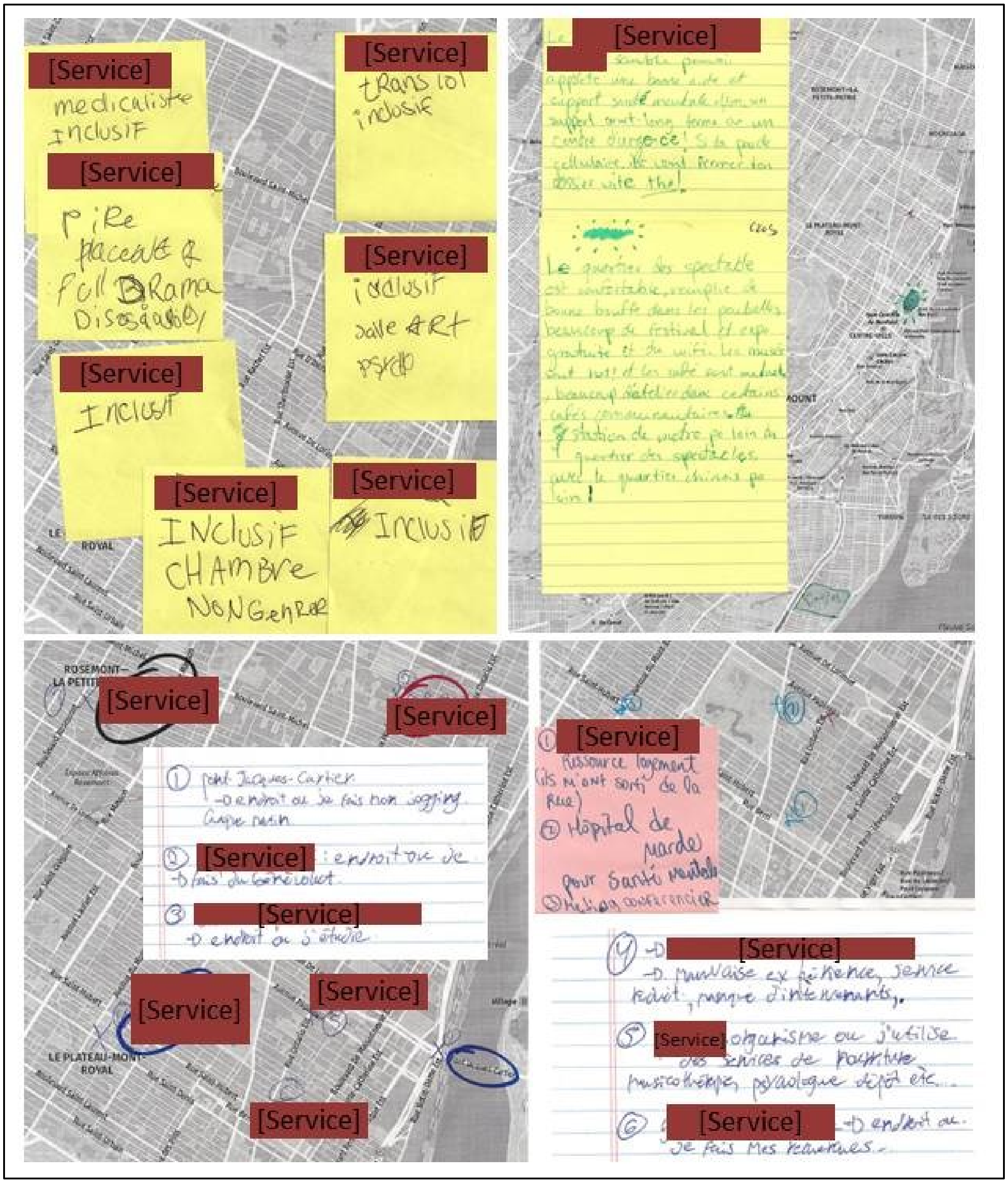
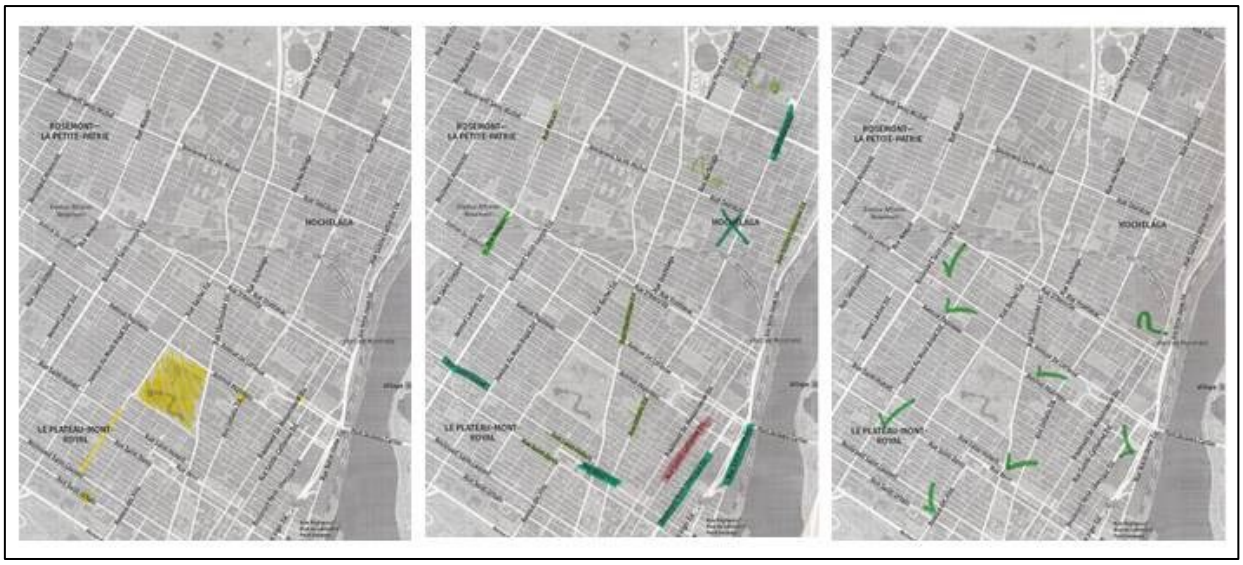


Figure 8 – Examples of individual maps with no details



4.3.2 Group maps

Looking at the differences between the linguistic minority (Figure 9) and the linguistic majority (Figure 10) maps, we notice right away that the linguistic majority map identifies a lot more services around the city. The linguistic majority map reflects more diversity in the services. Both maps show a high concentration of services in the same area, where most of the RIPAJ services are located.

Interestingly, regarding services outside of the high-concentration area, the further-away services identified by the linguistic majority youths tend to be services for underage youths or services they used during their teenage years that they know about. Linguistic majority youths also identified a number of services extending North-East of the high-concentration area, which is a typically francophone (linguistic majority) area. This sector of the city has been typically associated with poverty, unemployment, and organized crimes (Montréal en statistiques, 2018). The high-concentration area identified by the youths is comprised within this sector.

The linguistic minority youths have identified further away hospitals that happen to be hospitals affiliated with the local English-speaking university hospitals (minority language). Travelling to the hospitals from the high-concentration area requires public transport tickets

and may not be doable regularly by the youths. The maps show that linguistic minority youths are constrained to the high-concentration area to obtain basic needs services.

Another striking difference is the fact that the linguistic majority map reports a greater variety of services. The types of services only brought up by the linguistic majority are: employment services, storage and postal services, and LGBTQ+ services. Conversely, the linguistic minority group identified more hospitals than the linguistic majority group.

Figure 9 – Map of services identified by linguistic minority youths

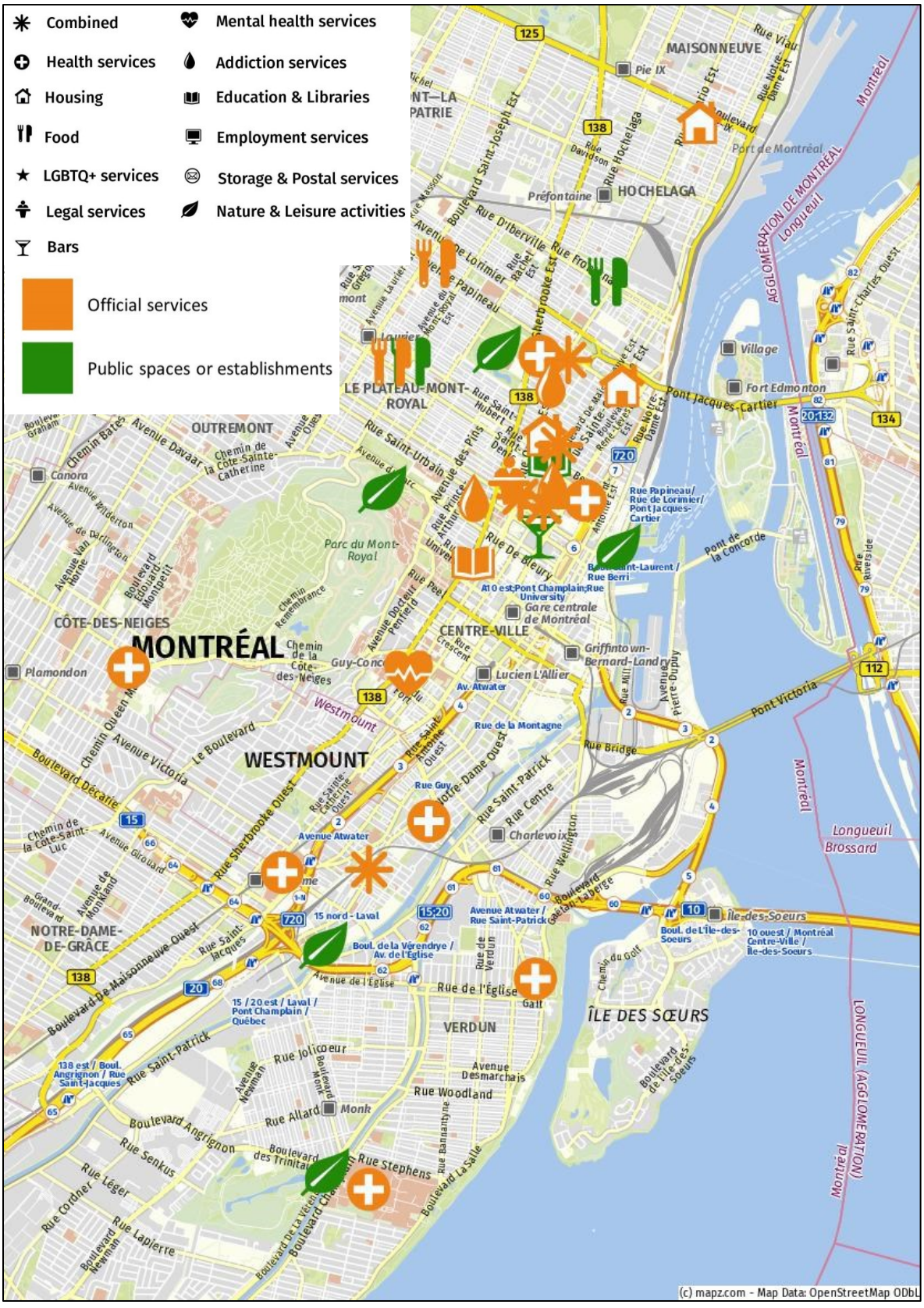


Figure 10 – Map of services identified by linguistic majority youths

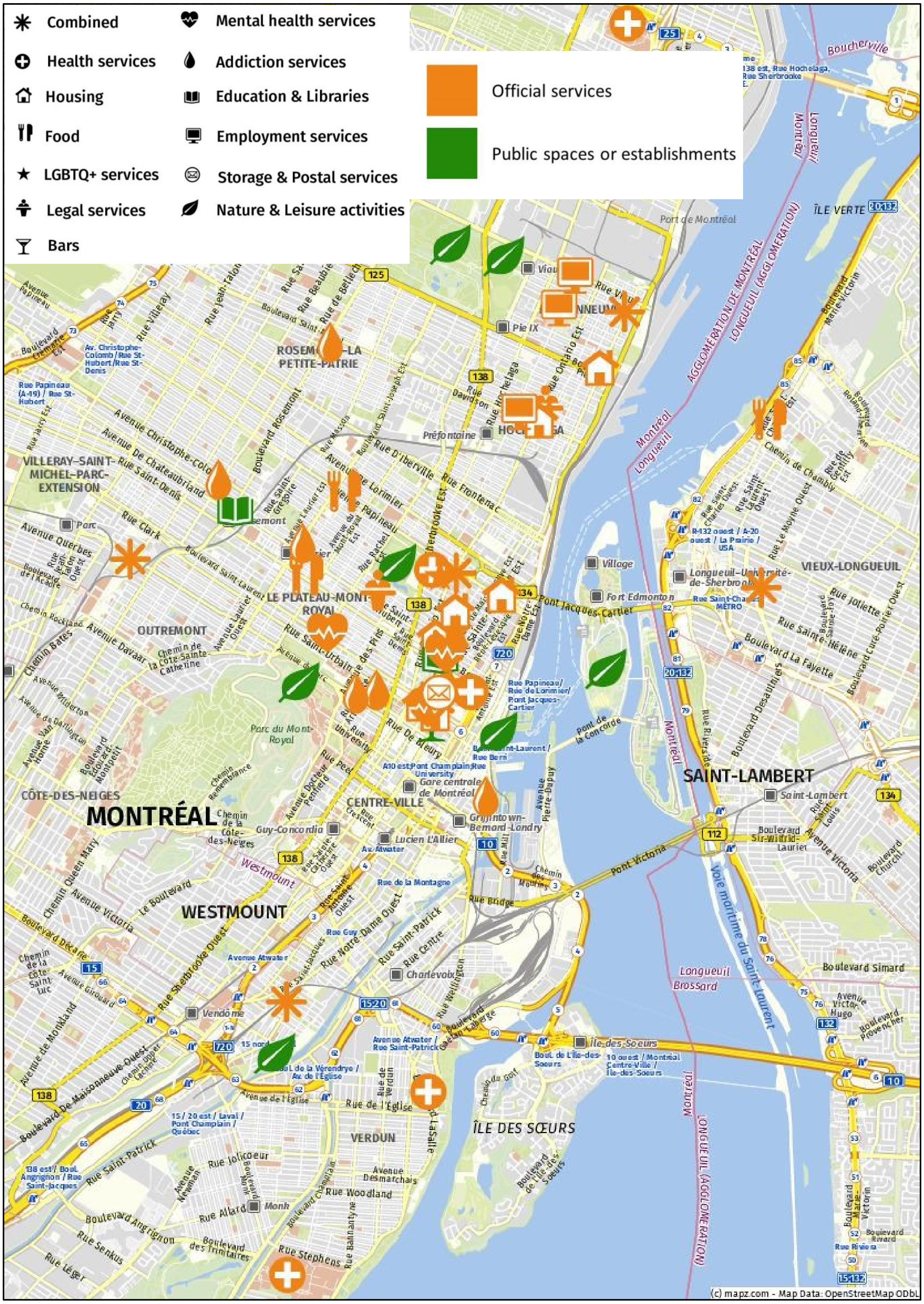
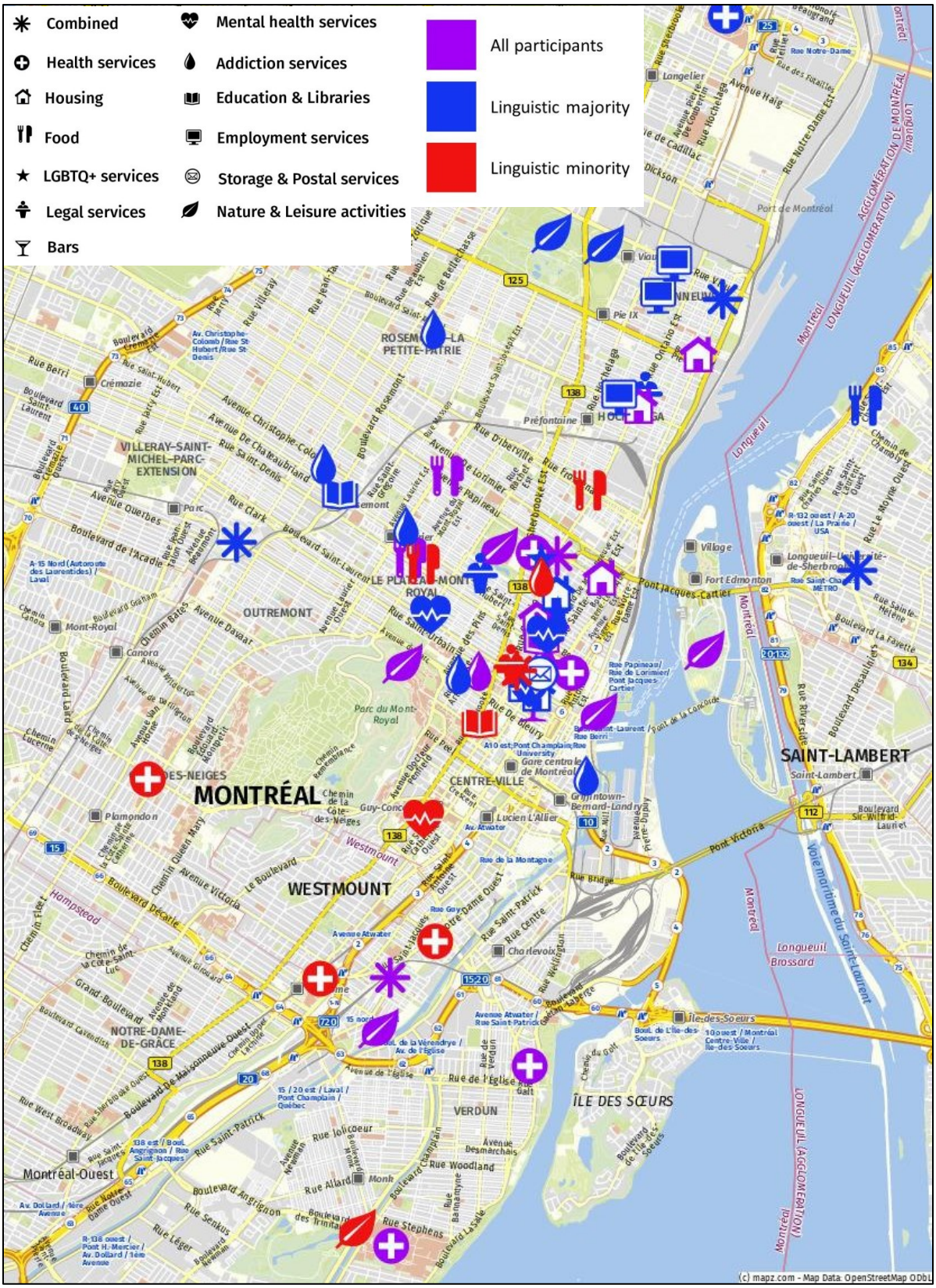


Figure 11 – Combined map showing the differences between the linguistic groups



CHAPTER 5 – DISCUSSION

The main goal of this study was to highlight the differences in experiences of access to mental health services among homeless youths of two distinct linguistic groups. To our knowledge, this study is the first to address how linguistic minorities, within the homeless youth population, experience access to mental health services. As such, we will discuss findings that reflect the needs of the general homeless youth population (regardless of their linguistic group), through factors related to youths' perception of the services and factors related to the structure of the services, and finally we will give specific attention to the needs and realities of linguistic minority youths.

5.1 Perception of services

Many themes brought up by the youths during the discussion groups referred to their perception of the services. One of the main findings is that homeless youths prefer homeless youth services as they provide an increased sense of safety (compared to adult homeless services) and social capital and decreased feelings of stigmatization (compared to general population services). This is important as homeless youths have previously reported issues with how they were treated within mental health and allied services (Collins & Barker, 2009; Darbyshire et al., 2006).

According to the youth narratives, equally important to them is the care provided to them in services. Services are valued positively if care was provided in a personalized manner with non-judgment. This is in keeping with previous studies that have identified the importance of a non-judgmental and empathic approach to care, especially for the homeless youth population (Collins & Barker, 2009; Darbyshire et al., 2006). This need for personalized care is not specific to homeless youths as other youths and adults report such a preference for mental health care approaches (Garcia et al., 2007; Noble & Douglas, 2004). We are not able to state whether this need is more prominent for homeless youths. However, homeless youths are likely to perceive additional benefits from such an approach as they present complex and diverse

autobiographical stories and profiles, often involving multiple traumatic experiences (Gaetz et al., 2016). In that regard, trauma-informed care provides a relevant strategy to personalized care, by avoiding experiences with services that may trigger or repeat past trauma (K. Hopper et al., 2010; Tomlinson & Klendo, 2012). Participants in this study furthered that importance by highlighting how homeless youth-specific services were more likely to provide personalized and non-judgmental care. However, participants also clarified that some of these services, or workers within the services, still do not provide such care; there is certainly still room for growth.

5.2 Structure of the services

Amongst the themes brought up by youths, many addressed structural aspects of services. One central theme identified across linguistic groups was the idea of co-locating and integrating services. Youths found it easier to receive the help they required when they were familiar with the space in which the mental health service was held, because they would use, at first, that service to meet their basic needs (e.g., food, shelter). This is even more important considering the many barriers that linguistic minority youths can face. When linguistic minority youths talked about youth services, they focused on already co-located services. It is possible that having been able to by-pass the language barrier within a service, and knowing that you will be able to communicate there, increases the chance that the youths will seek further services in this location, rather than taking their chance with a new service. Previous studies had identified that integrated services worked best for ethnic and linguistic minorities when they were aware of and adapted to the needs of these minorities (Kirmayer et al., 2007; Sadavoy et al., 2004).

As demonstrated in previous literature, homeless youths' preference is to have co-located and integrated services (Pedersen et al., 2016). Youths receiving services in drop-in centers were more likely to seek out further services in the same location (Pedersen et al., 2016) and were more likely to receive appropriate referrals (Kozloff et al., 2013). Similarly, other articles have mentioned barriers, for homeless youths, in access to mental health services due to lack of coordination between services: an issue easily addressed by offering multiple services under one management (Aviles & Helfrich, 2004; Darbyshire et al., 2006) or within a network

(Morisseau-Guillot et al., 2020). In the general youth population, there is a growing interest for the implementation of integrated care services to address mental health care needs in the youths population (Hetrick et al., 2017), with studies showing that youths desire services that offer a diverse range of support and opportunities (Garcia et al., 2007). In recent years, there has been a number of Canadian initiatives to implement integrated youth services (Halsall et al., 2019), representing a shift in the understanding of youths' needs and the decisions to address them. Specifically in Quebec, Aire Ouverte is a growing initiative offering a network of integrated youth services (Gouvernement du Québec, 2020; Graham Boeckh Foundation, 2019).

We cannot address the importance of co-locating and integrating services without addressing the separation of mental health and addiction services. Research has long reported problems with this separation and showed that integration of those two services provides better outcomes to the patients (Drake et al., 1998, 2004; Drake & Wallach, 2000; Settipani et al., 2019). In the homeless youths population, co-occurring SUDs and mental health disorders are very prevalent (Slesnick & Prestopnik, 2005). Individuals presenting with comorbid diagnoses are often sent back and forth between services to treat the SUDs and mental health disorders separately (Centre for Addiction and Mental Health & Rush, 2002). Although some youths from the present study have reported this experience, presently and in the past, there are services within RIPAJ that provide hand-in-hand specialized mental health services and addiction services (Morisseau-Guillot et al., 2020).

Another finding on structural aspects of the services addresses how youths learn about services. A lack of proper advertising of the services has been reported previously (Darbyshire et al., 2006) and emerged again in our study. Homeless youths rely on alternatives means of finding out about services, mostly through forms of networking in the streets. Homeless youths were adamant that the websites used by the various homeless youth services seemed to be built for donators and not to inform homeless youths about the services. With the current generation, homeless youths have more access to the internet and information than ever, and it seems the homeless youth services have not adapted to this reality. Previous studies have

shown that youths turn to the internet to seek mental health information (Clarke et al., 2015; Dooley & Fitzgerald, 2012; Gould et al., 2002). Having information targeted at homeless youths on the internet could help many of them bypass a fear of the unknown and avoid the cost of travelling for information before coming to the services. With that in mind, some organizations have started posting short introduction video on their websites (e.g.: *La Maison Tangente*) . It could also significantly help youths who first step in the streets and, most likely, do not have enough homeless social networks to learn of the services available to them. Needless to say, receiving proper services sooner could help many of them find ways out of homelessness quicker.

The usual administrative barriers reported in the literature were again brought up in our study: needs for proper legal identification for the youths, cost of services or transportation, and wait times (Aviles & Helfrich, 2004; Barker et al., 2015; Black et al., 2018; Busen & Engebretson, 2008; Darbyshire et al., 2006; Edidin et al., 2012). These are meaningful barriers, nonetheless, as homeless youths need to prioritize their basic needs, food or shelter, and may not have time or resources to bypass these (Morisseau-Guillot et al., 2020). Some organizations provide public transport tickets to homeless youths to ensure they can receive the services they require. Some homeless youths are on welfare and are therefore able to get reimbursed for transportation for medical services (Règlement sur l'aide aux personnes et aux familles, 2006). However, the process of getting reimbursed can be difficult for some or too long to manage a budget. Other homeless youths end up using public transports without paying which results in a significant accumulation of fines, which they are unable to pay (Bellot & Sylvestre, 2017; Chesnay et al., 2013). A simple solution to transportation barriers which would cover all homeless youths is warranted.

5.3 Linguistic minority youth

An interesting perspective to take on the results is to look at topics that were mainly brought up by linguistic minority youths. Informal strategies for mental health care were discussed by linguistic minority youths only. This may be due to a complexity of factors and possibilities. For one, it is possible that linguistic minority youths simply did not access or know many services

and therefore are more likely to rely mainly or only on informal alternative self-help strategies or it is possible that they resorted to talking about informal strategies for mental health care as a way of still addressing the questions asked. Previous research has shown that ethnic minorities and immigrants tend to believe in and use alternative therapies such as music, spirituality, family support and staying busy (Thomson et al., 2015). Sociodemographic data of the participants of the linguistic minority group suggests that fewer linguistic minority youths in our sample used homeless shelters compared to the other homeless youths (n=3 vs. n=5) and more of them slept in the streets (n=5 vs. n=2). This suggests that those youths in our sample may present very different profiles that impact their ability or willingness to use formal mental health services, therefore possibly representing only one side of the spectrum. Indeed, those who reported informal self-help mental health strategies were often travellers – homeless youths who travel across Canada and/or the U.S.A. In many ways, this could impact their relationship to mental health services if they do not necessarily stay in one place for long enough. They seemed to show survival and self-agency centered perspectives on life, which could lead to self-care practices regarding mental health. Those same participants also talked about problematic and harmful past experiences with psychiatric care, which could also explain their tendency towards informal mental health strategies and even avoidance of psychiatric or mental health services.

Only linguistic minority youths talked about adult-oriented services and the difficulties they experienced there. One explanation is that, because linguistic minority youths have access to fewer services specifically for homeless youths because they cannot communicate in French (the main language spoken in homeless youth services), they are often obligated to use adult homeless services. In the latter, most services are offered in both English and French, since most of these adult homeless organisations stem from the Montreal Anglophone community. However, youths do not feel comfortable and safe in these services, in part because they are exposed to older men. Although, it is possible that youths in the linguistic majority had so many youth-specific services to choose from that they never had to go to adult services, it is also possible that they did not address their experiences with this kind of services because these

were only marginally used by them. Interestingly, these adult-oriented services were only mentioned in the discussion groups and did not appear on the maps.

Findings related to the distance of psychiatric services in hospitals for the linguistic minority youths may be very specific to Montreal, a city where hospitals exist in the two official languages. However, this reality still ties in with the accumulating number of barriers experienced by minorities in the homeless youth population. If an individual's psychiatric service is far away, they may not have the financial means to access their hospital or the services that address their other needs. Similarly, they spend a significant amount of time in transport to receive mental health services, in a city where such services are accessible through the public system and supposed to be available within one's neighbourhood. In Quebec, English-speakers are entitled to receive health and social services in English (minority language) through designated establishments within a region, taking into account the organizational structure and human, material, and financial resources of the institutions (Loi sur les services de santé et les services sociaux, 1991). Certain linguistic majority hospitals are mandated with offering their services in the minority language as well (Loi sur les services de santé et les services sociaux, 1991). However, due to negative experiences with linguistic majority hospitals, youths seem more likely to reach out for care at hospitals associated with their linguistic preferences.

Also, youths may not be aware that a number of linguistic majority hospitals in the city are mandated to provide services in English, as they may not even be aware of the laws surrounding that topic. For example, one anglophone youth in particular kept saying "Law 101" (referring to Bill 101, known as Loi 101 in French) to explain the group's frustration with the lack of English service in the health care system. Bill 101 confirms French as Quebec's official language and requires all parapublic institutions and all businesses to mainly communicate in French to Quebec's citizens (Charte de la langue française, 1977). In practice, Bill 101, la Charte de la langue française (Charte de la langue française, 1977), and the Act respecting health services and social services, mentioned earlier (Loi sur les services de santé et les services sociaux, 1991), work conjointly as using French as the main language of communication does

not prevent an institution from offering services in English, or being mandated to do so. Homeless youths often have lower educational achievements than other youths which makes them less likely to be familiar with their legal and housing rights (Busen & Engebretson, 2008; Edidin et al., 2012). In the same vein, they are less likely to know of community resources than could help them advocate for those rights (Busen & Engebretson, 2008; Edidin et al., 2012).

When unable to find linguistic minority services, linguistic minority homeless youths relied on workers within the services that were able to speak the minority language. Previous statements in Quebec have commented on the importance of adapting front-line services to the cultural and linguistic diversity in the province (Vissandjee et al., 2005). Studies have shown that significant miscommunication can occur when health care providers cannot properly communicate with linguistic minorities (Brisset et al., 2014; Leanza et al., 2013). Bilingual workers often played a vital role in breaking down future linguistic barriers by referring youths directly to other services.

Sociodemographic data for linguistic minority youths showed that linguistic minority youths in our sample were more likely to identify with a visible minority group (n=4 vs. n=1). Linguistic minority youths are already experiencing barriers to mental health care due to the language barrier. They are more likely to be part of a visible minority and therefore experience further barriers. In immigrant populations, barriers related to the uptake of mental health services included a lack of awareness about mental health issues and services available, and cultural barriers such as expectations about the relationship between the mental health practitioner and the patient, stigma about mental illness, reluctance to seek outside health, gender roles, and a belief in alternate practices (Thomson et al., 2015). A review of mental health help-seeking behavior amongst African American youths identified provider mistrust, amongst others, as a barrier, stemming from negative past experiences with treatment and research, and more particularly cultural mistrust due to feeling that white professionals could not understand their realities (Planey et al., 2019).

The linguistic minority group included anglophones, who speak one of the Canadian official languages but not Quebec's official language, and allophones, who do not fluently speak either

of the Canadian official languages. We originally intended on highlighting differences between these two subgroups of the linguistic minority group. However, recruiting allophones proved difficult as the participants still needed to be able to communicate in English or in French fluently enough to take part in the study. As a result, no clear distinction could be extracted from the data. Also, participants were recruited within the services. It is therefore highly probable that allophone youths could not be recruited in significant numbers because they do not access the services in the first place. Indeed, many studies have identified that not speaking French or English represents a barrier in access to mental health services for immigrant populations or results in underuse of the services (Thomson et al., 2015). Similarly, Canadian studies have found that francophones in English-speaking provinces, in the linguistic minority, experience similar barriers to access to health care as allophones (Ngwakongnwi et al., 2012). There are no studies that we could find that compare the experiences of individuals in the linguistic minority who speak an official language with allophones.

5.4 Unexpected findings

It is interesting to notice that youths seemed to consider all services similarly without categorizing them, seemingly finding no differences in their experiences of access to services whether the service was specifically for mental health issues or not. It is possible that this emerging finding is linked to youths' preference for integrated and centralized services or because they consider responding to their basic needs as a necessary first step towards bettering their mental health, or that they consider their mental health needs and their basics needs on the same level. When we think of the multiplying levels of marginalization found within this community of individuals facing homelessness, with higher proportions of LGBTQ+ youths, youths of colour, and Indigenous youths than the general population, it is absolutely primordial that doors to access be integrated, which could imply having multiple services under the same roof or having strong collaboration and partnership between various services within a network (Abdel-Baki et al., 2019). Rather than having hundreds of doors that may all lead to different types of access, one would want a few doors that open easily to all communities, behind which one would find hallways and pathways towards various services.

In a multicultural, multilingual city such as Montreal, homeless youths can present multiple marginalizing characteristics. The different barriers and needs regarding access to health care experienced by different groups of marginalized youths are well-reported in the literature (Robards et al., 2018) and are similar to the ones reported here for mental health services. For example, refugee and vulnerable migrant youths talk about language barriers, needs for cultural sensitivity and the complexity of the health system (Robards et al., 2018). Similarly, Indigenous youths discuss a need for cultural sensitivity and improving knowledge of how the services work and how to access them (Robards et al., 2018). Youths in the LGBTQ+ community mention discrimination by professionals and systems and lack of professionals' knowledge (Robards et al., 2018). Such factors create additional barriers to care for homeless youths already experiencing barriers due to homelessness.

5.5 Critical reflection

We propose to present the strengths and weaknesses of this study through a critical reflection on the procedure taken, including comments on working with homeless youths and a reflexive analysis of the researcher's profiles. Multiple aspects of researchers can have an impact on the data: gender, race, affiliation, age, sexual orientation, immigration status, personal experiences, linguistic tradition, beliefs, biases, preferences, theoretical, political and ideological stances, and emotional responses to participants (Berger, 2015). In this study, familiarity with the homeless, and specifically the homeless youths, population is another important aspect. We will discuss the specific profiles of each person involved in the recruitment, the data collection, and the analysis.

The choice to use an arts-based qualitative methodology proved to be a strength to this study in many ways. Youths were clearly enthusiastic about participating in an artistic activity. Unstructured discussions allowed the participants to bring up new perspectives on their access to mental health services. A strong example for that is the emergence of a theme around informal strategies for mental health care. This theme was furthered facilitated by the community mapping method: engaging with city maps encourage the youths to consider various locations in the city associated with their mental health (Amsden & VanWynsberghe,

2005; Ensign & Gittelsohn, 1998). Unsurprisingly, parks are easier to see and think about when looking at a map; others have reported the use of community mapping in the awareness and implementation of green spaces (Lydon, 2003).

Participant recruitment had to be adaptive on multiple levels. Working with homeless youths, participants were unlikely to commit to the research activity too ahead of time. Most of the recruitment ended up taking place during lunch hour at one of the RIPAJ organizations, with the research activity starting shortly after lunch. Researchers therefore had to be ready for unreliable attendance and unpredictable group size. Discussion groups' size ranged from 2 to 9 participants. We had originally planned for groups of 6 to 8 participants. In the facilitator's opinion, groups of about 5-6 participants were ideal. Despite the unpredictability, it is a major strength of this study that we were able to recruit participants with diverse profiles, as well as a representative sample of each linguistic group.

One limitation of this study is that participants were recruited within the services of the RIPAJ network only. All participants were therefore able to enter at least one service within the network and there is a possibility that some homeless youths never enter outreach services in Montreal, as has been reported previously in the USA (Kort-Butler & Tyler, 2012). In our results, we highlighted that participants felt that the services were concentrated in one area of the city, where most of the RIPAJ services are located. Although this could suggest that the youths only know about RIPAJ services, youths also identified services not associated with RIPAJ. Services for the homeless population in Montreal are also generally concentrated in that area.

I, as the main recruiter and facilitator for this study, was 25-years old at the time of the study, which puts me within the same age range as the participants. I strongly suspected that my age and general appearance had an impact on recruitment and data collection by making some participants feel like they were talking to a peer or a familiar person; workers from the RIPAJ organizations have previously mistaken me for a youth using the service, and youths have previously mistaken me for a youth worker. This most likely had a facilitating impact on recruitment. However, my personal situation (completing a master's degree, being housed, etc.) compared to the youths', despite our similar age could potentially have created a difficult

atmosphere during data collection although it did not seem to be the case, by exposing differences between us. It is hard to assess the profile of all parties involved in the recruitment. Multiple posters and pamphlets were made available and some workers in the RIPAJ organizations told youths about our study. In-person recruitment involved an undergraduate female volunteer (of the same age range) and myself. The undergraduate volunteer was unfamiliar with RIPAJ organizations at the time. However, she did not appear out of place and worked along my side the whole time. It is fair to say that most individuals involved in the recruitment process were familiar to the youths or had no conceivable impact on youths' willingness to participate.

The data collection took place in June and September 2018 in Montreal, Canada in one of the RIPAJ organizations. This was a facilitator to data collection and also a limitation. The space chosen was easier because the youths were already familiar with the organization. However, the participants may be biased for youths who already had good opinions of this specific organization, or youths may not have felt as comfortable sharing negative feedback about this organization while being in the space. The facilitators made sure to clarify that they were not directly involved with the organization and that any comments would be reported anonymously and as part of research dissemination only.

The discussion groups were non-structured, although the facilitators had access to a question guide to facilitate a conversational flow and to make sure the different topics were covered, if required. The general ideas behind the potential questions were consistently addressed without needing to refer directly to the set of questions. Intersectional factors, such as LGBTQ+ identity, gender, and race, were not probed by the facilitators and were only addressed if they were brought up by the youths. Although this is in line with the study goals, it did limit our ability to understand how a variety of social constructs come together in relation to access to mental health services.

All three facilitators involved in data collection were female. Although, the researchers involved in this project do not believe that gender had an impact on participants' ability to share during the discussion, one male participant did express issues interacting with female

employees in an organization. It's our belief that his ability to communicate this issue during the discussion is an indicator that the female facilitators were not negatively impacting his participation. All facilitators speak English with various degrees of accents, as it is their second language and some youths have shared it made it hard to follow in one group, however when this happened, the other facilitator attempted to rephrase or re-engage the youths in the conversation. All facilitators were white; it is possible that this limited the disclosure of experiences related to racism, especially in a group setting where, to minority youths, not all participants may have felt safe. Previous research has shown that similar racial identity between the participants and the facilitators played a role in the participants' disclosure (Chiu & Knight, 1999). Racism was raised as a discussion point in a group where more than one participant identified as a person of colour. Similarly, LGBTQ+ participants may not have felt comfortable in the group setting as no facilitator disclosed their identity/orientation, opting instead to show knowledge and acceptance. It is interesting to point out that the main issues raised about the LGBTQ+ experience happened in one discussion group where two participants knew each other from a LBGTQ+ friendly gathering in one of the organizations.

At various steps of data analysis, up to four researchers were involved. All researchers had some level of proficiency in both English and French. All researchers had input at all levels of the data analysis process. Most discussions on the data analysis involved at least three of the researchers. It is our belief that any potential biases were remedied by the group exchanges.

5.6 Implications and recommendations

Results from this study have important implications for future practice in mental health care for homeless youths. The importance of homeless youth-specific services, such as those in the RIPAJ network (Abdel-Baki et al., 2019), is evident. Similarly, there is a need for improved knowledge on the needs of racialized and LGBTQ+ homeless youths. This highlights necessity to fund and grow mental health services that address the specific needs of marginalized populations.

The idea of co-locating services for youths requires a lot of resources for any one organization. However, establishing networks and strong partnerships between varied services would already address a significant portion of the issue with delayed referrals and access to mental health services. Our findings add to the literature that has previously shown that a lack of coordination between services, resulting in referrals, creates frustration in homeless youths due to time and transport logistics but also to having to repeat their stories (Darbyshire et al., 2006). This is even more important for linguistic minorities who seem to rely on referral by youth workers to access services that appear to have linguistic barriers.

While this study looked at the differences between homeless youths in the linguistic majority and ones in the linguistic minority, we were not able to extract differences within the linguistic minority group (Anglophones and Allophones). This is mostly due to the fact that Allophones still needed to speak English at a conversational level to participate in this study, which means they could at least discuss general services. It would be interesting to understand how Allophones with lower fluency levels in an official language experience access to mental health services.

Previous research has shown a high proportion of Indigenous youths (30.6%) amongst the homeless youth population (Gaetz et al., 2014). The few Indigenous youths in our sample did not address the impact of their Indigenous identity on their access to mental health services. Our research did show that multiple aspects of the youths' identities impact youths' experiences and it is likely that Indigenous identity plays a significant role. Our research team attempted to recruit more Indigenous perspectives. However, after discussion with members of the RIPAJ network, it seems the services do not receive visits from the expected proportion of Indigenous youths. It is unclear where the Indigenous youths are going or why they do not use the RIPAJ services. Further research is required to explore the realities of Indigenous homeless youths accessing mental health services.

On a similar note, it would be valuable to understand the specific needs of other minorities when it comes to accessing mental health services. Although this study did extract some realities specific to LGBTQ+ and racialized youths, the proportion of participants who identified

with these communities was lower than reported in the literature; our primary goal was to recruit for linguistic differences. The few findings on other minorities suggest there may be more to unveil.

This study highlighted the reality that different youths have different needs. In practice, it would be complex for any organisation or project to completely and thoroughly discover and understand the different needs experienced by the youths. We strongly suggest that future initiatives and changes in youth mental health make sure to learn from each other.

Participants seemed to rely on self-agency and a form of social networking/barter system in the streets to meet their basic needs and gather information about services. The tendency for homeless youths to rely on peers to learn about services for their basic needs has been previously reported (Pedersen et al., 2016). This suggests that peer support workers could partly respond to that need. Indeed, some peer workers are involved in RIPAJ in some organisations with one of them, fully dedicated to peer support (*GIAP*). Previous research has shown that having a social network familiar with mental health services increases a person's likelihood to use mental health services (Vogel et al., 2007). Interestingly, ethnic minorities have been shown to be more likely to be referred to mental health services through lay referral sources such as family or friends (Akutsu et al., 1996). It would be beneficial to understand how the social networking/barter process takes place for homeless youths as it could inform future attempts in reaching out to youths in the streets.

To improve access to mental health services for linguistic minority homeless youths, the youths mentioned the importance of documentation/paperwork being available in their language and the key role that a youth worker able to speak their language could play. Interpretation services are often available within the health care system (Dowbor et al., 2015). It could be relevant to consider the feasibility of interpretation services within homeless youth organisations, taken into account the cost and the degree of integration required. For interpretation services to be meaningful in this setting, they would most likely need to be present as soon as the youth comes in contact with the service, as they are unlikely to express mental health needs to youth workers they cannot speak to. To mitigate the cost of

interpretation services, some institutions have turned to telephone interpretation with positive outcomes (Dowbor et al., 2015). However, other studies report a preference for in-person interpretation services (Ngwakongnwi et al., 2012). Health care providers sometimes fail to recognize the value of interpretation services (Dowbor et al., 2015): in one example preferring to find a worker able to rudimentarily translate instead of providing proper translation (Ngwakongnwi et al., 2012). Issues brought up by health care providers include timeliness of access to an interpreter and the extended time required for a clinical interview with an interpreter (Dowbor et al., 2015; Mayo et al., 2016).

In order for youths to come in contact with the services, all documentations should be translated, that includes physical and digital documentation. Youths are unlikely to reach out to a service with a website in a language they do not understand. In fact, many of the RIPAJ's websites are not available in English (linguistic minority). It is unclear why as one-time translation services are relatively accessible in a multicultural city.

Similarly, as noted in one of the participant's quotes, youths do not seem to differentiate between *social workers* and *youth workers* who may not be social workers. This suggests that youths do not have a working understanding of the different professions of the persons who work within the community organisations and the governmental health and social services and the roles they can play to help each individual considering their expertise. A deeper understanding of the differences may help youths make more informed decisions when choosing where to seek help with their mental health, by choosing forms of help more suited to their needs.

CHAPTER 6 – CONCLUSION

This study updated and deepened current knowledge on access to mental health services by highlighting unreported issues in the literature, such as the experiences of linguistic minorities within the homeless youth population. Specifically, we found that linguistic minorities seem to rely more often on services for the general adult homeless population and services which were further away from their core services; thereby, using services that did not match the preferences expressed by homeless youths in general. Concurrently, linguistic minority youths were more likely to use informal mental health strategies.

Building on previous knowledge regarding the needs of homeless youths when accessing any type of services, integrated services that allow for prompt and informed referrals to mental health services are even more important for linguistic minority youths who experience linguistic, and other, barriers when accessing front-end services. An increasingly globalized world is likely to increase the numbers of homeless youths with low fluency in official languages. Initiatives to improve homeless youths' access to mental health services need to consider the needs of linguistic minority youths in order to implement integrated services that work for all youths.

In general, homeless youths expressed needing homeless youth-oriented services that were both co-located, by catering to their basic needs and offering a variety of services, and integrated with other services, by offering timely referrals and diminishing wait times when youths required more specific interventions for their mental health. In addition, homeless youths expressed individual needs in their preferences within services. Those individual needs were linked to specific minority communities, such as LGBTQ+ youths, racialized youths, and linguistic minority youths. They were also linked to youths' individual personalities and preferences relating to worker's approaches. A very clear conclusion from this study is that different youths have different needs. It is primordial for any service to take the time to understand the youths as an individual and understand the specific needs of minority groups.

There is indeed a tremendous amount of field knowledge on the needs of specific youths; knowledge that was slowly gathered by youth workers and initiatives around the world. New initiatives to improve homeless youths' access to mental health services are growing and would benefit significantly from field knowledge, allowing them to implement minority-adapted approaches.

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APPENDIX A – CONSENT VERIFICATION QUESTIONS

A.1 English version

- Do you have any questions about the consent form?
- What do you understand this study to be about?
- Are there any risks associated with this study?
- Do you know where to find the right contact information if you have any issues with the study?
- Do you have to participate in this study?
- Can you end your participation if you wish to do so?

A.2 French version

- As-tu des questions concernant le formulaire de consentement?
- Peux-tu me décrire ce que tu as compris de cette étude?
- Il y a -t-il des risques associés à cette étude?
- Sais-tu où trouver un contact si tu as des problèmes vis-à-vis de l'étude?
- Es-tu obligé de participer à cette étude?
- Peux-tu mettre fin à ta participation si tu le désires?

APPENDIX B – RECRUITMENT DOCUMENTS

Figure 12 – Recruitment poster – French

Figure 13 – Recruitment poster – English

ACCESS ESPRITS OUVERTS OPEN MINDS
RIPAJ-Montréal / Homeless Youth Network

STUDY ON ACCESS TO MENTAL HEALTH SERVICES FOR YOUTH

Tell us your experience and opinions through visual arts and discussion

Do you (or someone you know) use mental health services?
Did you (or someone you know) experience difficulty in accessing them?
Or were you satisfied with them?
Did the language you speak (or the one used by the service provider) become an issue in accessing services?

We want to hear about YOUR experience with those services!
This is a study which may allow your voice to bring change.

Photography workshop, activity and discussion
*about 7 hours long (lunch provided)
*Compensation for inconveniences: 50$

Community mapping and discussion
*about 3-4 hours long (snacks provided)
*Compensation for inconveniences: 25$

You can participate in both or one of the two.

If you are interested in participating or if you want more information, take one!
You can also ask for a flyer with the ACCESS-RIPAJ team or a worker in this organization (display location).

Camille – Mental Health Services Study
camille.arbaud@umontreal.ca
514 890-8000 x 23224

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ACCESS OPEN MINDS ESPRITS OUVERTS

IHSP Institute for Health and Social Policy

ÉTUDE SUR L'ACCÈS AUX SERVICES DE SANTE MENTALE CHEZ LES JEUNES

Parles-nous de ton expérience et de tes opinions à travers les arts visuels et la discussion

Utilises-tu (ou connais-tu quelqu'un qui utilise) des services de santé mentale? As-tu (ou quelqu'un que tu connais) vécu des difficultés d'accès à ces services? Ou étais-tu satisfait(e) par ces services?
Ta langue parlée a-t-elle eu un impact sur ton accès à ces services?

Nous voulons entendre parler de TES expériences avec ces services!

Cette étude pourrait permettre à tes opinions et ta créativité de changer ta communauté.

McGill UNIVERSITY

CR CHUM

Université de Montréal

www.accessopenminds.ca | www.accessespritsouverts.ca

Deux activités sont offertes:

Atelier de photographie, activité et discussion
*durée d'environ 7 heures (repas fourni)
*Compensation pour le dérangement: 50$

Cartographie communautaire et discussion
* durée d'environ 3-4 heures (collation fournie)
*Compensation pour le dérangement: 25$

Tu peux participer à l'un d'entre eux, ou aux deux.

ACTIVITÉS FRANCOPHONES - INFORMATION

Photographie
Date: _____
Heure: _____
Endroit: _____

Cartographie communautaire
Date: _____
Heure: _____
Endroit: _____

Pour plus d'informations ou pour t'inscrire, contacte Camille
camille.arbaud@umontreal.ca
514-890-8000 x23224

Figure 14 – Recruitment flyer – French

ACCESS OPEN MINDS ESPRITS OUVERTS

IHSP Institute for Health and Social Policy

STUDY ON ACCESS TO MENTAL HEALTH SERVICES FOR YOUTH

Tell to us about your experience through art and discussion

Do you (or someone you know) use mental health services? Did you (or someone you know) experience difficulty in accessing them? Or were you satisfied with them?

Did the language you speak (or the one used by the service provider) become an issue in accessing services?

We want to hear about YOUR experience with those services!

This is a study which may allow your voice and creativity to bring change to your community.

McGill University | CRCHUM | Université de Montréal

www.accessopenminds.ca | www.accessesprits ouverts.ca

Two activities are available to you:

Photography workshop, activity and discussion

*about 7 hours long (lunch provided)

*Compensation for inconveniences: 50$

Community mapping and discussion

*about 4 hours long (snacks provided)

*Compensation for inconveniences: 25$

You can participate in both or on of the two.

INFORMATION FOR ENGLISH ACTIVITIES

Photography

Date: _____

Time: _____

Location: _____

Community mapping

Date: _____

Time: _____

Location: _____

For more information or to register, contact Camille

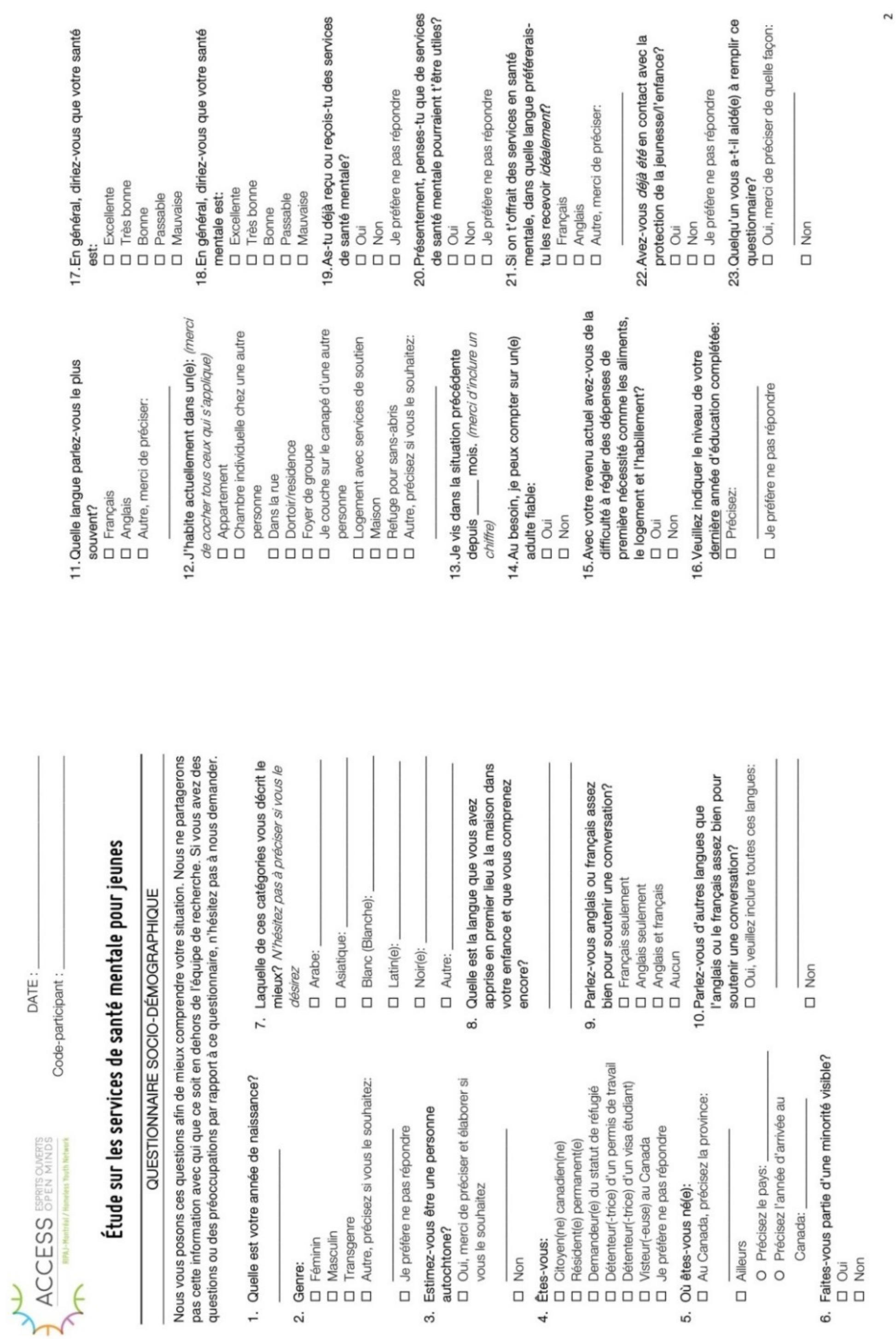
camille.arbaud@umontreal.ca

514-890-8000 x23224

Figure 15 – Recruitment flyer – English

APPENDIX C – SOCIODEMOGRAPHIC QUESTIONNAIRE

Figure 16 – Sociodemographic questionnaire – French


ACCESS ESPRITS OUVERTS OPEN MINDS
RIPAJ-Montréal / Homeless Youth Network

DATE : ____________

Code-participant : ____________

Étude sur les services de santé mentale pour jeunes

QUESTIONNAIRE SOCIO-DÉMOGRAPHIQUE

Nous vous posons ces questions afin de mieux comprendre votre situation. Nous ne partagerons pas cette information avec qui que ce soit en dehors de l'équipe de recherche. Si vous avez des questions ou des préoccupations par rapport à ce questionnaire, n'hésitez pas à nous demander.

1. **Quelle est votre année de naissance?** ____________

2. **Genre:**
   - ☐ Féminin
   - ☐ Masculin
   - ☐ Transgenre
   - ☐ Autre, précisez si vous le souhaitez: ____________
   - ☐ Je préfère ne pas répondre

3. **Estimez-vous être une personne autochtone?**
   - ☐ Oui, merci de préciser et élaborer si vous le souhaitez ____________
   - ☐ Non

4. **Êtes-vous:**
   - ☐ Citoyen(ne) canadien(ne)
   - ☐ Résident(e) permanent(e)
   - ☐ Demandeur(e) du statut de réfugié
   - ☐ Détenteur(-trice) d'un permis de travail
   - ☐ Détenteur(-trice) d'un visa étudiant)
   - ☐ Visteur(-euse) au Canada
   - ☐ Je préfère ne pas répondre

5. **Où êtes-vous né(e):**
   - ☐ Au Canada, précisez la province: ____________
   - ☐ Ailleurs
     - O Précisez le pays: ____________
     - O Précisez l'année d'arrivée au Canada: ____________

6. **Faites-vous partie d'une minorité visible?**
   - ☐ Oui
   - ☐ Non

7. **Laquelle de ces catégories vous décrit le mieux?** *N'hésitez pas à préciser si vous le désirez*
   - ☐ Arabe: ____________
   - ☐ Asiatique: ____________
   - ☐ Blanc (Blanche): ____________
   - ☐ Latin(e): ____________
   - ☐ Noir(e): ____________
   - ☐ Autre: ____________

8. **Quelle est la langue que vous avez apprise en premier lieu à la maison dans votre enfance et que vous comprenez encore?** ____________

9. **Parlez-vous anglais ou français assez bien pour soutenir une conversation?**
   - ☐ Français seulement
   - ☐ Anglais seulement
   - ☐ Anglais et français
   - ☐ Aucun

10. **Parlez-vous d'autres langues que l'anglais ou le français assez bien pour soutenir une conversation?**
    - ☐ Oui, veuillez inclure toutes ces langues: ____________
    - ☐ Non

11. **Quelle langue parlez-vous le plus souvent?**
    - ☐ Français
    - ☐ Anglais
    - ☐ Autre, merci de préciser: ____________

12. **J'habite actuellement dans un(e):** *(merci de cocher tous ceux qui s'applique)*
    - ☐ Appartement
    - ☐ Chambre individuelle chez une autre personne
    - ☐ Dans la rue
    - ☐ Dortoir/residence
    - ☐ Foyer de groupe
    - ☐ Je couche sur le canapé d'une autre personne
    - ☐ Logement avec services de soutien
    - ☐ Maison
    - ☐ Refuge pour sans-abris
    - ☐ Autre, précisez si vous le souhaitez: ____________

13. **Je vis dans la situation précédente depuis _____ mois.** *(merci d'inclure un chiffre)*

14. **Au besoin, je peux compter sur un(e) adulte fiable:**
    - ☐ Oui
    - ☐ Non

15. **Avec votre revenu actuel avez-vous de la difficulté à régler des dépenses de première nécessité comme les aliments, le logement et l'habillement?**
    - ☐ Oui
    - ☐ Non

16. **Veuillez indiquer le niveau de votre dernière année d'éducation complétée:**
    - ☐ Précisez: ____________
    - ☐ Je préfère ne pas répondre

17. **En général, diriez-vous que votre santé est:**
    - ☐ Excellente
    - ☐ Très bonne
    - ☐ Bonne
    - ☐ Passable
    - ☐ Mauvaise

18. **En général, diriez-vous que votre santé mentale est:**
    - ☐ Excellente
    - ☐ Très bonne
    - ☐ Bonne
    - ☐ Passable
    - ☐ Mauvaise

19. **As-tu déjà reçu ou reçois-tu des services de santé mentale?**
    - ☐ Oui
    - ☐ Non
    - ☐ Je préfère ne pas répondre

20. **Présentement, penses-tu que de services de santé mentale pourraient t'être utiles?**
    - ☐ Oui
    - ☐ Non
    - ☐ Je préfère ne pas répondre

21. **Si on t'offrait des services en santé mentale, dans quelle langue préférerais-tu les recevoir *idéalement*?**
    - ☐ Français
    - ☐ Anglais
    - ☐ Autre, merci de préciser: ____________

22. **Avez-vous *déjà été* en contact avec la protection de la jeunesse/l'enfance?**
    - ☐ Oui
    - ☐ Non
    - ☐ Je préfère ne pas répondre

23. **Quelqu'un vous a-t-il aidé(e) à remplir ce questionnaire?**
    - ☐ Oui, merci de préciser de quelle façon: ____________
    - ☐ Non

2

Figure 17 – Sociodemographic questionnaire – English

ACCESS ESPRITS OUVERTS OPEN MINDS
RISQ / Montréal / Réseau Youth Network

DATE : _____

Participant Code : _____

Study on Youth Access to Mental Health Services

SOCIODEMOGRAPHIC FORM

We are asking these questions to understand your situation. We will not share this information with anyone other than the study team. If you have any questions or concerns regarding this form, please do not hesitate to ask us.

1. **What is your year of birth?**
   _____

2. **Gender:**
   ☐ Female
   ☐ Male
   ☐ Transgender
   ☐ Other, specify if you desire:
   _____
   ☐ Decline to answer

3. **Do you identify yourself as Indigenous?**
   ☐ Yes, please specify and elaborate further if desired
   _____
   ☐ No

4. **Are you:**
   ☐ A Canadian citizen
   ☐ A permanent resident
   ☐ A refugee claimant
   ☐ On a work visa
   ☐ On a student visa
   ☐ A visitor to Canada
   ☐ I prefer not to answer this question

5. **Were you born in:**
   ☐ Canada, specify province:
   _____
   ☐ Elsewhere
   ○ Specify country: _____
   ○ Specify year of arrival in Canada:
   _____

6. **Are you part of a visible minority?**
   ☐ Yes
   ☐ No

7. **Which of these categories best describes you?** *Feel free to specify further if you desire*
   ☐ Arab: _____
   ☐ Asian: _____
   ☐ Black: _____
   ☐ Latino: _____
   ☐ White: _____
   ☐ Other: _____

8. **What language(s) did you first learn at home in childhood and still understand?**
   _____

9. **Can you speak English or French well enough to conduct a conversation?**
   ☐ English only
   ☐ French only
   ☐ Both English and French
   ☐ Neither

10. **Do you speak any languages other than English or French well enough to conduct a conversation?**
    ☐ Yes, please list all:
    _____
    _____
    ☐ No

11. **What language do you speak most often?**
    ☐ English
    ☐ French
    ☐ Other, please specify:
    _____

12. **I currently live in a:** *(please check all that apply)*
    ☐ Apartment
    ☐ Dormitory residence
    ☐ Group Home
    ☐ Homeless shelter
    ☐ House
    ☐ I couch surf
    ☐ On the street
    ☐ Supported housing
    ☐ Single room in someone else's house
    ☐ Other, specify if desired:
    _____

13. **I have been living in the above arrangement for _____ number of months.** *(please put a number)*

14. **There is a reliable adult who is around when I am in need:**
    ☐ Yes
    ☐ No

15. **With your current income, do you have any difficulty meeting basic expenses such as food, shelter, and clothing?**
    ☐ Yes
    ☐ No

16. **Please indicate the level of the last year of education you've completed:**
    ☐ Please specify:
    _____
    ☐ I prefer not to answer this question

17. **In general, would you say your health is:**
    ☐ Excellent
    ☐ Very good
    ☐ Good
    ☐ Fair
    ☐ Poor

18. **In general, would you say your mental health is:**
    ☐ Excellent
    ☐ Very good
    ☐ Good
    ☐ Fair
    ☐ Poor

19. **Are you currently or have you ever received mental health services?**
    ☐ Yes
    ☐ No
    ☐ I prefer not to answer this question

20. **Currently, do you think mental health services could be helpful to you?**
    ☐ Yes
    ☐ No
    ☐ I prefer not to answer this question

21. **If mental health services were to be offered to you, in which language would you *ideally* prefer these services to be?**
    ☐ English
    ☐ French
    ☐ Other, please specify:
    _____

22. **Have you *ever been* involved with youth protection/child welfare?**
    ☐ Yes
    ☐ No
    ☐ I prefer not to answer this question

23. **Did anyone help you complete this survey?**
    ☐ Yes, please specify how:
    _____
    ☐ No

2

APPENDIX D – POTENTIAL QUESTIONS FOR DISCUSSION GROUPS

D.1 English version

Opening Questions

- Can you please introduce yourself: tell us your name, if you wish, tell us something about yourself?
- Tell me your favorite place in the city

Introductory Questions

- What are services meant to help with mental health?
- What are "mental health services" to you?

Key Questions

- What are mental health services that you know about?
- What do you use those services for?
- How do you feel about those services?
- How do you feel when you use those services?
- How do other youth you know feel about those services?
- What experiences have you had or have heard about with mental health services?
- What are things that make it difficult for youth to access/use these services?
- What is a bad experience you've had with those services?
- What are things that make it easy for youth to access/use these services?
- What is a good experience you've had with those services?
- What makes some of those services harder/easier to access then others?
- Which languages are used in this service?
- Were there services you could not access because of your language, or did not feel you could communicate well enough to get good quality services?
- How do these services react to who you are?
- How does it make you feel?

- Which services could you (or other young people that you know) not access because of who you are? Why?
- Do you feel your language keeps you from accessing services? How important is language compared to other things keeping you from accessing services?

Ending Questions

- We want to know how to help youth like you to access mental health services. What can be done to help you access mental health services?
- Is there anything else you would like to say today?

D.2 French version

Questions d'ouverture

- Pouvez-vous vous introduire: dire votre nom et, si vous voulez, un petit quelque chose à propos de vous?
- Parle-moi de ton endroit préféré en ville

Questions d'introduction

- Quels sont des services qui aident avec la santé mentale?
- Qu'est-ce que "services de santé mentale" veut dire pour vous?

Questions clés

- Quels sont des services de santé mentale que vous connaissez?
- Pour quoi utilisez-vous ces services?
- Comment vous sentez vous par rapport à ces services?
- Comment vous sentez-vous lorsque vous utilisez ces services?
- Comment est-ce que d'autres jeunes que vous connaissez se sentent par rapport à ces services?
- Quelles sont des expériences que vous avez eues ou dont vous avez entendu parlées par rapport à ces services de santé mentale?

- Quels sont des facteurs qui rendent difficile l'accès ou l'utilisation de ces services pour les jeunes?
- Quelle est une mauvaise expérience que tu as eu avec ces services?
- Quels sont des facteurs qui rendent facile l'accès ou l'utilisation de ces services pour les jeunes?
- Quelle est une bonne expérience que tu as eu avec ces services?
- Qu'est-ce qui rend certain de ces services plus ou moins facile d'accès que les autres?
- Quelles sont les langues utilisées dans ce service?
- Il y a-t-il des services auxquels vous ne pouvez pas accéder à cause de votre langue, ou des services où vous n'avez pas l'impression de pouvoir communiquer suffisamment facilement pour recevoir un service de qualité?
- Comment est-ce que ces services réagissent à qui vous êtes?
- Comment vous sentez-vous à propos de cette réaction?
- Quels services ne pouvez-vous pas accéder à cause de qui vous êtes? Pourquoi?
- Avez-vous l'impression que votre langue vous empêche d'accéder à des services? Quelle est l'importance de la langue de communication par rapport à d'autres facteurs dans votre capacité d'accéder à ces services?

Questions de conclusion

- Nous aimerions savoir comment aider des jeunes comme vous à accéder à des services de santé mentale. Qu'est-ce qu'on peut faire pour vous aider à accéder à des services de santé mentale?
- Il y a -t-il autre chose que vous aimeriez dire aujourd'hui

APPENDIX E – SCHEDULE FOR COMMUNITY MAPPING ACTIVITIES

E.1 English version

- Consent form
- Introductions
- Explanation of the study
- Individual mapping
- *Break*
- Individual mapping sharing
- Group mapping
- *Break*
- Group mapping
- Demographic information
- Art usage consent
- Info for results and photovoice
- Honorarium

E.2 French version

- Formulaire de consentement
- Introductions
- Présentation de l'étude
- Cartographie individuelle
- *Pause*
- Partage de la cartographie individuelle
- Cartographie de groupe
- *Pause*
- Cartographie de groupe
- Information démographie
- Consentement pour utilisation de l'art
- Information pour résultats et photovoice
- Honorarium