2.1 SUPPORTING INDIGENOUS YOUTH EXPERIENCING HOMELESSNESS

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INTRODUCTION

Indigenous peoples is a term used in Canada to describe three distinct cultural groups: First Nations (status and non-status Indians), Métis, and Inuit. There are approximately 1.4 million Indigenous people in Canada, representing about 4% of the country's total population (Statistics Canada, 2009). Over 40% are under age 24, and 28% are under 14 (Statistics Canada, 2013). The Indigenous population has become highly urbanized. Since the 1970s, there has been a large migration of Indigenous peoples from rural areas and reserves to cities. More than 600,000—54% of the total Indigenous population—live in cities—and the numbers continue to grow (Statistics Canada, 2009). Urbanized Indigenous youth are the largest and fastest growing youth demographic in the country (Statistics Canada, 2013).

The number of Indigenous people experiencing homelessness varies from city to city, but what remains constant is the significant overrepresentation of Indigenous peoples in the homeless population. Figures from Statistics Canada (2009) indicate a near crisis of homelessness and street-involvement among First Nations, Métis, and Inuit young adults; they represent 5%–60% of the homeless population in any given area. Some data show significant differences in rates of homelessness between Indigenous groups; for example, rates are higher among Métis and Inuit. In Toronto, Indigenous people make up 15%–20% of the homeless population (City of Toronto, 2008). As the Indigenous community continues to grow, so does the number of young people on the homelessness spectrum. This ranges from youth who stay with friends or family while searching for housing (couch surfing) to those living on the streets (Stewart, 2016).

As a population, Indigenous peoples face multiple housing barriers that are rooted in centuries of colonization. Monette et al. (2009) highlighted this connection: "Aboriginal peoples, who share a common legacy of oppression and resilience, experience some of the worst housing conditions in Canada and have an exceedingly difficult time locating affordable housing" (p. 42). Housing barriers include poverty, lack of access to culturally

appropriate social services and housing, literacy issues, discrimination, addiction, mental health problems, and intergenerational trauma resulting from experiences with residential schools and the child welfare system. Systemic racism affects access to housing and supports (Monette et al., 2009; Walker, 2008).

HISTORICAL CONTEXT OF HOMELESSNESS AMONG INDIGENOUS PEOPLES

Indigenous homelessness has its roots in colonialism and the social determinants of health. Indigenous peoples in North America experienced a profound disruption to their ways of life when Europeans arrived. Prior to this first contact in 1492, the incidence of health and social problems among Indigenous peoples was low (Waldram, 2006). European contact brought a dramatic increase in physical and mental illness and social problems (Kirmayer, Boothroyd, Tanner, Adelson, & Robinson, 2000). Although more than 7 million Indigenous people inhabited North America before European contact, by 1600, almost 90% had died as a direct or indirect result of European settlement. Infectious disease was the major killer, followed by a change in traditional diet (Waldram, 2006). The legacy of colonialism continues today, with high rates of health problems such as diabetes and obesity (Kirmayer et al., 2000), chronic unemployment, low educational achievement, and homelessness linked to intergenerational trauma (Stewart, 2015).

Federal government policies that were established in the 1800s—and that are still in place today—attempted to destroy Indigenous cultures. These policies included the creation of land reserves and residential schools, child welfare apprehensions and adoptions, and strict bureaucratic control. The government forced Indigenous groups off their traditional lands and into government-created settlements, which often grouped bands that had no history of living together (Dickason, 1997). These arbitrary groups were forced to develop new social structures and sustainable ways of life. They were also relegated to land with little or no natural resources—land that was deemed unlivable for white settlers (Royal Commission on Aboriginal Peoples, 1996). This experience of forced homelessness is still felt today in the form of intergenerational trauma and its many effects, including poor mental health and precarious housing and homelessness (Stewart, 2015).

Before European contact, Indigenous communities had effective ways to prevent and treat illness and injury and manage social problems (Young, 1988). Housing and homelessness were not issues. Colonialist policies and practices transferred control of healing and other health and social practices to government-sponsored programs and institutions (Waldram, 2006). These Western medical approaches, which shifted the focus of healing from the community to the individual and from a holistic perspective to a deficit-based disease model, were foreign to Indigenous peoples. It is well documented that Indigenous people are more likely than non-Indigenous people to suffer serious medical complications or die while in the care of medical staff and hospitals; this problem is rooted in culturally unsafe practices by health practitioners that reflect racism and oppression (Smylie & Firestone, 2016).

Residential schools were one the most damaging and painful experiences for Indigenous peoples, and the effects continue to be felt today. The first schools were established in the 1800s by the federal government and were administered by Christian churches. Premised on the belief that Euro-Christian culture was superior, the goal of the schools was to eradicate Indigenous cultures and assimilate Indigenous peoples into the dominant culture: to "kill the Indian in the child" (Truth and Reconciliation Commission of Canada, n.d.). Children were forced from their families and placed in boarding schools, often far from home. Siblings were separated and children were forbidden to speak their native languages. Each child was given a Christian name. Some children were able to visit their families during the summer holidays, but others never returned home. Statistics about school attendance, completion, and deaths in the schools are sparse and unreliable because the federal government and the churches destroyed or hid information and survivors of the residential schools were warned never to talk about their experiences. Thus, official data may underestimate the number of children involved and the extent of the trauma they experienced. Records indicate that from the 1870s until the 1990s, about 150,000 children attended residential schools; at least 3,000 died, and the identities of 500 of these are unknown (Canadian Press, 2013). Diseases such as tuberculosis and influenza were a major cause of death, followed by malnutrition, drowning, and exposure. Many children were victims of physical and sexual abuse, and many died by suicide or from exposure when they tried to run away (Truth and Reconciliation Commission of Canada, 2015).

Although the residential schools are now closed, they have left a legacy of intergenerational trauma that extends beyond the survivors of the schools. Many children are born into families and communities that have been struggling with trauma and its social, economic, and health effects for years. When children were sent to the residential schools, leaving

entire communities with no children, parents and grandparents received no support for dealing with the grief and loss; the Indian Act prohibited traditional spiritual practices, which were punishable by incarceration or even death. An Indian Agent of the Bureau of Indian Affairs was assigned to each reserve to supervise residents and report violations of the Indian Act. Children in the residential schools also received no support in dealing with separation from their families and communities. Not only were these children stripped of their Indigenous identity; they also lost the opportunity to learn skills related to positive parenting and relationships, healthy eating, and substance use, and basic life skills they would need as adults to secure housing and manage money.

Historical child welfare system policies and practices are another colonial aggression that continues to affect the social determinants of health and well-being of Indigenous peoples. From the 1960s until the 1980s, about 20,000 Indigenous children were removed from their families by child welfare workers and placed in foster care or put up for adoption (Humphreys, 2015). The Sixties Scoop, as the practice has been called, resulted in the overrepresentation of Indigenous children in the child welfare system (Maurice, 2014). In 1977, Indigenous children accounted for 44% of children in care in Alberta, 51% in Saskatchewan, and 60% in Manitoba (McKenzie & Hudson, 1985). Children were placed with white families against the will of their birth families and communities, with little or no basis for apprehension other than being Indigenous. Children were cut off from their culture, identity, families, and communities; parents lost their children with no legal recourse (Maurice, 2014). In many cases, children were sent to adoption agencies in other provinces, or to Australia, Europe, and America. Birth certificates were locked in a federal government vault and made inaccessible to adoptees (Truth and Reconciliation Commission of Canada, 2015).

Residential school and child welfare policies and practices amounted to cultural genocide whose effects persist among Indigenous individuals, families, and communities. The many impacts—mental, physical, emotional, and spiritual—of these policies and practices can be understood as social determinants of homelessness. For Indigenous peoples, their journey toward homelessness began when they were forced from their birth families and communities.

HOMELESSNESS, IDENTITY, & BARRIERS TO HOUSING AMONG URBAN INDIGENOUS POPULATIONS

Being housed—or not—is one way we establish meaning and identity in our lives. It also affects domains that contribute to quality of life, such as work, school, and physical and mental health. Risk factors contributing to homelessness and street involvement in urban areas include Indigenous identity, being a member of an ethnic minority, living in a single-parent family, and identifying as female (City of Toronto, 2011; Menzies, 2009). In recent decades, many Indigenous people have moved to cities to access culturally based services and housing and to pursue work and educational opportunities (Belanger, Weasel Head, & Awosogo, 2012; Gaetz, 2010; Wente, 2000). However, many youth who migrate do not access services that are available for them, and instead become involved in a street lifestyle (Canadian Mortgage and Housing Corporation, 2001). Many end up homeless, which takes them even further from their traditional cultural identities. Street life often pulls these young people into the sex trade and into substance use and addiction (Ward, 2008).

Many barriers exist to supporting street-involved Indigenous youth. A study that involved in-depth interviews with urban Indigenous people who had experienced homelessness or were currently homeless revealed major issues around accessing mental health and social services (Stewart, 2016). These issues included racism and stigmatization, conflicting mainstream and Indigenous approaches to health and healing, concurrent disorders, and a need for harm reduction services in homeless shelters and transitional housing. A strong relationship between homelessness and multiple oppressions such as racism was revealed through reports by Indigenous people who accessed shelters and mental health services that they were denied housing. They also reported being stigmatized based on mental health and substance use—the stereotype of the "drunk Indian." These findings support those of an earlier study which found that Indigenous identity and substance use or mental health problems were barriers to housing (Stewart et al., 2013).

A tension exists between Indigenous cultural protocols and the harm reduction approach within the shelter system (Stewart, 2016; Stewart et al., 2013). Indigenous people report a need for a continuum of harm reduction services in shelter and housing services, which ranges from wet shelters, which allow alcohol and drug use, to abstinence-based shelters (Stewart, 2016). It is important for Indigenous Elders and healers to recognize that some people will not be able to follow cultural protocols around substance use and engaging in cultural practices, for example, having to be abstinent for a few days to attend a traditional

ceremony. Elders and healers must work with Indigenous people wherever they are at with respect to substance use and their healing journey because engaging with the culture is often the mechanism for healing and recovery, and for moving out of homelessness.

In 2009, the City of Toronto conducted a street needs assessment, whose results indicated a need for an Indigenous homelessness strategy, which would involve increasing research and funding to improve Indigenous-specific services. Such a strategy would reduce the number of Indigenous youth at risk of or experiencing homelessness. Research has found that tailored programming is effective, but it has had limited success in Toronto (Belanger et al., 2012). This may be due to limited implementation encapsulating Indigenous knowledge; that is, failing to reflect the population's needs, perceptions, and preferences around a homelessness prevention strategy that acknowledges Indigenous peoples' unique histories and social determinants of health (Stewart et al., 2013).

HOMELESSNESS & HEALING

Healing from mental health and addiction issues is a big challenge facing Indigenous people who are homeless. There is a strong relationship between homelessness, healing from the trauma of colonization, and recovery from mental health and addiction issues. Many Indigenous people explain that they ended up on the street as a result of complex issues that include poverty, physical disability, emotional distress, and intergenerational trauma, and that substance use often is a way to cope with these stresses (Stewart et al., 2013). Substance use is also a way to connect and relate with others and to create community and belonging—essentially, a spiritual and cultural home (Stewart, 2016). What makes recovery unique for this population is that it often involves engagement with cultural communities and reconnecting with Indigenous identity. Ultimately, successful housing is related to recovery from addiction and mental health issues, which, in many cases, correlates with the development of cultural identity.

INTERVENTION COMPONENTS

Culturally appropriate mental health and addiction interventions for Indigenous people experiencing homelessness are based on a paradigm shift away from mainstream concepts of health and well-being to a holistic framework that emphasizes relationships. Mainstream

approaches to counselling, such as cognitive-behavioural therapy and motivational interviewing, have shown success with Indigenous clients when they include several key components: these culturally adapted interventions are culturally based, are grounded in a holistic framework, focus on relationships, and incorporate cultural context into mental health assessment (Rowan et al., 2014).

CULTURALLY BASED INTERVENTION

Cultural connection promotes healing among Indigenous people. It needs to be formally included at all levels of mental health and addiction service (e.g., programs, interventions, research, policy). Providing culturally based services means understanding that Indigenous and mainstream approaches to health and well-being differ in some ways and finding points of convergence from which to develop or adapt services. Incorporating an Indigenous worldview into interventions can strengthen the therapeutic alliance, reduce treatment dropout rates, improve outcomes, and support client change. While practice will vary across professional settings, what remains constant is the need to create space for respect and to deliver interventions that reflect Indigenous worldviews and approaches to healing. This can be challenging because there are fundamental differences between Indigenous and mainstream approaches to working with clients. For example, in contrast to the mainstream therapeutic dyad, which involves the client and the therapist, it is rare for an Indigenous Elder or healer to work with a client in isolation; rather, Indigenous healing often includes the extended family and community to promote the interconnectedness necessary for good mental health (Duran, 2007). This way of working is challenging in typical mental healthcare settings, where rigid rules exist about client confidentiality and family involvement in treatment. With the emphasis that Indigenous cultures place on community, another challenge in treatment is working with clients who are not in touch with their birth or adoptive family, or are not connected to an Indigenous community, be it their own or one that exists nearby. However, it is important to seek opportunities to include important community or family members in assessment and treatment despite any barriers.

DEVELOPING A HOLISTIC FRAMEWORK

Hybridism is an epistemological model that has emerged out of postcolonial thinking. It acknowledges that there can exist two or more ways of knowing, without one having to dominate the other. In a healthcare context, hybrid treatment interventions integrate mainstream and Indigenous paradigms and practices of healing (Duran, 2007). It means bringing together the best of differing worldviews or practices to best meet clients' needs. For example, a hybrid approach acknowledges spirituality, a component of healing that is missing from mainstream mental health interventions (Stewart, 2008). Practitioners of hybrid approaches do not merely demonstrate cultural sensitivity; they are actually able to think in both mainstream and Indigenous ways. In practice, mental health professionals create a space where the expression of different ways of knowing and healing is accepted as valid and equal. Hybridism allows the practitioner and the client to jointly explore the client's identity, culture, and worldview in order to clarify the client's needs and determine the appropriate interventions for facilitating healing. Essentially, bringing together the strengths of each perspective culminates in a holistic approach to addressing the client's needs (Duran, 2007).

FOCUSING ON RELATIONSHIPS

Building relationships is an important component of culturally based interventions with Indigenous people. By demonstrating empathy and positive regard and by using appropriate humour, practitioners forge trust with clients. Self-disclosure can be another way to strengthen the therapeutic relationship because Indigenous cultures value reciprocity. This disclosure, of course, should be guided by professional ethics to ensure it is used to promote the therapeutic alliance, not the practitioner's own needs.

ACKNOWLEDGING CULTURAL CONTEXT IN MENTAL HEALTH ASSESSMENT

No psychometric measurement tools exist that are specific to Indigenous populations. Instead, assessment tools are normed for non-Indigenous populations, and none are more or less culturally appropriate. Standardized assessment tools include the Minnesota Multiphasic Personality Inventory, Wechsler Adult Intelligence Scale, Structured Clinical Interview for

DSM-IV I & II, Drug Abuse Screening Test, and Michigan Alcohol Screening Test, as well as trauma assessment tools. The effectiveness of these tools with Indigenous people requires that clinicians have the skill to gather information and interpret results within a cultural context. This means taking into account the client's personal story of colonialism and the wider context of colonialist history, and not making clinical judgements from a solely Western lens. This cultural context can be acknowledged by using a holistic perspective for understanding symptoms and behaviours, and by developing a concept of identity that includes cultural values, family, and impacts of colonialism. Culturally competent assessment may involve consulting with keepers of Indigenous cultural knowledge such as Elders and healers as part of the information-gathering process. These perspectives can be included in the conclusions and recommendations of the assessment and in treatment plans. The following questions can be useful in compiling a client's clinical history:

- Indigenous identity:
  - Can you tell me about your identity as an Indigenous person?
  - What is your cultural background?
  - How does being _____ (cultural identity) impact your_____ (experience/mental health/forensic history/parenting/symptoms/treatment/homelessness)?
- Racism and oppression:
  - Have you ever experienced racism? Discrimination? If so, how and when? How does this affect your current situation?
- Intergenerational trauma:
  - Have you or has anyone in your family attended a residential school? Have any of you been involved in the child welfare system or foster care, or been adopted?
  - How has this affected your life? Your mental health issues? The development of your cultural identity?
- Working with Indigenous Elders or healers:
  - Have you ever seen a traditional Indigenous Elder or healer?
  - Would you like to?

IMPLEMENTATION CONSIDERATIONS

Using a Western paradigm of practice with Indigenous peoples has been criticized as a form of continued colonial oppression (Battiste, 2007; Gone, 2004; Stewart, 2008, 2009). Indigenous clients may not trust mainstream mental health practitioners and treatment due to historical and ongoing experiences of trauma and oppression. Working with these

clients requires clinical assessments and interventions that are culturally competent and safe. These considerations apply across the spectrum of services, including interpreting assessments within a cultural context, providing cultural competence training, offering clinical supervision, and consulting with Indigenous communities and knowledge keepers. Shelters and transitional housing that offer mental health and social services as part of the housing process can integrate Indigenous practices into standard services. These services usually involve addiction counsellors, psychologists, and physical health professionals, as well as social service staff who help clients around literacy and life skills, vocational development, and education. These mainstream staff and services can be expanded to include Indigenous practitioners and practices, such as Elders, healers, traditional teachers, and ceremonies. Failing to recognize the unique needs of Indigenous people who are homeless means that services will be ineffective at best and harmful at worst.

KEY MESSAGES

What does being homeless mean? An academic definition would describe homelessness as the condition of not being housed or having a fixed address. But in an Indigenous context, defining homelessness requires a more holistic view. Homelessness for many Indigenous people may not simply mean lacking physical housing; it may also include feeling spiritually and culturally bereft. For example, not having a stable or clear sense of cultural identity as an Indigenous male or female or as a two-spirited person can perpetuate colonial harm that contributes to homelessness. These individuals may continue to feel as though as they are homeless even when they have housing, or they may act in a manner they would when they were homeless (e.g., engage in substance use) because their cultural identity is not coherent to them and does not match their living environment.

Homelessness is not always easy to discuss. It often elicits strong emotional reactions—pity and sympathy, disdain, anger, blame, fear. In the consciousness of the average Canadian thinking about people who are homeless, particularly Indigenous people, a blame the victim mentality prevails. Non-Indigenous Canadians misunderstand the Indigenous experience of homelessness at best and are ignorant or blatantly racist at worst—this attitude is particularly evident when clinicians must serve Indigenous people who are homeless.

In this chapter, I have tried to impart an Indigenous, culturally based understanding of homelessness and provide guidance to mental health professionals for ethical and effective ways to work with this population. Doing this work means understanding historical factors that underlie and mediate the cycle of Indigenous homelessness, and exploring practices that best support youth who are homeless in getting off the streets and finding stable housing. The ultimate goal is to end homelessness for all Indigenous people by supporting those who were failed by the Canadian social service system that helped put them out on the streets in the first place.

REFERENCES

Battiste, M. (2007). Research ethics for protecting indigenous knowledge and heritage: Institutional and researcher responsibilities. In N. K. Denzin & M. D. Giardina (Eds.), *Ethical futures in qualitative research: Decolonizing the politics of knowledge* (pp. 111-132). Walnut Creek, CA: Left Coast Press.

Belanger, Y. D., Weasel Head, G., & Awosoga, O. (2012). *Assessing urban Aboriginal housing and homelessness in Canada*. Final report prepared for the National Association of Friendship Centres and the Office of the Federal Interlocutor for Métis and Non-status Indians, Ottawa, ON.

Canadian Mortgage and Housing Corporation. (2001). *Environmental scan on youth homelessness*. (Research Highlight: Socio-economic series). Retrieved from www.cmhc-schl.gc.ca

Canadian Press. (2013, February 18). At least 3,000 died in residential schools, research shows. Retrieved from CBC News website: www.cbc.ca/news/canada/at-least-3-000-died-in-residential-schools-research-shows-1.1310894

City of Toronto. (2008). *Toronto Aboriginal persons demographic snapshot 2006*. Toronto, ON: Author. Retrieved from www1.toronto.ca/city_of_toronto/social_development_finance__administration/files/pdf/aboriginal-affairs-cttee-presentation.pdf

City of Toronto. (2009). *Street needs assessment results*. Toronto, ON: Author. Retrieved from www.toronto.ca/legdocs/mmis/2010/cd/bgrd/backgroundfile-29123.pdf

City of Toronto. (2011). *Profile of low income in the City of Toronto*. Toronto, ON: Author. Retrieved from www1.toronto.ca/city_of_toronto/social_development_finance__administration/files/pdf/poverty_profile_2010.pdf

Dickason, O. P. (1997). *Canada's First Nations: A history of founding peoples from earliest times*. Toronto, ON: Oxford University Press.

Duran, E. (2007). *Healing the soul wound: Counseling with American Indians and other Native peoples*. New York, NY: Teachers College Press.

Gaetz, S. (2010). The struggle to end homelessness in Canada: How we created the crisis, and how we can end it. *Open Health Services and Policy Journal, 3*, 21–26.

Gone, J. (2004). Keeping culture in mind. In D.A. Mihesuah & A. C. Wilson (Eds.), *Indigenizing the academy* (pp. 124–142). Lincoln, NE: University of Nebraska Press.

Humphreys, A. (2015, January 24). "A lost tribe": Child welfare system accused of repeating residential school history. National Post. Retrieved from http://nationalpost.com/news/canada/a-lost-tribe-child-welfare-system-accused-of-repeating-residential-school-history-sapping-aboriginal-kids-from-their-homes

Kirmayer, L. J., Boothroyd, L., Tanner, A., Adelson, N., & Robinson, E. (2000). Psychological distress among the Cree of James Bay. *Transcultural Psychiatry, 37*, 35–56.

Maurice, J. M. (2014). *The lost children: A nation's shame*. Prospect, KY: Professional Woman Publishing.

McKenzie, B., & Hudson, P. (1985). Native children, child welfare, and the colonization of native people. In K. Levitt & B. Wharf (Eds.), *The challenge of child welfare* (pp.125–141). Vancouver, BC: University of British Columbia Press.

Menzies, C. R. (2009). Reflections on research with, for, and among Indigenous peoples. *Canadian Journal of Native Education, 25*, 19–38.

Monette, L., Rourke, S. B., Tucker, R., Greene, S., Sobota, M., Koornstra, J., . . . Guenter, D. (2009). Housing status and health outcomes in Aboriginal peoples living with HIV/AIDS in Ontario: The Positive Spaces, Healthy Places study. *Canadian Journal of Aboriginal Community-Based HIV/AIDS Research, 2*, 41–60.

Rowan, M., Poole, N., Shea, B., Gone, J. P., Mykota, D., Farag, M., . . . Dell, C. (2014). Cultural interventions to treat addictions in Indigenous populations: Findings from a scoping study. *Substance Abuse Treatment, Prevention, and Policy, 9*, 34.

Royal Commission on Aboriginal Peoples. (1996). *Report of the Royal Commission on Aboriginal Peoples* (Vol. 1–5). Ottawa, ON: Author. Retrieved from Library and Archives Canada website: www.bac-lac.gc.ca

Smylie, J., & Firestone, M. (2016). The health of Indigenous peoples. In D. Raphael (Ed.), *Social determinants of health: Canadian perspectives* (3rd ed.; pp. 434–467). Toronto, ON: Canadian Scholars' Press.

Statistics Canada. (2009). *Aboriginal peoples in Canada in 2006: Inuit, Métis and First Nations, 2006 Census* (Catalogue no. 97-558-XIE). Ottawa, ON: Author. Retrieved from www12.statcan.ca/census-recensement/2006/as-sa/97-558/pdf/97-558-XIe2006001.pdf

Statistics Canada. (2013). *Aboriginal peoples in Canada: First Nations people, Métis and Inuit* (Catalogue no. 99-011-X2011001). Ottawa, ON: Author. Retrieved from Statistics Canada website: www12.statcan.gc.ca/nhs-enm/2011/as-sa/99-011-x/99-011-x2011001-eng.cfm

Stewart, S. (2008). Promoting Indigenous mental health: Cultural perspectives on healing from Native counsellors in Canada. *International Journal of Health Promotion and Education, 46*, 49–56.

Stewart, S. (2009). Indigenous family therapy: Constructivist perspectives. *First Peoples Child & Family Review, 4*(2), 99–118.

Stewart, S. (2015). *Aboriginal homelessness: Policy recommendations*. Ottawa, ON: Canadian Institutes of Health Research, Indigenous Health Research and Development Program.

Stewart, S. (2016). *Aboriginal homelessness: New directions for policy*. [Research report].

Stewart, S., Teekens, S., Beaulieu, T., Waites, J., Elliott, N., & Kidwai, A. (2013, March). *Examining relationships between homelessness, mental health and harm reduction: Narratives from Aboriginal peoples in urban spaces*. Paper presented at the Ontario Shores 2nd Annual Research Day, Whitby, ON.

Truth and Reconciliation Commission of Canada. (n.d.). About the Commission: Indian residential schools Truth and Reconciliation Commission. Retrieved from www.trc.ca/websites/trcinstitution/index.php?p=39

Truth and Reconciliation Commission of Canada. (2015). *Honouring the truth, reconciling the future: Summary of the final report of the Truth and Reconciliation Commission of Canada*. Retrieved from www. trc.ca

Waldram, J. B. (2006). The view from the Hogan: Cultural epidemiology and the return to ethnography. *Transcultural Psychiatry, 43*, 72–85.

Walker, R. C. (2008). Aboriginal self-determination and social housing in urban Canada: A story of convergence and divergence. *Urban Studies, 45*, 185–205.

Ward, J. (2008). *Dealing effectively with Indigenous homelessness in Toronto: Final report*. Toronto, ON: Jim Ward Associates.

Wente, M. (2000). *Urban Aboriginal homelessness in Canada*. Toronto, ON: University of Toronto, Faculty of Social Work.

Young, D. E. (Ed.) (1988). *Health care issues in the Canadian North*. Edmonton, AB: Boreal Institute for Northern Studies.

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