

Gagner et perdre du terrain : les paradoxes de l'itinérance en milieu rural

**Cheryl Forchuk, Phyllis Montgomery, Helene Berman,
Catherine Ward-Griffin, Rick Csiernik, Carolyne Gorlick,
Elsabeth Jensen, Patrick Riesterer**

Cet article examine les questions relatives au logement et à l'itinérance en milieu rural en établissant une comparaison avec le contexte urbain. Elle se fonde sur une analyse secondaire de données recueillies lors d'une étude sur la santé mentale et le logement menée de 2001 à 2006 dans le cadre des Alliances de recherche universités–communautés. Les résultats mettent en lumière certaines préoccupations concernant le manque de services, un facteur susceptible de précipiter un déménagement de la campagne à la ville. Les services de transport inadéquats posent souvent des difficultés aux habitants des régions rurales qui tentent d'accéder aux services. Bon nombre de répondants ont rapporté préférer vivre à la campagne, mais qu'il leur avait fallu choisir entre le lieu de résidence et l'accès aux services essentiels. Dans certains cas, des familles entières ont été déracinées dans leur quête de services adéquats. Une fois arrivés en milieu urbain, les participants ont éprouvé des difficultés à accéder à un emploi, à un logement et aux services, une source de déception à l'égard de leur nouvel environnement. La raison première invoquée par les personnes qui ont recours aux refuges est le manque de ressources et de solutions de rechange. Il faudra augmenter les services offerts en région rurale de façon à remplacer le modèle actuel de gestion de crise par un modèle de soins axé sur la promotion de la santé et la prévention des maladies.

Mots clés : santé mentale, région rurale, itinérance, pauvreté

Gaining Ground, Losing Ground: The Paradoxes of Rural Homelessness

**Cheryl Forchuk, Phyllis Montgomery, Helene Berman,
Catherine Ward-Griffin, Rick Csiernik, Carolyne Gorlick,
Elsabeth Jensen, Patrick Riesterer**

The study examined rural housing and homelessness issues and looked at similarities and differences between rural and urban areas. It involved a secondary analysis of focus group data collected in a 2001–06 Community University Research Alliance study of mental health and housing. The findings highlight concerns regarding the lack of services, which can precipitate a move from a rural to an urban community. Inadequate transportation services often posed a challenge to rural residents attempting to access services. Many participants preferred rural living but felt they had to choose between residing where they wanted to and having access to essential services. In some cases entire families were uprooted in pursuit of services. Once in an urban environment, rural participants had ongoing difficulty obtaining employment, housing, and services, which in turn led to disappointment in their new environment. The primary reason given for entering the shelter system was lack of alternatives and supports. Increased services need to be allocated to rural communities so that a health promotion and illness-prevention model of care can replace the current emphasis on crisis management.

Keywords: mental health, rural, homelessness, poverty

Background

A recent Canada-wide study estimated that 6 million Canadians, or 19% of the population, live in rural areas (Statistics Canada, 2008). Compared to their urban counterparts, rural Canadians are profiled as having poorer health status, engaging in more economic and lifestyle risk behaviours, attaining lower educational levels, and having fewer socio-economic resources (Canadian Population Health Initiative, 2006). Despite variations among provinces with respect to urban-rural income differences, in 2000 rural annual income was approximately 20% less than urban annual income (Statistics Canada, 2004). Persons diagnosed with enduring mental illness are a lower-income rural sub-population. The amounts received by single adult persons relying on Ontario Disability Support are generally “a mere 63% of the poverty line” (Schizophrenia Society of Ontario, 2006). Low income does not cause mental illness, but vulnerable persons are at greater risk of “drifting” to even lower socio-economic

strata (Hurst, 2007; Wilton, 2004). Unable to pay for their basic needs, such as shelter, these individuals are at increased risk for homelessness.

“Degrees of destitution” (Speak, 2004) may not be apparent to outsiders, since rurality’s distance and lack of density can distort the nature and magnitude of poverty. By association, rural homelessness is also hidden from public and policy decision-makers. Living in inadequate accommodations or with violent others, staying temporarily with friends or relatives, and seeking non-local services contribute to the invisibility of rural homelessness in Canada (Burns, Bruce, & Martin, 2003; Rupnik, Tremblay, & Bollman, 2001) and internationally (Milbourne & Cloke, 2006). Of particular relevance to Canadian rural areas, income changes secondary to loss of employment also cause homelessness (Burns et al., 2003). Manufacturing-related jobs are substituted with low-paying, limited-contract employment — if indeed they are substituted at all. The few Canadian studies that have sought to gain a better understanding of rural homelessness among persons with mental illness consistently report a lack of housing accessibility, adequacy, and affordability (Canada Mortgage and Housing Cooperation, 2003; Canadian Institute for Health Information, 2008; Skott-Myhre, Raby, & Nikolaou, 2008).

While there is little available Canadian research on rural issues and homelessness, the problems that have been identified are complex. Resources for disadvantaged persons in rural Canada are sparse, which contributes to poverty and inaccessibility of affordable and suitable housing. The research also shows a dire need for better access to mental health services for rural individuals (Brannen, Johnson Emberly, & McGrath, 2009). These factors greatly affect a person’s chances of becoming homeless and negatively affect one’s overall well-being and quality of life. As a result, many people relocate to urban centres to access services. This national housing issue demands further investigation on the basis that it is a social, political, and economic problem with severe consequences for the rural population (Bruce, 2006).

In addition to housing needs, persons with mental illness have unique health-service needs. According to Philo, Parr, and Burns (2003) in their critical review of the rural international mental health literature, the rates of psychiatric illness in rural areas are undetermined. The combination of lack of continuity and inaccessibility of services, travel distances, lack of readily available transportation, and attrition of health professionals exacerbates stress and affects the ability of this population to secure adequate income and housing (Canadian Mental Health Association, 2005; Moore & Skaburskis, 2004; Philo et al., 2003). While the needs of rural persons with mental health issues are similar to those of their urban counterparts, integrating mental health and social services in rural areas has proved to be a challenge.

Purpose

The purpose of the study was to identify and describe housing and homelessness issues related to rural as compared to urban residents. More specifically, the investigation was guided by two research questions: 1. *What are the housing issues described by shelter residents from rural areas compared to those from urban areas?* 2. *What are the homelessness issues described by participants from rural areas compared to those from urban areas?*

Method

Design

This study was a secondary analysis of data from the Community University Research Alliance, an investigation of mental health and housing. The original study collected quantitative and qualitative data from 2001 to 2006. Its qualitative approach was ethnography, which involved thick descriptions of housing circumstances for persons with mental health issues. In the original study, 550 persons were recruited to participate in focus groups. A total of 63 focus groups were conducted in southwestern Ontario and its surrounding smaller communities within a 200-kilometre radius of London, Ontario. The original study, including the present analysis, received ethical approval from the Health Sciences Research Ethics Board at the University of Western Ontario.

Sample

The sample for this secondary analysis included informants who defined themselves as “rural” residents at the time of the interview or who had previously lived in a rural area. They were not asked to specifically identify their rural home community. There were four categories of informant. The “consumer” groups comprised persons who had a diagnosed mental illness. Most of these individuals were current or former consumers of mental health services. The “peer support worker” groups comprised consumers who were successfully living in the community and who provided help to other consumers attempting to reintegrate into the community. The “family” group informants were for the most part mothers and fathers of consumers; however, spouses, siblings, and children also took part in the discussion. The fourth category of participants, “service providers,” comprised community mental health workers such as nurses, doctors, social workers, and police officers, as well as landlords. Aside from the service providers, the majority of participants came from low socio-economic strata.

Data Collection and Analysis

In the original study, the main qualitative data-collection strategy was semi-structured focus group interviews conducted in diverse urban and

rural locations. The interviews focused on such topics as current housing situation, recent changes in housing, housing preferences, and experiences of finding, securing, and maintaining affordable housing. Although the interviews included no specific questions about “rurality,” many of the participants discussed aspects of the influence of geographic location on health and housing. The focus groups generally comprised 8 to 14 participants. The trained interviewers ensured that every participant had an opportunity to take part in the group discussion; this sometimes meant that additional focus groups were held, either concurrently with or subsequent to the scheduled interview. All interviews were audiorecorded and transcribed verbatim as soon as possible following an interview. Transcripts were reviewed by the interviewer for accuracy. All identifiers were removed during transcription.

The data-analysis team for this study consisted of several members of the original investigation and some additional researchers. Analysis involved reading all of the original transcripts to identify participants’ references to rural experiences. Once relevant data were identified, content analysis — a process of systematically coding and grouping qualitative data to identify discernable patterns or themes — was undertaken (DeSanits & Ugarriza, 2000; Hsieh & Shannon, 2005; Morgan, 1993). This process involved several researchers independently reading the transcripts to code data. As patterns were identified in the data, focused codes were identified. The code list was continuously revised to accommodate new perspectives and to collapse overlapping groups of data. In turn, the code list guided the analysis and more abstract themes became identifiable with increased familiarity of the data.

Findings

Participants described a dynamic theme of gaining and losing ground constituted by a complex interplay of health, place, and social and service processes. Efforts at community integration (and, for some, re-integration) were necessary for desired health outcomes. Rural attributes, however, challenged the efforts of clients, families, and community mental health workers to establish or maintain health and to secure adequate housing. Gaining ground was described as having physical, social, and service supports that enabled participants to live in a familiar, socially connected rural setting of their choosing. Losing ground, in contrast, referred to having limited choices and opportunities and being viewed as “a hick from the sticks” — vulnerable and dependent. Participants described gaining and losing ground in four areas: *social ties, mental health and social services, transportation, and relocation.*

Social Ties

Participants often described their physical and social geographies in ideal terms: “peaceful,” “tranquil,” “tight-knit,” “full of relaxing recreational options.” Rural places provided them with a sense of security and belonging. As one participant stated, “Everyone has their place in the social fabric, even if you’re only a second cousin.” However, attending to the needs of a rural person diagnosed with some form of mental illness, or being the recipient of such attention, altered the perceived value of “close-knit” social connections.

Consumers, families, and service providers spoke about the implications of a community’s small size, noting that “everybody [knows] everyone else’s business.” Consumers who “fall in with a bad crowd” shared the stress of stigmatization as well as discrimination. Their stress was heightened when the conflict involved social service providers. Such strained relationships negatively influenced their ability to secure supports and services. Some consumers, in order to cope, made the choice to relocate to an urban area. Lack of supports and resources led to homelessness and uncertainty about the future:

I couldn't live there. I was ashamed of myself. So I moved to . . . a bigger city where there [were] more people. I guess I figured . . . I could hide or something. I had a car, so I slept in the car so I wouldn't have to pay rent. That way, my money would go farther . . . I was trying to figure out where [I] was going.

By association, their families also perceived stigma.

Mental Health and Social Services

Numerous factors contributed to the inaccessibility of mental health services in rural areas, including shortages of primary care workers or specialists, insufficient support and service programs, lack of trusting relationships with health-care workers, overburdened health-care providers, long waiting lists, and lack of transportation to and from services.

Some individuals tried to gain ground by relying on the private sector for mental health services (psychologists, counsellors, psychiatrists). However, even these services were limited and their cost was a barrier for many people living with mental illness. Without access to supports or services, the consumers were put at risk of relapse:

There are no external options. There used to be a private psychiatrist, so if for some reason a person did not qualify for adult mental health services or they were kicked out for whatever reason [or were] ineligible for it, there was at least a private site that you could access and still maintain psychiatric services.

Given the few external options available, trust in the abilities of one's health-care worker was critical. Lack of trust often contributed to the consumer's sense of powerlessness:

The fact that there's a monopoly in the area relating to psychiatric clinical support — that's not a criticism, that's just the way it is . . . it's like there's a monopoly on psychiatric services and if that psychiatric service has made a decision on somebody — you know, like [with] any monopoly — you're kind of stuck, going, "Well, now what?"

The emphasis within rural mental health services was crisis intervention rather than prevention or rehabilitation. This emphasis led to negative outcomes for consumers, the community, and the system. The limited availability of treatment served to increase the likelihood that consumers and their families would experience crises. Moreover, crisis services also faced severe shortages. In some communities, crisis services were available during business hours only, with very few resources being offered evenings and weekends. While consumers waited to be seen they contacted crisis lines, only to get no answer and have no option but to leave a voice message; they often had to wait hours or even days for someone to return their call. For those without access to a phone, as was often the case among the homeless or consumers with limited income, crisis services were not able to return their calls; these people were forced to try again or to seek relief from other services. One consumer appraised the crisis services available in her community:

Maybe 4 days then, and if they have a holiday then they're off the Wednesday, and that gives you Thursday, Friday, and Saturday to have your nervous breakdown. I mean, you know, because you have to call crisis on the weekend, and who wants to do that? I'm making a joke of it, but it's not funny.

Professionals and crisis line volunteers had similar concerns. These service providers all viewed the system as "very reactive and not proactive." They felt overwhelmed, partly due to the structure of current mental health services and the dearth of human resources available.

In the absence of crisis support, many consumers lost ground. Prolonged crises often led to decreased functioning and the prospect of eviction. Those who had difficulty accessing crisis services often engaged in risky behaviours and/or found themselves homeless before they could secure the services they needed. One consumer said, "You have to throw a brick through a window to get shelter."

Some individuals tried to gain ground by entering the legal system in order to access services. Such actions reflected consumers' frustration and desperate need for services. If consumers "can't get the help they need"

when they need it, a “vicious circle” develops and they end up shuffling between the legal and health-care systems. Some professionals believed that if mental health services were more accessible, consumers “wouldn’t have to resort to violence.”

Even when consumers were able to access crisis services without resorting to violence, the process was still perceived as challenging. If there was no doctor available to conduct a psychiatric assessment, it was necessary for the consumer to be transported to an urban area even if he or she did not require hospitalization. Arriving at crisis services only to be denied care was a source of anger and frustration for consumers, their families, and the workers. Several people shared their stories of being “turned away” after long waits. One mother, who was also a peer support worker, described her wait for emergency services with her daughter, who was experiencing psychosis:

We’ve had to sit there and wait and wait and wait, and then they give her a high dose of some sort of a needle in order to put her to sleep so that she won’t cause any more trouble. She still lies there and waits and waits. It has been very, very frustrating when you’re trying to be there and be a comfort and a calming influence and you’re just sitting there.

Because of the lack of resources, voluntary admission was very rare. In most cases, consumers could receive psychiatric care only involuntarily. In many rural areas, being involuntarily admitted or “forced” had become a condition for access to any form of psychiatric services.

Vulnerability to illness placed individuals at serious risk of homelessness. Compared to urban areas, rural areas have far fewer resources for preventing and managing homelessness, and have few emergency shelters or crisis beds. In their search for housing, therefore, consumers moved frequently, being forced to adopt a nomadic lifestyle. Relocation was necessary, as some perceived that they had worn out their welcome and others needed to flee from abuse, creditors, family, the law, or their “own personal demons.” Many simply needed to have access to services.

While waiting as long as “5 to 6 years” for housing, consumers often tried to avoid losing ground by relying on their families for help. Without family and timely housing supports, consumers felt that their only choice was to return to unhealthy or unsafe environments. Moving in and out of shelters became a strategy for remaining safe. Lack of housing and support services caused consumers to lose ground, as they became “stuck,” grew “hopeless,” or “cycled in and out of services”:

Couch surfing becomes a way of life due to limited housing options, lack of support services, long waiting lists, lack of affordable housing, and low

income. Such temporary fixes in order to keep a roof over your head and away from unsafe situations impedes having a life.

Consumers and their families often perceived that they had no housing options within their community. Many possible arrangements, such as geared-to-income housing or group homes, were assessed as sub-standard due to disrepair or location in an unsafe neighbourhood. Some individuals with mental health issues had no choice but to reside in a retirement or nursing home. For places without an Assertive Community Treatment team, long-term care far from home was consumers' only option for gaining ground, unless they could be cared for by family members.

Simply increasing the number of dwellings was not perceived as a solution by consumers, families, or workers. Housing was viewed as a mediator of health. If consumers lack access to services that are responsive and sensitive to their needs and abilities, they are unlikely to secure permanent housing and achieve recovery. A community worker explains:

If we set up housing — a huge apartment building — and said, “Everybody who’s homeless or going to be, come and see us, we’ve got a place for you,” within 2 months a lot of those people will be homeless again, because the cause of their homelessness was never addressed. You have to address the basic problem, and every person is different — why they’re homeless.

To address lack of formal services, rural networks came up with creative solutions. Local grassroots organizations and informal volunteers provided housing and other services to consumers. The rural communities represented in this study relied heavily on donations of money and housing space rather than depend on funded shelters and community agencies. In one community, for example, a church generously provided space for community groups; however, this generosity resulted in scheduling conflicts with other events. In another community a 24-hour consumer-run drop-in centre offering a few beds and a kitchen was a valuable resource for individuals at immediate risk of homelessness. Volunteers opened up their homes as emergency shelters and initiated consumer groups.

Transportation

Transportation was a frequent concern for consumers, family members, and community workers. Transportation plays a key role in people's tendency to gain or lose ground. Transportation was more than a means of getting from one place to another; it was an aspect of making and maintaining connections, becoming integrated into communities, and adher-

ing to treatment regimens. It was also an essential component of the safety strategy for rural women living in abusive situations. Many consumers wanted to gain ground by becoming involved in support groups. However, without adequate transportation, many lost ground instead of gaining it. Often, people who had a mental illness but no transportation became isolated and despondent and subsequently relapsed. Consumers and workers often spoke of being frustrated by how much time they had to spend travelling. Longer distances were particularly onerous if consumers had to rely on others for transportation or if driving conditions were poor because of the weather.

Available transportation was described in terms of “lucky,” “too expensive,” or “non-reimbursable from Ontario Works or Ontario Disability.” Several communities had no public transit and therefore consumers had to rely on family, friends, or neighbours. If their situation was perceived as a crisis, they often relied on police services. Some resorted to hitchhiking. One individual shared her story about the dangers associated with lack of transportation:

I hitchhiked home [from the hospital] because I don't have any family . . . and it was very scary as an older woman. But [the driver], he says, “Don't worry, honey.” He says, “You come from the hospital?” I said, “Yeah.” . . . Well, I tell you, I was scared. Even though the man had a cross dangling [from his mirror], I was still very scared.

Relocation

A number of rural residents and their families reported trying to gain ground by relocating in order to access mental health services, housing, or safety. One woman described her need to keep moving:

I, uh, I couldn't, like, abuse was, ran through the house. So I couldn't take it no more. So I finally stood up for myself and I went and told somebody and I was taken out of the house and sent to another place and then, like, foster homes. And then just kept on running away and doing all that, and then just continued on from there.

Participants were faced with the dilemma of moving away from home or living without proper access to the services they required. However, relocation for the sake of “a new life” entailed additional risks: isolation and lack of urban preparedness. These risks often resulted in people losing rather than gaining ground.

Often, it was a community worker's recommendation that led an individual to relocate to an urban community. Many clients could be “processed” for either psychiatric services or housing only if they were situated in an urban environment. Many individuals lamented the fact

that they had to move. Often, family members moved with the consumer in order to provide support. One mother recognized her daughter's need for services, yet relocation threatened her daughter's safety and security:

They want to send [daughter] to [name of city]. I said, "Over my dead body," because she needs to stay home — she needs her family, friends, church, and community. I'm over 70. I visit her every day or every other day. It's a grave concern, you know, when you have someone who there's no place for.

If people decided to relocate, they risked losing their informal social network. The anonymity of the city was viewed as both a blessing and a curse. The city presented many opportunities unavailable in small towns, such as more services, employment, housing, and education. As well, many people relocated to urban centres in order to access shelters. While access to a shelter could be extremely beneficial, shelters could also be very dangerous, especially for people from small towns who were unaware of the realities of shelter life. Participants claimed that shelters had some dangerous residents and were "riddled with thefts, violence, and drugs." Many participants who relocated from rural areas expressed disappointment with what they were confronted with in the city. Once people moved to the city and entered the shelter system, they were "bounced" from one shelter to another. Moving in and out of shelters became their strategy for maintaining a sense of safety. Some former rural residents even expressed a preference for living on the streets, for they felt safer there than in the shelters that had been their reason for moving to the city in the first place.

Discussion

Challenges

The findings suggest that the structure of housing and mental health supports available in rural communities undermines people's efforts to improve their health and living conditions. Ensuring that rural residents have better access to health and housing services may not only allow them to remain in their home communities, but also help prevent them from becoming homeless in the first place. Given the connection between the lack of access to services and the lack of transportation, mobile services may be an effective solution. Agencies serving rural communities might look into the possibility of creating their own public transit systems. For example, providing a hospital van may be a way to address both service issues and transportation issues in rural communities. Finally, perhaps responsibility for the administration of social housing should be shifted back to the province, given that many rural communi-

ties are unable to afford public housing due to their small municipal tax base. The project's findings suggest that implementing these few changes could help rural residents living with mental health issues to gain more ground than they lose.

The limited services offered to those with mental health issues tend to focus on crisis rather than prevention. The findings show that when mental health crises are left unmanaged, many individuals are unable to cope, which in turn results in the loss of their accommodations. Exacerbating the problem is the fact that most rural communities have few if any shelters and lack affordable transport to the services that are available. While communities try to supplement these supports through voluntarism, the needs of the rural homeless population are so great that the supply cannot meet the demand. In this study, there simply were not enough volunteers and service providers available within the rural communities to help everyone in need. Those consumers who were unable to access the services they required often moved to the city. However, many were unable to adjust to city life and found themselves homeless. Once they moved into urban shelters for the homeless, they found it difficult to get out again. Despite attempts by consumers and families to find help, they often experienced frustration in the face of inaccessible or inadequate services.

Resilience

It would be misleading to report that all the rural individuals at risk of homelessness were forced to relocate to urban environments due to the lack of choice. Individuals in rural areas were not passive victims of forces beyond their control. They devised many innovative strategies in an effort to stay in their communities. Families often went to great lengths to keep their loved ones in their rural homes. A number of individuals opened their homes to those in need and became peer support workers. Some persons with mental health issues resorted to living in tents, makeshift cabins, or abandoned cars. Others hitchhiked from one rural community to another. While often forced to move to an urban area, some returned to their rural roots once they regained a degree of stability in their lives. Nevertheless, many former rural residents were uprooted by their experiences with mental illness and the inadequacy of locally available services.

Policy Development and Recommendations

With regard to homeless policy, attention and analysis have typically focused on urban populations (Bruce, 2006). Issues of rural homelessness awareness and housing affordability, availability, and action appear to have been overlooked or simply ignored in policy discussions and decision-

making. To look at urban issues in isolation from rural issues is to miss the issue of forced migration from a rural to an urban landscape in search of services. Yet while rural communities are losing members, urban centres can inherit problems as uprooted rural residents may well be more prone to homelessness in an urban setting. Articulating these issues clearly, and then linking them to relevant policies, is essential for effecting constructive change with respect to the complex issue of homelessness in the rural setting.

Conclusion

Gaining ground and losing ground were not exclusive categories in this study. The homeless people who took part in the study spoke about times when they felt they were overcoming the challenges of their everyday lives and in fact gaining ground. However, the same individuals spoke about setbacks, frustration with an unsupportive social system, and forced relocation from rural to urban settings. In this respect, they perceived that they were losing ground. While the participants clearly demonstrated a great deal of strength and resilience in the face of adversity by relying on informal support, the balance was heavily tipped against them; they had a very real sense that they were losing more ground than they were gaining.

In the absence of any means of supporting rural individuals in their home communities, urban centres will continue to inherit the problem of uprooted rural individuals at high risk for homelessness. Emphasizing health promotion and preventing crisis situations could serve to improve quality of life for the rural population and reduce the number of both rural and urban homeless persons.

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Cheryl Forchuk, RN, PhD, is Professor/Scientist, Arthur Labatt Family School of Nursing, Faculty of Health Sciences, and Lawson Health Research Institute, University of Western Ontario, London, Ontario, Canada. Phyllis Montgomery, RN, PhD, is Associate Professor, School of Nursing, Laurentian University, Sudbury, Ontario. Helene Berman, RN, PhD, is Associate Professor, Arthur Labatt Family School of Nursing, University of Western Ontario. Catherine Ward-Griffin, RN, PhD, is Associate Professor, Arthur Labatt Family School of Nursing, and Scientist, Lawson Health Research Institute, University of Western Ontario. Rick Csiernik, RSW, PhD, is Professor, School of Social Work, King's College, London, Ontario. Carlyne Gorlick, PhD, is Associate Professor, School of Social Work, King's College. Elisabeth Jensen, RN, PhD, is Assistant Professor, School of Nursing, York University, Toronto, Ontario; and Scientist, Lawson Health Research Institute, University of Western Ontario. Patrick Riesterer, MA, is a student in the Faculty of Law, University of Toronto, Ontario.