emerald insight

Article information:

For Authors

If you would like to write for this, or any other Emerald publication, then please use our Emerald for Authors service information about how to choose which publication to write for and submission guidelines are available for all. Please visit www.emeraldinsight.com/authors for more information.

About Emerald www.emeraldinsight.com

Emerald is a global publisher linking research and practice to the benefit of society. The company manages a portfolio of more than 290 journals and over 2,350 books and book series volumes, as well as providing an extensive range of online products and additional customer resources and services.

Emerald is both COUNTER 4 and TRANSFER compliant. The organization is a partner of the Committee on Publication Ethics (COPE) and also works with Portico and the LOCKSS initiative for digital archive preservation.

*Related content and download information correct at time of download.

A moral case for universal healthcare for runaway and homeless youth

Scott B. Harpin, April S. Elliott and Colette L. Auerswald

Abstract

Purpose – *Runaway and homeless youth (RHY) are among the most vulnerable youth globally. The United Nations Convention on the Rights of the Child (UNCRC) states that all children have the right to the highest level of health, and that universal healthcare rights are afforded to RHY and all children. Social determinants of health (SDH) are universal factors that frame the experiences of RHY as facilitators or barriers for accessing healthcare. The purpose of this paper is to describe practical best approaches, and policy recommendations, for improving clinical care systems to make healthcare more accessible to RHY.*
Design/methodology/approach – *The authors describe and apply an adapted socio-ecological framework that includes SDH specific to RHY around the globe.*
Findings – *There are multiple and complex factors in the social ecology of RHY that determine their chances of accessing healthcare. While many intrapersonal reasons for homelessness are the same globally, systems of care vary by country and by developing/developed country status. Structurally competent care systems offer a new lens for how to best provide care to RHY to take into account SDH and the unique needs of RHY.*
Originality/value – *The UNCRC serves as a moral guide and frame of universal child healthcare provision for countries around the world. The authors uniquely argue for UNCRC, tailored-SDH, and care delivered in a structurally competent manner to make a moral case for both physical and mental health for all RHY.*

Keywords Social determinants of health, Human rights, Healthcare policy, Runaway/homeless youth
Paper type Viewpoint

Scott B. Harpin is an Associate Professor at the College of Nursing, University of Colorado at Denver – Anschutz Medical Campus, Aurora, Colorado, USA.
April S. Elliott is based at the Department of Paediatrics, University of Calgary, Calgary, Canada.
Colette L. Auerswald is based at the School of Public Health, University of California Berkeley, Berkeley, California, USA.

> Of course healthcare should be a right! How are we supposed to succeed in our day-to-day lives if we can't be well? (Ben, 20 years old).

The United Nations Convention on the Rights of the Child (UNCRC) has stood the test of time as a guiding framework and moral compass for the human rights of vulnerable youth worldwide (United Nations General Assembly, 1989). The UNCRC articles addressing healthcare rights pose an important moral challenge when considering the world's runaway and homeless youth (RHY). In this paper, we make a moral case for universal healthcare for RHY worldwide, based on the principles of the UNCRC. As described in the WHO report on the social determinants of health (SDH), the health of a population can only be optimized when the SDH are addressed (World Health Organization (WHO), 2008). Thus, we make the further argument that youth not only have the right to universal healthcare, but also the right to care that is structurally competent, i.e., care that takes into account their SDH, including the resulting multi-level needs and obstacles to their well-being (Metzl and Hansen, 2014). This includes, but is not limited to, parity of access to care for both their physical and mental health.

Each section of this paper opens with words of wisdom from homeless youth in Denver, Colorado in the USA, imparted for use with their enthusiastic permission, to add their voice to our argument.

Definition of RHY

The definitions of RHY differ widely by discipline, governmental program, and geographical location. In the USA, definitions include youth "for whom it is not possible to live in a safe environment with a relative and who has no other safe alternative living arrangement" (United States Department of Housing and Urban Development, 2009), a definition which acknowledges youth's rights to live with

a supportive adult, and individuals who "lack a fixed, adequate, and regular nighttime residence" (United States Congress, 2008), a definition which recognizes the importance of have a predictable place to stay. We include in this definition unaccompanied adolescents or young adults aged 10-25 years old living on the streets, in a crisis shelter, a transitional housing program, "uprooted," "couch-surfing" with a stranger, or any temporary living arrangement that could be deemed precarious or unfit for human habitation. The international definition has traditionally been focused on the term "street children," which has long been recognized as stigmatizing. More recently, "youth on the streets" has been used to describe "young people for whom the street plays a central role during this period of their lives," often in a transitory way (United Nations, n.d.).

Panter-Brick (2002) described the obfuscation and stigma related to labeling RHY while pressing for identifying realities of living on the street instead of describing youth themselves. Importantly, being homeless is not an identity, but a status. Thus, the population of RHY is not homogenous, including youth with varying lengths of homelessness and overlapping with other marginalized youth who are more likely to be homelessness due to their social exclusion, such as refugees, exploited/prostituted/trafficked youth, LGBTQ youth, immigrant youth, and youth who are street based to support their families.

Accurate estimates of numbers of precariously housed adolescents and young adults are not available in developed countries with refined census systems, let alone globally in low- and middle-income countries (Embleton et al., 2016). The lack of such estimates hinders advocacy for youth as well as policy, planning, and resource allocation for service provision.

SDH and the health of RHY

The WHO defines the SDH as "the conditions, in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life" (WHO, 2008). These forces and systems include economic policies and systems, development agendas, social norms, social policies, and political systems that create disparities and influence individual health across the lifespan. Viner et al. (2012) described two sets of forces – structural and proximal in nature – that make up adolescents' determinants of health. They described the strong associations between SDH with national wealth, economic inequality, access to education, as well as other more intra- and inter-personal factors closer to the individual. The central role of the SDH in youth health and well-being was reiterated in a the more recent report of the Lancet Commission on Adolescent Health (Patton et al., 2016), which recognized vulnerable youth populations as a group for whom inequalities in health and well-being are particularly evident.
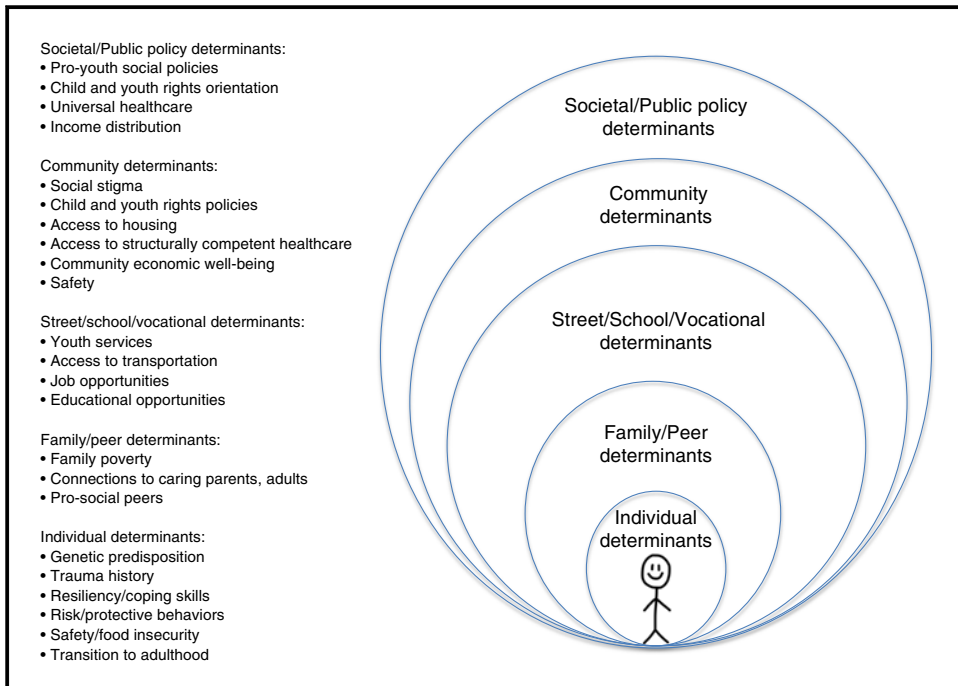
In their systematic review of street children in low- and middle-income countries, Woan et al. (2013) described the key role of family, housing, nutrition, and poverty on the health of RHY. In a global systematic review of causes of youth street-involvement by Embleton et al. (2016), poverty emerged as the top cause of child and youth homelessness for those younger than 25 years old globally. Given the role of poverty as a central social determinant of health for RHY, it is reasonable to apply interventions to address its consequences with the same vigor as more medical causes of youth morbidity, such as cancer, infectious diseases, or other preventable illnesses. Figure 1 is an illustration of the SDH for RHY employing Bronfenbrenner's (1979) classic socio-ecologic framework. It should be noted that some factors do not exist in a single sphere of influence (i.e. poverty, economic disparity), but might be cross-cutting in nature and existing both proximal and distal to the individual.

UNCRC

The UNCRC, adopted by the United Nations General Assembly in November 1989, amended twice, most recently in 2014, includes several articles that are particularly relevant to the well-being of RHY. The healthcare rights outlined Article 24 most specifically describes the ethics-based framework for care:

> States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such healthcare services (UNCRC Article 24.1).

Figure 1 Social determinants of health adapted for the social ecology of runaway/homeless youth

Societal/Public policy determinants:
• Pro-youth social policies
• Child and youth rights orientation
• Universal healthcare
• Income distribution

Community determinants:
• Social stigma
• Child and youth rights policies
• Access to housing
• Access to structurally competent healthcare
• Community economic well-being
• Safety

Street/school/vocational determinants:
• Youth services
• Access to transportation
• Job opportunities
• Educational opportunities

Family/peer determinants:
• Family poverty
• Connections to caring parents, adults
• Pro-social peers

Individual determinants:
• Genetic predisposition
• Trauma history
• Resiliency/coping skills
• Risk/protective behaviors
• Safety/food insecurity
• Transition to adulthood

Societal/Public policy determinants
Community determinants
Street/School/Vocational determinants
Family/Peer determinants
Individual determinants

This Article mirrors the WHO definition of health outlined in their original constitution (World Health Organization, 2006): "Health is a state of complete physical, mental and social well-being" and "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being." The complementary CRC and WHO definitions of health not only frame an ideal of health for all children and adolescents, but also serve as a moral compass for how care should be delivered to the most vulnerable around the world.

In Table I, we have identified a number of related UNCRC articles that pertain to the rights of RHY. Overall these articles outline three types of rights related to their health and well-being: the rights of children to protection from harm; the rights of children to health, well-being, and quality of life; and the rights of children to the services necessary to their well-being and growth to adulthood, such as education, healthcare, and, importantly, care for the "physical and psychological recovery and social reintegration of a child victim of any form of neglect, exploitation, or abuse (Article 39)." Thus, the UNCRC advocates for the rights of all children to the positive SDH, explicitly making the case for economic security, safety, education, and a home in addition to the healthcare rights already described.

Currently, two United Nations supporting documents (General comment no. 4, 2003; General comment no. 15, 2013) offer guidance for applying the principles of the UNCRC to creating healthcare systems that support vulnerable youth. These guidelines emphasize the "indivisibility and interdependence of children's rights" (United Nations Convention on the Rights of the Child (UNCRC), 2013, p. 2) that mirror the SDH. Recognizing the interrelated deficits that RHY face, General comment no. 4 (United Nations Convention on the Rights of the Child, 2003) specifically calls-out special protections for RHY, noting their extreme vulnerability and requiring that signatories provide for educational, healthcare, and social-developmental policies to promote their well-being.

Clinical rights of RHY: a parity of esteem and structural competence

> There is so much stress and anxiety here at the shelter. Even after we get settled in and feel safe here, then you have to drive yourself crazy trying to figure out the next steps in life. Thank God we have therapists here to access if we need them (Mae, 19 years old).

Table I	UN convention on the rights of the child, articles related to the health of runaway and homeless youth
Article 19	"[…] to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse […]"
Article 20	"A child temporarily or permanently deprived of his or her family environment, or in whose own best interests cannot be allowed to remain in that environment, shall be entitled to special protection and assistance provided by the State"
Article 22	"A child who is seeking refugee status or who is considered a refugee […] receive appropriate protection and humanitarian assistance in the enjoyment of applicable rights set forth"
Article 23	"[…] a mentally or physically disabled child should enjoy a full and decent life, in conditions which ensure dignity, promote self-reliance and facilitate the child's active participation in the community"
Article 24	"[…] the right of the child to the enjoyment of the highest attainable standard of health […]"
Article 27	"[…] the right of every child to a standard of living adequate for the child's physical, mental, spiritual, moral and social development"
Article 28	"[…] right of the child to education, […]"
Article 29	"[…] development of the child's personality, talents, mental and physical abilities to their fullest potential"
Article 34	"[…] to protect the child from all forms of sexual exploitation and sexual abuse"
Article 35	"[…] take all appropriate national, bilateral and multilateral measures to prevent the abduction of, the sale of or traffic in children for any purpose or in any form"
Article 36	"[…] protect the child against all other forms of exploitation prejudicial to any aspects of the child's welfare"
Article 39	"[…] to promote physical and psychological recovery and social reintegration of a child victim of: any form of neglect, exploitation, or abuse; torture or any other form of cruel, inhuman or degrading treatment or punishment; or armed conflicts. Such recovery and reintegration shall take place in an environment which fosters the health, self-respect and dignity of the child"

Source: United Nations General Assembly (1989)

The aforementioned Lancet Commission report (Patton *et al.*, 2016) outlines steps for countries to address and improve the health of their youth. Their suggested four-step accountability framework can be applied in the context of RHY health systems to account for and act on behalf of systems of care for young people. These steps include: assessment ("take the account"), communication ("share the account"), governance ("hold to account"), and health actions ("respond to the account").

Structural competence represents the translation of the SDH to the care setting, recognizing the need to incorporate the wider forces impacting a patient's health. In the case of RHY, this requires developing and managing the infrastructure, community, and social systems to support a structurally competent care system for youth (Metzl and Hansen, 2014; Hansen and Metzl, 2016). From a clinical standpoint, structurally competent care for youth needs to be adolescent-friendly. "Adolescent-friendly healthcare" is defined by the WHO as addressing five domains: equity, effectiveness, accessibility, acceptability, and appropriateness (World Health Organization, 2012). Co-located services are exemplars for how integrated and "wrap-around" care can be delivered to homeless populations (Ensign, 2004; National Health Care for the Homeless Council, 2011), including mental health services, case management, and linkage to housing, and educational/vocational services. In the USA, integrated behavioral healthcare (Blount, 2003) has been bolstered by the Affordable Care Act (Kuramoto, 2014). In Canada, universal healthcare provides the support and impetus for collaborative interagency programs and clinics for RHY (Covenant House, 2016; Safe Communities Opportunity and Resource Centre (SORCe), 2017; Woods Homes, 2017). These programs are essential, though barriers to care for RHY persist, such as lack of health insurance, the absence of prescription coverage, the need for a permanent address or consent from adults, poor coordination and accessibility of services, and youth's lack of trust of adults, previous victimization and/or fear of being reported to authorities (Elliott, 2013). "Parity of esteem" in the UK (Centre for Mental Health, 2013), the Mental Health Parity Act in the USA (Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 2008), and similar principles held elsewhere hold that mental health services should receive the same priority and coverage as physical health services. Though mandated in some countries, this principle is far from universal in the practice of healthcare for RHY.

In addition to co-located models for physical and mental healthcare for RHY, integrated, holistic care models for RHY can be uniquely effective to address the negative downstream psychological effects of youth's social environments. Many RHY have experienced complex trauma secondary to domestic violence, sexual or physical abuse and struggle with resulting negative effects on their mental health. These models include trauma-informed care (Hopper *et al.*, 2010; Ko *et al.*, 2008), dialectical behavioral therapy (McCay *et al.*, 2015), and

mindfulness interventions (Grabbe *et al.*, 2012; Viafora *et al.*, 2015). These can be applied in the context of shelters or other housing options for RHY, or in the clinical setting, such as the co-located youth-centric service programs described above.

Finally, the use of a resiliency framework for care can be particularly useful for clinicians (Resnick, 2000; Taylor-Seehafer, 2004), especially considering the prevalence of past or current trauma experienced by RHY, including the lived experience of finding oneself homeless. A resilient youth is one who bounces back from adversity and finds hope and strength in the face of challenges. Regardless of the causes of their homelessness, RHY demand the respect given any other young person when accessing healthcare. They not only possess the same developmentally appropriate healthcare needs as domiciled youth but also have specific healthcare needs that either preexist or are the result of being homeless which need to be acknowledged and addressed to maximize their positive outcomes (Elliott, 2013).

Policies to cover all youth: rights-based healthcare

> People shouldn't have to pay to stay alive. Getting healthcare is like a choice between spending your money or paying with your life (Brian, 21 years old).

Given the argument that youth not only have a right to healthcare but also to care that addresses their SDH, policies are key to providing access, availability, and financing of universal healthcare for RHY. This is especially true in countries where such coverage does not yet exist or where resources are too slim to cover those needs. A greater challenge still is for societies to enact policies to address the SDH of youth outside of the healthcare system. As stated by UNICEF Canada (2016), "The well-being of children is a shared responsibility among families, communities and public institutions, but all of the well-being indicators […] are influenced by policy choices. Addressing child poverty in Canada will go a long way to improving the wellbeing of children in Canada in all areas – improving family and peer relationships and health and education, and decreasing risky behavior."

Models for addressing the SDH in all systems could include policies such as a universal basic income to address poverty as the primary reason for child and youth homelessness, the recognition of housing and food as a form of healthcare and a human right (Bamberger, 2016), and overturning laws that criminalize homelessness (Canada Without Poverty, 2016).

Conclusion

> To be yourself in a world that is constantly trying to make you something else is the greatest accomplishment (Ralph Waldo Emerson).

Adolescents 10 to 25 years of age now make up nearly a quarter of the world's population (Sawyer *et al.*, 2012). Global economic disparities and geopolitical crises threaten to create growing segments of marginalized youth who are increasingly vulnerable and at risk for becoming uprooted. Other papers in this special issue of IJHRH highlight the interconnectedness of vulnerable youth groups who may find themselves in and out of homelessness along their life course.

Research regarding RHY populations has become more robust over the past 15 years to include complex sampling methods, innovative technologies, and creative/poignant research questions to better understand the lives of unaccompanied young people. More research is needed regarding evidence-based interventions. Notably absent are studies of policy and structural interventions addressing the SDH on youth well-being, including studies of the pathways and effectiveness of structural interventions and of the effect on well-being of rights-based approaches to RHY healthcare (de Benitez, 2003; Uvin, 2007).

As signatories to the UNCRC, all countries (with the notable exception of the USA) are obligated to consider and report on their response to the specialized needs of RHY in their healthcare provision. The moral case for universal, youth-centered, structurally competent healthcare to promote wellness among RHY is compelling, and protected by international human rights treaties. We must be mindful of the fact that we are, above all, facilitators who work to enable our youth to reach their own potential: each of them as rare, unique, and deserving of specialized care as our the children in our own families.

References

Bamberger, J. (2016), "Reducing homelessness by embracing housing as a medicaid benefit", *JAMA Internal Medicine*, Vol. 176 No. 8, pp. 1051-2.

Blount, A. (2003), "Integrated primary care: organizing the evidence", *Families Systems and Health*, Vol. 21 No. 2, pp. 121-34.

Bronfenbrenner, U. (1979), *The Ecology of Human Development*, Harvard University Press, Cambridge, MA.

Canada Without Poverty (2016), "Youth rights! right now! ending youth homelessness: a human rights guide", Monograph, available at: http://homelesshub.ca/sites/default/files/YouthRights-GuideEU-final.pdf (accessed February 10, 2017).

Centre for Mental Health (2013), "Briefing 46: the NHS mandate and its implications for mental health", available at: www.centreformentalhealth.org.uk/briefing-46-nhs-mandate (accessed January 23, 2017).

Covenant House (2016), "Covenant House Health Care Clinic", available at: www.covenanthouse.ca/homeless-youth/Health-Care-Clinic (accessed February 15, 2017).

de Benitez, S.T. (2003), "Reactive, protective and rights-based approaches in work with homeless street youth", *Children Youth and Environments*, Vol. 13 No. 1, pp. 134-49.

Elliott, A.S. (2013), "Meeting the healthcare needs of street-involved youth", *Paediatrics & Child Health*, Vol. 18 No. 6, pp. 317-21.

Embleton, L., Lee, H., Gunn, J., Ayuku, D. and Braitstein, P. (2016), "Causes of child and youth homelessness in developed and developing countries: a systematic review and meta-analysis", *JAMA Pediatrics*, Vol. 170 No. 5, pp. 435-44.

Ensign, J. (2004), "Quality of healthcare: the views of homeless youth", *Health Services Research*, Vol. 39 No. 4, pp. 695-708.

Grabbe, L., Nguy, S.T. and Higgins, M.K. (2012), "Spirituality development for homeless youth: a mindfulness meditation feasibility pilot", *Journal of Child and Family Studies*, Vol. 21 No. 6, pp. 925-37.

Hansen, H. and Metzl, J. (2016), "Structural competency in the US healthcare crisis: putting social and policy interventions into clinical practice", *Journal of Bioethical Inquiry*, Vol. 13 No. 2, pp. 179-83.

Hopper, E.K., Bassuk, E.L. and Olivet, J. (2010), "Shelter from the storm: trauma-informed care in homelessness services settings", *The Open Health Services and Policy Journal*, Vol. 3, pp. 80-100.

Ko, S.J., Ford, J.D., Kassam-Adams, N., Berkowitz, S.J., Wilson, C., Wong, M., Brymer, M.J. and Layne, C.M. (2008), "Creating trauma-informed systems: child welfare, education, first responders, healthcare, juvenile justice", *Professional Psychology: Research and Practice*, Vol. 39 No. 4, pp. 396-404.

Kuramoto, F. (2014), "The Affordable Care Act and integrated care", *Journal of Social Work in Disability & Rehabilitation*, Vol. 13 Nos 1-2, pp. 44-86.

McCay, E., Carter, C., Aiello, A., Quesnel, S., Langley, J., Hwang, S., Beanlands, H., Cooper, L., Howes, C., Johansson, B., MacLaurin, B., Hughes, J. and Karabanow, J. (2015), "Dialectical behavior therapy as a catalyst for change in street-involved youth: a mixed methods study", *Children and Youth Services Review*, Vol. 58, pp. 187-99.

Metzl, J.M. and Hansen, H. (2014), "Structural competency: theorizing a new medical engagement with stigma and inequality", *Social Science & Medicine*, Vol. 103, pp. 126-33.

National Health Care for the Homeless Council (2011), "Key elements of integrated care for persons experiencing homelessness: a guide for healthcare for the homeless providers", available at: www.nhchc.org/wp-content/uploads/2011/10/Key-Elements-of-Integrated-Care.pdf (accessed January 10, 2017).

Panter-Brick, C. (2002), "Street children, human rights, and public health: a critique and future directions", *Annual Review of Anthropology*, Vol. 31, pp. 147-71, doi: 10.1146/annurev.anthro.31.040402.085359.

Patton, G.C., Sawyer, S.M., Santelli, J.S., Ross, D.A., Afifi, R., Allen, N.B., Arora, M., Azzopardi, P., Baldwin, W., Bonell, C. and Kakuma, R. (2016), "Our future: a Lancet commission on adolescent health and wellbeing", *The Lancet*, Vol. 387 No. 10036, pp. 2423-78.

Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (2008), "H.R.6983, 110th Congress (200708)", available at: www.congress.gov/bill/110th-congress/house-bill/6983 (accessed January 10, 2017).

Resnick, M.D. (2000), "Protective factors, resiliency, and healthy youth development", *Adolescent Medicine: State of the Art Reviews*, Vol. 11 No. 1, pp. 157-64.

Safe Communities Opportunity and Resource Centre (SORCe) (2017), "The foundations of a community collaborative", available at: https://static1.squarespace.com/static/5119a54be4b0dcc6d897dc2b/t/53a20 872e4b0d80b1acc28d5/1403127922587/SORCe+-+Year+In+Review.pdf (accessed February 23, 2017).

Sawyer, S.M., Afifi, R.A., Bearinger, L.H., Blakemore, S.J., Dick, B., Ezeh, A.C. and Patton, G.C. (2012), "Adolescence: a foundation for future health", *The Lancet*, Vol. 379 No. 9826, pp. 1630-40.

Taylor-Seehafer, M.A. (2004), "Positive youth development: reducing the health risks of homeless youth", *MCN: The American Journal of Maternal/Child Nursing*, Vol. 29 No. 1, pp. 36-40.

UNICEF Canada (2016), "Child well-being in rich countries: a comparative overview [Website]", available at: www.unicef.ca/en/our-work/article/child-well-being-in-rich-countries-a-comparative-overview (accessed February 15, 2017).

United Nations (n.d.), "Briefing note on youth: youth on the streets", Monograph, available at: www.un.org/esa/socdev/unyin/documents/briefingnotestreetyouth.pdf (accessed February 15, 2017).

United Nations Convention on the Rights of the Child (2003), "General comment no. 4: adolescent health and development in the context of the convention on the rights of the child (CRC/GC/2003/4)", available at: www.ohchr.org/EN/HRBodies/CRC/Pages/CRCIndex.aspx (accessed December 15, 2016).

United Nations Convention on the Rights of the Child (UNCRC) (2013), "General comment no. 15 on the right of the child to the enjoyment of the highest attainable standard of health, art. 24 (CRC/C/GC/15)", available at: www.ohchr.org/EN/HRBodies/CRC/Pages/CRCIndex.aspx (accessed February 10, 2017).

United Nations General Assembly (1989), "Convention on the Rights of the Child (UNCRC)", United Nations, Treaty Series, Vol. 1577, p. 3, November 20, available at: www.ohchr.org/EN/ProfessionalInterest/Pages/CRC.aspx (accessed December 15, 2016).

United States Congress (2008), "Reconnecting Homeless Youth Act of 2008", Public Law 110-378, 122 Stat. 4068.

United States Department of Housing and Urban Development (2009), "The McKinney-Vento Homeless Assistance Act as amended by S. 896 the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009", available at: www.hudexchange.info/resources/documents/Homeless AssistanceActAmendedbyHEARTH.pdf (accessed December 15, 2016).

Uvin, P. (2007), "From the right to development to the rights-based approach: how 'human rights' entered development", *Development in Practice*, Vol. 17 Nos 4-5, pp. 597-606.

Viafora, D.P., Mathiesen, S.G. and Unsworth, S.J. (2015), "Teaching mindfulness to middle school students and homeless youth in school classrooms", *Journal of Child and Family Studies*, Vol. 24 No. 5, pp. 1179-91.

Viner, R.M., Ozer, E.M., Denny, S., Marmot, M., Resnick, M., Fatusi, A. and Currie, C. (2012), "Adolescence and the social determinants of health", *The Lancet*, Vol. 379 No. 9826, pp. 1641-52.

Woan, J., Lin, J. and Auerswald, C. (2013), "The health status of street children and youth in low-and middle-income countries: a systematic review of the literature", *Journal of Adolescent Health*, Vol. 53 No. 3, pp. 314-21.

Woods Homes (2017), "Street services (website)", available at: www.woodshomes.ca/site/PageNavigator/programs/street_services/programs_street_services.html (accessed February 15, 2017).

World Health Organization (2006), *The Constitution of the World Health Organization*, 45th ed., World Health Organization, available at: www.who.int/governance/eb/who_constitution_en.pdf (accessed February 15, 2017).

World Health Organization (WHO) (2008), "Closing the gap in a generation: health equity through action on the social determinants of health", Final report of the Commission on Social Determinants of Health, World Health Organization, Geneva.

World Health Organization (2012), *Making Health Services Adolescent Friendly: Developing National Quality Standards for Adolescent Friendly Health Services*, Department of Maternal, Newborn, Child and Adolescent Health, available at: http://apps.who.int/iris/bitstream/10665/75217/1/9789241503594_eng.pdf (accessed January 10, 2017).

Further reading

Kidd, S.A. and Carroll, M.R. (2007), "Coping and suicidality among homeless youth", *Journal of Adolescence*, Vol. 30 No. 2, pp. 283-96.

Richardson, L.P., McCarty, C.A., Radovic, A. and Suleiman, A.B. (2017), "Research in the integration of behavioral health for adolescents and young adults in primary care settings: a systematic review", *Journal of Adolescent Health*, Vol. 60 No. 3, pp. 261-9.

UNICEF Office of Research (2013), "Child well-being in rich countries: a comparative overview", Innocenti Report Card No. 11, UNICEF Office of Research, Florence, available at: www.unicef.ca/sites/default/files/legacy/imce_uploads/DISCOVER/OUR%20WORK/ADVOCACY/DOMESTIC/POLICY%20ADVOCACY/DOCS/unicef_report_card_11.pdf (accessed February 10, 2017).

United Nations Human Rights Council (2012), "Homelessness (unpublished document)", November 23, available at: www.ohchr.org/Documents/Issues/Housing/homelessness.pdf (accessed February 10, 2017).

Corresponding author

Scott B. Harpin can be contacted at: scott.harpin@ucdenver.edu