Abstract

Introduction: On any given night, thousands of Canadian youth face homelessness in either absolute (living on the street) or relative (couch surfing) terms. Youth experiencing homelessness report disproportionately high rates of illness and unique influences on their access to health care as compared to their stably housed peers.

Method: I conducted a mixed methods study to examine influences on homeless youth access to health care. First, I interviewed eight homeless youth about their experiences accessing health care. Next, I conducted a focused analysis of the 2014 Homeless and Street-Involved Youth Survey which was conducted in 13 communities across British Columbia with 671 youth. Finally, I facilitated a solutions-focused dialogue with a panel of 4 health care and allied service providers who work with homeless youth. Data analysis was informed by procedures consistent with interpretive description as the methodological orientation.

Results: I identified three themes from the interviews: youth experiencing homelessness feel powerless when interacting with health care providers; health care systems exist as ‘rule-based’ bureaucracies; and homeless youth are in ‘survival mode’ when it comes to their health. At the same time, findings from the focused survey analysis suggest that the effect of individual factors (e.g., age) on access to health care is confounded by more systemic factors, such as discrimination and access to stable shelter, which are themselves associated with foregone care. The expert panel supported these findings and further suggested that hurtful interactions may damage not only a youth’s relationship with the health care system but also their overall trust in others. The panel also suggested that before health care providers can ‘do health stuff’ with a youth they need to have had several opportunities to cross paths and connect in more informal ways first.
**Discussion and Implications:** A multi-pronged intersectoral approach founded on communication, collaboration and coordination of care is needed to facilitate access to health care for homeless youth. Additionally, specialized training is needed for people who work with these youth. More work is also needed across health care and social service sectors to empower youth in relation to their health and seeking health care.
Preface

I selected the methodology and design for this project (interpretive description; mixed methods). I performed all parts of the research including preparing the ethics application, conducting the recruitment, collecting the data, transcribing the interviews and analyzing the data. The one exception to this was the data set used in my focused analysis of the 2014 Homeless and Street-Involved Youth Survey, which was designed and conducted by the McCreary Center Society. I used the survey data with the permission of the McCreary Center Society’s Executive Director. I wrote the content of this thesis with my thesis committee providing editorial feedback and support. None of the content from this thesis has been published elsewhere to date. The UBC Behavioural Research Ethics Board granted ethics approval for this thesis, and the certificate number for this project was H15-02473.
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Glossary

• **Foregone Health Care:** Foregone health care describes when a person needs but does not receive health care services. A person may report foregone health care for a number of reasons including not knowing how to seek or secure health care.

• **Homeless Youth:** For the purposes of my research, I defined ‘homeless youth’ as any person ages 12 to 19 years who has lived on or near the streets for 3 or more days in the previous 12 months. Similar although slightly altered definitions of this term were used by research referenced in this project (e.g., some research includes people up to the age of 25 in their definition of youth.) Throughout this paper, I have used the term ‘homeless youth’, ‘youth who are experiencing homelessness’ and ‘homeless and street-involved youth’ interchangeably, as many youth transition in and out of absolute and relative homelessness over any particular period of time.

• **Primary Health Care:** Primary health care describes any first points of contact between an individual and the health care system. This may include family physicians, nurse practitioners, walk-in clinics, etc.

• **Social and Structural Influences on Health Care:** This is a term used to describe those systems-level (e.g., political, institutional and social) influences that shape people’s access to health care. An example of a structural or systems-level influence on health care access includes such factors as the (un)availability of safe, reliable transit servicing local health centers. My definition of this term includes structural oppression such as racism and sexism.
Acknowledgements

I offer my enduring gratitude to the faculty, staff and my fellow students at UBC who have encouraged me throughout my studies. I owe particular thanks to Dr. E. Saewyc for her thoughtful guidance and continued support during this project. Drs. Saewyc, Browne and Rodney have each pushed me to use more nuanced thinking and language as I tackled several complex topics in the pursuit of a more thorough understanding of my research topic. I would like to acknowledge that this project could not have happened in its current form without the support of the Lyle Creelman Endowment Fund. Special thanks are owed to my parents, Jim and Wanda, my sister, Emily and, my partner Tim.
Dedication

I would like to dedicate this project to my mother for her unending dedication to promoting child and youth wellness as an inner-city middle school counsellor and to my father for his boundless patience and curiosity.
1.1 Problem Statement

On any given night, thousands of Canadian youth face homelessness in either absolute (living on the street) or relative (couch surfing, staying in emergency shelters) terms (Dawson & Jackson, 2013; Evenson & Barr, 2009; Feldmann & Middleman, 2003). These youth experience disproportionately high rates of illness (respiratory illnesses, skin conditions, exacerbations of pre-existing health conditions, sexually transmitted infections) compared to their stably housed peers (Dawson & Jackson, 2013; Elliott, 2013). Furthermore, youth who are experiencing homelessness face a range of social and structural barriers to accessing health care. The Canadian Pediatric Society recently stated that “[i]nadequate health care…for homeless and street-involved youth who present in various health care settings every day in Canada is one of this country’s great unmet needs” (Elliott, 2013, p. 1). This combination of factors (increased need plus decreased access) often leads homeless youth to wait until they are critically ill before seeking care, which further perpetuates and entrenches illness (Busen & Engebretson, 2008; Dawson & Jackson, 2013; Ensign & Panke, 2002).

1.2 Purpose

On an international stage, Canada is often lauded as a country that values excellent infrastructure, universal access to health care and a comprehensive social safety net. Recently, however, a growing body of research has revealed persistent inequities that exist in health care access amongst Canadians (Anderson et al., 2009; Reimer-Kirkham & Browne, 2006). Meanwhile, much of the country’s current health care discourse focuses on individual resources and responsibilities rather than critically reflecting on those structural
factors that shape everyday health care access. Youth who are experiencing homelessness are a population that faces particularly significant barriers to accessing health care services. Developing a more thorough understanding of these inequities and working to overcome them may help to ease the burden of illness currently shouldered by this population. Such action requires attention to all modes of health care delivery, particularly primary health care.

Primary health care describes any first points of contact between an individual and the health care system. This may include family physicians, nurse practitioners, walk-in clinics, and other sites of interaction. Enhancing primary health care access amongst disadvantaged populations is essential to reducing health and health care inequities (Browne et al., 2012). The findings from this thesis may help to challenge the current discourse around the ‘ease’ and equity of primary health care access in Canada by asking the following three research questions:

1. How do social and structural factors influence homeless and street-involved youth’s experiences accessing primary health care in British Columbia?
2. What social and structural influences might be evident in the extent to which and reasons why homeless and street-involved youth in British Columbia report foregone health care?
3. From the perspectives of health care and allied service providers, how might the findings from this thesis help to improve homeless and street-involved youth access to primary health care services?

In the literature review for this thesis in Chapter 2, I address three topics: (1) homeless youth health and health care access; (2) social and structural influences on health
care; and (3) the concept of critical social justice. For the purposes of this project, I will focus on ‘younger’ homeless and street-involved youth, ages 12 to 19 years, as they are an often-overlooked population (Edinburgh & Saewyc, 2008). Moreover, I will focus on social and structural influences on health care, or, in other words, those systems-level (e.g., political, institutional and social) influences that shape people’s access to health care (Browne et al., 2012). An example of a structural or systems-level influence on health care access includes such factors as the (un)availability of safe, reliable transit servicing local health centers. I also include structural oppression such as racism and sexism in my definition of social and structural influences. As such, my thesis will draw heavily on the concept of critical social justice (Reimer Kirkham & Browne, 2006).

Although the term ‘critical theory’ describes a broad family of theories, I focused specifically on the ideas underpinning critical social justice as a concept integral to critical theoretical perspectives. This approach enabled me to “move between the individual and the social to make visible the mutually constitutive social processes that shape individual experience” (Anderson et al., 2009, p. 287). For example, rather than solely describing individual youth’s experiences accessing primary health care, I strove to identify those broader social and political forces which shape people’s experiences. Likewise, rather than describing youth experiencing homelessness as a single, homogeneous population, I questioned how systemic discrimination and structural oppression based on such factors as class, religion, and sexual orientation may intersect to further marginalize certain homeless youth over others (Anderson et al., 2009; Reimer Kirkham & Browne, 2006).

In Chapter 3, I describe the design and methodology used in this mixed methods study, and the approach to analysing the data informed by interpretative description (Thorne,
I used an iterative 3-stage qualitative-quantitative-qualitative design, where findings from each stage guided subsequent data collection and analysis. Data collection methods included semi-structured interviews, focused data analysis of the McCreary Center Society 2014 Homeless and Street-Involved Youth Survey, and an expert consultation. In Stage 1, I conducted semi-structured interviews with eight homeless and street-involved youth. In Stage 2, I further analyzed existing anonymous survey data, which included responses to research questions that were part of the original purpose of the 2014 Homeless and Street-Involved Youth Survey. This was done with the support of the original Principal Investigator (Dr. Saewyc). In Stage 3, I facilitated a discussion with 4 health care and allied service providers who work with street-involved and homeless youth.

1.3 Background and Significance

Since 1986, all Canadians have been (at least on paper) guaranteed access to universal health care as dictated by the Canada Health Act (CHA, 1985). In reality, a complex relationship exists between federal and provincial governments when it comes to health care delivery. Provincial governments receive lump sums of tax-funded ‘health care dollars’ from the federal government. Each province is then responsible for deciding how that money will be spent and how additional funds will be raised.

In most provinces, people pay a progressive provincial tax based on their income to fund provincial healthcare infrastructure (Government of Canada, 2010). In British Columbia, however, people pay set monthly premiums based on family size rather than income (MHCSR, 2014). This means that, no matter how much or little a family earns, all families of the same size except for the most extremely impoverished pay the same amount for health care premiums. These premiums can sometimes amount to several hundreds of
dollars per year, whether a family earns $30,000 per year or $300,000 per year (MHCSR, 2014). Additionally, even when granted strictly regulated concessions for the monthly premiums, people living well below the poverty line, along with everyone else in the province, must still register with Health Insurance BC and carry a BC Services/Care Card before receiving ‘free’ health care (MHCSR, 2014).

As of January 1, 2017, the Government of British Columbia plans to make some adjustments to Medical Services Plan (MSP) premiums. For example, the government will increase the minimum household income for people to qualify for assistance and they will charge MSP premiums based on the number of adults (not children) living in a household (Province of British Columbia, 2016.) Although these are steps in the right direction, they are minimal compared to what may be needed to truly address the gaps and inequities in health care access that will be described in this project.

In British Columbia, primary health care clinics are largely physician-run and almost always require that people present their BC Services/Care Card to receive care. This card acts like a ‘pass’ enabling these privately run health clinics to then bill the provincial government for what are most often 15-minute appointments. It is easy to imagine how such a system could seem both alien and alienating to a homeless youth who is, for example, unfamiliar with a bureaucratic system or who has never been taught how to summarize their health concern within the confines of a 15-minute appointment with a stranger. Researchers Ensign and Bell (2004) noted that homeless youth often have not received the same ‘training’ on how to navigate the health care system that other youth may have received.
1.4 My Practice Context

Over the past five years, I have worked across the Lower Mainland as a Child and Youth Public Health Nurse and a sexual and reproductive health nurse with youth and adults. In this role, I have repeatedly worked with youth whose health has been compromised by a lack of access to primary health care due to factors such as not having a BC Services/Care Card, not having access to a family physician they trust and not having access to adequate transportation to reach a clinic. For example, I have witnessed youth being turned away from addictions services or eating disorder programs because they do not have a consistent primary health care provider (e.g. physician, nurse practitioner, nurse, etc.), and I have witnessed other youth stop or alter their use of prescription psychiatric medications because they do not feel supported or heard by their primary health care provider. Although there are some resources available to try to connect ‘vulnerable’ youth to primary health care services, such piece-meal referral networks remain largely inadequate to meet the needs of all youth, let alone youth who are experiencing homelessness. Witnessing youth fall through the cracks of the health care system became the “genesis of my inspiration” (Thorne, 2008, p. 69) to explore this topic further. Ultimately, I would argue that primary health care providers ought to be asking: “Whose needs are being served by our current system? And whose needs are being overlooked?” These are questions I have aimed to address within my thesis.

Based on both my experiences as a public health nurse and as someone who uses the Canadian health care system, I strongly identify with Beck’s (1973) notion of a ‘medical iceberg.’ In this model, the tip of the iceberg represents those medical needs for which an individual receives medical care. Meanwhile, a whole host of ‘less visible’ and often more complex health issues may persist, unidentified and unaddressed, below the surface. Beck
(1973) suggests that as a person experiences increased access to health care, so too increases
the surface area of the iceberg that rests “above the water” visible to the health care provider.
Notably, one chart-review study of 214 homeless youth visiting a street clinic in San
Francisco reported that 98.6% of participants appeared ‘healthy’ to their health care provider,
and it was only upon further investigation that the provider was able to recognize hidden yet
significant ailments and illnesses (Sherman, 1992). The findings from my thesis may help to
illustrate how inclusive primary health care services can foster homeless youth’s ability and
willingness to share their ‘whole iceberg’ and not just those most critically acute health care
issues.
Chapter 2: Literature Review

2.1 General Overview

This thesis is grounded in a review of both peer-reviewed and non-traditional literature related to homeless youth’s access to primary health care services. I have elected to use both peer-reviewed and non-traditional literature as this provides a more comprehensive view of what is currently known on any given topic (Thorne, 2008). I will first present the findings from a community friendly report (non-traditional literature) followed by a summary of the peer-reviewed literature. Lastly, I will present five peer reviewed journal articles which have specifically informed the theoretical foundation of this thesis.

2.2 A Community Friendly Report on Homeless Youth Health in BC

The community-friendly report I reviewed, written by Smith et al. (2015), is titled “Our communities, our youth: The health of homeless and street-involved youth in BC”. This report describes the findings from the 2014 Homeless and Street-Involved Youth Survey. In Stage 2 of this thesis, I built on the findings from this report by providing a focused analysis of the health-care related questions from the survey.

The 2014 Homeless and Street-Involved Youth Survey was conducted in 13 diverse communities across British Columbia with youth ages 12 to 19 years old (Smith et al., 2015). Of the youth surveyed, just over a quarter (26%) missed out on needed medical care in the previous year while 16% did not have a Care Card or BC Services/ID Card (Smith et al., 2015). Furthermore, over 1 in 10 youth (12%) did not access prescription medications when they needed them and over 1 in 3 youth (37%) stated that their community needed more youth clinics (Smith et al., 2015). I used this information as a launching pad for my focused data analysis, which I describe in Chapter 3.
2.3 Peer Reviewed Literature: The Process

I identified relevant peer-reviewed literature using four databases: CINAHL, PubMed, Academic Search Complete and PsycInfo. I chose these databases because my topic bridges both health and social science disciplines; CINAHL and PubMed are health discipline databases (nursing and medicine, respectively), while Academic Search Complete and PsycInfo are social science databases. Although my professional background is in nursing, I aimed to review literature from multiple disciplines to “develop a reading familiarity with the basic elements and foundational concepts underlying the[se other] disciplines” (Thorne, 2008, p. 56). This was particularly important given that so many health care professionals and allied service providers (including nurses, physicians, social workers and counsellors) often collaborate to provide optimal primary health care services for homeless and street-involved youth.

To determine my search terms, I generated a list of relevant words and searched various combinations of those words until I began to get a sense of how wide (or narrow) to cast the net. For example, initially, I used the search terms: [youth OR teen* OR adolescen*] AND [homeless OR street involve*] AND [primary care] AND [health care] AND [access] AND [foregone]. I quickly realized, however, that by using so many terms, I was casting too narrow of a net, generating no results in any of the four databases. Ultimately, I dropped the terms [primary care] and [foregone] from the search. As such, my final search terms were [youth OR teen* OR adolescen*] AND [homeless OR street involve*] AND [health care] AND [access]. As I began my review, I also scanned each article’s key words to ensure that I had not omitted any key search terms. In the end, I was
confident that this combination of search terms helped me to locate relevant articles. The
search generated 355 articles in total, with the number of results per database as follows:

Table 1

<table>
<thead>
<tr>
<th>Database</th>
<th>CINAHL</th>
<th>PubMed</th>
<th>Academic Search Complete</th>
<th>PsycInfo</th>
</tr>
</thead>
<tbody>
<tr>
<td># of Articles</td>
<td>55</td>
<td>183</td>
<td>77</td>
<td>40</td>
</tr>
</tbody>
</table>

From the results, I identified 21 articles to include in this literature review. I included or
excluded articles based on the following criteria:

Table 2

<table>
<thead>
<tr>
<th>Inclusion Criteria</th>
<th>Exclusion Criteria</th>
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<tbody>
<tr>
<td>Peer reviewed journal articles relevant to the research question, written in English, focus on youth population</td>
<td>Sole Focus On: intervention research; specific health issues (e.g., addictions, asthma); youth in foster care; sexual minority youth; adult population; families who are homeless</td>
</tr>
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</table>

I chose to include only peer-reviewed journal articles for this stage of the literature review given the academic nature of this thesis and the need to identify rigorous, credible pieces of literature (Barker, 2010). Moreover, because I am only fluent in English, it was important to include only English studies. The exclusion criteria were selected to ensure the search generated a reasonable number of relevant results. For example, I excluded articles with a too-narrow focus given the broad nature of my research question (e.g., excluding articles specifically about youth in foster care, adult populations, small-scale intervention
studies, etc.) I did not, however, exclude articles based on publication year or location as I did not want to risk overlooking a study by placing arbitrary temporal or geographical limitations on the search given that “most fields have an important history and trajectory” (Thorne, 2008, p. 58).

2.4 Overall Trends in the Literature

Overall, there were some notable trends in the peer-reviewed literature. The primary authors from the studies hail from a range of geographical and professional origins. Geographically, the majority were from English-speaking developed nations. For example, the only narrative synthesis identified reviewed 12 studies, ten of which were conducted in urban American contexts and two of which were conducted in metropolitan Australian contexts (Dawson & Jackson, 2013).

Professionally, the researchers included nurses, physicians and health researchers. Although such variety has in some ways added to the richness and credibility of the literature available on this topic, it has also limited its cohesiveness. In essence, because people are tackling this topic from so many different perspectives, there is a lack of a conceptual or theoretical framework guiding this research. Instead, the majority of the articles simply described the data without addressing how the findings fit into a broader understanding of the issues at hand. I will discuss such gaps in the literature further on in this chapter.

2.5 Key Findings

Virtually all of the literature I reviewed identified homeless and street-involved youth as a population with unique health care needs. For example, in a study of 95 homeless and street-involved youth ages 15-25 years old in Houston, Texas, Busen and Engebrtson (2008)
determined that lengthier stays on the street resulted in poorer health outcomes. Likewise, in a study of 15 youth ages 15-24 years old in Seattle, Washington, the participants identified several health problems that concern them, including sexually transmitted infections, unplanned pregnancies, depression, injuries and health risks associated with drug use (Ensign & Gittelsohn, 1998).

These findings were mirrored by several others studies which reported that youth experiencing homelessness face higher than average rates of: respiratory problems (including asthma), dental disease, dermatological problems (including lice, scabies, acne and infection), foot problems, injuries, sexually transmitted infections, injuries and unplanned pregnancies (Dawson & Jackson, 2013; Elliott, 2013; Ensign & Santelli, 1997; Rew, 1996). Many studies also found that despite this increased need for health care, many homeless and street-involved youth forego health care until they can no longer bear to deal with their health issue(s) on their own (Dawson & Jackson, 2013; Ensign & Panke, 2002; Ensign & Santelli, 1997).

Several researchers report similar findings regarding the structural factors that influence homeless youth’s access to primary health care. For example, in a study of 24 young adults in Santa Monica, Hudson et al. (2010) found that structural barriers to health care included: lack of appropriate health care facilities (accessibility, hours of operation, adequately trained health care providers), issues with insurance and confidentiality, as well as long wait times. These findings were supported by several other studies, reviews and commentaries (Dawson & Jackson, 2013; Elliott, 2013; Ensign & Gittelsohn, 1998; Ensign & Panke, 2002).
In addition to these barriers, the Canadian researchers specifically identified the following structural barriers to health care: inability to access a health services card due to not having a permanent address, lack of dental and vision care, and lack of understanding regarding the individual ‘cost’ of health care in Canada (Haldenby, Berman & Forchuk, 2007; Reid, Berman & Forchuk, 2005). Only one article, written by Dawson and Jackson (2013), identified structural facilitators to health care access such as well-organized, safe services, and friendly or caring staff who listened. None of the studies reviewed addressed broader structural influences that have mixed influence; rather, each of them spoke of either barriers or facilitators. This may be problematic, because dichotomizing these influences as either barriers or facilitators may force over-simplification of highly complex ideas. As such, in my analyses I will address influences on primary health care access rather than dichotomized facilitators or barriers.

Much of the research I reviewed also established that youth experiencing homelessness are not necessarily a homogeneous population. For example, although there may be some common antecedents to homelessness (trauma, physical and sexual abuse, neglect, family chaos), researchers have equally noted the many paths that exist into homelessness for youth (Busen & Engebretson, 2008; Feldmann & Middleman, 2003). Some youth run away from home while others are ‘kicked out’ (Busen & Engebretson, 2008; Feldmann & Middleman, 2003). Rew (1996) specifically identified lesbian, gay and bisexual youth as unique within the homeless and street-involved youth population, as they have often been forced to leave their homes due to the fear or reality of being rejected by family.

Although individual experiences of trauma and social alienation may not immediately appear to be ‘systemic’ or structural influences on primary health care access, it is important
to note that a relationship exists between trauma and experiences of systemic oppression (racism, sexism, anti-poverty bias etc.) (Coates & McKenzie-Mohr, 2010). Such oppression along with histories of trauma have often been linked to struggles with trust, power and control (Coates & McKenzie-Mohr, 2010; McManus & Thompson, 2008). One can imagine, then, how homeless youth who have suffered trauma and/or structural oppression may face unique challenges in accessing, let alone forging and maintaining meaningful relationships with, primary health care providers (McManus & Thompson, 2008).

2.5.1 Critical Social Justice As a Lens for Considering Health and Healthcare Inequities

Very few of the studies reviewed examined differences in health status and access to primary health care between sub-groups of homeless youth (Ensign & Santelli, 1997). Likewise, only a limited number of the studies reviewed addressed how systemic oppression may affect access to care (Haldenby et al., 2007; Reid, et al., 2005). In an effort to address this gap, I specifically sought out additional perspectives and research papers that address homeless youth access to health care from a broader, critical perspective.

In the context of analyzing health and healthcare inequities, a critical social justice lens challenges the “widespread reliance on individualistic rather than socially oriented interpretations” of the term ‘social justice’ (Reimer Kirkham & Browne, 2006). The authors further suggest that the “postcolonial feminist perspective [inherent in critical social justice] results in interpretations of social justice as relational, contextual and intersectional” (Reimer Kirkham & Browne, 2006, p. 336). This approach encouraged me to move beyond describing individual stories to develop insights about and articulate how systemic factors such as context and intersecting forms of discrimination may influence access to health care.
Riley, Underwood and Carter (2003) specifically set out to “challenge the dominant political discourse on homelessness” (p. 473) which pathologizes homeless individuals. Likewise, Klodawsky, Aubry and Farrell (2006) argue that the Canadian Federal government’s focus on funding employment programs rather than comprehensive services for youth experiencing homelessness detracts from the ability of service providers to truly meet the needs of this population. In both articles, health care conversations are framed in terms of what the system ought to look like from an ethical perspective, rather than simply describing what ‘is’ or what would be ‘nice’ to have.

In a further effort to build on these findings and to bolster the theoretical foundation of my research, I reviewed an additional two papers recommended by experts in the fields of foregone health care and equity; one by Aday and Andersen (1974) and one by Anderson and colleagues (2009).

2.5.2 Aday & Andersen (1974): Foregone Medical Care

This article was important for me to review, as it informed the 2014 Homeless and Street-Involved Youth Survey questions which I analyzed in Stage 2. Aday and Andersen’s (1974) framework identifies five domains that affect health care access. Each domain includes two types of variables: (1) policy (changeable) and (2) outcome (unchangeable). This thesis focuses primarily on how changeable aspects of health policy (see model below) affect homeless youth access to primary health care services. For the purposes of this thesis, I have stated that foregone health care describes when a person needs but does not receive health care services. A person may report foregone health care for a number of reasons including not knowing how to seek or secure health care.
2.5.3 Anderson et al. (2009): Health Care Access and Equity

In the second theoretical paper I reviewed, Anderson et al. (2009) blend critical, feminist, postcolonial and intersectional theories to “examine the power dynamics that lie behind the inequities in people’s access to health as well as healthcare” (p. 285). This paper builds on Reimer Kirkham and Browne’s (2006) work which presented critical social justice as a lens for considering health inequities. In the latter paper, the authors address how both policy-level and everyday front-line care decisions have the power to create or combat inequities by formally and informally labeling (or not labeling) marginalized and vulnerable people as ‘Other’ (Anderson et al., 2009). The authors contend, then, that nurses can reduce inequities by engaging in interdisciplinary dialogues to “unmask and disrupt the processes
that underpin the construction of ‘Other’” (Anderson et al., 2009, p. 283). This process of ‘unmasking’ and of questioning privilege (and oppression) is something I have tried to do within this project. Additionally, such reflection is of utmost importance for nurses, as it is within our Code of Ethics to promote justice (CNA, 2008).

2.6 Key Strengths and Weaknesses

All of the works included in this review foster an increased understanding of the unique health challenges and social and structural factors that influence homeless youth’s access to primary health care. A strength, then, lies in the consistency across all of the articles and reports. However, some of the articles presented within the peer reviewed literature lack theoretical and methodological rigor. Furthermore, many, although not all, of the articles failed to move beyond simple descriptions. As Reid et al. (2005) critiqued, much of the current literature on youth experiencing homelessness focuses only on individual reports of biomedical pathologies and experiences of barriers to primary health care, rather than critiquing the system as a whole. These factors limit the ability of primary health care providers to use current research to advocate for much needed changes to the primary health care system. Additionally, very little of the current literature focuses on either a Canadian or rural context, and none of the studies included both youth and primary health care provider participants.

2.7 Addressing Gaps in the Literature

In summary, my thesis aimed to address three key gaps in the current literature. First, I aimed to shed light on the experiences of homeless youth in a Canadian, specifically British Columbian, context by collecting data in BC. Second, the findings from my thesis may increase insight into the experiences of both urban and rural youth experiencing
homelessness by drawing upon focused data analyses of the 2014 *Homeless and Street-Involved Youth Survey*, which was conducted in 13 communities across British Columbia. Finally, in Stage 3 of this project, I engaged primary health care professionals and allied service providers in a solutions-focused dialogue about homeless youth access to primary health care, to supplement the youth voices captured in Stages 1 and 2 of this project.
Chapter 3: Methodology

3.1 General Overview: Mixed Methods

I conducted a 3-stage mixed methods study (qualitative-quantitative-qualitative) guided by Thorne’s (2008) interpretive description methodology. In Stage 1 I collected interview data, in Stage 2 I conducted a focused analysis of existing survey data and in Stage 3 I engaged an expert panel in a solutions-focused dialogue about my research findings. By meaningfully integrating these types of data, I strove to generate nuanced understandings of this topic that may not have been possible using only one source of data or method of data collection (Loiselle, Profetto-McGrath, Polit & Beck, 2007). This research followed an iterative process. Findings from Stage 1 interviews with youth informed my approach to the focused data analyses in Stage 2, while the Stage 3 expert consultation included a presentation of, and therefore was inherently shaped by, the findings from Stages 1 and 2. I chose to include 3 distinct methods of data collection (interviews, quantitative data analysis and expert consultation) as each has unique strengths and weaknesses.

3.2 Methodology: Interpretive Description

This study is informed by interpretive description methodology as described by Thorne (2008). I selected this methodology primarily because of its emphasis on “extend[ing] beyond mere description and into the domain of the ‘so what’” (p. 33). I also found its emphasis on constant comparative and iterative analysis reflected my professional background where the nursing process emphasizes continuous and concurrent cycles of ‘doing’ and ‘evaluating’. Thorne (2008) also encourages the use of multiple data collection methods to “advance substantive understanding” (p. 43) where the “most probable truths are those we have arrived at using multiple angles of vision” (p. 78).
As previously noted, each data collection method has unique strengths and weaknesses. A strength of interview data is that it can provide the researcher with special insight into the sometimes hidden nature of another’s experiences (Thorne, 2008). Conversely, one of its weaknesses is that interview data relies on a participant’s ability to verbalize those very experiences (Thorne, 2008). To overcome this limitation, I have used information from my literature review to guide the critical analysis of my findings while still remaining true to participants’ words. For example, although the youth I interviewed may not have directly named specific influences on access to health care, in my analysis I have developed insights about and articulated some of those influences (e.g., power, bureaucracy, etc.)

Although not specifically discussed by Thorne (2008), a strength of conducting a focused quantitative analysis of existing survey data is that it allows for access to a large data set that reflects one’s research question(s). For example, in my case, the 2014 Homeless and Street-Involved Youth Survey has already been collected and contains anonymous data from almost 700 youth from across British Columbia. It would simply be impossible for me, as a single researcher, to collect that volume of data on my own in a timely fashion. A weakness, however, is the data has by definition already been collected and so may not meet my exact research needs. Finally, a strength of expert consultations is that, similar to focus groups, such data can provide an excellent means to create new knowledge about and social movement within a population just by the very act of participating in the group (Thorne, 2008). A weakness of this form of data collection, however, is that it can also privilege the types of information people are willing to share in public, simply because everything said must be shared with the group (Thorne, 2008).
By carefully planning how I collected and analyzed data from each stage, I have aimed to create credible, defensible “findings that have impact beyond sitting on a shelf” (Thorne, 2008, p. 86). To help me achieve this goal, I have drawn on regular field memoing and analytic memoing, as well as the support of my thesis committee, to identify and overcome any challenges to this study’s rigour and credibility. For example, based on interpretive description (Thorne, 2008), I ‘entered the field of research’ armed with a balance of curiosity and existing knowledge. I also acknowledged that it was a genuine curiosity about homeless youth experiences accessing health care (which I was first exposed to as a youth clinic nurse) that led me to formulate my research questions as I did. Meanwhile, it was my grounding in the current literature that enabled me to conduct informed, ethically defensible research. As I consciously struck a balance between curiosity and embracing existing knowledge, I embarked on concurrent data collection and analysis. For example, during my Stage 1 data collection, I confirmed at the end of each interview with the participant whether I correctly understood their key messages. As I collected and reflected on those key messages, I inherently began to take the first steps towards understanding the ‘pieces and parts’ which informed my subsequent formal data analysis (Thorne, 2008).

As I moved towards identifying the core findings in my data, I relied heavily on analytic memos as well as the guidance of my thesis committee to move beyond surface-level analysis. I achieved this by identifying the “pieces and parts…[followed by the] patterns and relationships” within and across my data sources (Thorne, 2008, p. 166). Meanwhile, I avoided premature closing while coding by remaining cognizant of questions such as, “What might I not be seeing?” (Thorne, 2008, p. 161.) For example, my initial coding and analysis hovered very close to each participant’s exact words. Following guidance from my thesis
committee, I reviewed the components of my literature review that focused on critical theory and a critical social justice lens and delved further into the data, identifying more subtle and nuanced analyses regarding power, control and survival. Ultimately, my data analysis, analytic memos and ongoing conversations with my thesis committee helped to determine how I structured Chapters 4 (results) and 5 (discussion) of this thesis. The goal throughout was to generate a credible, defensible and useful piece of research (Thorne, 2008).

3.3 Stage 1 Semi-Structured Youth Interviews: Data Collection and Analysis

3.3.1 Participants

The purpose of the Stage 1 interviews was to explore the question, “How do social and structural factors influence homeless and street-involved youth’s experiences of accessing primary health care in British Columbia?” To help me answer this question, I used convenience sampling to recruit eight homeless and street-involved youth to participate in one-on-one semi-structured interviews. I chose this sample size for three main reasons. First, existing literature has identified fairly consistent findings regarding homeless and street-involved youth health issues, and influences on primary health care access. This suggests that, even amongst eight youth, participants may likely share experiences which will enable me to identify meaningful patterns and differences in the data. Second, although such themes may exist, because youth who experience homelessness often form a heterogeneous group, it was important to interview youth from varying demographics (e.g., gender, sexual orientation, age, etc.) which existed amongst the eight youth interviewed. Third, as a Master thesis project, it was important that the scope of this project be both manageable and realistic, which it was with 8 participants. Inclusion criteria for Stage 1 interview participants was:
ages 14-19 years, self-identified as homeless and street-involved for at least 3 days in the past year, English-speaking and needed health care in the past year.

### 3.3.2 Recruitment

I recruited youth from the Lower Mainland of British Columbia. This recruitment was done by using posters (see Appendix A) and word of mouth through two youth drop-ins and shelters, *Covenant House* and *Directions*. I chose these locations as they offer services to a wide variety of youth and not only those youth who are already accessing health care. I contacted these organizations via e-mail and phone calls to introduce myself and to request they display my posters. Youth who were interested in joining the study were invited to contact me via telephone or e-mail to arrange an interview time and date. I also attended several youth drop-in hours at both organizations to introduce myself to both youth and staff members. Youth workers at both organizations played an integral role in recruitment by introducing me to youth who met my inclusion criteria.

### 3.3.3 Data Collection

Each interview was conducted at a time and location of the participant’s choice (e.g., public library, coffee shop, community center, etc.) This option was offered in an effort to empower the youth to choose an environment that felt ‘natural’ for them (Thorne, 2008). Initially during recruitment, I asked that all potential participants take at least 24 hours to review and consider their participation in the study prior to providing consent. During recruitment, several youth identified this process as barrier to their ability to participate. Many of the youth I spoke with identified that survival needs related to securing food and shelter often interfered with their ability to return to an exact location at an exact time for a
scheduled interview. In consultation with my thesis supervisor, and following guidance from the staff at the organizations where I was recruiting (all of whom worked closely with homeless youth), I used several strategies to address these challenges. For example, I increased the amount of time I spent at the youth drop-ins to provide ample opportunity to discuss the study with staff and youth. I also ensured that posters were well displayed at both locations and that copies of the consent form (minus the signature page) were available if any youth wanted to review the content prior to contacting me. I also provided youth with the opportunity to hear about and agree to participate in the study within the same day. With these adjustments, I remained very conscious about needing to ensure any potential participants had adequate time to reflect on and understand the content of the consent form prior to consenting to participate.

At the beginning of each interview, I provided the youth with a paper copy of the consent form to read (see Appendix B). I offered participants the option that they could first review the information on their own or we could review it together. I offered this option to account for youth who may struggle with literacy. We then reviewed the consent form together in its entirety and I confirmed at several points whether the youth had any questions and that they understood the types of questions I would be asking (e.g., demographics, questions about their experiences accessing health care etc.) I confirmed that each youth understood the information in the consent form by noting cues such as their overall alertness and engagement while reviewing the consent form, the appropriateness of their questions (e.g., their ability to ask relevant questions), ensuring any potential distractions were eliminated (e.g., waiting until after a youth had eaten dinner to ensure they were not preoccupied by hunger).
Each participant provided both verbal and written consent prior to beginning the interview, and signed two copies of the consent form – one for their records and one for my records. Signed consent forms were stored in a secure location within the UBC School of Nursing as directed by Dr. Saewyc. Once the participant signed the consent form, I assigned them a Participant Identification Number (PID) and provided them with a $20 cash honorarium. I tracked the assignment of PIDs in an Enrolment Log (see Appendix C) which was stored in a secure file cabinet at UBC. To ensure confidentiality, participants’ demographics forms (discussed later) contained their PID only, rather than their name.

I provided each person with a cash honorarium to acknowledge the work of being interviewed and sharing their experiences. I elected to provide $20, as this amount is similar to honoraria provided by other studies in Vancouver, and thus would not be interpreted as coercive. Furthermore, by providing a cash honorarium rather than a gift card, the participant was able to choose where they would prefer to spend the money. As well, providing the honorarium at the start of the interview was done intentionally to promote a sense of agency with participants, where they need not feel pressure to ‘adequately perform’ in order to ‘earn’ the honorarium, as might happen if it were provided at the end of the interview.

Because I planned to analyze whether sub-groups of the homeless youth population experience structural influences on primary health care access differently, I needed to collect some basic demographic information from each participant. However, because such information (e.g., age, gender, sexual orientation) can be sensitive in nature, I asked each participant how they would prefer that I gather that information. Ultimately, each participant was invited to complete a Demographics Form (see Appendix D). The details of how this
form was completed (e.g., self-directed using pen and paper or with my assistance; at the start of the interview or at the end) was decided by each participant. In using such an approach, I aimed to build rapport and trust with the youth by negotiating with them, in the moment and on their own terms, how the interview would proceed.

I recorded the interviews using a handheld audio recorder. I also made brief written notes during the interviews using a standard template (the interview guide with room below each question for notes) to supplement the audio recordings. I used an interview script (see Appendix E) and the following questions to guide the interview:

Table 3
Stage 1 Interview Guide Template

<table>
<thead>
<tr>
<th>Stage 1 Youth Interview Guide</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Current Health Status</strong></td>
</tr>
<tr>
<td>1. How would you describe your health over the past year?</td>
</tr>
<tr>
<td>2. Please tell me about a time in the past year when you needed health care services?</td>
</tr>
<tr>
<td><strong>B. Experiences Accessing Health Care</strong></td>
</tr>
<tr>
<td>1. Were you able to access health care services when you needed them?</td>
</tr>
<tr>
<td>2. If you were able to access health care services:</td>
</tr>
<tr>
<td>a. What sort of care did you access (e.g., nurse, doctor, walk-in clinic, ER?)</td>
</tr>
<tr>
<td>b. What, if anything, helped to make that experience easy or comfortable for you?</td>
</tr>
<tr>
<td>c. What, if anything, made that experience harder or uncomfortable for you?</td>
</tr>
<tr>
<td>3. If were you unable to access health care services:</td>
</tr>
<tr>
<td>a. What got in the way of you being able to access health care services?</td>
</tr>
<tr>
<td>b. Have there been other times in the past when you have accessed health care services? If so:</td>
</tr>
<tr>
<td>What, if anything, helped to make that experience easy or comfortable for you?</td>
</tr>
<tr>
<td>i. ii. What, if anything, made that experience harder or uncomfortable for you?</td>
</tr>
</tbody>
</table>
Stage 1 Youth Interview Guide

C. Other’s Experiences

1. Based on the questions we’ve talked about, are there any stories or experiences you’d like to share that may not be your own but that you’ve witnessed since becoming street-involved or homeless about people trying to get health care services?

2. I would like to take a second to summarize some of the key things I think I’ve heard you talk about so you can add anything or correct me if I’ve misunderstood anything. Is that okay with you? [summarize 1-2 key points]

3. Is there anything else you would like to add?

D. Conclusion

1. After I interview other youth, I will also be looking at the results of a survey of street-involved or homeless youth from across B.C. Once I’m done looking at the interviews and the survey, I am going to be getting a group of youth together in early 2016 to get their thoughts on what I’ve learned. Would you be okay with it if I contact you in a few months to invite you to be part of that focus group?
   a. If yes: What is the best way to contact you? ________________________

   b. Whether yes or no: Would you like me to share information about what I find with you? ________________________________

I created these questions to gently guide the interviews towards a meaningful conclusion without leading them in any single direction (Thorne, 2008). Likewise, I chose open-ended questions that begin with “How” and “What” to encourage participants to share their experiences. Lastly, I concluded each interview by summarizing my understandings of the key points that the participant had shared to ensure I accurately understood their main thoughts. This approach proved meaningful, as it allowed participants to hear their stories reflected back to them, and sometimes prompted further conversation or clarifications. I also added to or altered the interview questions as needed with each participant. This included using questions such as “Can you tell me more about that?” and “What did that look like for you?”
Following each interview, I recorded field notes describing the context of the interview, my immediate reactions to the data, ‘key’ points I noted during the interview, and so forth. These notes as well as the audio files were encrypted and then uploaded to a secure UBC server (Workspace 2.0) as soon as possible after the interview.

3.3.4 Data Analysis

I transcribed and analyzed the interview data myself using NVivo software. In light of striking the balance between curiosity and existing knowledge, as previously discussed, I prepared a small number of codes before I began my analysis based on the Aday and Andersen (1974) and Anderson et al. (2009) papers. These codes were intended to reflect the theoretical foundations of this thesis. Additionally, these preliminary codes were intended to act as ‘sticky note codes’ or placeholders, helping me to later navigate through and find meaning in the data. Following guidance from my thesis committee, I expanded my sticky note codes to draw less on the Aday & Anderson (1974) model and to instead draw more generally on my entire literature review and topics I was noting in the data itself. I ultimately developed the following 5 parent codes and 18 child codes

Table 4
Stage 1 Interview Data Analysis: Sticky Note Codes

<table>
<thead>
<tr>
<th>Parent Codes</th>
<th>Child Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Care Delivery System</td>
<td>Type of Service Accessed</td>
</tr>
<tr>
<td>Access to Health Care Services: Individual Factors</td>
<td>Point of Entry</td>
</tr>
<tr>
<td></td>
<td>Structure</td>
</tr>
<tr>
<td></td>
<td>Health Status</td>
</tr>
<tr>
<td></td>
<td>Health beliefs and values</td>
</tr>
<tr>
<td></td>
<td>Social support networks</td>
</tr>
<tr>
<td></td>
<td>Living conditions</td>
</tr>
</tbody>
</table>
As I delved further into the data and moved beyond sticky note coding, I continued to remain open to the nuances in the data without imposing or forcing my own perhaps researcher-imposed themes or incorrect assumptions on the data. To avoid such pitfalls, I used ongoing analytical memoing and conversations with my thesis committee to ensure my preliminary codes were defensible and reasonable. Thus, I began to develop the analytic codes once I had been sufficiently immersed in the data. Thorne (2008) recommends initially referring to groups of like ideas as simply as for example ‘Category A’. Such an approach prevents the researcher from prematurely over- or under-valuing any single pattern identified in the data (Thorne, 2008). Remaining conscious of this advice while also discussing my process with my thesis committee enabled me proceed with the coding and subsequent identification of themes in a defensible manner.

As previously mentioned, through this process I was encouraged by my thesis committee to initially hover quite close to the data. Subsequent analyses, however, drew me
slightly further from the participants’ exact words and phrases. I therefore began to analyze and track relationships between the analytic codes using NVivo (e.g., where similarities exist in the data, where difference exist, repeating themes etc.). This type of coding led me from identifying sticky note codes to analytical codes and ultimately to thematic codes. The thematic codes from the interviews served two purposes: (1) to address the research question and (2) to guide Stage 2 data analysis. The analytical codes I developed ultimately fell under three thematic codes: 1. Youth experiencing homelessness feel powerless in their interactions with health care providers; 2. Health care systems exist as rule-based bureaucracies; and 3. Youth experiencing homelessness are in ‘survival mode’ when it comes to their health. The 14 subsequent analytical codes are as follows:

<table>
<thead>
<tr>
<th>Thematic Codes</th>
<th>Analytical Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Youth experiencing homelessness feel powerless when interacting with health care providers</td>
<td>Differences between how health care provider and homeless youth interact with others; the words and language they use; how they see themselves etc. Experiences with health care providers that give youth the message they don't deserve the provider’s time, kindness, understanding, flexibility, services etc. Health care providers acting like youth are to blame for their circumstances. Homeless and street-involved youth avoid disappointment by expecting little of health care providers. Health care providers focus only on medical issues and medical ‘ways of knowing’ Lack of acknowledgment by health care providers of youth’s social identities and contexts Health care providers addressing only the 'tip of the iceberg' of homeless youths’ health</td>
</tr>
<tr>
<td>Health care systems exist as rule-based bureaucracies</td>
<td></td>
</tr>
</tbody>
</table>

Table 5

*Stage 1 Interview Data Analysis: Thematic Codes*
After developing the codes, I reviewed all of the transcripts numerous times and, using NVivo, assigned notable quotes from all of the interviews to one or more codes. Throughout this process, I continued to question if anything was being left out or overlooked with the current coding structure. Ultimately, in discussion with my thesis committee, I was confident that my current coding structure sufficiently captures and represented a comprehensive accounting of the various aspects of my data. These findings from these interviews, including exemplar quotes, are described in Chapter 4 of this thesis.

3.4 Stage 2 Focused Data Analysis: Data Set and Analysis Plan

The purpose of the Stage 2 survey analysis was to answer the question, “What social and structural influences might be evident in the extent to which and reasons why homeless and street-involved youth in British Columbia report foregone health care?” In order to address this question, I conducted focused data analyses of the 2014 *Homeless and Street-Involved Youth Survey*. I have chosen to use this survey as it was conducted by The...
McCreary Center Society, one of the leading research centers in youth health in British Columbia. Additionally, the types of questions asked on the survey were a good fit for this project as they addressed social and structural influences on access to primary health care services.

As previously mentioned, the survey included 689 youth ages 12-19 years old from 13 communities across British Columbia: Abbotsford/Mission, Burnaby, Chiliwack, Kelowna, Kamloops, Nanaimo, Nelson, North Shore, Prince George, Prince Rupert, Surrey, Vancouver and Victoria. The survey asked about all aspects of youth’s lives including education, employment, sleep, family, past trauma etc. I focused specifically on those questions related to health status and health care access. The data were analyzed using SPSS v. 23 and v.24. My analyses were guided by two main factors: the Stage 1 interview findings and my literature review, including The McCreary Center Society community-friendly report on this dataset. Although this McCreary Center report identified that just over a quarter of homeless and street-involved youth missed out on needed medical care in the previous 12 months, it did not take a more focused look at which of these youth may be missing out on health care the most (Smith et al., 2015). I analyzed key survey questions to describe ‘who’ may be missing out on health care, to what extent and for what reasons.

Findings from my literature search suggest that certain sub-groups of youth experiencing homelessness are at greater risk of facing barriers to primary health care than others (e.g., younger youth, LGB youth, the most severely precariously housed youth) (Sherman, 1992; Rew, 1996; Ensign & Santelli, 1997). Based on this information and my Stage 1 interview findings, I focused my analysis on the following questions from the survey:
Table 6
Stage 2 Focused Survey Data Analysis: Selecting Survey Questions

<table>
<thead>
<tr>
<th>Theme</th>
<th>2014 Homeless and Street-Involved Youth Survey Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>Qu1 1- How old are you?</td>
</tr>
<tr>
<td>Gender</td>
<td>Qu 2 – Are you…male, female, transgender, another</td>
</tr>
<tr>
<td>Sexual Orientation</td>
<td>Q12 – Which of the following best describes your feelings? Completely heterosexual, mostly heterosexual, bisexual, mostly homosexual, homosexual, questioning, I don’t have attractions</td>
</tr>
<tr>
<td>Access to Care Card</td>
<td>Q49 – Do you have a Care Card or BC Identification/Service Card?</td>
</tr>
<tr>
<td>Foregone health care</td>
<td>Q55 - In the past 12 months, have you thought you needed medical help because you were physically sick or hurt, but didn't get it?</td>
</tr>
<tr>
<td></td>
<td>19. People can live in a lot of different places for short or long periods of time. Please tell us where you live now (yesterday) and any place you’ve ever lived: House or apartment (alone or with roommates), hotel/motel/SRO/hostel, other relative’s home (grandparent, aunt, sister, brother, etc.), college dorm/college accommodation, safe house/shelter, extreme weather shelter, transition house, squa/abandoned building, on the street, living nowhere/living all over (couch surfing), tent/car, other.</td>
</tr>
<tr>
<td>Experiences of discrimination</td>
<td>Qu 112. In the past 12 months, have you been discriminated against or treated unfairly because of - your race, ethnicity or skin colour, your sexual orientation (being or thought to be gay or lesbian), your gender/sex, a disability you have, how much money you or your family have, your age, people seeing you as different, being on Income Assistance, being homeless or street involved</td>
</tr>
</tbody>
</table>

For each question, I ran analyses (independent sample t-tests and/or Chi-Square tests) to determine if there were statistically significant relationships to foregone care.

3.5 Stage 3 Expert Consultation: Data Collection and Analysis

For the expert consultation, I invited 4 health care and allied service providers who are involved in the policy and front-line work of supporting homeless and street-involved
youth. These experts were purposefully chosen based on both recommendations from others in this field of work as well as based on my own experiences working as a Child and Youth Public Health Nurse in the Vancouver area. Initially, I had planned to run two parallel focus groups, one for service providers and one for homeless youth. In light of my experiences over the course of this project and especially during my Stage 1 data collection, I revisited this approach. I elected to not run a youth focus group for a number of reasons. First, during recruitment for the Stage 1 youth interviews, I truly began to understand the multiple competing survival needs that many homeless youth face. Several youth expressed to me the challenges they faced in setting a time and returning to a specific location days later for an appointment (as had been my initial plan for conducting the interviews.)

Given the often transient and sometimes chaotic nature of the lives of youth experiencing homelessness,, I began to question whether it would reasonable or even ethical for me to ask youth to show up at a specific location at a specific time with no guarantee that other youth would show up and therefore no guarantee that a true ‘focus group’ could occur. Additionally, I found it took a lot of careful rapport building and sensitive communication during each interview to ensure that youth felt safe sharing their feelings and experiences. I was not confident that I would be able to, in a potential follow-up focus group setting, meet the social and emotional needs of each youth who participated in Stage 1 interviews. This was especially true given that some youth may have a history with one another and may or may not be comfortable speaking in a group. The potential risks (jeopardizing youth’s safety and time) seemed to far outweigh any possible benefits (opportunity to re-engage youth around this topic when they had already shared so much.)
Given these challenges, I decided it was important to proceed only with a health care and allied service provider expert consultation. This approach still enabled me to engage in a solutions-focused dialogue with people who are working in this field without placing onerous demands on anyone. Additionally, my intention in using a more casual approach to the conversation (e.g., no audio recording, no secondary note taker), while still clearly framed as a form of data collection, allowed for organic discussion. This discussion may also have helped to further disrupt the current discourse around the ‘ease’ and equity of health care access in Canada. For example, although the experts at the consultation were all very well versed in the health care needs of vulnerable youth, participating in the consultation seemed to increase their awareness of the gaps in services not only in their specific organizations but also more broadly. This approach for including service providers’ voices was important for this project, as I wanted to ensure the final product would be both useful for and useable by people who are in positions to potentially affect homeless youth experiences in accessing health care.

3.5.1 Participants

There were 4 expert health care and allied service providers in the expert consultation. These experts come from a range of professional backgrounds, including nursing, education/counselling and social work/social support. The participants came from different youth-serving organizations, all local to Vancouver, BC.

3.5.2 Recruitment

Participants were recruited via a personalized e-mail invitation (see Appendix F). This e-mail clearly stated that the recipient was being invited to participate in a research
project with information about the research project and the purpose of the expert consultation. I proposed three dates and two locations for the consultation and asked people to respond within 1 week. Based on people’s replies, I sent a follow-up e-mail to interested participants, which included the confirmed date and location. I also included copies of the consent form and a summary of findings to be discussed (see Appendices G and H.) I asked potential participants to review both documents and to print and sign a copy of the consent form which they would bring to the consultation. Because my thesis was still underway at the time of the consultation, I asked potential participants to not share the summary of findings document with anyone outside of the consultation.

3.5.3 Data Collection

Data were collected in an informal manner on flipchart papers visible to the entire group throughout the consultation. This approach intended to foster organic conversation where main themes, rather than verbatim quotes, could be captured. Additionally, having the flipchart paper visible to all participants during the consultation offered a way to recap and confirm my understanding of what people were saying as they built on previously shared ideas.

To help facilitate and keep track of the conversation, I posted 5 flipchart papers around the room – four with a question written at the top and one to capture additional comments and questions. The questions were:

1. How do the findings described reflect (or not reflect) your experience working with street-involved and homeless youth? Are there important aspects of your experience that are not reflected in the findings above?
2. What if any anything from the findings stands out to you? If so, what and why is that important?

3. If you had a magic wand, what changes could make it easier for homeless and street-involved youth to get health care services?

4. How can the findings from this study be put to “good use”?

During the 1-hour consultation, I first collected signed consent forms from all participants, distributed a thank-you card with a $20 cash honorarium inside, and reviewed a summary of my findings, before facilitating a discussion based on the 4 questions. Following the consultation, I also made field notes detailing my initial reactions to the conversation, which comments in particular stood out to me, and remaining questions I had regarding how to translate knowledge from this study to various communities of practice.

3.5.4 Data Analysis

Given the nature of the data collected, I did not create a formal coding structure to analyze the Stage 3 data. Rather, I thoroughly reviewed my notes from the consultation and identified the main themes, directions of the conversation, key points, etc. I used this content to shape my own understandings of how my findings might fit (or not fit) into the current health care and allied social services systems that homeless and street-involved youth access. The results of this analysis are described in the next chapter.
Chapter 4: Results

The results from this study are presented in three sections:

1. Qualitative findings from Stage 1 youth interviews

2. Quantitative findings from the Stage 2 focused analysis of the 2014 Homeless and Street-Involved Youth Survey

3. Qualitative findings from the Stage 3 expert consultation.

After all results have been presented, I will compare, contrast and highlight the implications of these findings in the Chapter 5 (Discussion).

4.1 Stage 1 Youth Interviews

4.1.1 Demographics

Participants were between the ages of 18 and 19 years old. Four participants identified as female and 4 identified as male (options provided included: male, female, transgender, another: _______). For sexual orientation, two of the participants identified as completely heterosexual, one identified as mostly heterosexual, four identified as bisexual and one wrote in the option “pansexual” (options provided included: completely heterosexual, mostly heterosexual, bisexual, mostly homosexual, completely homosexual, questioning, I don’t have attractions.) For ethnicity, three participants identified as Aboriginal, two identified as Aboriginal/European, one identified as West Asian, one identified as Canadian/American and one said they did not know.
In terms of where participants lived before becoming homeless, four participants listed places outside of Vancouver but in the Lower Mainland (Surrey, Burnaby and North Vancouver), two people said “elsewhere in Canada” (one further specified Toronto, ON), one person said Africa and one person selected “Other” and wrote Alberta-New Brunswick-Quebec-New Brunswick-Okanagan Valley-Alberta-Okanagan Valley-Surrey-Vancouver. Participants stated they first became homeless at a range of ages including: 11 years old (x1), 14 years old (x2), 17 years old (x1), 18 years old (x2) and 19 years old (x2). Participants completed the demographics form in a range of ways, including at the start of the interview on their own (x6), at the start of the interview with my help (x1) and at the end of the interview with my help (x1). It is notable that although my inclusion criteria spanned the ages of 14 to 19 years old, I was not able to recruit any youth under the age of 18 years old. I partnered closely with the organizations where I was recruiting youth, and reached out to other organizations that work with vulnerable youth in an attempt to recruit younger participants. I consistently heard, however, that very few if any ‘younger youth’ were accessing the drop-in and shelter services during the time when I was recruiting.

4.1.2 Interview Findings: Three Analytical Themes

I identified 3 main themes in my Stage 1 qualitative data. These themes were: 1. Youth experiencing homelessness feel powerless when interacting with health care providers, 2. Health care systems exist as rule-based bureaucracies, 3. Youth experiencing homelessness are in ‘survival mode’ when seeking it comes to their health.
4.1.2.1 Youth Experiencing Homelessness Feel Powerless When Interacting with Health Care Providers

Several youth described situations where their needs and concerns were not addressed by health care providers. Rather, youth faced power differentials that, although invisible, were often felt acutely, and clearly dictated how care was (or was not) delivered. For example, youth described feeling like they had to change the way they spoke, looked, acted, and lived to secure treatment and avoid judgement by health care providers. One youth described trying to access medical care while he was living in a temporary shelter and suffering from a serious influenza-like illness. Initially, he tried to see the shelter nurse but was told they were on leave indefinitely and would not be replaced. The youth then walked to a nearby walk-in clinic where the medical office assistant (MOA), acting as a gatekeeper to services, casually mentioned the extensive forms and wait required to see a health care provider. This participant, unable to jump through those hoops, opted to forego care. In his words, he described, “She [the MOA] wanted me to fill out this big form and then she also mentioned that there’d be a 2 hour wait. And then I just said, ‘Mmm…I’m not…I can’t…like, I don’t have the energy for this.’ Right? So I just pretty much left.” (Male, 19 years old). He returned to the shelter and did not seek further medical attention.

Participants also described interactions with health care providers that left them feeling like they were ‘lesser than’ or ‘not worth’ the same care another person might reasonably expect. One youth was admitted to a large, urban hospital with pneumonia and broken ribs. She spent 5 days on a medical unit before leaving against medical advice. She left because she missed her boyfriend, who she had not been able to speak with during her hospital stay. As she explained, "I kept asking them [the nurses] questions and they kept..."
brushing me off like “Oh yah, whatever.” And I kept asking them if they could like, if anyone could call my boyfriend cuz I didn’t have a phone and I didn’t have money for a payphone. […] The health care team assumed ‘cuz her parents aren’t here, it must not be that big of a deal. Like, stupid shit like that” (Female, 19 years old).

Another participant, 19-years old, pregnant and living in a homeless shelter, stated she preferred to access routine prenatal health care in an Emergency Room (ER) setting rather than with her primary care provider or midwife for two main reasons: location and rapport. She could walk to the ER from her shelter, while visiting the midwife required her to take a bus, which she struggled to afford. She also found the ER staff particularly friendly, saying, “They’ll actually conversate with me. They’ll ask me how far along I am […] and if I knew if I was having a boy or girl. They’re just so amazing there. They get me in there quick, they give friendly smiles, they kind of conversate a little bit. Like, sometimes. Sometimes not.” Essentially, accessibility and the simple act of having a fellow human being show the smallest amount of curiosity, some of the time, about her pregnancy was enough to keep this potentially vulnerable young woman eager to return for health care from certain providers instead of others.

Participants also described feeling blamed for their homelessness and having to ‘edit’ information about their lives to receive better health care services. For example, when asked what advice she might give to other youth accessing health care services, one participant said, “Don’t tell them you’re homeless. […] People say to do it cuz they’re your doctor, they need to know for your health. […] If they even find out you’re homeless or you do drugs, you’re fucked. […] They treat you like a bag of shit. They’re all like, “You’re a fuckin’ waste of tax payers money”” (Female, 19 years old).
Several youth also described experiences where, after being treated poorly, they began to expect less from the health care system, and to communicate differently about their circumstances to avoid further disappointment. For example, one participant ‘justified’ poor treatment by health care providers before catching and correcting herself, saying, “Like, you’re 17 years old, you’re on the streets, you don’t know how to talk to a health care professional or whatever. And sometimes they’re, they’re not patient. They aren’t. Like, it’s not their job to be patient with you or whatever. I guess it is though <laughs>” (Female, 19 years old). In this interview, faced with these conflicting views, the youth simply laughed off the comment and moved on.

Another 19 year old female participant described the personal blame she felt at the hands of health care providers in relation to both her homelessness and her overall health. In response to a question about health care providers, she said, “No, they’re just mean. They’re mean. [...] I’ve been on both aspects, like, when they know [that you're homeless] and then they…Like, I’ve been housed in very wealthy family and the experiences…it’s a completely different 360 […] Yah, it just doesn’t make sense. It’s not my fault I got pneumonia. Maybe it’s my fault that I did something else. But when I had the money and I had the family and I was fuckin’ someone who mattered to society…” The participant then trailed off and ultimately brushed off and excused that negative treatment, calling herself a ‘little shit’.

One youth further justified poor treatment by health care providers, saying, “Some of the people [working in the hospital] were rude, I’m not going to lie. Because I guess they’ve been working there for so long they’re just, like, bored of their job. [...] To be honest, I don’t blame them. Everybody is like that at their job. When you have a long day at work, I don’t think you have time to splash smiles for people, to be honest with you” (Male, 18 years old).
Yet another participant spoke of feeling hurried by a health care provider, saying if he could change one thing about the health care system, it would be “the way the doctor would come off would be preferably a bit more welcoming. Some of the walk-in clinics I’ve been to in the past have been kind of like, sort of like, he’s trying to like rush you through” (Male, 19 years old). When another participant was asked if anything helps her feel comfortable in health care settings, she simply said, “Mmmm…no […] I don’t really have a very comfortable experience with it” (Female, 19 years old). This same participant had recently had to delay getting an abortion because her MSP coverage lapsed when transitioning from a Youth Agreement to Income Assistance.

One participant described feeling initially powerless and ‘brushed off’ when she sought care for back pain during her pregnancy. She first went to her midwife but later followed-up with a non-urgent Emergency Room visit, as she wanted a second opinion. In her own words, she explained why she preferred the care she received in the ER, saying, “They made sure by checking […] And, um, then I had a better understanding of what was going on with my body. Compared to the midwife who was just like ‘Oh, do this, it should work’ or ‘Do that, it should work.’ She didn’t really tell me, you know, she was just like ‘Oh, it’s just natural’” (Female, 19 years old). After having her concerns all but dismissed by her primary health care provider, this young woman returned to a place where she felt comfortable – the ER of a busy, urban hospital.

This same participant described how her boyfriend, who has Generalized Anxiety Disorder, avoids seeking mental health care, because he fears having no power over or say in his course of treatment. She explained, “He can’t go out and get the help he needs. And that’s because he can’t go to see his family doctor. He can’t go here, he can’t go there, even.
He can’t go to [urban center ER]’s cuz they’ll put him in the Psych ward and that, they’ll put him on medication. He was only on medication once – he wants, he wants to be on a certain medication so he wants to talk to a doctor who will help him with that.” Here, health care providers are seen as ‘rule setters’ and youth as ‘rule followers’.

This participant also described a dehumanizing experience when she sought treatment for an outbreak of a pre-existing herpes infection in an ER. She said, “I knew I was having an outbreak of herpes [...] but I had to go and make sure so I could get the medicine. It took them 2 hours to come back and tell me that it was herpes and I already knew. And it was just, it was so annoying. [...] They told me to get into this gown and I was stuck in it for like an hour and a half with half my clothes off. So, it was uncomfortable and cold <laughs>.” Here, the health care providers’ need to confirm the patient’s word outweighed her own need for safety, comfort and timely treatment. These examples lead into the next theme, about health care systems as rule-based bureaucracies.

4.1.2.2 Health Care Systems as Rule-Based Bureaucracies

The Merriam-Webster dictionary defines a bureaucracy as, “a system of government that has many complicated rules and ways of doing things” (2016). This definition is particularly apt in British Columbia, where layers of federal, provincial and municipal governments affect both the context in which health care is delivered as well as the delivery of care itself. These bureaucratic layers are also heavily shaped by our current social and political belief that the health care system is ‘strapped for cash’. Such an approach lays the foundation for a system where ‘rules’ are needed to dictate such things as who can (and cannot) get health care, where care is to be delivered and what that care will look like. While this bureaucracy and these rules may function most of the time for most people, several
participants identified that such a system hindered their access to high quality, timely health care.

As a result of authoritarian, broad-stroke rules, several youth described being ineligible for MSP and/or the extended health coverage required to access needed medical care and prescription medications. For example, youth reported having to forgo such things as timely abortion services, limb-saving antibiotic regimes and illness-related doctors’ notes to excuse work or school absences. As one youth said, “It’s hard for some of these girls on the streets to like find the right meds for whatever they’re dealing with. Because, first of all, most of them cost money and most of them don’t have coverage. And so, that’s just the first step” (Female, 19 years old).

Another participant described being told that, after turning 19 years old, she was no longer eligible to receive transportation vouchers or bus tickets from youth clinic. She said, “At the youth clinic, I actually get bus tickets. Not anymore cuz I’m 19. But I did up until I was 19. They would give bus tickets so I could come back for my next appointment.” This same participant described struggling now to afford transit and occasionally having to make overnight arrangements to stay with friends or family to be able to attend early morning medical appointments far from the shelter where she was currently living. Another participant summed it up, when talking about needing new prescription eyeglasses saying, “If it’s more than to your basic eye thing, you’ve gotta pay and all that. And if you’re homeless, you can’t really pay for it” (Male, 19 years old). In each of these situations, it is important to question whose needs were being met and whose were being overlooked when strict rules about MSP premiums and health care costs are enforced in an equal rather than equitable
manner (i.e., applying the same rules to everyone with no regard for each person’s individual context.)

Moreover, in a bureaucratic system where health care providers ‘set the rules’, breaking those rules can mean the difference between getting or not getting needed care. One youth, mentioned earlier, left the hospital against medical advice while being treated for pneumonia and broken ribs. Although she attributed her departure to missing her boyfriend, she detailed several instances of disrespectful treatment by health care providers during her 5-day stay. When describing her departure, she said her health care team, “pretty much said, ‘We’re washing our hands...if you sign this piece of paper, sign yourself out of the hospital, we’re washing our hands of you. We’re done. Not liable.’ That’s all they care about” (Female, 19 years old). The message she received loud and clear was that if she ‘broke the rules’ she no longer ‘deserved’ care. This approach to the delivery of health care services exists in contrast to a more client-centered, trauma-informed approach which would see a more even playing field between health care providers and people seeking care, where both parties could engage in dialogue and share information about what may be happening, what remains unknown, what treatment regimes are available, and so forth.

Along with all British Columbians, homeless youth largely access primary health care services in a physician-driven, fee-for-service based system. Here, the quality of care seems to be far too often dictated by the payment structure set out by the government which states doctors can bill for most services in one-time 15-minute increments only. For vulnerable youth, the rules and restrictive demands inherent in such a system can lead to rather alienating health care experiences. One youth said, “I have trouble going to the doctor cuz I have problems with, um, more social situations. And like, I can’t really go and like, plan
“things out for myself” (Male, 19 years old). It is easy to imagine how this young man, faced with the prospect of describing what might be a fairly complex and private health issue to a stranger within the confines of a 15 minutes visit, might simply ‘choose’ to forgo care.

Similarly, bureaucratic rules also dictate who pays for health care in British Columbia and how. As previously described, all British Columbians must carry a BC Services/Care Card as proof of enrolment in the Medical Services Plan to access ‘free’ health care services. One participant described needing to have a severe leg infection treated. However, because he had recently moved to British Columbia from another province, he was ineligible for MSP coverage. The infection worsened without the attention it needed until a youth worker at a shelter approached the youth and accompanied him, as an advocate, to seek health care. Describing what happened, he said, “So, [the youth worker] took me to the doctor…and they kind of just been putting it on the bill. So, the bill pretty much came up to like $5000. Which then, they [youth worker] fight it for me so it kind of like disappeared I guess” (Male, 18 years old).

Another youth went as far as to say she routinely avoided needed health care, and specifically ambulance services, because she cannot afford it. When asked what suggestions she might have to improve access to health care, this participant responded, “If they had free ambulances […] cuz honestly, half the time I don’t go to the hospital or to the doctor or something like that just because like I don’t, I know I can’t afford the ambulance bill. I fuckin am a hobo, okay? I owe so much money in ambulance bills, it’s retarded” (Female, 19 years old).
Yet another youth described the challenges she faced after her MSP lapsed when she transitioned from a Youth Agreement to Income Assistance. Because she was not able to ‘follow the rules’ of the health care system (e.g., present proof of MSP coverage or pay for medical services), she was faced with the prospect of having to pay out-of-pocket to terminate an unplanned pregnancy. In her own words, when asked what influences her access to health care she said, “Just like, not having income or anything. Like, the struggle of like, having to pay for your own medication. Cuz like I hadn’t really realized, like, how much abortions are. And that you have to pay for it” (Female, 19 years old). She described trying to pick up odd jobs to cover the cost of the abortion before ultimately waiting for her MSP coverage to be reinstated. In the words of another youth, “You shouldn’t need a health card to be healthy” (Male, 18 years old).

Participants also described the challenges they faced in simply trying to understand the ‘rules’ of the health care system let alone to play by them. As one youth said, “I feel like the whole, just, way to make appointments and way to like get a doctor or get a nurse practitioner is just not quite as accessible or as understandable for people my age. Like, we just don’t know how to do it. Like, we’re homeless <laughs>. Just need a little bit of extra help” (Female, 19 years old). Another youth described challenges he faced after he left home, saying, “I was connected with my parents so they would help me pay for like medicine and stuff because my mom has like health coverage. […] I’m not sure how I would go about it if I did [need health care now]. I have a BC Services Card so I have like a health number but I don’t know how far that, like, can get me” (Male, 19 years old). Without a trusted adult or peer to help them navigate the health care system, homeless youth’s questions too often go unanswered.
4.1.2.3 Youth Experiencing Homelessness Are in Survival Mode When It Comes to Their Health

Although none of the youth expressly spoke about this theme, it was evident that some youth ‘learned how to survive’ in a health care system that treats them as ‘other’. Often, this came at the cost of expecting what they seemed to consider ‘frills’ – kindness, comfort, thorough assessments, individualized care and so forth. As previously mentioned, one youth ‘chose’ to not seek medical attention for a chest infection after the shelter nurse was on leave and he was told the walk-in clinic had a 2+ hour wait. Unable to face the prospect of sitting in a waiting room for that long while feeling so ill, he said, “I just pretty much just dropped it and just like, tried, like, deal with it on my own. Right? So, yah” (Male, 19 years old). He never did seek further medical attention, although eventually the infection did clear on its own. Essentially, he used his albeit limited resources (access to shelter, usual good health) to survive.

Another participant, when describing his experience receiving I.V. antibiotics in the hospital for a severe leg infection, said, “To be honest, it was just another day for me” (Male, 18 years old). When asked if anything made him feel (un)comfortable while he was accessing health care, he struggled to identify anything saying, “The fact that I thought I was going to lose my leg [made me uncomfortable]. Other than that, no. […] I wasn’t even in a state of mind to be looking at the comfortability of my surroundings. I was really dealing with a big injury.” After further conversation, he identified that a youth worker from a nearby drop-in center helped him to feel more comfortable while in hospital. The youth worker advocated for him to receive care despite not having MSP coverage and accompanied him to hospital visits, which, he said, “Made me feel that I’m not alone. Like, it’s not only
me. Basically, it was someone to rely on.” At first glance and in many ways, this youth was so busy surviving, little else seemed to matter to him.

Participants also described a range of interpersonal ‘strategies’ used to ‘better survive’ their experiences seeking health care. One youth described first forgoing health care, then asking her boyfriend for help, then lashing out at a health care provider before ultimately breaking down in tears when she was pushed beyond her emotional limits. Sick with pneumonia, this young woman had been living on the streets and then staying in a hotel prior to being sent to the hospital via ambulance. When describing the time leading up to her hospital stay she said, “It was getting worse and worse and worse and worse. Til the one, in the middle of the night, I just like spazzed out and I was like, ‘You need to call an ambulance. I’m done.’ I swear, I was like puking up foam and then I started coughing up blood. And then the stabbing pain. And like, I couldn’t, like, I had him [her boyfriend] holding my ribs cuz like, I don’t know why…but like with his support it didn’t hurt as much. […] I just wanted to be a sooky baby and have him hold my ribs” (Female, 19 years old). It is notable that, in describing this situation, the participant felt it was important to acknowledge that she could support her own ribs but she did not want to. Furthermore, she believed that asking her boyfriend for help made her a ‘sooky baby’. She ultimately left in the ambulance as her boyfriend stayed in the hotel room to secure a source of shelter in anticipation of her return home.

When the participant arrived in the Emergency Room of a busy urban hospital, she was carrying all of her belongings, fearing her boyfriend might get evicted from their hotel room while she was gone. When it was time to have her chest x-rayed, a health care provider told her to carry belongings into the examination room. Unable to lift the items because of
her (as yet undiagnosed) broken ribs, she asked a member of the security or health care team (she was uncertain which) for help. Her request was denied and she was told to either carry her own belongings or leave them unattended in the waiting room. The participant, opting to leave her only possessions behind so as to not forgo the much needed x-ray, said, “I got in the room, he closes the door, leaving my shit in the middle of there. So I just like fuckin’ lost it. I was like ‘You’re a f…I hope you’re fucking happy that now like I’m gonna lose all my stuff because you’re a goof piece of shit.’ And just fuckin’ went right off.” Another doctor then became involved, telling her she needed to calm down or risk not getting an x-ray.

Pushed beyond her emotional limit – and wanting much needed health care after having tried to avoid it for several days – the participant said she, “Just burst into tears and I just started fuckin’ like *crying voice* “I want my stuff…” Like, I just didn’t know what to do. […] Then they immediately, seeing that I actually had real injuries [after the x-ray was done], and I wasn’t just a dumb…kid, a street kid being stupid [provided me with painkillers].” The youth essentially used any and all tools at her disposal to help her ‘survive’ within a health care system that expected her, broken ribs and all, to carry her own belongings from room to room.

Another youth said, “Basically, we [homeless youth] just walk around and tell everybody about all the good things about where we go. Because if you’re gonna focus on the bad things, that’s all that’s gonna happen. You’re gonna have a bad outlook on it, so…just because you have a bad outlook on something, doesn’t mean you have to make it bad for everybody else” (Male, 19 years old). While this approach may be commendable on many levels and likely helps this person make the best of challenging circumstances, it raises the question of who is (or is not) encouraging homeless youth to share their honest opinions.
regarding the care they receive. One youth, discussing whether anything helped her to feel ‘more comfortable’ when accessing health care, simply said, “There isn’t really ‘more comfortable’. You’ve just gotta get it over with. […] Actually, I think we all try not to [seek health care] if we don’t have to cuz like, if it’s avoidable, avoid the fuck out of it” (Female, 19 years old). Hearing sentiments like that, accompanied by all of the previous quotes and stories, it becomes increasingly apparent why homeless and street-involved youth report increased health care needs and decreased health care access.

4.2 Stage 2: Statistical Analysis of 2014 Homeless and Street-Involved Youth Survey Data

As I have explained earlier, to supplement the Stage 1 interviews, I also conducted focused statistical analyses of select questions from the 2014 Homeless and Street-Involved Youth Survey data. I conducted analyses using questions that I hypothesized may have been related to health care access. The purpose of these analyses was to determine, “What social and structural influences might be evident in the extent to which and reasons why homeless and street-involved youth in British Columbia report foregone health care.” Additionally, my aim was to determine if all homeless youth experience similar influences around access to health care. As described in Chapter 3, I looked for relationships between the question “In the past 12 months, have you thought you needed medical help because you were physically sick or hurt, but didn't get it?” and the following questions in Table 7:
Table 7  
Stage 2 Survey Questions: Final Selection

<table>
<thead>
<tr>
<th>Theme</th>
<th>2014 Homeless and Street Involved Youth Survey Question</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td>Qu1 – How old are you?</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td>Qu 2 – Are you…male, female, transgender, another</td>
</tr>
<tr>
<td><strong>Sexual Orientation</strong></td>
<td>Q12 – Which of the following best describes your feelings? Completeness heterosexual, mostly heterosexual, bisexual, most homosexual, homosexual, questioning, I don’t have attractions</td>
</tr>
<tr>
<td><strong>Access to Care Card</strong></td>
<td>Q49 – Do you have an Care Card or BC Identification/Service Card?</td>
</tr>
<tr>
<td><strong>Shelter (current precarious vs. stable housing)</strong></td>
<td>Qu19 - People can live in a lot of different places for short or long periods of time. Please tell us where you live now (yesterday) and any place you’ve ever lived: House or apartment (alone or with roommates), hotel/motel/SRO/hostel, Other relative’s home (grandparent, aunt, sister, brother, etc.), college dorm/college accommodation, safe house/shelter, extreme weather shelter, transition house, squat/abandoned building, on the street, living nowhere/living all over (couch surfing), tent/car, other.</td>
</tr>
<tr>
<td><strong>Experiences of discrimination</strong></td>
<td>Qu 112. In the past 12 months, have you been discriminated against or treated unfairly because of - Your race, ethnicity or skin colour, Your sexual orientation (being or thought to be gay or lesbian), Your gender/sex, A disability you have, How much money you or your family have, Your age, People seeing you as different, Being on Income Assistance, Being homeless or street involved</td>
</tr>
</tbody>
</table>

4.2.1 Demographics

A total of 681 people participated in the survey. All participants self-identified as having lived on or near the streets (e.g., in shelter, couch-surfing etc.) for 3 or more days in the previous year. Respondents came from 13 urban and rural communities across British Columbia (Abbottsford/Mission, Burnaby, Chiliwack, Kelowna, Kamloops, Nanaimo, Nelson, North Shore, Prince George, Prince Rupert, Surrey, Vancouver and Victoria.) The majority of participants identified as female (n=307), while 281 identified as male, 10
identified as transgender and 10 identified as another gender. The age range was from 12 to 19 years old, with a mean age of 16.83 years old (SD = 1.68). The majority of respondents identified as completely heterosexual (n=362), while 44 people identified as mostly heterosexual, 126 identified as bisexual, 6 identified as mostly homosexual, 15 identified as completely homosexual, 19 identified as questioning and 28 identified as not having attractions.

4.2.2 Rates of Foregone Health Care and Select Variables

4.2.2.1 Age

Based on my literature review and professional experience, I hypothesized that younger youth would report more foregone care than older youth. I based this hypothesis on the assumption that older youth may have had more experience with health care, and therefore be better equipped to overcome barriers to accessing health care than younger youth. Unfortunately, I was not able to use Stage 1 interviews to inform my hypothesis for this particular question, as all of the participants interviewed were 18 and 19 years old.

My hypothesis was not supported with these data from the 2014 Homeless and Street-Involved Youth Survey. Using an independent sample t-test, I found no statistically significant relationship between age and rates of foregone health care (t= -1.391, p = 0.319). Because these findings contradicted my hypothesis, I conducted further analyses to determine if all ages reported similar levels of foregone care. I ran a crosstabs analysis with chi-square to compare rates of foregone care across each age. Again, there was no statistically significant difference for the entire group ($X^2 = 8.941$, $p = 0.257$; see Table 1.) It is evident with this analysis, however, that not all ages report similar rates of foregone care. Rather, 18 year olds faced notably higher (albeit not statistically significantly different) rates of
foregone care. Over one third (34.1%) of 18-year old participants reported forgone care as compared to 25% across all ages (see Table 6).

4.2.2.2 Gender

Based on my literature review and Stage 1 interviews, I hypothesized that there would be no statistically significant differences in rates of foregone health care based on gender. I based this hypothesis on the fact that none of the Stage 1 interview participants mentioned gender as an influence on their access to health care. Additionally, little information arose in my literature review identifying that a specific gender may face more foregone health care than another. That being said, research on youth in general (i.e. not specifically on homeless and street-involved youth) has identified that transgender youth may face greater barriers to accessing health care than cisgender youth (Alencar Albuquerque et al., 2016). It is possible that this finding has not been reflected in my data or in homeless youth research to date because the number of participants who identify as transgender/another gender are not sufficiently powered to reach statistical significance.

In the 2014 Homeless and Street-Involved Youth Survey, 10 participants identified as transgender and 10 identified as another gender. These numbers may be too small a group to allow for meaningful statistical analysis of these groups. To confirm this assumption, I ran chi-square tests with only participants who identified as male or female and again with participants who identified as male or female or transgender or another gender. Both tests yielded results that were similarly not statistically significant. As such, I opted to run the final analyses using only participants who identified as male or female.
My hypothesis was supported with these data from the 2014 *Homeless and Street-Involved Youth Survey*. There was no statistically significant relationship between gender and rates of foregone health care ($X^2 = 0.248 \ p = 0.619$; see Table 6.)

**4.2.2.3 Sexual Orientation**

Based on my literature review, I hypothesized that there would be no statistically significant differences in rates of foregone health care based on sexual orientation. Again, I based this hypothesis on the fact that little information arose in my literature review identifying sexual orientation specifically as having an influence on foregone care. Furthermore, none of the participants from the Stage 1 interviews mentioned sexual orientation as influencing their access to care. That being said, again, research on youth in general has identified that sexual minority youth may face greater barriers to accessing health care (Alencar Albuquerque et al. 2016.) It is possible, then, that this relationship has also not been reflected in homeless youth research to date largely because of limited numbers of participants who identify as lesbian, gay, bisexual (LGB), so studies may not be sufficiently powered to detect such nuances.

The majority of survey participants identified as completely heterosexual. To account for smaller numbers in other response categories, I combined some response categories based on guidance from my thesis supervisor. The final categories I used for analysis were: completely heterosexual, mostly heterosexual, bisexual, and mostly homosexual/gay or lesbian. I omitted participants who identified as questioning (n=19) and as not having sexual attractions (n=28) as these participants represented a very small proportion of the overall sample. To confirm that omitting these participants would not affect the overall analysis, I
ran the analysis both with and without these groups, and neither approach yielded a statistically significant result.

My hypothesis was supported with these data from the 2014 *Homeless and Street-Involved Youth Survey*. There was no statistically significant relationship between sexual orientation and rates of foregone health care ($X^2 = 6.858, p = 0.77$; see Table 6.)

### 4.2.2.4 Rates of Foregone Health Care and Owning a Care Card

Based on my literature review, professional experience and Stage 1 interview findings, I hypothesized that not having a Care Card would increase rates of foregone care. I based this hypothesis on existing research that named lack of insurance coverage as a barrier to accessing health care (Hudson et al, 2010). Additionally, a number of participants in Stage 1 identified not having a Care Card as a barrier to accessing to health care.

My hypothesis was not supported in these data from the 2014 *Homeless and Street-Involved Youth Survey*. There was no statistically significant relationship between owning a Care Card and rates of foregone health care ($X^2 = 0.872, p = 0.647$; see Table 6.)

### 4.2.2.5 Precariousness of Housing

Based on my literature review, professional experience and Stage 1 interview findings, I hypothesized that increased precariousness of housing would increase rates of foregone care. I based this hypothesis on existing research that named lack of stable housing as a barrier to accessing health care (Gaetz, Scott & Gulliver, 2013.) Additionally, a number of participants in Stage 1 identified how the precariousness of their housing (e.g., living in shelters, on the streets, in hotels) negatively influenced their access to health care (e.g., illnesses worsening while living on the streets). In my analysis, I considered the following as ‘stable housing’: 
house or apartment, parents’ home, relative’s home and college dorm. Meanwhile, I considered the following as ‘precarious housing’: hotel/motel/SRO/hostel, safe house/shelter, extreme weather shelter, transition house, squat, on the street, nowhere, tent/car. I based these categories on the perceived long-term viability and stability of each type of shelter (e.g., an emergency/temporary shelter is inherently a form of precarious housing.)

My hypothesis was supported by the results of this analysis. There is a statistically significant relationship between precariousness of housing and rates of foregone health care ($X^2 = 9.899, \ p = 0.002$; see Table 6.)

### 4.2.2.6 Perceived Discrimination

Based on my literature review and Stage 1 interview findings, I hypothesized that there would be a statistically significant relationship between rates of foregone health care and various types of perceived discrimination. I based this hypothesis on existing research that named perceived discrimination as a barrier to accessing health care (Alencar Albuquerque et al. 2016.) Additionally, a number of participants in Stage 1 identified that perceived discrimination (related to being homeless, not having their parents around, etc.) negatively influenced their access to health care.

In my analysis, I used questions that asked about perceived discrimination based on a number of factors (e.g., age, gender, sexual orientation) in the previous 12 months. It is important to note that this was not specifically discrimination in a health care context. However, I hypothesized that perceived discrimination, even outside of health care, may influence rates of reported foregone care. I ran Pearson Chi-Square tests for each type of perceived discrimination (e.g., based on skin colour, gender, sexual orientation, etc.)
My hypothesis was supported for certain types of discrimination and not supported for others. There were statistically significant relationships between rates of foregone care and perceived discrimination based on: skin colour/race/ethnicity ($X^2 = 10.118, p = 0.001$), gender ($X^2 = 10.606, p = 0.001$), physical disability ($X^2 = 14.442, p = 0.000$), amount of money you or your family have ($X^2 = 21.215, p = 0.000$), age ($X^2 = 37.273, p = 0.000$), being different ($X^2 = 7.563, p = 0.006$) and being homeless ($X^2 = 14.09, p = 0.000$). There were no statistically significant relationships between rates of foregone care and perceived discrimination based on sexual orientation ($X^2 = 2.682, p = 0.102$) or being on income assistance ($X^2 = 2.857, p = 0.091$). These statistics are available in full in the table below.

Table 8
Comparing Rates of Foregone Care Based on Selected Variables

<table>
<thead>
<tr>
<th>Age</th>
<th>Yes (%)</th>
<th>Total (n)</th>
<th>$X^2$</th>
<th>df</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>12</td>
<td>25.0</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>25.0</td>
<td>16</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>18.9</td>
<td>37</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>18.6</td>
<td>59</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>27.2</td>
<td>114</td>
<td>8.941</td>
<td>7</td>
<td>0.257</td>
</tr>
<tr>
<td>17</td>
<td>21.7</td>
<td>120</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>34.0</td>
<td>147</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>24.6</td>
<td>110</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>25.9</td>
<td>607</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
In the past 12 months, have you thought you needed medical help because you were sick or hurt, but didn’t get it?

<table>
<thead>
<tr>
<th>Gender</th>
<th>Yes (%)</th>
<th>Total (n)</th>
<th>X²</th>
<th>df</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>24.9</td>
<td>281</td>
<td></td>
<td></td>
<td>0.619</td>
</tr>
<tr>
<td>Female</td>
<td>26.7</td>
<td>307</td>
<td>0.248</td>
<td>1</td>
<td>0.619</td>
</tr>
<tr>
<td>Total</td>
<td>25.9</td>
<td>588</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sexual Orientation</th>
<th>Yes (%)</th>
<th>Total (n)</th>
<th>X²</th>
<th>df</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completely Heterosexual</td>
<td>22.4</td>
<td>362</td>
<td></td>
<td></td>
<td>0.077</td>
</tr>
<tr>
<td>Mostly Heterosexual</td>
<td>31.8</td>
<td>44</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bisexual</td>
<td>33.3</td>
<td>126</td>
<td>6.858</td>
<td>3</td>
<td>0.077</td>
</tr>
<tr>
<td>Completely/Mostly Homosexual</td>
<td>28.6</td>
<td>21</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>25.9</td>
<td>553</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Owning Care Card</th>
<th>Yes (%)</th>
<th>Total (n)</th>
<th>X²</th>
<th>df</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>25.5</td>
<td>509</td>
<td></td>
<td></td>
<td>0.647</td>
</tr>
<tr>
<td>No</td>
<td>29.0</td>
<td>100</td>
<td>0.872</td>
<td>2</td>
<td>0.647</td>
</tr>
<tr>
<td>Total</td>
<td>26.1</td>
<td>609</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Precarious Housing</th>
<th>Yes (%)</th>
<th>Total (n)</th>
<th>X²</th>
<th>df</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stable Housing</td>
<td>22.2</td>
<td>415</td>
<td></td>
<td></td>
<td>0.002</td>
</tr>
<tr>
<td>Precarious Housing</td>
<td>34.7</td>
<td>170</td>
<td>9.899</td>
<td>1</td>
<td>0.002</td>
</tr>
<tr>
<td>Total</td>
<td>25.8</td>
<td>585</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Perceived Discrimination Based On…</td>
<td>Yes (%)</td>
<td>Total (n)</td>
<td>$X^2$</td>
<td>df</td>
<td>p-value</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>---------</td>
<td>-----------</td>
<td>--------</td>
<td>----</td>
<td>---------</td>
</tr>
<tr>
<td>Race/ethnicity</td>
<td>30.8</td>
<td>133</td>
<td>10.11</td>
<td>1</td>
<td>0.001</td>
</tr>
<tr>
<td>Total</td>
<td>21.1</td>
<td>521</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual Orientation</td>
<td>20</td>
<td>130</td>
<td>2.682</td>
<td>1</td>
<td>0.102</td>
</tr>
<tr>
<td>Total</td>
<td>15.5</td>
<td>516</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender/sex</td>
<td>28.9</td>
<td>128</td>
<td>10.60</td>
<td>1</td>
<td>0.001</td>
</tr>
<tr>
<td>Total</td>
<td>19.1</td>
<td>513</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disability</td>
<td>26.0</td>
<td>131</td>
<td>14.442</td>
<td>1</td>
<td>0.000</td>
</tr>
<tr>
<td>Total</td>
<td>15.6</td>
<td>514</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How much money you have</td>
<td>45.4</td>
<td>130</td>
<td>21.215</td>
<td>1</td>
<td>0.000</td>
</tr>
<tr>
<td>Total</td>
<td>29.5</td>
<td>516</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>57.7</td>
<td>130</td>
<td>37.273</td>
<td>1</td>
<td>0.000</td>
</tr>
<tr>
<td>Total</td>
<td>35.5</td>
<td>515</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>People seeing you as different</td>
<td>50.4</td>
<td>131</td>
<td>7.563</td>
<td>1</td>
<td>0.006</td>
</tr>
<tr>
<td>Total</td>
<td>40.2</td>
<td>520</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Being on Income Assistance</td>
<td>14.6</td>
<td>130</td>
<td>2.857</td>
<td>1</td>
<td>0.091</td>
</tr>
<tr>
<td>Total</td>
<td>10.7</td>
<td>516</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Being Homeless</td>
<td>38.2</td>
<td>131</td>
<td>14.094</td>
<td>1</td>
<td>0.000</td>
</tr>
<tr>
<td>Total</td>
<td>25.8</td>
<td>516</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
4.3 Stage 3: Expert Consultations

4.3.1 Support for Overall Findings

Overall, the participants in the expert consultation were in support of the findings from Stages 1 and 2, saying it was notable how ‘familiar’ the findings sounded to them. One of the main findings the participants discussed was how much perceived discrimination affects youth access to care. Two participants specified that it is not just perceived but also blatant discrimination, much of which they had witnessed when accompanying youth in health care spaces. For example, one participant described accompanying a youth in a hospital ER waiting room while another man who appeared homeless was brought in on a stretcher. One of the ER nurses, when walking past the man on the stretcher, reacted in an over-the-top dramatic fashion, saying “Phew! You smell terrible! Put your shoes back on!” to this man awaiting care.

The participant described witnessing how this level of discrimination and judgment affect not only the person it was targeting (the man on the stretcher) but also the homeless youth he was accompanying in the waiting area. After overhearing this nurse, the youth began to check his own shoes to make sure they were on securely while also trying to tell if he ‘smelled’ and might be subjected to the same theatrics by the nurse. Additional stories were shared of youth being subjected to similar types of discrimination and either choosing to forgo care as a result or having health care provider brush off requests for care based on the assumption that youth were simply drunk or high.

The participants emphasized that such experiences negatively affect not only youth’s relationships with the health care system but also their understanding of and expectation for
how the whole world perceives them. Essentially, hurtful interactions with what should be trusted health care providers may damage not only a youth’s relationship to the health care system but their overall connection with and trust in others.

This was particularly concerning for the expert panel participants who identified that, amongst youth, others’ comments and judgements tend to sink in deeper. Or, in other words, negative experiences (whether with health care or otherwise) at this age can affect a person’s perceptions for the rest of their lives. The participants recognized that this seemed to be especially true amongst marginalized and vulnerable youth who, in the participants’ experiences, had often experienced a great deal of trauma in childhood and adolescence. The participants suggested that for youth who have grown up and may still be living in traumatizing circumstances, negatives experiences with the health care system can add to trauma, or re-traumatize already vulnerable youth.

Participants also endorsed the negative effects of ‘health care systems as rule based bureaucracies’ on access to health care. For example, all of the participants described the amount of time and trust-building required for youth to engage honestly and comfortably with health care providers. One participant suggested that before health care providers can ‘do health stuff’ with a youth they need to have had several opportunities to cross paths and connect in a more informal way first. One participant described repeated efforts to encourage a youth she had met during outreach to come into a nearby primary care clinic. The youth finally agreed to drop in and so a plan was made to see them between existing appointments that afternoon. Part of the way through a busy afternoon, the youth arrived at the clinic and began waiting in the waiting room. While the participant was in previously scheduled visits, the youth got into a very heated conflict with the front-desk receptionist as
the youth did not have an appointment but did not want to leave. Ultimately, the participant described returning to the waiting room after a particularly lengthy visit and witnessing this confrontation between the youth and the receptionist. The participant described needing to carefully de-escalate the situation and rebuild the trust of the youth who – as requested by the participant – had been waiting in the waiting room. Meanwhile, the conflict arose because this youth was not ‘following the rules’ (e.g., on paper no additional appointment times were open.)

Expert panel participants also described how youth are in survival mode in all areas of their life, not just when it comes to their health. For example, the timing of when homeless youth seek health care often aligns with the demands that shelters place on their lives, where youth are often kicked out of shelter by 8am and not allowed to return until the evening. Thus, youth often seek health care services first thing in the morning (before most clinics are open) and at the very end of the day (after most clinics are closed.)

Many participants also agreed that health is not a priority for homeless youth…until it is. This aligns with the notion that homeless youth often avoid seeking care until their needs become too pressing to ignore. Given the often dehumanizing and traumatizing experiences described in the preceding pages, one can begin to understand why youth might forgo care until they simply no longer can.

4.3.2 What Was Missing from the Data

After reviewing the summary of findings, participants were asked if they thought there was anything missing from the data or anything that did not reflect their experiences. The only thing the participants identified is that they would further highlight how requiring
appointments and lengthy wait times to see a health care provider can deter youth who are experiencing homelessness from seeking health care.

4.3.3. Improving Homeless Youth Access to Primary Health Care Services

All of the expert consultation participants stated there is not name a single strategy or ‘quick fix’ that could improve homeless youth access to health care services. Rather, a multi-pronged approach would be needed to both better engage youth in the first place while also better supporting and welcoming youth once they enter health care services. Many of the participants identified the importance of being able to engage with youth ‘on their turf’ before engaging in health care conversations. Such an approach to health care delivery demands flexibility and support on behalf of individual practitioners and the organizations that employ them. For example, participants identified that specialized training is needed for health care and social service providers who work with vulnerable youth. This training could include topics on everything from trauma informed care to conflict de-escalation and resolution techniques.

Participants also advocated for abridged versions of such training and information to be shared with all service providers regardless of how (in)frequently they work with vulnerable youth. This suggestion was made as there was an understanding amongst participants that, while most people who work with youth ‘get it’ (e.g., the importance of providing trauma-informed, non-judgmental care), such messages and training are not necessarily shared within the broader health care and social services communities. Additionally, even providers who are immersed in this work every day can benefit from
regular, perhaps annual, ‘refresher’ training opportunities as these are complex topics that demand nuanced thinking.

Within organizations that support vulnerable youth, the participants emphasized the value of having people within and across various disciplines shadow each other’s work. In this way, successes could be celebrated and challenges addressed as a team rather than individual practitioners having to shape their own practice in isolation from others. On this same topic, the participants emphasized the importance of co-workers engaged in this area of work supporting one another. The participants identified peer support of colleagues being important, given the demanding and sometimes ambiguous nature of working with vulnerable youth, where service providers may not always have all the answers. As one participant suggested, health care and allied service providers must be provided with the organizational support needed to know they must ask the right questions of youth while creating safe, non-judgmental spaces but that they do not necessarily need to have all of the right answers.

In addition to providing training for service providers, the participants suggested more work needs to be done to empower youth in regards to accessing health care. The participants suggested health care and allied service providers could partner with peer leaders from youth-driven communities to engage in such conversations. For example, before a youth can access health care, they often need to know how to do things like getting a government-issued identification, applying for MSP coverage, understanding whether they are covered under their parents’ extended health coverage, and so forth. These are all areas where inter-sectoral collaboration and peer leadership initiatives that are designed to support and include youth could foster more holistic, equitable access to health care.
Such collaborations could lead to and advocate for the creation of much needed youth-focused services such as clinics with flexible care delivery models (e.g., evening and weekend hours, both appointment and drop-in visits, outreach and in-clinic encounters) and expanded clinic services (e.g., youth-friendly ambulatory care spaces that could offer 'quick turn-around’ lab testing, intravenous antibiotics, etc.) The participants were clear in stating that such services need not be in addition to what is currently available. Rather, existing services could partner in innovative ways to ensure gaps in care are being addressed and existing services are partnering to best leverage their unique capabilities and capacities.

Participants also identified that when designing youth-friendly services, it is important to seek out and listen to the voices of all youth and not just those voices that happen to be the loudest or easiest to hear. For example, one participant identified that when satisfaction surveys are conducted within existing clinic spaces, they inherently fail to acknowledge the voices of those youth unable to access the clinic in the first place. Likewise, participants identified the challenges vulnerable and marginalized youth, including homeless youth, can face when accessing ‘mainstream’ services where they may fear being judged by health care and allied service providers, as well as by other youth. Work is needed, by many accounts, to create safer and more inviting spaces for youth outside of traditional primary health care models.

All participants agreed that there is not currently a single, central person or organization that is leading the way where vulnerable youth health is concerned. Rather, various health authorities and not-for-profit, non-governmental organizations each hold some of the expertise or area of practice. While such an approach has worked in the past, the participants in this consultation identified that this inherently leads to confusion regarding
who is doing what and what needs remain outstanding. The participants suggested that two
or three times a year, it would be very helpful to have an open-door meeting where any
interested parties could gather to discuss service delivery for vulnerable and marginalized
youth in the Lower Mainland (e.g., what is happening, what is needed.)

When asked who might organize and host these meetings, the participants returned to
the fact that no single person or organization is currently seen to be ‘the’ leader or hub in this
area. The participants then suggested that the City of Vancouver create two positions
focused on improving youth wellness; one health care and one social services provider. This
two-person team could then be tasked with developing a ‘big picture’ understanding of what
services exist in the city and creating resources and meeting spaces to share this information
with front-line practitioners, program developers and policy makers. For example, the
participants identified that a Red Book or resource directory is needed for health care and
allied service providers working with vulnerable youth, as well as a similar resources
accessible to youth themselves.

The creation and management of such a resource could, as per the participants’
suggestion, fall under the responsibility of that 2-person City of Vancouver team. Similarly,
this duo could be responsible for updating stakeholders about the outcome of partnerships,
meetings, pilot projects, etc. The participants identified that they often hear about new
projects or upcoming consultations on various initiatives; however, they rarely hear what the
outcomes were or how those programs went. Again, the participants identified that there is
not a central place to access information, updates or to ask questions about vulnerable youth
wellness services that extend beyond the borders of a single organization (e.g., Vancouver
Coastal Health practitioners can comment on what is happening within their health authority but not necessarily Providence, Provincial Health Services or Fraser Health.

Regardless of whether the formal creation of new City of Vancouver positions may be feasible, the underlying message is important. Increased communication, intersectoral collaboration and coordination are needed to optimize health care services for marginalized and vulnerable youth health in the Lower Mainland. Homeless youth are one key group who clearly exemplify where gaps in the current health care system exist, and how such gaps affect access to health care. Furthermore, as the expert panel participants identified, vulnerable youth wellness is not a topic that can be adequately addressed by a single organization or person. Rather, greater awareness of the needs of vulnerable youth is needed, both within and outside of people who work directly with youth, as well as awareness of the intersectoral partnerships required to address those needs.
Chapter 5: Discussion

5.1 Key Findings

Social and structural factors influence homeless youth’s experiences accessing health care in a number of ways. When homeless youth feel powerless accessing health care in rule-based, survival-focused bureaucratic systems, they suffer. Furthermore, there is evidence of the extent to which and reasons why youth forgo care, in that youth who face certain types of discrimination and who live in precarious housing face the greatest barriers to accessing health care. These findings challenge the current discourse around the ‘ease’ and equity of health care access in Canada, as this evidence contradicts the notion that all Canadians share equal, unhindered access to health care services. Moving forward, then, it is imperative for nurses to adopt a critical social justice lens to shift how we conceptualize both the day-to-day care we provide and the systems we work within to ensure we neither formally nor informally label marginalized and vulnerable people as ‘Other’.

From the perspectives of the expert panel participants, these findings widely matched their experiences. As for how the findings might help to improve homeless youth’s access to primary health care services, participants spoke largely of how we might change health care and allied service delivery systems (e.g., increasing training for health care and allied services providers, increasing intersectoral collaboration, creating more positions intended to support vulnerable youth wellness, and so forth.) Notably, none of the participants spoke of individual youth needing to change who they are or how they interact with the health care system to ‘better navigate’ the system. In other words, while each individual youth’s needs ought to be better attended to, more attention must also be paid to acknowledging the
systematic influences on homeless youth access to health care. A systemic approach includes fostering more opportunities for practitioner training and intersectoral collaboration.

5.2 Strengths and Limitations

A key limitation of this study is its geographic limits, in that it only included interviews with youth and experts in the Lower Mainland of British Columbia. Such an approach, while chosen to ensure the project was feasible as a Masters thesis, excluded the voices of homeless youth and experts living and working in more rural and remote areas. This research may have also not adequately represented the voice of lesbian, gay, bisexual and transgender youth, given the nature of my data collection, and the data collection for the 2014 *Homeless and Street-Involved Youth Survey* (i.e., convenience rather than purposive or stratified sampling.) Another limitation of this research is I was only able to recruit 18 and 19 year old youth for the interviews, rather than also recruiting younger youth.

A strength of this research is its inclusion of both youth and health care and allied service provider voices. It also included input from urban and rural youth, from the McCreary Center Society survey data. The analysis also included a critical analysis of the data rather than a narrow and pathologizing focus on individual youth. Such a lens has previously been largely absent from existing literature.

5.3 Implications for Research and Practice

The findings from this thesis support the notion that many youth who are experiencing homelessness experience an increased need for health care services, while also experiencing decreased access to services. Moreover, many youth’s access to services is negatively influenced by how the current Canadian health care system is structured. A
crucial question that nurses, as a profession, must ask ourselves is: ought Canadians change to meet the needs of our imperfect health care system, or ought our system change to meet the needs of Canadians? I would argue that based on our Code of Ethics (CNA, 2008), which demands we act in a socially just manner, and based on the findings of this thesis, it is the system that must change. As such, nurses can advocate for both immediate and longer-term changes to the way we deliver services for marginalized youth (e.g., offering more outreach services, supporting the creation of purpose- and value-driven health care initiatives, changing the way we interact and speak with vulnerable youth in health care contexts.)

Health care and allied service providers ought to pursue and promote training opportunities to inform how we can best support those people and populations who face challenges accessing health care. This training can begin in undergraduate and professional programs and extend into regular, ongoing continuing education opportunities for people working everywhere from front-line practice to program and policy development. The focus of such training could include topics such as trauma-informed practice, conflict de-escalation, how to support marginalized or vulnerable populations, and so forth. Additionally, such training must not be offered only to those people most interested in pursuing it or only those people who work directly with marginalized and vulnerable populations. Rather, such conversations and growth must be woven into the fabric of how we as nurses, as health care providers and as members of inter-disciplinary teams discuss the ‘what and why’ of the work we do.

Intersectoral collaboration that crosses professional and organizational boundaries is also needed to improve homeless youth health. This can be achieved in two main ways: increased communication amongst existing practitioners and creating purpose-driven
positions to foster greater understanding of the ‘big picture’ strengths and limitations within the current health care system. Where individual practitioners and organizations can sometimes face challenges in balancing their immediate work demands with broader scale advocacy work, people and positions are needed that can act as a bridge between the frontline and those systems-level influences that shape our health care and social services.

Similar findings apply to the research community. Greater partnerships are needed between academic researchers and front-line practitioners and between researchers themselves. For example, while a growing wealth of research exists on how to improve primary health care services for adult marginalized populations, few partnerships have developed amongst researchers to tailor these findings to youth-serving organizations. Similarly, while individual organizations may pursue quality improvement initiatives, there is a lack of peer reviewed academic research on the topic of homeless youth’s access to health care that includes both youth and practitioner voices. Such research and partnerships could inform the direction of the primary health care service delivery system in Canada, which could in turn inform the direction of the research.

5.4 Conclusion

Youth who are experiencing homelessness face unique influences on their health. Much can be done to help facilitate their access to health care services and thus, to enhance their ability to achieve healthy outcomes. Youth in such circumstances may benefit from a health care system that offers service providers specialized training and resources and one that empowers youth experiencing homelessness to seek care when they need it. Such changes can happen in two main ways: from within by individual nurses and on a broader, systemic scale by amending existing policies and programs.
References


*Health Services Research, 9*(3), 208-220.


Bureaucracy. (n.d.) In *Merriam-Webster’s dictionary (Web)*. Retrieved from:


Canada Health Act (CHA) (1985, c C-6). Retrieved from The Canada Legal Information Institute website:


Medical and Health Care Services Regulation (MHSCR) (2014). Retrieved from the Queen’s Printer BC website:


Appendices

Appendix A: Stage 1: Youth Recruitment Poster

WE WANT TO HEAR WHAT YOU HAVE TO SAY!

In the past 12 months, have you thought you needed health care (whether you got it or not)?

Are you: 14-19 years old? Been street-involved or homeless for at least 3 days in the past 12 months? Got 30-60 minutes to spare?

If so, a UBC Grad Student Researcher would love to hear about your experience getting (or trying to get) health care.

For more info, please call Claire at or e-mail at

UBC

"Note: People who take part will receive $20 cash as a thanks for your time"
Appendix B: Stage 1: Youth Consent Form

Study: Street Involved and Homeless Youth Access to Primary Health Care Services: What Helps and What Gets In the Way?

Information Sheet

Principal Investigator: Dr. Elizabeth Saewyc, Professor, UBC School of Nursing

Graduate Student Researcher: Claire Pitcher, RN

Co-Investigators: Dr. Annette Browne, Dr. Patricia Rodney, UBC School of Nursing

In 2014, the McCreevy Center Society did a survey with street-involved and homeless youth from across British Columbia. At that time, 1 in 4 youth said they needed health care in the previous year but didn’t get it. As a Graduate Student and researcher, I would like to learn more about what helps and what hurts street-involved and homeless youth’s chances of getting the health care services they need.

Purpose: You are being invited to participate in a research interview to talk about your experiences getting health care services since you’ve been street-involved or homeless.

Who Can Participate: You can participate if you are:

- Age 14 to 19
- Street-involved (have been homeless or couch-surfed or been involved in the street lifestyle at least 3 days in the past year)
- Needed health care during the past year – even if you didn’t end up getting the care you needed (examples: needed a prescription refill, a check-up with a doctor or nurse etc.)
- Can read, speak and understand English

What you will be asked to do: If you agree to participate, you will have an interview with a researcher that will last up to 60 minutes. This interview will happen when and where you are most comfortable (it could be a room at a public library or community center, at a quiet coffee shop, a private space at a youth shelter etc.) The interview will be recorded and then written down later. You will be asked questions about your experiences getting or trying to get health care. For example:

- Please tell me about a time in the past year when you needed health care.
- Were you able to get health care when you needed it?
Study: Street Involved and Homeless Youth Access to Primary Health Care Services: What Helps and What Gets In the Way?

Possible Benefits and Risks: While there are no direct benefits for participating in this study, you will have the opportunity to talk about your experience, and help possibly improve health care services for street-involved youth. To reimburse you for your time, you will receive $20 in cash to acknowledge the work and time required to participate in an interview.

A risk of participating in this study is that you may feel awkward talking about your experiences. You can refuse to answer any question you do not want to, and can stop the interview at any time.

Confidentiality: Personal records in this study will be kept confidential and private. There are a few times I would not be able to keep your information private: if you tell me that you are being abused, or that you are thinking about hurting yourself, or you are planning to hurt someone else, I have to report this, to help keep you and others safe. Any research data collected about you during this study will not identify you by your name, only by a code number. Your real name will not be disclosed to anyone beyond the research team. Your name will not be said or recorded once the interview has started. Any report published as a result of this study will not identify you by name. All recorded interviews and transcribed interviews will be stored securely and separately from any contact information to ensure confidentiality. All data, including audio-recordings will be securely stored for at least 5 years and then destroyed.

Voluntary Participation: You can decide to participate or not, and you are free to refuse to answer any question, stop the interview, or withdraw from the research study at any time. Your access to services or involvement with UBC will not be affected in any way if you choose not to participate.

Want to know more? Want to participate? Call Claire (Graduate Student) at ______________ or email at ______________

You may also contact the Principal Investigator for this study:
Dr. Elizabeth Saewyc

Who can you contact if you have complaints or concerns about the study? If you have any concerns or complaints about your rights as a research participant and/or your experiences while participating in this study, contact the Research Participant Complaint Line in the UBC Office of Research Ethics at 604-822-8598 or if long distance e-mail RSIL@ors.ubc.ca or call toll free 1-877-822-8598.

To Consent to This Study, complete the next page.
Research Consent Form (Participant ID #: _________)

Study: Street Involved and Homeless Youth Access to Primary Health Care Services: What Helps and What Gets In the Way?

Contact Person: Claire Pitcher (Graduate Student Researcher)
Principal Investigator: Dr. Elizabeth Saewyc

Part 1

Do you understand that you have been asked to be in a research study? □ Yes □ No

Have you read and received a copy of the attached information sheet? □ Yes □ No

Do you understand the benefits and risks involved in taking part in this research study? □ Yes □ No

Were you able to ask questions and discuss this study? □ Yes □ No

Do you understand that you are free to stop the study at any time without having to give a reason? □ Yes □ No

Has confidentiality been explained to you? □ Yes □ No

Who explained this study to you? ____________________________

Part 2

Research Participant Name (Printed) ________________________________

Research Participant Signature ________________________________

Interviewer Signature ________________________________

Receipt of Honorarium

I confirm that after signing this consent form, I received a $20 cash honorarium to acknowledge the work of being interviewed. □ Yes □ No

THE INFORMATION SHEET MUST BE ATTACHED TO THIS CONSENT FORM AND A COPY GIVEN TO THE RESEARCH PARTICIPANT

v.3: 15-Oct-2015

page 1 of 1
Appendix C: Stage 1: Participant Enrolment Log

<table>
<thead>
<tr>
<th>Date</th>
<th>Last Name</th>
<th>First Name</th>
<th>PID</th>
<th>Honorarium Given (Y/N)</th>
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<tbody>
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Appendix D: Youth Interview Demographics Form

<table>
<thead>
<tr>
<th>Demographics Questions</th>
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</thead>
<tbody>
<tr>
<td>How old are you?</td>
</tr>
<tr>
<td>□ 14 years old</td>
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<tr>
<td>□ 15 years old</td>
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<tr>
<td>□ 16 years old</td>
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<tr>
<td>□ 17 years old</td>
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<tr>
<td>□ 18 years old</td>
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<tr>
<td>□ 19 years old</td>
</tr>
</tbody>
</table>

| Are you...             |
| □ Male                 |
| □ Female               |
| □ Transgender          |
| □ Another: ____________ |

<table>
<thead>
<tr>
<th>What is your background?</th>
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<tbody>
<tr>
<td>(Mark all that apply)</td>
</tr>
<tr>
<td>□ Aboriginal</td>
</tr>
<tr>
<td>□ African (Kenyan, Ugandan, etc.)</td>
</tr>
<tr>
<td>□ European (British, Irish, German, Dutch, Ukrainian, Italian, Russian, etc.)</td>
</tr>
<tr>
<td>□ East Asian (Chinese, Japanese, Korean, etc.)</td>
</tr>
<tr>
<td>□ South Asian (East Indian, Pakistani, Sri Lankan, etc.)</td>
</tr>
<tr>
<td>□ Southeast Asian (Cambodian, Filipino, Indonesian, Vietnamese)</td>
</tr>
<tr>
<td>□ West Asian (Afghani, Iranian, Arab, Kazakhstani, etc.)</td>
</tr>
<tr>
<td>□ Latin American, South American, Central American</td>
</tr>
<tr>
<td>□ Caribbean (Jamaican, Trinidadian, etc.)</td>
</tr>
<tr>
<td>□ Australian, Pacific Islander</td>
</tr>
<tr>
<td>□ Other, specify: ____________</td>
</tr>
<tr>
<td>□ Don't know</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>People have different descriptions about themselves when it comes to being attracted to other people. Which of the following best describes your feelings?</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Completely heterosexual (straight; attracted to people of the opposite sex)</td>
</tr>
<tr>
<td>□ Mostly heterosexual</td>
</tr>
<tr>
<td>□ Bisexual (attracted to both males and females)</td>
</tr>
<tr>
<td>□ Mostly homosexual</td>
</tr>
<tr>
<td>□ Completely homosexual (gay/lesbian; attracted to people of the same sex)</td>
</tr>
<tr>
<td>□ Questioning (I'm questioning who I'm attracted to)</td>
</tr>
<tr>
<td>□ I don't have attractions</td>
</tr>
</tbody>
</table>
## Study: Street Involved and Homeless Youth Access to Primary Health Care Services: What Helps and What Gets In the Way?

<table>
<thead>
<tr>
<th>Before you were street involved/homeless, where did you come from</th>
</tr>
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<tbody>
<tr>
<td>□ Vancouver</td>
</tr>
<tr>
<td>□ North Vancouver</td>
</tr>
<tr>
<td>□ Burnaby</td>
</tr>
<tr>
<td>□ Surrey</td>
</tr>
<tr>
<td>□ Elsewhere in British Columbia</td>
</tr>
<tr>
<td>□ Elsewhere in Canada</td>
</tr>
<tr>
<td>□ Other, specify: _________________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How old were you when you first became homeless?</th>
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</thead>
<tbody>
<tr>
<td>□ Less than 9 years old</td>
</tr>
<tr>
<td>□ 9 years old</td>
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<tr>
<td>□ 10 years old</td>
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<tr>
<td>□ 11 years old</td>
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<td>□ 12 years old</td>
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<td>□ 19 years old</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Form Completed</th>
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</thead>
<tbody>
<tr>
<td>□ At the start of the interview, by the participant</td>
</tr>
<tr>
<td>□ At the end of the interview, by the participant</td>
</tr>
<tr>
<td>□ At the start of the interview, with the interviewer</td>
</tr>
<tr>
<td>□ At the end of the interview, with the interviewer</td>
</tr>
</tbody>
</table>
Appendix E: Stage 1 Semi-Structured Youth Interview Script

Hi there, my name is Claire and I’m a graduate student nurse from the University of British Columbia. I’m here today to chat with you today about your experiences getting or trying to get health care.

So, it sounds like you saw a poster talking about the project we’re doing and you got in touch with us to let us know you’d be comfortable talking to us?

That’s great! Have you had the chance to look over the consent form at all that tells you a bit about the project and what it will mean for you to be part of it? Okay, I have a copy here that we can go over together and then I can answer any questions you may have. Before we even get to the consent form though, do you have any questions for me right now? [Review the consent form & invite the participant to sign the bottom.]

As the consent form said, I’m going to be recording our conversation using this [motion to audio recorder.] I’m just going to double check to make sure it’s on. Also – I know that sometimes people can feel a bit uncomfortable knowing their voice is being recorded. I just want you to know that the only people who will listen to the recording will be me and a few other researchers like me who are working on this project. We’re interviewing a few people just like you but all of your answers will be kept really private. If we do mention the interviews in our final project, we’ll be talking about topics we heard people talk about or, if we do use any direct quotes, we’ll make sure we take out any information that might mean someone could identify who said what. Does that make sense? Any questions about that?

Also, because your answers will be kept very private, I hope you’ll feel comfortable answering honestly. I’m interviewing a number of people just like you and I most likely don’t work directly with any of the organizations or people you may mention. My hope is just to understand more about what your experience was like and to understand, from your perspective, what worked and what maybe didn’t work when you’ve tried to get health care in the past year. So, please feel free to be honest with your answers and if anything is unclear or if you want to skip any questions or come back to any questions, just let me know and that’s totally okay. Also, if you want to end the interview at any point or to take a break, just let me know and that’s totally okay. Depending on how detailed your answers are and things like that, I’m expecting the interview to take anywhere from a few minutes up to 45 minutes. Does that sound good?

As part of the interview, I have to gather some information from you about your age, gender and stuff like that. I have short form I’ll ask you to fill out that asks for that info. Just a reminder that all of this information is kept private and you won’t even write your name on the form. Would you prefer to answer those questions now or at the end of the interview? And, do you want me to go through them with you or would you prefer to do it on your own? Either way works for me!

Any questions before we begin?
Appendix F: Expert Consultation Invitation E-mail Template

My name is Claire Pitcher, I’m a Graduate Student with the UBC School of Nursing and Dr. Elizabeth Saewyc is my thesis supervisor. Please accept this invitation to participate in a one-time, 60-minute expert consultation on homeless youth access to health care services in British Columbia.

My Masters thesis is titled, “Street Involved and Homeless Youth Access to Primary Health Care Services: What Helps and What Gets In the Way?” This project has 3 stages of data collection. First, I interviewed 8 Lower Mainland homeless youth. Second, I conducted further analysis of existing data from the 2014 McCreary Homeless and Street Involved Youth Survey. Lastly, I am holding a small expert consultation.

The Consultation: I have selected you as a potential participant based on my working knowledge of this field and/or based on recommendations from other experts in the field. The purpose of the consultation is to generate solutions-focused conversations about my research findings and what could make it easier for homeless youth to get health care services in British Columbia. The consultation will include a brief presentation of my research findings followed by facilitated conversation amongst the 5 participants.

Where/When: The consultation will occur on Tuesday Nov 1st from 12:30pm to 1:30pm. It was be held at the Robert and Lily Lee Community Health Center in Room 246 (1669 East Broadway). I can meet participants in the main lobby of the building at 12:25pm to lead you upstairs.

Providing Consent: Please reply to this e-mail by Friday October 25 to let me know if you would like to participate. If you would like to participate, I will send you a copy of the consent form to review and sign as well as a brief summary of my results which you can review before the session if you have time.

Questions: If you have any questions about the study or about your participation, please don’t hesitate to contact me by e-mail at: claire.pitcher@ubc.ca

Sincerely,

Claire Pitcher,
Graduate Student
UBC School of Nursing
Appendix G: Expert Consultation Consent Form

Information Sheet

Principal Investigator: Dr. Elizabeth Saewyc, Professor, UBC School of Nursing

Graduate Student Researcher: Claire Pitcher, RN

Co-Investigators: Dr. Annette Browne, Dr. Patricia Rodney, UBC School of Nursing

In 2014, the McCreary Center Society did a survey with street-involved and homeless youth from across British Columbia. At that time, 1 in 4 youth said they needed health care in the previous year but didn’t get it. As a Graduate Student and researcher, I would like to learn more about what helps and what hurts street-involved and homeless youth’s chances of getting the health care services they need.

Purpose: You are being invited to participate in a one-time expert consultation with fellow professionals/service providers. The purpose of this consultation is to draw on participants’ expertise regarding my Masters thesis research findings and to generate solutions-focused conversations about what could make it easier for homeless and street-involved youth to access health care services.

Who Can Participate: You can participate if you:

☐ Are a professional/service provider involved in delivering or planning health care and allied support services for street-involved and homeless youth

☐ Are able to attend a one-time 60 minute expert consultation group

☐ Can read, speak and understand English

What you will be asked to do: If you agree to participate, you will attend an expert consultation with 4 other health care/allied service providers. This consultation will be scheduled at a mutually agreeable time and location and will last up to 60 minutes. Prior to the consultation, I will e-mail you a brief summary (3 pages, point form) of my results. If you have time prior to the consultation, you can review this information. At the consultation, I will present a summary of my research findings. You will then be invited to engage in a facilitated discussion and to share your reactions to the data. Participants will also be encouraged to share ideas for what could make it easier for homeless youth to get health care. The consultation will not be audio recorded. I will take notes, visible to
the group on flip-chart paper, during the consultation. Examples of questions you may be asked include:

- What if any anything from the findings stands out to you? If so, what and why is that important?
- If you had a magic wand, what changes could make it easier for homeless and street-involved youth to get health care services?

**Possible Benefits and Risks:** While there are no direct benefits for participating in this study, you will have the opportunity to share your expertise and possibly help improve health care services for street-involved youth. To thank you for your time, you will receive $20 in cash to acknowledge the work and time required to participate in the consultation. There will also be light refreshments provided during the consultation.

There are no anticipated risks associated with participating in this study.

**Confidentiality:** Personal records in this study will be kept confidential and private. Your real name will not be disclosed to anyone beyond the research team. Your name will not recorded in any of the notes taken during the consultation. Any report published as a result of this study will not identify you by name. Any notes resulting from the meeting will be stored securely and separately from any contact information to ensure confidentiality. All data will be securely stored for at least 5 years and then destroyed.

**Voluntary Participation:** You can decide to participate or not, and you are free to refuse to answer any question or withdraw from the research study at any time.

Want to know more? Want to participate?
Please email the graduate student researcher:

You may also contact the Principal Investigator for this study:
Dr. Elizabeth Saewyc

Who can you contact if you have complaints or concerns about the study? If you have any concerns or complaints about your rights as a research participant and/or your experiences while participating in this study, contact the Research Participant Complaint Line in the UBC Office of Research Ethics at 604-822-8598 or if long distance e-mail RSIL@ors.ubc.ca or call toll-free 1-877-822-8598.

To Consent to This Study, complete the next page.
Study: Street Involved and Homeless Youth Access to Primary Health Care Services: What Helps and What Gets In the Way?

Research Consent Form

Contact Person: Claire Pitcher (Graduate Student Researcher)  Principal Investigator: Dr. Elizabeth Saewyc

Part 1
Do you understand that you have been asked to be in a research study? □ Yes □ No

Have you read and received a copy of the attached information sheet? □ Yes □ No

Do you understand the benefits and risks involved in taking part in this research study? □ Yes □ No

Were you able to ask questions and discuss this study? □ Yes □ No

Do you understand that you are free to stop the study at any time without having to give a reason? □ Yes □ No

Has confidentiality been explained to you? □ Yes □ No

Who explained this study to you? ____________________________

Part 2
Research Participant Name (Printed) ____________________________

Research Participant Signature ____________________________

Interviewer Signature ____________________________

Date ____________________________

THE INFORMATION SHEET MUST BE ATTACHED TO THIS CONSENT FORM AND A COPY GIVEN TO THE RESEARCH PARTICIPANT
Appendix H: Expert Consultation Summary of Findings Handout

Stage 3 Expert Consultation Summary of Results Handout

Thesis Title: Street Involved and Homeless Youth Access to Primary Health Care Services: What Helps and What Gets in the Way?

Research Project: I interviewed 8 youth who were experiencing homelessness from across the Lower Mainland. I also analyzed health care related questions from the 2014 B.C. Homeless and Street-Involved Youth Survey.

Research Findings (Youth Interview Themes & Quotes)

| Theme 1: Homeless youth feel powerless when interacting with health care providers |
|-------------------------------------------------
| One youth was admitted to a large, urban hospital with pneumonia and broken ribs. She spent 5 days on a medical unit before leaving against medical advice. She left because she missed her boyfriend who she had not been able to speak with during her hospital stay. As she explained, “I kept asking them [the nurses] questions and they kept brushing me off like ‘Oh yah, whatever.’ And I kept asking them if they could like, if anyone could call my boyfriend cuz I didn’t have a phone and I didn’t have money for a payphone. […] The health care team assumed [cuz her parents aren’t here, it must not be that big of a deal. Like, stupid shit like that.” (Female, 19 years old)
| One participant ‘justified’ poor treatment by health care providers before catching and correcting herself, saying, “Like, you’re 17 years old, you’re on the streets, you don’t know how to talk to a health care professional or whatever. And sometimes they’re, they’re not patient. They aren’t. Like, it’s not their job to be patient with you or whatever. I guess it is though <laughs>.” In this interview, faced with these conflicting views, the youth simply laughed off the comment and moved on. (Female, 19 years old.)
| One youth further justified poor treatment by health care providers, saying, “Some of the people [working in the hospital] were rude, I’m not going to lie. Because I guess they’ve been working there for so long they’re just, like, bored of their job. […] To be honest, I don’t blame them. Everybody is like that at their job. When you have a long day at work, I don’t think you have time to splash smiles for people, to be honest with you.” (Male, 18 years old)

| Theme 2: The health care system is a ‘rule-based’ bureaucracy |
|-------------------------------------------------
| “It’s hard for some of these girls on the streets to like find the right meds for whatever they’re dealing with. Because, first of all, most of them cost money and most of them don’t have coverage. And so, that’s just the first step” (Female, 19 years old.)
| When describing her departure from the hospital against medical advice, one participant said her health care team, “pretty much said, ‘We’re washing our hands…if you sign this piece of paper, sign yourself out of the hospital, we’re washing our hands of you. We’re done. Not liable.’ That’s all they care about” (Female, 19 years old.) The message she received loud and clear was that if she ‘broke the rules’ she no longer ‘deserved’ care.
| One youth described the challenges she faced after her MSP lapsed when she transitioned from a Youth Agreement to Income Assistance. Because she was not able to ‘follow the rules’ of the health care system (eg, present proof of MSP coverage or pay for
Stage 3 Expert Consultation
Summary of Results Handout

medical services), she was faced with the prospect of having to pay out-of-pocket to terminate an unplanned pregnancy. In her own words, when asked what influences her access to health care she said, “Just like, not having income or anything. Like, the struggle of like, having to pay for your own medication. Cuz like I hadn’t really realized, like, how much abortions are. And that you have to pay for it” (Female, 19 years old). She described trying to pick up odd jobs to cover the cost of the abortion before ultimately waiting for her MSP coverage to be reinstated.

“You shouldn’t need a health card to be healthy” (Male, 18 years old).

“I feel like the whole, just, way to make appointments and way to like get a doctor or get a nurse practitioner is just not quite as accessible or as understandable for people my age. Like, we just don’t know how to do it. Like, we’re homeless <laughs>. Just need a little bit of extra help” (Female, 19 years old.)

“I was connected with my parents so they would help me pay for like medicine and stuff because my mom has like health coverage. […] I’m not sure how I would go about it if I did [need health care now]. I have a BC Services Card so I have like a health number but I don’t know how far that, like, can get me” (Male, 19 years old)

**Theme 3: Homeless youth are in ‘survival mode’ when it comes to their health**

One youth had a severe leg injury which became infected. He was unable to get treatment as he had recently moved to B.C. and did not have MSP coverage. Ultimately, a youth worker advocated for him to receive no-cost I.V. antibiotic treatment. When asked if anything made him feel (un)comfortable during that whole experience, he said, “The fact that I thought I was going to lose my leg [made me uncomfortable]. Other than that, no. […] I wasn’t even in a state of mind to be looking at the comfortability of my surroundings. I was really dealing with a big injury.” After further conversation, he identified that the youth worker helped him to feel more comfortable while in hospital, saying, “[they] made me feel that I’m not alone. Like, it’s not only me. Basically, it was someone to rely on” (Male, 18 years old.) At first glance and in many ways, this youth was so busy surviving, he felt little else mattered beyond saving his limb.

One youth, discussing whether anything helped her to feel ‘more comfortable’ when accessing health care, simply said, “There isn’t really ‘more comfortable’. You’ve just gotta get it over with. […] Actually, I think we all try not to [seek health care] if we don’t have to cuz like, if it’s avoidable, avoid the fuck out of it.” (Female, 19 years old).

One 19 year old male "chose" to not seek medical attention for a chest infection after being told the shelter nurse where he was staying was on leave and the nearby walk-in clinic had a 2+ hour wait. Unable to face the prospect of sitting in a waiting room for that long while feeling so ill, he said, “I just pretty much just dropped it and just like, tried, like, deal with it on my own. Right? So, yah.” (Male, 19 years old.) He never did get medical attention although eventually the infection cleared on its own. Essentially, he used his albeit limited resources (access to shelter, usual good health) to survive.
2014 Homeless Street Involved Youth Survey: Summary of Findings

- Just over a quarter (26%) of participants reported foregone care (needing health care but not getting it for a variety of reasons)
- There was an association between youth who reported foregone care and:
  - Living situation (e.g., precarious living conditions were linked to higher rate of youth reporting foregone care)
  - Self-reported discrimination related to their presumed race, gender, physical disability, amount of money they or their family have, homelessness, and being perceived as ‘different’
- There was NOT an association between youth who reported foregone care and their:
  - Age
  - Gender
  - Sexual orientation
  - Owning a Care Card
  - Perceived discrimination based on sexual orientation or being on income assistance

Note: The questions about discrimination were not specifically about discrimination in a health care context. However, I hypothesized that perceived discrimination, even outside of health care, may influence rates of reported foregone care.

Conclusion: These findings suggest that it may not just be individual factors such as a youth’s demographics (e.g., age, gender, sexual orientation etc.) that are associated with foregone care. Rather, individual factors are confounded by more systemic factors, such as discrimination and access to stable shelter (e.g., the precariousness of their housing), that are associated with foregone care.

**Expert Panel Discussion Questions**

1. How do the findings described reflect (or not reflect) your experience working with street-involved/homeless youth? Are there important aspects of your experience that are not reflected in the findings above?
2. What if anything from the findings stands out to you? If so, what and why is that important?
3. If you had a magic wand, what changes could make it easier for homeless and street-involved youth to get health care services?
4. How can the findings from this study be put to “good use”? 