

Access to Primary Health Care Services for Youth Experiencing Homelessness: “You shouldn’t need a health card to be healthy.”

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Abstract

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 (Gaetz, Dej, Richter, & Redman, 2016). This study explores influences on primary health care access among youth experiencing homelessness in a large Canadian urban centre. Using a qualitative research design and critical social justice lens, eight youth participated in individual interviews and four expert clinicians participated in a facilitated, solution-focused dialogue about access to primary health care services for youth experiencing homelessness. Themes identified were: (1) Youth experiencing homelessness feel powerless when interacting 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 accessing health care services. The authors offer recommendations to foster equitable access to primary health care services for youth experiencing homelessness.

Key Words: Homeless, Youth, Access, Primary Health Care, Nursing, Critical, Social Justice

Introduction

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 (Gaetz, Dej, Richter, & Redman, 2016). Here, we are using the term “youth” in the way the World Health Organization (2014) defines it, as young people generally within the ages of 15 through 24. Our use of the term includes young people of all genders and includes both adolescents and young adults.

Lack of housing and its related harms violate young peoples’ fundamental survival and protection rights, guaranteed under the United Nations Convention on the Rights of the Child (UNCRC, 1989) including Article 3, the right to “such protection and care as is necessary for his or her well-being” (p. 2); Article 27, the right to an adequate standard of living, including adequate nutrition, clothing and housing; and Articles 34 through 37, the right to be safe from various types of violence and exploitation, including sexual and physical abuse, and cruel and degrading treatment. When their survival and protection rights are not supported,

young people experiencing homelessness face significant health inequities, including mental health challenges and substance use problems (Rew, 1996; Smith et al., 2015).

Health care systems have a further social justice obligation that may be unmet for youth experiencing homelessness; Article 24 of the UNCRC (1989) requires “the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care” (p. 7), yet the Canadian Pediatric Society has stated that “inadequate 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. 317). Moreover, youth experiencing homelessness continue to be affected by systemic oppression where racialized and lesbian, gay, bisexual, transgender, queer, questioning and two-spirit (LGBTQ2S+) young people are over-represented among populations of youth experiencing homelessness (Smith et al., 2015). For example, a study of youth experiencing homelessness in British Columbia, Canada found that 53% of participants identified as Indigenous (Smith et al., 2015), while only 5.9% of the province’s total population identify as Indigenous (Statistics Canada, 2017). Consistent with accepted terminology used in landmark international reports, the term ‘Indigenous people’ is used to refer to the diversity of populations throughout the world. In Canada, ~1.7 million people of the total population of ~34.5 million (4.9%) identify as Indigenous (Statistics Canada, 2019), including First Nations, Metis, and Inuit people. The term Aboriginal is also commonly used, and the colonial term ‘Indian’ is still used in federal government policy documents (e.g., The Indian Act). Research has also shown that LGBTQ2S+ youth experience high rates of violence at home and are often forced into homelessness as a result (Price, Chanchan, Wheeler, Seip,

& Rush, 2019). Such statistics highlight how colonization, racism, homophobia and transphobia underlie some of the reasons that youth in Canada experience homelessness, and how these forms of oppression further affect their health and access to health care services.

Without access to equity-oriented primary health care services, youth experiencing homelessness will often wait until they are critically ill before seeking care, which further perpetuates and entrenches illness (Busen & Engebretson, 2008; Ensign & Panke, 2002; Nicholas et al., 2015). Browne et al. (2018) define ‘equity-oriented health care’ as an approach that aims to reduce: “the effects of structural inequities [...] that sustain health inequities; the impact of multiple and intersecting forms of racism, discrimination and stigma [...] on people’s access to services and their experiences of care; and the frequent mismatches between dominant approaches to care [...] and the needs of people who are most affected by health and social inequities” (p. 2). Creating and providing such primary care services are well within the purview of critically- and equity-oriented nurses, given that, for example, the Canadian Nurses Association Code of Ethics (2017) specifically addresses matters of equity and social justice.

Creating equity-oriented services demands an awareness of the socio-political context within which the Canadian health care system exists given it “has become increasingly clear over the years...that spending more money on health-care without addressing the root causes of health and illness will do little to shift the overall health of our populations” (Browne & Tarlier, 2008, p. 87). Addressing these root causes requires us to assess how political agendas such as neoliberalism impact our current health care system. The main features of neoliberalism include emphasizing small government, reducing social programs, and emphasizing individual

responsibilities for poverty, homelessness, unemployment, and poor health, for example (Browne & Tarlier, 2008). Such approaches to health care design and delivery can overlook and ultimately systematically disadvantage those members of our population who are the most targeted, including youth experiencing homelessness. The purpose of this paper is to explore the question: How do social and structural factors influence the experiences of youth experiencing homelessness accessing primary health care in a large urban centre in British Columbia? The term 'primary health care services' refers to any first point of contact between an individual and a health care provider, including a walk-in clinic or the Emergency Room (Canada, 2012).

A variety of research has documented youth experiencing homelessness as a population with unique health care needs. For example, one study with 95 youth ages 15 to 25 years old in Houston, Texas, determined that lengthier stays on the street resulted in poorer health outcomes (Busen & Engebretson, 2008). Several national studies in the United States and Canada have reported that youth experiencing homelessness face higher than average rates of health issues, such as: respiratory problems, including asthma; dental disease; dermatological problems, including lice, scabies, acne, and infection; foot problems; injuries; sexually transmitted infections; and unplanned pregnancies (Dawson & Jackson, 2013; Elliott, 2013; Ensign & Santelli, 1997; Nicholas et al., 2015; Rew, 1996). Many studies have also found that despite this increased need for health care, many youth experiencing homelessness forgo health care until they can no longer manage the health issue(s) on their own (Dawson & Jackson, 2013; Ensign & Panke, 2002; Ensign & Santelli, 1997; Nicholas et al., 2015). Much of the existing literature is focused on individual reports of biomedical pathologies or behavioural-based reasons for forgoing care, rather than critiquing the health care

system's lack of responsiveness to homelessness overall (Barker, Kerr, Nguyen, Wood, & DeBeck, 2015; Reid, Berman, & Forchuk, 2005). Existing literature often fails to acknowledge how the effects of structural oppression such as poverty, racism, and colonization can intersect such that the burden of illness is shouldered more heavily by certain populations than others (Barker et al., 2015). Canadian researchers increasingly draw attention to the structural barriers impacting youth who experience homelessness, and in particular, the impact on access to primary health care services, such as: inability to obtain a services card without a permanent address, lack of dental and vision care, and limited knowledge about the individual 'cost' of health care in Canada, for example, which services and medications are covered under provincial health care plans and which are not (Barker et al., 2015; Haldenby, Berman, & Forchuk, 2007; Klodawsky, Aubry, & Farrell, 2006; Reid et al., 2005). A 'services card' is a government-issued card that a person in Canada must present in order to access universal, taxpayer funded health care services. One Canadian study found that while 90% of youth experiencing homelessness expressed an interest in getting an eye exam, only 17.8% had visited an optometrist or ophthalmologist in the past year (Noel et al., 2016). Another Canadian study with people who were vulnerably housed or experiencing homelessness found that participants of all ages, not just youth, "identified a [health care] system [in Canada] that was...designed for a perceived middle-class population" (Purkey & MacKenzie, 2019, p. 5) examples of which include services predicated on people having a fixed address, never being late for or missing appointments, and not needing a harm reduction approach in the context of substance use.

To further address gaps in the literature, the theoretical perspective informing this study is *critical social justice* (Anderson et al.,

2009; Browne & Tarlier, 2008; Browne & Reimer-Kirkham, 2014; Reimer-Kirkham & Browne, 2006). As Browne and Tarlier (2008) describe, a “critical social justice lens raises morally significant questions, for example, why certain individuals and groups bear a disproportionate burden of illness and suffering” (p. 85). Critical social justice perspectives are informed by critical theories such as postcolonial feminist theory and they “take into account the structural inequities - the ‘causes of causes’ – of health and social inequities” (Browne & Reimer-Kirkham, 2014, p. 24). This approach enabled the researchers of this current paper 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, the researchers strove to identify those broader social and political forces which shaped people’s experiences such as power, control and bureaucracy. Likewise, rather than describing youth experiencing homelessness as a single, homogeneous population, we questioned how systemic discrimination and structural oppression based on such factors as class, ethnicity, and sexual orientation may intersect to further marginalize certain homeless youth over others (Anderson et al., 2009; Browne & Reimer-Kirkham, 2014; Reimer-Kirkham & Browne, 2006). In this regard, the current study draws on the works of Browne and Reimer-Kirkham (2014) and Anderson et al. (2009) which address how power dynamics in both policy-level and everyday frontline care decisions create inequities by (in)formally labeling marginalized people as ‘Other’. “Unmask[ing] and disrupt[ing] the processes that underpin the construction of ‘other’ ” (Anderson et al., 2009, p. 283) becomes an integral part of challenging those inequities, and a foundation for this current paper.

Methods

This study, which included individual interviews with eight youth and a facilitated solution-focused dialogue with four expert clinicians who work with youth, was part of a larger mixed methods study on access to primary care among youth experiencing homelessness (Pitcher, 2016). The study was guided by Interpretive Description (Thorne, 2008), a methodology meant to “help the reader grapple intelligently with the ‘how to’ in conjunction with the ‘why’” (p. 36). This methodology guided decisions such as how much literature to review prior to entering the field, and how to integrate critical theoretical perspectives in a meaningful way. It is important to note that Thorne’s (2008) methodological approach in Interpretive Description supported the integration of a theoretical framework such as critical social justice. Strategies that helped ensure rigour in this study included using multiple data collection methods, discussing findings with the research participants, and attuning to the influence of power and oppression. The credibility of the analysis was continually evaluated and discussed among the research team members, which included researchers with expertise in adolescent health, primary health care and equity-oriented health care services. Trustworthiness of the analysis was established by triangulating the data using three data sources: youth interviews; a solution-focused dialogue with expert clinicians; and a focused analysis of existing survey data (not included in this current paper). Throughout, records were also kept of analytical insights and decisions.

Youth Interviews

Convenience sampling was used to recruit eight youth experiencing homelessness to participate in one-time, semi-structured interviews. Inclusion criteria were: 14 to 19 years old, self-identified as experiencing homelessness for at least three days in the

past year, English-speaking, and needed health care in the past 12 months. Youth were recruited using posters and word of mouth at two local youth drop-ins and shelters, where they were invited to contact the research team in person, via telephone or e-mail. To facilitate in-person communication, the lead author attended several drop-in hours at these services where staff assisted in connecting interested participants with the researcher using face-to-face introductions.

Each youth interview occurred at a time and place selected by the participant, to empower them to choose an environment that felt 'natural,' as is recommended with Interpretive Description (Thorne, 2008). Initially, all potential participants were asked to take at least 24 hours to review the consent form before agreeing to participate in the study. However, after several youth identified this as a barrier to participating in the study, the lead author increased the amount of time spent at the drop-ins, ensured printed study information was always accessible at the drop-ins, and offered youth the opportunity to hear about and agree to participate in the study within the same day. At the beginning of each youth interview, participants were provided a paper copy of the consent form and invited to first review the information on their own or the researcher and youth could review it together, to support youth who may struggle with literacy. The consent form was then reviewed in-depth by the researcher with each youth in a private and quiet setting to ensure the youth understood the nature of the study, and could ask questions before providing verbal and written consent to participate in the study. Two copies of the consent form were signed: one for the participant's and one for the researcher's records.

Youth were provided with a \$20 cash honorarium to acknowledge the work of being interviewed. This amount was

selected as it is similar to honoraria provided by other local studies and thus would not be considered coercive nor exploitative. Providing cash rather than a giftcard empowered participants to spend the money how and where they chose. The honorarium was provided immediately after the consent form was signed rather than waiting until the interview was completed, 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.

Basic demographic information for each youth was captured using a written form to be completed independently or with the assistance of the researcher at the beginning or end of each interview based on the youth's preference. This approach acknowledged the sensitive nature of some of these questions while co-creating with participants how the interview would proceed. Interviews were conducted between January and April 2016. They were digitally recorded along with brief written researcher's notes captured on a standard template. All interviews were based on a set of questions and concluded with the interviewer summarizing her understanding of the youth's key points. This proved meaningful, as it allowed participants to hear their stories reflected back to them, which occasionally prompted further conversation or clarification. Interview questions were also added or altered as needed, such as asking for clarification of earlier comments.

Data from the youth interviews were transcribed verbatim, organized, and coded using NVivo software. Following Interpretive Description methodology (Thorne, 2008), the analysis initially began by assigning pre-prepared sticky note codes to assist with navigating the data. As the analyses progressed, the lead author used ongoing analytical memoing and

conversations with her co-researchers to ensure the analyses flowed clearly from the youths' experiences, while also incorporating a critical perspective on the structural constraints and the power dynamics their accounts revealed. Although initially the analysis hovered quite close to the data, subsequent passes moved towards more analytical and ultimately thematic codes.

Solution-Focused Dialogue with Expert Clinicians

The second part of this study was an in-person, solution-focused dialogue with health care and allied service providers such as nurses and counsellors who had expertise in working with youth experiencing homelessness and whom, for the sake of brevity in this paper, will be referred to as 'expert clinicians'. This group dialogue occurred in November 2016. While this dialogue followed many of the principles of a more formal focus group, it did not meet the threshold required to be considered a focus group with verbatim data collection and a fulsome coded analysis of the data. The decision to not hold a formal focus group was made as a more extensive study of provider perspectives was outside of the scope of this current project, and we prefer to privilege the voices of young people. However, including data from this dialogue was intended to generally introduce some perspectives of service providers in response to the findings, as other research has largely focused on either youth or service provider voices, not both. Limitations of this approach and suggestions for related future research are addressed in the discussion section of this paper.

Potential expert clinician participants were recruited in three ways: using purposive sampling; personalized e-mails based on the lead author's working knowledge of local services; and in partnership with the organizations where youth recruitment

occurred. Upon agreeing to participate in the research, four expert clinician participants were e-mailed a copy of the consent form, a summary of the findings from the youth interviews and the results of a focused analysis of an existing survey data set; the latter was not included in this paper. The four expert clinician participants and the lead author met face-to-face as a group at a mutually agreeable time and location. The expert clinician participants signed consent forms, received \$20 cash honorariums, and listened to a brief presentation by the lead author on findings from the youth interviews and survey data. The lead researcher then facilitated a dialogue with the expert clinicians focused on: (1) Whether the findings from the youth interviews and survey data reflected their professional experiences working with youth experiencing homelessness and (2) What solutions they would propose based on the findings and their professional experiences to help facilitate access to primary health care services for youth experiencing homelessness.

Participants' responses to guiding questions were captured by the lead author in bullet form on flipchart papers visible to the entire group. The intention of using this more informal approach (e.g., no audio recording; no secondary note taker), while still clearly framed as a form of data collection, was to encourage organic and spontaneous group discussion. Having the flipchart paper visible to all participants also offered a way to recap and confirm the interviewer's understanding of the conversation. The lead author also wrote field notes after the consultation to capture her initial reactions to the context and overall dialogue. Data from the solution-focused dialogue with expert clinicians, which included the flipchart papers and field notes, were then reviewed in-depth by the research team to identify main findings.

Findings

Youth Interviews

Eight youth participated in interviews (see Table 1 for demographic information). It is important to note that although the inclusion criteria spanned 14 to 19 years old, it was only possible to recruit youth between the ages of 18 and 19 years old, despite reaching out to several youth-serving organizations. At the time of study recruitment, for unknown reasons, the partnering organizations stated that very few ‘younger youth’ were accessing drop-in and shelter services. Excerpts from the data described below are presented in Tables 2 and 3.

Several of the youth described situations where they faced power differentials with health care providers that, although invisible, were felt acutely and affected the ways youth spoke, looked, acted and lived. For example, one participant, who was 19 years old, pregnant, and living in a shelter, stated that she preferred to access routine prenatal care in a busy, urban Emergency Room (ER) rather than with her 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 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 [...] They kind of conversate a little bit.”

Some youth also described feeling blamed for their homelessness. 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 f***ed [...] They treat you like a bag of shit” [Female, 19 years old]. Another youth ‘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 not patient. They aren’t. Like, it’s not their job to be patient with you or whatever. I guess it is, though...” [Female, 19 years old]. Reflecting on the conflicting views, this youth simply laughed off the comment and moved on. Another youth further justified poor treatment from health care providers, saying, “Some of the people [working in the hospital] were rude [...] To be honest, I don’t blame them [...] When you have a long day at work, I don’t think you have time to splash smiles for people” [Male, 18 years old]. A 19 year old woman reported that her boyfriend avoids health care for fear that he will have no input into his treatment plan, saying, “He can’t go out and get the help he needs [...] cuz they’ll put him in the Psych ward and they’ll put him on medication.”

Many youth also described being ineligible for basic provincially-funded medical and/or extended health coverage. 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, who was now pregnant, said after she turned 19 years old, she was no longer eligible to receive bus tickets from her local youth clinic to help her return to future appointments. This same participant described struggling now to afford transit, and occasionally having to make overnight arrangements to stay with friends or family to attend early morning midwifery appointments far from the shelter where she was currently living.

One youth left the hospital against medical advice while being treated for pneumonia and broken ribs, and she reported her health care team “pretty much said, ‘We’re

washing our hands...if you sign this piece of paper [...] we're done. Not liable.' That's all they care about" [Female, 19 years old]. Another youth described needing to forgo antibiotic treatment for a severe leg infection as he had recently moved between provinces in Canada, and thus was briefly ineligible for basic local health insurance. The infection worsened until a youth worker at a local shelter advocated for him to get medical treatment, despite not having health coverage. Speaking about the youth worker, this youth said, "[she] 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]. Another young person stated her health coverage lapsed when she transitioned from youth to adult social assistance, and she was subsequently faced with the prospect of having to pay out-of-pocket to terminate an unplanned pregnancy. She described trying to pick up odd jobs to cover the cost of the abortion before ultimately waiting for her health coverage to be reinstated. Another youth 'chose' not to seek medical attention for a chest infection after the shelter nurse where he was staying was on leave, and he was told the local walk-in clinic had a wait of more than two hours and required extensive paperwork. He said, "I just pretty much just dropped it and just like, tried to, like, deal with it on my own" [Male, 19 years old]. Instead of receiving medical care, he used whatever limited resources he had, such as access to shelter and usual good health, to survive. Other youth described challenges with simply understanding the 'rules' of the health care system, let alone trying to play by them. In the words of one youth, "You shouldn't need a health card to be healthy" [Male, 18 years old]. Another 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. We just need a

little bit of extra help" [Female, 19 years old].

Participants also used a range of interpersonal approaches to 'better survive' their experiences accessing primary health care services. The participant described previously, a 19-year old female who had pneumonia and broken ribs, had been living on the streets, and then staying in a hotel, prior to being sent to the hospital via ambulance. Upon arrival in the ER, 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 her belongings into the examination room. Unable to lift the items because of her as yet undiagnosed broken ribs, she asked for help, but was told to either carry her own belongings or leave them unattended in the waiting room. This young woman said, "I got in the room, he closes the door, leaving my shit in the middle of there so I just like f***ing' lost it." After seeking the very care she had tried so hard to avoid, this youth was pushed beyond her emotional limit. She said, "I just burst into tears and I just started f***ing' like, (crying voice) *I want my stuff*." This youth simply wanted a modicum of assistance from another human, a request which was denied. Based on such stories, it becomes increasingly apparent why youth experiencing homelessness report increased health care needs and decreased access. When youth repeatedly have been given the message that they cannot trust health care providers, it ought to be no surprise when they avoid seeking health care until their needs become absolutely urgent.

Solution-Focused Dialogue with Expert Clinicians

Demographic information was not collected for expert clinician participants, beyond capturing that the four participants were health care and allied service providers

representing nursing, counseling, and social services. The dialogue focused first on whether the findings from the youth interviews and survey data reflected the expert clinicians' professional experiences working with youth experiencing homelessness. On this topic, participants unanimously agreed that the data reflected their professional experiences, especially as findings related to discrimination against youth experiencing homeless. For example, one expert clinician described sitting in a local hospital ER waiting room with a youth while an older man who appeared homeless was brought in on a stretcher. A nurse walked by and reacted in a dramatic fashion, saying to the older man loud enough for surrounding people to hear, "Phew! You smell terrible! Put your shoes back on!" The expert clinician then witnessed how this affected not only the targeted man but also the nearby youth, who began to check his own 'smell,' for fear he might be subjected to the same inappropriate and shaming response by the nurse.

One of the expert clinicians further emphasized the existence of discrimination against youth experiencing homelessness, sharing that their clients were sometimes denied health care and social services based on other providers' assumptions that the clients were drunk or high. This clinician described a time when he accompanied an ongoing client of his, who is Indigenous, to the ER. The youth, facing a serious infection which left him feeling quite run down and drowsy, was repeatedly 'brushed off' by staff, before being told to leave and to 'sleep it off.' During the solution-focused dialogue, this expert clinician reported the youth said he was 'treated like a drunk Indian.' The expert clinicians also highlighted how requiring appointments and lengthy wait times can interfere with youths' access to health care.

The second question the lead researcher explored with the expert clinicians was what

solutions they would propose to help facilitate access to primary health care services for youth experiencing homelessness. The clinicians suggested that before professionals can 'do health stuff' with a youth, they need to first have had several opportunities to informally connect on the youth's 'turf.' The participants also recommended more youth-focused options within existing services, such as evening and weekend hours in clinics, both appointment and drop-in visits, outreach and in-clinic encounters, and ambulatory care with 'quick turn-around' lab testing. They emphasized that offering youth-friendly services requires individual practitioner and systems-wide flexibility, supported by ongoing specialized training on topics such as trauma-informed care and conflict de-escalation. They felt that brief versions of such training ought to be shared with all service providers, regardless of how often they work with youth.

Participants also highlighted the value of having service providers within and across disciplines shadow each other's work. For example, a social worker could spend a day shadowing a nurse, and vice versa. The expert clinicians asserted such an approach would facilitate a more nuanced understanding of each other's roles, scope of practice and team-based problem solving, which is crucial, given the demanding and sometimes ambiguous nature of working with diverse and marginalized populations. Such team-based approaches may also help foster the types of dialogue and innovation that are often necessary for actively resisting the forces of neoliberalism and oppression. As one participant suggested, service providers must be afforded the organizational support needed to ask the right questions, without necessarily needing to have all the right answers. These expert clinicians also highlighted the importance of engaging peer mentors and seeking a wide range of youth voices in decision-making, not just the loudest voices, or those of youth

already accessing services. For example, one participant described how bureaucracies sometimes unintentionally centre the ‘easier to digest’ voices of ‘docile’ youth, while perhaps more rebellious youths’ voices are marginalized. Overall, the expert clinicians suggested more work is needed to create safer, better integrated, and more inviting spaces for youth in and outside of traditional primary health care models.

Discussion

As previously mentioned, analysis of the youth interviews initially hovered quite close to the data, while subsequent passes shifted towards more analytical coding, and ultimately thematic codes. The three main themes identified, followed each by an exemplar quote from a youth, were:

- 1) Youth experiencing homelessness feel powerless when interacting with health care providers: *“If they even find out you’re homeless [...] they treat you like a bag of shit.”*
- 2) Health care systems exist as rule-based bureaucracies: *“You shouldn’t need a health card to be healthy.”*
- 3) Youth experiencing homelessness are in survival mode when it comes to accessing primary health care services: *“I just tried to, like, deal with it on my own.”*

For the youth interviewed, health care providers largely existed as ‘rule setters’ and breaking those rules could mean not getting needed care. This is where applying a critical social justice lens to the data revealed levels of discrimination and ‘othering’ that may not have been immediately apparent in the primary data. For example, in our analysis, we noted that although none of the youth expressly spoke about being in survival mode, it was evident that some had ‘learned to survive’ in a

health care system that treats them as ‘other.’ Additionally, while none of the youth mentioned their race, gender identity or sexual orientation specifically in the interviews, we note that five out of the eight or almost 63% of the youth identified as having Indigenous heritage, which is far above the provincial average in British Columbia of 5.9% (Statistics Canada, 2017). Similarly, only two out of eight youth reported their sexual orientation as ‘completely heterosexual’ which is far below the provincial average (Smith et al., 2019). These experiences of being in survival mode and expecting to be treated as ‘other’ often came at the cost of expecting what the youth participants seemed to consider ‘frills’ – kindness, comfort, thorough assessments and individualized care. Some of the youth described how seemingly basic gestures of human kindness, such as asking a pregnant woman how far along she is, made all the difference in their experiences accessing care. Other youth described how a lack of such kindness negatively affected their experiences accessing primary health care services, such as when one youth was told to carry her belongings from a waiting room to an exam room despite experiencing extreme pain related to as yet undiagnosed broken ribs. Meanwhile, it is almost impossible to imagine a situation where a person seeking care could walk into a health care setting and be told to carry his or her own belongings while injured, or where such a person would not be pleasantly asked about their pregnancy while seeking related health care services. In the absence of a critical social justice lens, the experiences these youth described could be viewed as ‘one-off’ bad experiences. However,

“critical interpretations of social justice, for example, address issues of equity vs. equality; conceptualize health as a human right; explicitly challenge neoliberal policies; draw attention to racialization, cultural

devaluing and discrimination as factors constraining social justice; and generally prioritize collectivism vs. individualism” (Browne & Tarlier, 2008, p. 84).

Based on these factors, it is our assertion following our analysis of the data that youth experiencing homelessness face unique, socially constructed barriers to accessing primary health care services in Canada. The social construction of these barriers is rooted in ‘power over’ relationships between health care providers and patients, which in themselves have longstanding roots in a health care system grounded in patriarchal and racist systems of care. For example, when youth described being treated ‘differently’ once a health care provider found out they were homeless, it was evident that such interactions may damage not only a youth’s relationship to the health care system in that moment, but their overall trust in others. This maltreatment and its effects were especially relevant for youth who had experienced historical or ongoing trauma, such as the intergenerational effects of colonization and residential schools, which continue to be felt by Indigenous people in Canada today.

Efforts were taken during data collection and analysis to consider how gender, sexual orientation and race affect youth experiencing homelessness’ experiences accessing primary health care services. This was done by collecting demographic information from each youth on their gender identity, sexual orientation, and ethnicity (see Table 1). We note, however, that none of the youth specifically mentioned whether, or how, these factors affected their experiences accessing primary health care services. However, given the amount of research described earlier in this paper linking systemic inequities, homelessness and access to primary health care services, it is likely the lack of such connections in our data was due to the small sample size, and

not reflective of a true lack of oppression experienced by these participants. It could also be an indication of how neoliberalism and the ideology of individualism operate, whereby the individual youth participants unconsciously shouldered the blame and burden of their illnesses and subsequent experiences seeking health care with no view of the larger forces and inequities shaping those experiences. An example of a Canadian study that links ‘othering’ to how one is treated in a health care context is Hardill’s recent study (2019). In this study, people who used opioids reported an abrupt shift for the worse, ‘like a switch had been flipped’ in terms of how they were treated, when nurses found out the patient had a history of opiate use. This shows how stigma can be both pervasive and destructive. Our research shows that when accessing health care in a bureaucratic context, youth experiencing homelessness are in survival mode, they feel powerless, and they suffer. This challenges the common discourse around the ‘ease’ and accessibility of health care in Canada. It is imperative, then, for nurses and other interdisciplinary team members to adopt a critical social justice lens to shift how we conceptualize both the day-to-day care we provide, and the policies that shape the systems we work within. The Canadian Nurses Association Code of Ethics (2017) expressly states that nurses must “uphold principles of justice by safeguarding human rights, equity and fairness and by promoting the public good” (p. 15). This document is an example of how health care providers can use policy-level action to inform frontline work.

A recent example of an innovative approach to providing youth-friendly health care services is the Foundry model implemented in British Columbia, Canada (Foundry, n.d.). This model, the first of its kind for youth and young adults in Canada, was created in 2015, and focuses on providing integrated access to mental health, substance use,

primary care and social services (Foundry, n.d.). Since 2015, Foundry has supported the creation of over 10 existing or in-development centers across the province (Foundry, n.d.). Each of these sites has been tailored to the needs and partnerships unique to each community, and this initiative is continuing to expand across the province, while striving to incorporate youth and family input in decision making and program creation.

Strengths and Limitations

A key limitation for this study was the interviews only included urban participants, although the larger project included rural data. The sample also may not have sufficiently included the voices of LGBTQ2S+ and racialized youth, or younger youth, given data collection involved convenience sampling, rather than purposive sampling. Finally, as the solution-focused dialogue with expert clinicians was not a formal focus group, the robustness of data collected may have been limited.

In contrast, a strength of this research was its inclusion of both youth and service provider voices. This work also included a critical analysis of data rather than a pathologizing focus on individual youth. Future research could be further strengthened by including focus groups with expert clinicians and using purposive sampling to facilitate a more robust gender and ethnicity-based analysis.

Future Recommendations

The findings from this research raise an essential question: How might the health care system change to better welcome youth experiencing homelessness into our services? Service providers ought to advocate for both immediate and longer-term changes to the way we deliver services

for marginalized youth in ways that will influence practice, policy and research. Practice-related changes require that staff have the time and training needed to best support this population. This can include ensuring time to build rapport with youth on the youth's terms, while also having professional development opportunities to learn about relevant topics, such as the adolescent brain, mental health, substance use, and the effects of trauma and toxic stress. It is also important for all primary health care and allied service providers to receive training on equity-oriented approaches to enhancing access to services (Browne et al., 2018), and how various forms of oppression intersect to affect access to health care services for young people living on or near the street. For example, all health care and allied service providers in Canada ought to complete training and education on the impacts of colonization. Such information must also be woven into the fabric of how we, as members of interdisciplinary teams, discuss the 'what, how and why' of the work we do, so we are perpetually questioning who is and who is not accessing our services, and why that might be the case. This information can also help nurses and other health care and allied service providers recognize and address the implicit biases we often hold against commonly stigmatized and 'othered' groups, such as youth experiencing homelessness. It is through recognizing our biases and working through these challenges as teams, rather than in isolation from one another, that we can strive to create attitudinal shifts in the contexts and cultures within our health care services. EQUIP, also known as Equipping Primary Health Care for Equity, is an example of a current Canadian research group offering practical, service-oriented strategies for promoting equitable access to primary health care services (Browne et al., 2018). We also note that, although beyond the scope of this current paper to explore, there is a growing and crucial role for nurses in the realm of upstream political activism.

For policy-level changes, we must pursue the funding and operational changes that will support the creation of more youth-friendly health care spaces, where rapport and trust-building are at the core of the work being done. Such an approach inherently challenges neoliberal ideals around limited resources and a need for increased efficiency, and therefore, our health care and nursing leaders must be well-versed in the socio-political context of our Canadian health care system. Such knowledge will empower our health care and nursing leaders to question expectations presented as 'absolute truths' within the health care system related to financial and time constraints. As health care and allied service providers and leaders, we can also routinely invite youth to comment on how the structures of our health care system, such as clinic hours and wait times, affect their experience accessing care, and then we can work to implement policies that reduce some of these barriers. One such example could include dismantling policies that punish youth who miss appointments by closing their files.

Finally, changes in research and academia can begin in undergraduate and professional programs and extend into ongoing

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continuing education opportunities for people working in diverse settings, from front-line practice to program and policy development. Where individual practitioners and organizations often face challenges balancing immediate work demands with advocacy work, people are needed in positions who can act as a bridge between the frontline and those systems-level influences that shape our health care and social services. Building on such work, partnerships between health care regions and local academic institutions could foster a reciprocal feedback loop between research and practice related to youth health.

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. Changes can happen in two main ways: from within, by individual health care and allied service providers, and on a systemic scale, by amending existing policies, programs and research initiatives to address the inherent systemic oppression they often perpetuate and to ensure equitable access to health care service for youth experiencing homelessness.

See it. Speak it. Write it. Change it.

Table 1. Youth demographics	
Age	
18 years old	1
19 years old	7
Gender	
Male	4
Female	4
Transgender	0
Another:	0
Sexual Orientation	
Completely heterosexual	2
Mostly heterosexual	1
Bisexual	4
Mostly homosexual	0
Completely homosexual	0
Questioning	0
I don't have attractions	0
Pansexual (note: this option was written in by a participant)	1
Ethnicity	
Indigenous	3
Indigenous/European	2
West Asian	1
Canadian/American	1
Do not know	1
Age When You First Became Homeless	
11 years old	1
14 years old	2
17 years old	1
18 years old	2
19 years old	2

See it. Speak it. Write it. Change it.

Table 2. Excerpts from the youth interviews		
Participant A [Female, 19 years old]	<p>“If I was somebody who wasn’t really comfortable with clinics, I’d probably say just [having] somebody there to explain to me, like: What’s happening? And like who am I going to be seeing and like what does this mean? Are they a doctor? What can they give me? Like, do I talk to them about this or do I talk to them about this? Because like, I dunno, like, a teenager doesn’t know the difference between like a rheumatologist and like an orthopedic surgeon. Like, I like, I dunno <laughs>.”</p>	<p>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. To like, tell him what was going on. Two days later, someone brought me to a freaking phone. And they kept saying “Oh yah, we’ll tell the nurse to do it [call my boyfriend]. We’ll get so-and-so to do it.” Well, they’re not even allowed to tell the nurse to do it. And I didn’t know that. They told me that they were. So, what the f***?”</p>
Participant B [Male, 19 years old]	<p>“With work or school, getting things like doctor’s notes. A lot of walk-in clinics will charge like quite a bit of money just for a written note. Like, that’s just, that’s one of the difficulties I had with that.”</p>	<p>Participant D [Female, 19 years old]</p> <p>“I felt like she [midwife] didn’t understand me at some point. Cuz I talked to her – I was really, really sore in my back and everything. And she said it was natural and it comes with pregnancy and stuff [...but] it was in my back. It wasn’t in the front or where the baby was [...]. They told me at the hospital the same thing my midwife did except they made sure by checking. They told me my discs are moving and stretching and what not and 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,</p>
Participant C [Female, 19 years old]	<p>“They [ER staff] immediately, seeing that I actually had real injuries, and I wasn’t just a dumb...kid, a street kid being stupid, then they gave me pain meds [for pain related to my broken ribs...]</p> <p>I kept asking them questions and they kept brushing me off like “Oh yah, whatever.” And I kept</p>	

she was just like “Oh, it’s just natural.”

“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 [staff in the ER] two 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>.”

See it. Speak it. Write it. Change it.

Table 3. Excerpts from the solution-focused dialogue with expert service providers

Youth need to know there is someone they can trust in life.

In addition to providing more traditional health care services, there needs to be more intersectoral collaborations so health care providers can partner with allied service providers who can help youth do things like sign up for health coverage, get identification, secure housing. These things are crucial for health but can be achieved in partnership with non-health care professionals.

There is a need for a youth-specific ambulatory care clinic to welcome young people and to provide lab and blood work with quick results and to provide antibiotics.

There is a need for health care providers to be more consistently kind/‘nice’ at all times – youth are extremely perceptive and they are often paying attention to every move and every interaction a health care provider has with others in the waiting room, coworkers, etc. It’s not just about the one-on-one interaction with the youth.

Our immediate colleagues exist in a bubble where coworkers are all on the same page and all support trauma-informed care. There is a need to step outside of that ‘bubble’ to partner with and increase education for others who may also interact with this population, such as walk-in clinic staff and Emergency Room staff.

Youth are not a ‘blank slate’ - - they come with a whole mix of previous

experiences including sources of resilience and also traumas.

When youth services do satisfaction surveys, they’re only asking people who are already at the services. This inherently excludes people who are not accessing the service in the first place. We must then ask: “How do we connect with *all* youth?”

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