FACTORS ASSOCIATED WITH ACCESS TO HEALTH SERVICES BY WINNIPEG STREET YOUTH

by
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A Thesis

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ABSTRACT

This study identifies factors associated with access to health services by Winnipeg street youth. A framework for understanding access to health services by Winnipeg street youth is developed based on these factors. Access to health services is particularly important in light of an extensive Canadian literature review which shows that street youth have numerous health problems at rates higher than their non-street-involved peers. Using a mini-ethnographic approach, semi-structured interviews and direct observations were used to gather data from street youth recruited through youth-serving agencies. Five major categories were identified from the analysis: (a) helping system characteristic, (b) provider characteristics, (c) street youth characteristics, (d) their social environment, and (e) satisfaction.

Health care system characteristics which facilitate access to health care included: affordability, immediacy, practical assistance, safety, and tailored services. Proximity, more often than not, facilitated access. Imposed services, more often than not, were barriers to use of health services.

Provider characteristics found to facilitate access to health services included: caring relationships, providing continuous services and respect for client control. There was disagreement about the importance of provider age and gender.

SY characteristics which facilitated access to health care include: knowing

about services, crisis orientation and experiencing pain. Barriers to access included: deferral of care, substance use, travel, environmental constraints, and various internal motivators (i.e., fear of pain, depression, and lack of trust in others). Experiencing a non-acute physical or emotional condition was more often than not a facilitator of, rather than a barrier to access.

The social environment around SY including the influence of family, friends and acquaintances enhanced access to services.

Satisfaction with health care encounters facilitated repeated use of services, while dissatisfaction did the opposite.

The study's findings are discussed and recommendations made.

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Chapter 1

Introduction

Statement of the Problem

This study identifies factors associated with access to health care by Winnipeg street youth (SY). There is much evidence that, as a group, street populations have poor health compared to their same-aged peers. It is recognized that traditional health care is but one of the many determinants of health, and in most cases probably one of the least important. Despite this, health care services have a practical importance, particularly for this population which has numerous health problems at rates higher than their non-street involved peers. Specifically, this study will identify factors associated with SY's actual and potential use of the health system as perceived by SY.

This is the first mini-ethnography that focuses on Winnipeg SY's access to health services. Some studies partially address the issue of SY access to health care though it is not their primary focus. Other studies describe SY's use of health service agencies that have a specific mandate to serve the health needs of SY. These reports are unable to provide adequate insight into factors that affect access to health care by SY. In a wide-ranging literature review no evidence was found of any rigorous qualitative Canadian study addressing the issues of access to health care.

The "Behavioral Model of Health Services Use" is a theoretical framework frequently used for analysis of equitable access to health care (Andersen, Kravitz, & Anderson, 1975; Andersen & Newman, 1973) and is one of the

frameworks for organizing the literature review in Chapter 2. The variables identified in the Behavioral Model should not be assumed to apply to marginalized, non-geographically bound SY populations. Factors associated with access to health services identified through this qualitative study provide insight into how to create greater access equity.

It is important to keep discussions about access in perspective. Access to health services, while very important, is but one of many important health system and consumer issues. Other important health system issues include, but are not limited to: appropriateness, quality, effectiveness, efficiency and cost.

McKnight (1995) expresses concern about health care reforms that seek achievement of equal access to health services because doing so confirms the value of medicine by broadening its clientele and confirming the... "premise that the right to *consume* (sic) medical services is the central 'health issue'" (p. 57). For many SY, achieving access may not be the most important health issue. Nonetheless, access to health services remains an issue for some SY. Equitable access to a range of respectful health services is likely to lead to significant health benefits for some or many SY. In the absence of many or any family or community supports, and without legitimate social and economic opportunities, formal helping systems also have a significant role in improving the health of SY. Studies measuring consumption or utilization of health services may deflect attention from one of the most important questions. Do health services actually improve health? Without access, the answer must be

"no". With access the answer may be "yes".

Definition of Terms

The concepts SY, health, health services, equity, use and access require definition.

Street Youth

The population with which this study concerns itself is that group of youth who are involved in street life at or beyond the margins of society. There is little harmony in the terms used to describe and classify dislocated youth populations. There is no generally agreed upon common sense definition of SY. When considered in comparison with Canada's largest centres, common sense definitions of SY may be more problematic in Winnipeg. Seasonal climatic conditions limit visible street life in Winnipeg, while in moderate climates street life can be more evident. SY is used as an umbrella term for the various sub-groups of youth on the street (Sergnese, 1995).

The lack of a standard definition or generally accepted typology has hindered prevention and intervention efforts for many years (Zide & Cherry, 1992). Authors define youth populations they study with one or more labels such as:

(a) "high risk youth" (Axelson & Dail, 1988);

(b) "homeless youth" (Dietz, 1991; Greene, Ennett & Ringwalt, 1997; Kipke, Simon, Montgomery, Unger & Iversen, 1997a; Lee, Gaetz, Goettler, 1994; Robertson, Greenblatt, Koegel & Mundy, 1990);

(c) "out of the mainstream youth" (Anderson, 1993; Caputo, Weiler, & Kelly, 1994a; Caputo, Weiler, & Kelly, 1994b; Caputo, Weiler, & Kelly, 1994c);

(d) "runaways", a term which usually explicitly includes youth who are abandoned, neglected or pushed out (Brannigan & Caputo, 1993; Dietz, 1991; Farrow, Deisher, Brown, Kulig & Kipke, 1992; Kufeldt & Nimmo, 1987; Kurtz, Jarvis & Kurtz, 1991b; Levine, Metzendorf & VanBoskirk, 1986; Rotheram-Borus, 1991; Royal Canadian Mounted Police, 1996; Social Planning Council of Winnipeg, 1990);

(e) "runaway and homeless youth" (Kufeldt & Nimmo, 1987; Runaway and Homeless Youth Study Committee, 1994);

(f) "street involved youth" (Adlaf, Zdanowicz & Smart, 1996; Smart & Adlaf, 1991; Smart, Adlaf, Porterfield & Canale, 1990; Smart, Adlaf, Walsh & Zdanowicz, 1992);

(g) "SY" (Clements, Gleghorn, Garcia, Katz & Marx, 1997; Community Street Youth Task Force, 1990; Gilchrist, 1996; Johnson, Aschkenasy, Herbers & Gillenwater, 1996; Kipke, M. D., Unger, J. B., O'Connor, S., Palmer, R., & LaFrance, 1997b; McCullagh & Greco, 1990; Radford, Kind & Warren, 1989; Read et al., 1993; Sergnese, 1995; Smart & Adlaf, 1991; Smart et al., 1990; Smart et al., 1992; Smart & Ogborne, 1994b; Smart & Walsh, 1993);

(h) "throwaways" (Farrow et al., 1992; Greenblatt & Robertson, 1993);

(i) "vulnerable youth" (Remillard, 1995); and

(j) "youths in high risk situations" (Anderson et al., 1996).

There is much variation in how each of these terms is defined. Table 1 (pages 15 and 16) provides examples of differences in definitions use in some Canadian studies.

The ages of dislocated youth samples in the literature vary widely. Some authors concern themselves only with adolescents under the age of majority. This definition may reflect the structure of the helping system, which is relatively inflexible in how it defines and treats children (those under 18) and adults (those 18 and over). Another approach to age range is to focus on the concerns, needs, abilities and services required by dislocated youth irrespective of a legal age of majority. This view reflects the definition that youth "are teenagers and young adults who have not achieved adult roles and status" (Adlaf et al., 1996, p. 11). SY-serving agencies in some major Canadian cities (e.g., Toronto, Calgary) provide services to dislocated youth up to and including the age of 24 (Brannigan & Caputo, 1993). SY may be socially and emotionally delayed because of a chaotic personal history and significant personal drug use, which may hinder social and emotional development.

There is disagreement about the length of time youth have to be away from "home" before being considered SY or runaways. For some researchers youth need to be away overnight. For others more than 24 hours must have elapsed. And others adhere to completely different time frames (Young, Godfrey, Matthews & Adams, 1983).

A source of further confusion is that some definitions of dislocated youth use typologies in their attempts to describe SY. While some authors have argued for the overall appropriateness of specific typologies (Jones, 1988; Zide & Cherry, 1992), it seems reasonable to judge the appropriateness of any developed classification scheme by how useful it is. Typologies or classification schemes can be useful if they do not create stereotypes by overly simplifying differences. A typology that creates too many sub-groups makes it difficult to understand study results (Zide & Cherry, 1992). Classification systems for dislocated youth are usually comprehensive but rarely are they mutually exclusive (Brannigan & Caputo, 1993).

Typologies of SY may be based on one or more of the following characteristics: (a) how youth came to the street (e.g., running away, being pushed out of their home or agency placement, being neglected, running to adventure, abandoned to provide for themselves, illegal immigrants) (Kurtz et al., 1991a; McCullagh & Greco, 1990; Zide & Cherry, 1992); (b) the length of time youth have spent on the street; and (c) the method used for generating income while on the street (McCullagh & Greco, 1990). Others classify SY by their participation in multiple aspects of street culture: (d) where they stay while without a fixed address (e.g., temporarily with friends or relatives, shelters, the street); (e) involvement in non-normative behaviour (e.g., dropping out of school, drug and alcohol abuse, gang participation, panhandling); (f) involvement in illegal activities (e.g., drug dealing, prostitution, break and enter, petty theft); (g)

the degree of street involvement (e.g., curb kids, runaway "inners and outers", entrenched SY); (h) use of SY-serving agencies; (i) the degree of contact with their family; and (j) subcultures that can be highly localized geographically or temporally (e.g., squeegees, hustlers, low track prostitutes, sniffers).

Some definitions of dislocated youth populations are limited and narrow in scope. For example, while the term "runaway" is almost intuitively understood, clearly not all youth on the street are runaways. SY are not all under 18; nor have they all run away from home; nor is the term "homeless" applicable to all youth involved in street life. Dislocated youth may move in and out of homelessness and may or may not have a current address. Street-involvement is a continuum that youth may drift in and out of (Kipke et al., 1997a). It is not uncommon for youth to be thrown out or to run away from home. Of Ontario students, 7.8% had run from home and 5.6% had been thrown out of home at least once in the last year (Smart, Adlaf, Walsh & Zdanowicz, 1994a). While these runaway and thrown-out youth are at risk for becoming SY, they are not necessarily street-involved.

The term "SY" could be criticized as an unsatisfactory and too vague catch-all. A newer term is not more precise and meaningful simply because an older term, for example SY, has been variously defined in the literature. Rather than adding to an ever-expanding multiplicity of terms to convey a similar meaning, it is preferable to adopt a standard definition.

Any argument in favour of the greater precision of the terms "runaways"

and/or "homeless youth" is unconvincing. Short of interviewing or directly observing people sleeping and otherwise living on the streets or in public shelters, there is no easy way of determining homelessness.

Another approach to definition and categorization is self-definition, using an ethnographic approach. On the one hand, this approach reflects local experience. On the other hand, self definition is likely to create multiple definitions and categorizations that make comparisons between geographically or temporally distinct groups difficult or impossible. In reflecting the reality of multiple SY cultures, self-definition supports the impression that there is no pan-temporally or pan-geographically homogeneous SY culture.

The term SY reflects the reality of various sub-groups of youth on the street (Sergnese, 1995). The current study asked what street-related terms participants associate themselves with, the definitional criteria to achieve that label, and how this association affects access to the health care system, if it does so at all.

As a tool to screen out obvious non-SY, the current study used a definition of dislocated youth populations that incorporates more than one dimension of the demography of street life. The definition of SY is meant to include the majority of youths described in the above paragraphs. The definition incorporates most classifications of dislocated and street-involved youth, including older SY who may be homeless or entrenched in street life. It is hoped that by conforming to defining criteria similar to those employed in other

Canadian studies, systematic collection of data will build on current knowledge.

The proposed definition of SY, or something very much like it, has been used by numerous other Canadian studies. The definition, while broad, is not overly vague. Consistency in defining SY across Canada will make meaningful comparisons of data easier. The primary criterion for being a youth is being aged 12 to 24. All youth who make use of a SY-serving agency are considered SY. If a youth's experience fits with three of the following four criteria they are also considered SY:

(a) leaving school before completing grade 12 and not working full time,

(b) living away "from their family (or guardian) for at least 2 days during the past year",

(c) running or being "thrown out of their home at least once",

(d) being "homeless (i.e., without a place to stay) at least once".

With the exception of the concept of a minimum age of 12 and "not working full time", which has been added to make the inclusion criterion more stringent, the previous definition can be found in Smart and Walsh (1990), Smart et al. (1992), Smart et al. (1993), and Smart & Adlaf (1991, p. 1000).

Most youth on the street become part of sub-groups that have unique demographic profiles and subsistence patterns with their own norms, values and beliefs (Kipke et al., 1997b). For example, among prostitutes there are vast differences such as: child or adult status; type of substance use or non-use; sex

(male, female or transsexual); degree of coercion or personal control over prostitution; and the locations where prostitution occurs. Among street subcultures there are clear differences in health, risk profiles and service use.

Health

Health is considered to be resource for living. It is the capacity "to realize aspirations and satisfy needs, and... to change and cope with the environment" (World Health Organization., 1984, p. 2). It is neither an end in itself nor is it simply the absence of death, disease, disability, discomfort or dissatisfaction (Young, 1997). As children and adults, homeless persons are influenced by the same mass culture and have views of health similar to those of non-homeless people. Conceptualizing health as not merely the absence of disease conforms with homeless adults' views of health (McCormack & Gooding, 1993).

Health Services

For the purposes of this study, health services are those services which address physical, emotional or mental health concerns. This is a more restrictive view of health services than that delineated by primary health care (Stewart & Langille, 1995). Addressing all aspects of primary health care is too complex within the time, resources and scope expected of a master's thesis.

Equity

One of the principles of primary health care is equitable access to health services. Equity and equality are not synonymous, and equity itself is a confusing word. Horizontal equity implies equal treatment of those who are

equal. Birch and Abelson (1993) suggest that horizontal equity applies most significantly to persons with the same characteristics, that is, where the determinants of health and expected health outcomes are similar. Vertical equity implies the unequal treatment of unequals. Vertical equity should apply to SY in comparison to the general population because determinants of health and health outcomes of SY differ substantially from the general population as well as differing among sub-groups of SY. According to the principle of vertical equity more resources should be directed to persons with higher rates of treatable conditions. "Reasonable access implies that positive discrimination be shown in terms of availability of services, if access is to be based on need" (p. 646).

Equity is not a core organizing principle of the current health services system. While universality is a principle of the Canada Health Act, "none of the current systems of remuneration relates to the needs of the individual or population receiving the service (Birch & Abelson, 1993, p. 649)." Hence, vertical equity is not financially or structurally valued. Payment systems "provide no incentive to behave in ways compatible with reasonable access to services or with goals concerned with reducing inequalities in health or the promotion of societal well-being" (Birch & Abelson, 1993, p. 649).

The essence of equity is equal access according to need (Anonymous, 1993a). Most people understand equity from the perspective of a negative criterion (Daniels, 1982). That is, they are aware that an inequity in health care exists where characteristics other than health status are responsible for use of

health care resources. While SY may identify barriers to care which they have experienced, they may not be able to gauge equity in access to health care.

Use of Health Services

Use of health services may be defined as the act of employing the health system for any purpose (Oxford English Dictionary, 1989). Use is but one aspect of access, albeit probably the most important one. Use of services is the realization of access and is most easily measured.

Access to Health Services

Access to health services describes the "potential and actual entry of a given population group to the health care delivery system" (Andersen, McCutcheon, Aday, Chiu, & Bell, 1983, p. 51). The Canadian Dictionary of the English Language (1996) describes access similarly as the means, act or right to approach, enter or make use of something. Access is influenced by the social context of the population and delivery system. Access to health services subsumes the concept of use. It is the potential for and actual entry into not only the first encounter, but the potential for and actual entry into every subsequent encounter with the health system. An implication of this definition is that if initial experience with a health delivery system leads to reduced or non-use of additional needed services, the system has problems with accessibility.

Relevance to Community Nursing

It is hoped that this study's findings will create a deeper appreciation of the factors influencing SY's access to health services. The study may contribute

to program and policy design and to nursing practice. The findings may provide guideposts for the development of quantitative measures of access to health care for SY. An important personal consideration in this study is the opportunity which it affords to influence the health care system to effectively address SY health needs.

Limitations of the Study

Findings from a Winnipeg survey of SY may not be directly transferrable to other jurisdictions because street involvement by young people and the relationship between youth and the health care system are strongly influenced by local circumstances. Further limits to transferability arise because each province's and city's health care system is unique. Because the sample is non-random, results cannot be assumed to be representative of the overall SY population. However, the sample is well described and readers may be able to determine whether the findings relate to the population of SY they serve. Interviewing, one of the methods by which data were collected, is highly subjective in that it is dependent upon memory, eloquence and personal perception. Despite these limitations, it is hoped that this study will provide insights worthy of consideration elsewhere.

Assumptions

This study is based upon a number of assumptions: a) In the detailed literature review which follows, where no epidemiologic data about Winnipeg SY exist, these SY are assumed to share the same health and illness trends as their

SY counterparts studied in other cities. The extent to which Winnipeg SY participate in the trend may differ. b) SY are able to communicate factors associated with access to health care. c) Interviews are based on an assumption of cognitive theory that it is possible to learn what people think by listening to what they say (Fetterman, 1989). d) A pre-existing theoretical framework used to organize the literature review would not limit recognition of themes emerging from the process of carrying out the ethnographic study.

Chapter Summary

This study explores factors influencing access to health services by Winnipeg SY. Terms such as street youth, health, health services, equity, access and use of health services have been described. Assumptions have been stated.

Table 1
Criteria Defining Street Youth and Street-Involved Youth

Study	Age of Youth	Location of Youth	Time Home-less	Saw-off Period for Study Criteria	Other Criteria
Radford et al., 1989	15 -20	- Living on the street	1 day	Year before data collection	none
McCullagh & Greco, 1990	n/a	n/a	n/a	n/a	Authors distinguish sub-groups by: how they came to the street, length of time on the street, and types of income generated on the street
Read et al., 1993	≤20	1. Ran away or were thrown out of home	2 days	Year before data collection	*Used a street youth agency* **or** *must fit 2 of the 3 numbered criteria*: 2. Dropped out of any level of school 3. Hang out on the streets and take part in a street lifestyle (homelessness, prostitution, selling or using drugs, engaging in criminal activities)
Smart et al., 1994b	n/a	- No fixed address **or** 1. Slept on the streets in past 6 months	≥6 months	n/a	*Must fit 2 of the 5 numbered criteria*: 2. Dropped out of school before grade 12 3. Ate at mission shelters in past 6 months 4. Food bank use in past 6 months 5. Scarce resources meant going without food for a whole day in past six months

Table 1
continued

Study	Age of Youth	Location of Youth	Time Home-less	Saw-off Period for Study Criteria	Other Criteria
Adlaf et al., 1996; Smart & Adlaf, 1991; Smart et al., 1990; Smart et al., 1992; Smart & Walsh, 1993	≤24	1. Living away from family or guardian 2. Being homeless at least once	≥2 days	n/a	*Used a street youth agency or must fit 3 of the 4 numbered criteria:* 3. School leaving before grade 12 4. Running or being thrown out at least once
Gilchrist, 1996	14-20	n/a	n/a	n/a	Youth who see street culture as a major reference point in their lives
Caputo et al. 1994a; Caputo et al. 1994b	n/a	n/a	n/a	n/a	4 quadrant model (conventional youth, victimized youth, delinquents, homeless youth) based on two continua from conventional behaviour to hazardous behaviour, and from at home to on the street.

Chapter 2

Literature Review

This chapter describes epidemiologic trends in Winnipeg SY populations, reviews frameworks for analysis of access to health services, and uses one of these frameworks to organize a review of the factors related to access to health services as discussed in the SY literature. The chapter begins with a critique of available research on street youth populations, describes epidemiologic trends, reviews demographic information about Winnipeg SY, discusses significant antecedents to street involvement, examines significant health problems and health risks, and related determinants of health and illness.

Critique of Available Research on Street Youth Populations

A discussion of need is germane to proper understanding of SY's access to health services. Conceptualizations of need affect decisions about allocation of resources at the policy, health service organization, and direct service levels. Need is related to whether to allocate resources and the type of resources to allocate (Jones, Brown & Bradshaw, 1983). Bradshaw (1972) identified four types of need:

- normative need based on expectations defined by experts,
- comparative need based on comparison between groups or individuals,
- expressed need based on actual use of services, and
- felt need based on individuals' expectations of their own outcomes.

The epidemiologic model in the following review is highly dependent upon

studies which identify comparative need (e.g., comparison of SY to non-SY health status). Some expressed needs based on utilization statistics are also provided in this chapter. The epidemiologic approach uses professionals to identify predominantly biomedical or social needs. There is very little mention of felt need in the epidemiologic literature.

The epidemiologic literature on SY reviewed hereafter is drawn from cross-sectional studies unless otherwise noted. Cross-sectional studies predominate in the literature about SY. None of the cross-sectional studies has used probability samples because the universe of SY fluctuates, is highly transient, often hidden, and very difficult to access by conventional means. Use of non-probability samples, while necessary, limits generalizability of findings, possibly even within the same city.

Highly divergent inclusion criteria for samples, including those defining SY and similar groups such as homeless youth, runaways or marginalized youth, will significantly affect findings. Differences in sample ages, source and method of recruitment, seasons and years of recruitment, and payment of subjects are among many other factors that affect findings. Differences between study results can be expected when samples are not uniformly recruited or defined.

While numerous national studies have incorporated data from Winnipeg respondents, few studies have focused specifically on Winnipeg SY. Great quantities of literature on SY are produced in Toronto or large American cities. Characteristics of populations in large metropolises may differ from mid-sized

cities such as Winnipeg. Geographically distinct population differences may arise for many reasons, including human services systems, weather, migrancy patterns, and differences in street cultures, norms and values.

This literature review will make almost no attempt to explain the differences between studies because of the huge number of factors which have not been controlled for but which could potentially influence the data. Owing to sampling and geographic variations it is impossible to be sure that any explanation of differences is correct.

Purely qualitative studies about SY's access to health care services are few in number. Those that do exist are American and include non-street populations as part of the sample (Resnick, Blum & Hedin, 1980; Rosenfeld, 1996). Some Canadian studies use qualitative data only as examples to illustrate quantitative results (e.g., Radford et al., 1989), or they have collected qualitative data related to services in general (e.g., Runaway and Homeless Youth Study Committee, 1994; Gilchrist, 1995). The following literature review of health services use relies on studies that are primarily epidemiologic.

Epidemiologic studies usually report findings without explaining the context in which participants find themselves and, sometimes, in which the study was carried out. Hence, a full appreciation of the meaning of epidemiologic data is usually impossible. However, a rudimentary understanding of the general drift and direction of purely epidemiologic data is possible. This chapter will draw on the epidemiologic data to draw attention to some of the major trends which may

affect access to health services.

In summary, many factors will influence cross-sectional studies including non-probability sampling, inclusion criteria for study samples, and geographic variability. To place enormous significance on specific study findings is certain to be a mistake. What would be equally mistaken is to discount synchronous trends of numerous cross-sectional studies. In this literature review, specific findings are cited mainly for the purpose of illustration. They are not cited to assert that the same findings hold true to the same degree for any population other than the one studied.

For the purposes of this chapter it is assumed that Winnipeg SY are not altogether different from their Canadian and American counterparts. Although data from other studies may not accurately reflect Winnipeg's reality, they are quoted when Winnipeg data are not available, or when trends in the SY literature are so consistently reported that it would be unlikely for a Winnipeg sample to diverge from this pattern. Where possible Winnipeg data are provided, even when the information is old, possibly not reflecting a current reality. Canadian studies have been analyzed in preference to American studies.

Population Demographics

The population of Winnipeg SY is impermanent and constantly shifting. Its size has never been reliably determined. Youth at various times run away from home and return, find themselves in child protection services placements,

or are incarcerated. SY are without a fixed address for variable periods of time. Winnipeg's SY population fluctuates according to the rhythms of seasonal, interprovincial and international migration. In Canada there is an increase in reported running away consistent with the start of warm weather in April and a noticeable decline beginning with cold November weather. A Canadian surge in reported running away occurs at the beginning of the September school year (Royal Canadian Mounted Police, 1997).

The visibility of Winnipeg's SY population is profoundly affected by seasonal weather changes. Winnipeg's cold winters and mosquito-infested summers make sleeping outdoors very difficult. SY are therefore less conspicuous in Winnipeg than in cities with more temperate climates.

The profile of young SY (under 18 years of age) is well known. Reported Canadian female runaways outnumber males by approximately three to two (57% vs. 43%) (Royal Canadian Mounted Police, 1997). According to surveys from across Canada, Toronto and elsewhere, older SY (aged 18 to 24) are much more likely to be male (Anderson, 1993; Oki, 1990; Radford et al., 1989; Read et al., 1993; Smart & Adlaf, 1991; Smart et al., 1990; Smart et al., 1992). Most females have the availability of the socially acceptable role of motherhood as a route off the street. The possibility of losing a child to child welfare agencies is a great motivator for staying away from the street. Males have no similar socially sanctioned escape route from the street.

According to the Royal Canadian Mounted Police Missing Persons

Registry the modal age for running away - not to be confused with the modal age for SY - is 14 to 15. Runaways leave home for varying lengths of time. Of Toronto SY, a third had been away from parents or caregivers for one year or less, and half had been away from home for three years or more (Read et al., 1993). The oldest children enrolled in the National Longitudinal Survey of Children and Youth are 10 to 11 years of age and report surprising rates of running away. Slightly more than 5% had run away at least once in the previous year. Slightly less than 5% had stayed out all night without permission (Susan McKellar, Statistics Canada, personal communication, April 16, 1998). There is evidence that SY under 16 tend to engage in repeated running more often than those over 16 years of age. Those over 16 are more likely to be on the street for a month or more and may have permanently broken ties with home (Anderson, 1993).

Most people running to the street are Canadian born (Radford et al., 1989; Smart & Adlaf, 1991; Smart et al., 1990; Social Planning Council of Winnipeg, 1990). In a Winnipeg sample 35% of SY were Caucasian, 19% were Treaty Indians, 7% were non-status Indians, 32% were Métis and 7% were from other backgrounds (Social Planning Council of Winnipeg, 1990). An agency serving Winnipeg prostitutes, found that half of their contacts were with Aboriginal females (Campbell & Heinrich Research Associates, 1994).

Statistics Canada reports a large and growing Manitoba Aboriginal child population where the size of the population increases as age decreases. For

example, there are over a third more Aboriginal children under the age of four than there are children aged 15 to 19. Based on demographics we can expect increasing numbers of Aboriginal youth who will become street-involved over the next decades.

In community consultations, Caputo et al. (1994b) found a pattern of "home leaving" among Aboriginal SY that differed from previous observations of leaving home. Aboriginal youth may leave home to stay with relatives or friends. They may also move back and forth between city and reserve and between family and friends. Aboriginal children tend to rely on extended family. These youth may intermittently be connected to schools, to reserves, and to other agencies. This type of impermanent home leaving and the consequent instability of no fixed address can persist for months or years. Some providers have called this "camping out". These youth may not be adequately reflected in runaway statistics. Hence the Caputo et al., (1994c) study showed that many (28%) Aboriginal SY had never run.

It is widely accepted that a disproportionate percentage of male SY are gay or bisexual. In a partial review of the literature, Kruks (1991) reports that in two large American cities between 25 and 40 percent of SYs are gay. The anonymity afforded by large gay and lesbian communities in urban centres may attract sexual minority youth.

In a cross-Canada purposive sample Radford et al. (1989) found about 7% of SY self-identified as gay, lesbian or bisexual. An additional 16% reported

sex with someone of the same gender. In a major cross-Canada study King et al. (1998) found only 4% of SY reported bisexuality and 2% reported being gay. However, 15% of their sample had had same-sex partners. As a consequence of the social undesirability of being labelled homosexual, directionality of studies may influence estimates of group size. Hence, if the population being studied is SY, the result may be an underestimation of the number self-identified gay youth. In contrast, if self-identified gay youth are studied, they may report high rates of street involvement. Although not reaching the extreme levels seen in very large cities such as Toronto (Smart et al., 1992), San Francisco (Sherman, 1992), or Los Angeles (Anderson, Freese, & Pennbridge, 1994), gay youth are probably over-represented on Winnipeg's streets.

Radford et al. (1989) found that 58% of SY attended church as youngsters, far in excess of the 28% comparison population of average Canadian youngsters. Coming to terms with non-traditional sexual relationships or substance use may be especially difficult for SY and their families who have a history of religious observance. Many SY serving agencies are run by religious organizations that hold values and beliefs incompatible with the cultural or religious experience of many of their clients.

Involvement in illegal activities is very common among SY. Winnipeg and Halifax SY have engaged in theft, shoplifting, fraud, drug dealing, and prostitution (Anderson, 1993; Social Planning Council of Winnipeg, 1990). Not surprisingly, police involvement (Anderson, 1993; Caputo et al., 1994a; Caputo

et al., 1994c) and incarceration rates are high (McCarthy & Hagan, 1992). Violent crime and willful damage to property are relatively less common among SY. Winnipeg, Halifax and Toronto data clearly indicate that many SY engage in illegal activities to meet basic needs (Anderson, 1993; McCarthy & Hagan, 1992; Social Planning Council of Winnipeg, 1990). Because SY have high rates of substance use some criminally obtained goods may be traded for money for drugs and alcohol. Involvement in illegal activities, including prostitution, is related to length of time on the street and the number of runaway and home leaving incidents (Kufeldt & Nimmo, 1987; McCarthy & Hagan, 1992; Nadon, 1991). Female SY are more likely to participate in prostitution, whereas male SY are more likely to participate in theft (McCarthy & Hagan, 1992).

Contrary to popular misconception, there is no linear relationship between poverty and running away or homelessness. The misconception that poverty is directly related to running away is frequently mentioned by authors who invariably fail to provide convincing evidence for their assertions. A major cross-Canada study (King et al., 1998) found that over half the SY interviewed were from middle to upper-class homes. The National Network of Runaway and Youth Services found that among all American member agencies surveyed the number of runaways from each socioeconomic class corresponded to overall socioeconomic status averages in the United States (Dietz, 1991). There is no comparable Canadian counterpart to numerous recent reports of impoverished American families, including their adolescent children, being forced into

homelessness.

Table 2
SY Involvement in Illegal Activities

Sample	% Involved in Illegal Activity	
Runaway Youth	Self-reported:	
Age 10-21	- shoplifting	72%
Winnipeg	- fraud	58%
(Social Planning Council of Winnipeg, 1990)	- drug dealing	56%
	- theft	51%
	- joyriding	42%
	- prostitution	32%
	- robbery	29%
	- forgery	28%
Out-of-the-Mainstream Youth	Self-reported:	
Age 10-24	- shoplifting	29%
Halifax	- break and enter	15%
(Anderson, 1993)	- fraud	10%
	- drug dealing	16%
	- prostitution	10%

Population Size

The very nature of street-involvement – having no permanent address, involvement in illegal activities, and avoiding child welfare and police systems – creates barriers to estimating the size of this population. There is no legal requirement to report missing or runaway children to the police. There are no census data on homeless populations.

There is no generally accepted or well-defined method for estimating the size of SY populations. The Winnipeg Police Service collects information only about the total number of reported missing children, as reflected in Table 3. Missing children reports only reflect annual incidence. Some missing

children may be repeatedly reported for different "missing" incidents, while other missing children are never reported. There is reason to believe that non-reporting may occur more often for families who have had bad experiences with child protection services or the police. It is possible that disproportionately more Aboriginal families may not report.

Table 3
Winnipeg Police Service Annual Missing Children Reports (S. Pilot, Youth Division, City of Winnipeg Police Service, personal communication, March 23, 1998)

Year		1994	1995	1996	1997
Missing Males	*(%)*	(39%)	(38%)	(35%)	(36%)
& number		873	800	938	1055
Missing Females	*(%)*	(61%)	(62%)	(65%)	(64%)
& number		1377	1290	1772	1882
Total Missing Children		2250	2090	2710	2937

The Canadian Missing Children's Registry provides information about missing and runaway children. We know from the Registry that in 1996 runaways accounted for 78% of all reported missing children in Canada and for 88% in Manitoba (Royal Canadian Mounted Police, 1997). The 1997 incidence of reported Winnipeg runaways is 2,585. Assuming that runaways account for the same percentage of missing children in Winnipeg as they do in Manitoba, the average monthly incidence of runaway reports originating in Winnipeg is 215. The reported incidence of 1996 Manitoba children running away is 2,987. It is important to note that, on the one hand, not all running away incidents are

reported, and, on the other hand, some youth may be reported more often than once annually. If Manitoba runaways are unable to find a safe place, they are likely to migrate to Winnipeg's streets. A rough estimate of the number of Winnipeg street youth under 18 years of age is approximately 3,000.

According to 1996 census data the annual incidence of Manitobans running away during childhood is 10.2/1,000 (Statistics Canada, personal communication, March 24, 1996). This ratio increases to 23.2/1,000 if running away is assumed to occur rarely for those under age 10. That is, each year 1 in every 49 children aged 10 or older runs away. Although reliable, these numbers are nevertheless estimates. Reporting is not mandatory and some adolescents run repeatedly.

While it is possible to estimate the size of the young adult SY population, those 18 through 24 years of age, it has never been attempted in any Canadian city. The population size could be estimated using a capture-recapture methodology, requiring the concerted effort of many SY serving agencies (Young, 1997). Rossi, Wright, Fisher and Willis (1987) describe another method for estimating the homeless population of Chicago, which involves no effort by service agencies but which requires a shelter survey and a stratified random survey of all city blocks. This method is very intrusive and cannot ensure complete accuracy in determining the size of SY populations.

The data are insufficient for a precise estimate of older SY. Radford et al. (1989) found that the modal age of SY they interviewed across Canada was 17.

Social Planning Council of Winnipeg (1990) found that the mode, median and mean age of Winnipeg youth they interviewed was 16. Beyond this information there are no guideposts to estimating the population of young adult SY.

Review of Epidemiologic Data

This section identifies problems and risks of SY populations based on a careful review of collected epidemiologic data. No comprehensive review of SY health problems and risks from a Canadian perspective has been published.

SY health concerns are highly inter-related and influence each other in many ways. For example, childhood abuse, drug use, depression, poor self-esteem, and sexual risk may occur in the same individual or in subsets of SY. No health problems or risks should be assumed to be independent of others. Within the population of SY, prostitutes have some of the highest risks and rates of illness.

The health of SY tends to be better than that of homeless adults because of their age and because they have been on the streets for shorter periods of time (Council on Scientific Affairs, 1989).

Most of the studies cited below do not have a similar-aged comparison group from the general population. Even when a comparison population is used, not enough is known about it to be sure that the two groups are indeed comparable. Thus the relative magnitude of the problems and/or risks cannot be ascertained. Despite these serious limitations and the inadvisability of generalizing the results of cross-sectional studies, a review of the literature

points to several obvious health problems and risks.

Depression

There is overwhelming evidence that depression is very common among SY (Anna Travers, Shout Clinic, personal communication, 1995; Read et al., 1993; Smart & Adlaf, 1991; Smart et al., 1990), homeless youth (Kurtz et al., 1991a) and runaways (Yates, MacKenzie, Pennbridge & Cohen, 1988).

The literature identifies a number of factors related to depression; among them are self esteem, social support and time spent in a hostel (Smart & Walsh, 1993). Females are more likely to be depressed (McCarthy & Hagan, 1992). Females report feeling sad (Adlaf et al., 1996), depressed (Adlaf et al., 1996; Read et al., 1993; Smart et al., 1992) and feeling like crying (Adlaf et al., 1996; Smart et al., 1992) significantly more often than males. Adlaf et al. (1996) found no age differences in rates of depressed mood. Street youth sexually abused as children felt depressed more often than those who had not been abused (Sherman, 1992) as did runaway youth (Kurtz, et al., 1991b). Alcohol use was related to major depression (Greenblatt & Robertson, 1993).
suicide were previously depressed (Canadian Task Force on the Periodic Health Examination, 1994).

Table 4
Depression

Sample	Indicator and Finding
Street youth Age 14-25 Toronto (Read et al., 1993)	Response to question: Do you often feel depressed? 38% agreed - Females 47% - Males 35%
Street youth Age =or< 24 Toronto (Smart & Adlaf, 1991; Smart et al., 1990)	Centre for Epidemiologic Studies Depression Scale - Felt sad 37% - Felt lonely 36% - Felt depressed 30% - Felt like crying 26%
Street youth clientele of Shout Clinic Toronto (Anna Travers, Shout Clinic, personal communication, 1995)	Based on encounter data depression is most common diagnosis
Homeless vs. non-homeless youth coming to the same shelters Age > 18 Hollywood (Yates, et al., 1988)	Unknown measure of depression Homeless 46% Non-homeless 38%
Runaways versus non-runaways using an ambulatory service Age 10-24 Southeastern USA (Kurtz et al. 1991a)	Based on chart reviews runaways four times as likely to be depressed

Suicide

Suicide history and current suicidality are very common among SY (Greenblatt & Robertson, 1993; Lamontagne, Garceau-Durand, Elie & Blais, 1988; Robertson et al., 1990; Social Planning Council of Winnipeg, 1990). The degree of suicidality among SY is not surprising given that in the general

Canadian population between 30% and 70% of those who have committed Suicide attempts are much more likely to occur among females than among males (Adlaf et al., 1996; Greene & Ringwalt, 1996; McCarthy & Hagan, 1992; Molnar, Shade, Kral, Booth & Watters, 1998; Read et al., 1993; Rotheram-Borus, 1993; Smart et al., 1992). In the general population males have a four-fold higher rate of completed suicide over females (Canadian Task Force on the Periodic Health Examination, 1994).

Suicide thoughts or attempts in Toronto SY were reported most often by youth 14 to 16 years old. Reported suicide thoughts and attempts decreased with age, but it is unclear if this is due to increasing age or to completed suicides (Read et al., 1993). Toronto findings contrast with an American multi-city sample, which found that suicide attempts were more common among older youth, aged 18 to 21, versus those youth aged 12 to 17 (Greene & Ringwalt, 1996). In the general population the highest rate of suicide occurs in males aged 20 to 24 (33.3%) (Canadian Task Force on the Periodic Health Examination, 1994).

In the general population the highest risk of a repeated attempt is in the three years following an attempt, and in particular, in the first six months following an attempt. Aboriginal rates of suicide are at least twice as high as those in non-Aboriginal populations (Canadian Task Force on the Periodic Health Examination, 1994).

There is adequate evidence to assume that just like their non-street-

involved counterparts, male gay SY are at higher risk for suicide attempts than their non-gay counterparts (Kruks, 1991). Sexual orientation does not seem to be a suicide risk for females. Using a population-based school sample, Remafedi, French, Story, Resnick and Blum (1998) found that, after adjusting for socioeconomic status, self-identified bisexual and homosexual males had a higher risk of suicidal intent (OR=3.61) and of suicide attempts (OR=7.10). Toronto self-identified gay or bisexual SY had more suicidal thoughts or actions compared to heterosexual youth (35% vs. 28%) (Read et al., 1993).

Table 5
Suicide Thoughts and Attempts

Sample	Indicator and Finding
Runaway Youth Age 10-21 Winnipeg (Social Planning Council of Winnipeg, 1990)	Suicide thoughts 65% Suicide attempt 54%
Homeless shelter users Age 18-30 Montreal (Lamontagne et al., 1988)	Suicide thoughts 71% Suicide attempt 48%
Street youth Age =or< 24 Toronto (Smart & Adlaf, 1991; Smart et al., 1990)	Suicide attempt 42% Current suicide plan 6%
Homeless adolescents Age 13-17 Hollywood (Greenblatt & Robertson, 1993; Robertson et al., 1990)	Suicide attempt: - ever 48% - more than once 28% - in previous 12 months 27% - hospitalized for 17%

Clearly, personal substance use is an important factor in suicide attempts (Greene & Ringwalt, 1996; Smart et al., 1992). Suicide history may indicate current or past life problems. In the general population, those persons with a substance abuse problem are at significantly higher risk for suicide (OR=2.4 to 23) (Canadian Task Force on the Periodic Health Examination, 1994).

Table 6
Suicide Attempts by Gender

Sample	Indicator and Findings
Street youth Age =or< 24 Toronto (Adlaf et al., 1996; Smart et al., 1992)	Suicide attempts - by females 61% - by males 37%
Runaway & homeless youth in shelters Age 12-21 Multi-city American (Greene & Ringwalt, 1996)	Suicide attempts - by females 34% - by males 22%
Street youth recruited by outreach staff Age 12-19 Multi-city American (Molnar et al., 1998)	Suicide attempts - by females 48% - by males 27%
Runaway adolescents using 4 programs Age 12-17 New York (Rotheram-Borus, 1993)	Suicide attempts - by females 44% - by males 29%

In an American multi-city study, youth in shelters who had any family members who used substances were almost twice as likely to have attempted suicide, and if a sibling used substances they had a four-fold risk (Greene & Ringwalt, 1996). Sherman (1992) found that San Francisco SY reporting childhood sexual abuse had suicidal thoughts or attempts twice as often as those who did not. Molnar (1998) also reported high odds ratios for physical and

sexual abuse. A Toronto study found that suicide attempts were positively related to length of time on the street (McCarthy & Hagan, 1992).

Table 7
Substance Use, Sexual Abuse and Suicide Attempts

Sample	Indicator and Findings
Street youth Age =or< 24 Toronto (Smart et al., 1992)	Alcohol or drugs associated with attempts: - always 34% - most of the time 7% - some of the time 23% - never 35%
Runaway & homeless youth Age 12-21 Multi-city American (Greene & Ringwalt, 1996)	Reported that drug or alcohol use caused them to attempt suicide in the past 12 months: - Shelter sample 29% - Street sample 50% Lifetime suicide attempts in context of familial substance use: - shelter sample OR=1.9 - street sample OR=1.7 - shelter sample with sibling substance use OR=3.9
Street youth clients attending three primary care clinics Ages 10-18 San Francisco (Sherman, 1992)	- Those sexually abused as children and attempting suicide 62% - Those not sexually abused as children and attempting suicide 37%
Street youth recruited by outreach staff Age 12-19 Multi-city American (Molnar et al., 1998)	Suicide attempts if abused prior to home leaving: - males sexually abused OR=4.3 - males physically abused OR=4.2 - females sexually abused OR=3.2 - females physically abused OR=1.9

Mental Illness

Aside from suicide and depression, SY populations have mental health problems far in excess of the general population. Greenblatt and Robertson

(1993) found that homeless youth met the DSM-III criteria for mental illness three times as often as non-homeless adolescents. Russell, Pennbridge and Stefanidis (1992) found that over half of California homeless sexually exploited youth had profiles suggesting that they should be sent to a psychiatrist to assess their need for psychotropic medication. Hollywood runaways had a 4½ -fold risk for being diagnosed with a serious mental health problem compared to non-runaways (Yates et al., 1988).

In a 12 year follow-up study on Washington D.C. runaways, Olson, Liebow, Mannino and Shore (1980) found that most had psychological symptoms and had been involuntarily committed for mental problems. They compared very poorly to their siblings. Of Toronto SY many had at least one or more psychotic thoughts over the last year. A large number also reported lifetime panic or anxiety attacks (Smart et al., 1992). A Toronto clinic serving SY found that anxiety and schizophrenia were among their seventh and ninth most common diagnoses (Anna Travers, Shout Clinic, personal communication, 1995).

Mentally ill persons with disturbed and violent behaviour face severe adversity and hardship. Repper and Perkins (1995) found that mentally ill persons living in London who were refused the opportunity for community rehabilitation services were more likely to be homeless, to exhibit disturbed and violent behaviour, and to have a diagnosis of personality disorder or a forensic history. Booth and Zhang (1996) found severe aggression (62%) and conduct disorder (55%) far more frequently among homeless and runaway adolescents

than in the general adolescent population. Robins (1957) carried out a thirty-year non-blinded matched follow-up of runaways compared to patients seen at a child guidance clinic and to individuals who had attended public schools. He found that runaways had significantly higher rates of psychiatric illness than both groups, particularly diagnoses of sociopathic personality.

It may well be that SY have a "higher threshold of distress" in determining their mental health needs because of the need for day to day survival taking precedence over other needs, a lack of insight, or poor experiences with mental health treatment (Herman, Struening & Barrow, 1993). SY may also reconcile themselves to higher levels of illness, only seeking care when they have trouble functioning at a basic level (Shiner, 1995).

The conditions associated with homelessness and having no fixed address can exacerbate symptoms of chronic mental illness (Robertson, 1986). Substance use, poor nutrition, sleep deprivation and disordered sleeping patterns, a history of negative life events, decreased social supports, social ostracization, and legitimate fears for safety and survival contribute to the symptomatology of mental illness (Jackson & McSwane, 1992).

Substance Use

Substance use and abuse is ubiquitous among SY (Council on Scientific Affairs, 1989). In fact, Radford et al. (1989) describe addiction to substances as a significant cause of entrenchment in street life. Hollywood SY have 4.1 times the likelihood of a diagnosis of alcohol and/or drug abuse compared to non-

runaways (Yates et al., 1988). Other than a report that 30% of Winnipeg male prostitutes identify substance abuse as a problem (Village Clinic, 1997), there is a dearth of Winnipeg data.

Table 8
Mental Illness

Sample	Indicator and Findings
Homeless Age 13-17 Hollywood (Greenblatt & Robertson, 1993)	3 times the expected prevalence of disorders meeting DSM-III criteria
Homeless sexually exploited youth Age 13-18 California (Russell, Pennbridge & Stefanidis, 1992)	Based on MMPI 58% should be sent for psychiatric assessment for medication
Runaways compared to non-runaways using an ambulatory service Age 10-24 Hollywood (Yates et al., 1988)	Diagnosis of a mental health problem based on chart reviews OR=4.5
Runaways compared to siblings Washington D.C., (Olson et al., 1980)	12-year longitudinal study showed that most runaways had psychological problems and had been referred for help. Only one sibling had such problems.
Street youth Age = or < 24 Toronto (Smart et al., 1990)	Psychotic thoughts - one 20% - two or more 8% Lifetime panic or anxiety attacks 42%
Street youth attending primary care clinic Age < 25 Toronto (Anna Travers, Shout Clinic, personal communication, 1995)	Diagnoses made during visit - Anxiety 7th most common diagnosis registered - Schizophrenia 9th most common diagnosis registered

Many SY report one alcohol or one drug problem or both (Anderson, 1993; Read et al., 1993). Problems with drug and alcohol use as well as use of treatment increase with age (Read et al, 1993). Of Montreal homeless aged 18 to 30, many had been hospitalized for alcoholism, experienced detoxification programs, and had attended Alcoholics Anonymous (Lamontagne et al., 1988).

Alcohol abuse is a serious problem for SY. Regardless of age or gender, close to half (46%) of Toronto SY identified a clinically significant number of problems with alcohol use (Smart & Adlaf, 1991; Smart et al., 1990). Youth drank an average of 18.1 drinks in the last week and 27% drank 29 or more drinks in a week (Adlaf et al., 1996). SY are heavy drinkers (Smart & Adlaf, 1991; Smart et al., 1990; Smart et al., 1992) . In comparison to Toronto students, Toronto SY used alcohol in much larger quantities and consumed far more drinks in a single sitting. For example, no student comparisons used alcohol daily but 6% of SY did. Adlaf et al. (1996) report heavy drinking among SY, 63% of whom drank five or more drinks at one time during the past month, while 30% drank the same amount at least five times in the past month. High alcohol use is consistent with findings in other cities (Anderson, 1993; Koopman, Rosario & Rotheram-Borus, 1994; Zimet et al., 1995) .

High levels of drug use are also common. Most Toronto SY reported some problems associated with drug use, and almost half (45%) were concerned about their own drug use (Smart & Adlaf, 1991; Smart et al., 1990). A major cross-Canada study (King et al., 1998) found that although 29% of youth never

used drugs, 5% did so monthly, 36% weekly, and 30% daily. Of Toronto SY 92% used cannabis in the past year and 16% used it daily (Smart & Adlaf, 1991; Smart et al., 1990). Older SY were almost three times as likely to use cannabis daily as younger SY. The average SY used 3.9 street drugs during the year. Inhalants were used by 17% of the population. The quantity of drugs used has never been reported. Of Montreal homeless aged 18 to 30, 17% had been hospitalized for drug use and 24% had been in drug detoxification programs (Lamontagne et al., 1988). Smaller centres may not have the same level of drug problems as that reported in North America's largest cities (Zimet et al., 1995).

Table 9
Treatment for and Problems Associated with Alcohol or Drugs

Sample	Indicator and Findings
Out-of-the-Mainstream Youth Age 10-24 Halifax (Anderson, 1993)	Self reported problem with: - alcohol 5% - drugs 5% - both 15%
Street youth Age 14-25 Toronto (Read et al., 1993)	Treated for overdose 10% Among 14-16 year olds: - problems with alcohol 20% - problems with drugs 17% - received treatment 6% Among 23-25 year olds: - problems with alcohol 53% - problems with drugs 51% - received treatment 40%
Homeless shelter users Age 18 to 30 Montreal (Lamontagne et al., 1988)	- Hospitalized for alcoholism 14% - Attended alcohol detoxification programs 23% - Attended alcoholics anonymous 34%

Males use more alcohol and drugs than females. In their cross-Canada study Radford et al. (1989) found that 41% of SY males used drugs heavily as did 34% of females. Antecedents to street life are a factor in drug use. The number of family members with alcohol and drug problems is related to the number of drugs used (Adlaf et al., 1996). A study of New York runaway shelter respondents found that the use of drugs and alcohol in a male's social network is closely related to his own consumption of drugs and alcohol (Koopman et al., 1994). The same is true of females and their social networks, but only in relation to drug use. Tobacco use is prevalent. Three quarters of Halifax SY smoked tobacco to some extent (Anderson, 1993). Fewer curb youth (those without parental involvement or connection to home), females and SY under 18 smoked compared to entrenched, male and older SY (Anderson, 1993).

Among factors predisposing persons to substance use, cumulative time spent on the street is the most important. An American national longitudinal study determined that one-time runners are more likely to abuse most substances, including cigarettes, than those who never run, and those repeatedly running are at high risk for substance abuse (Windle, 1989). A Toronto study found that as time on the street increases so do occasions of drinking and the number of drugs used (Adlaf et al., 1996). An American ten-city study found that street-based youth who have generally spent a great deal of time on the street used more of all drugs compared to shelter-youth who have spent less time on the street (Greene et al., 1997). Age at leaving home is

related to the number of drugs used once on the street. Those using more drugs left home earlier (Adlaf et al., 1996). Most Halifax SY (58%) report that they use drugs or alcohol as a means of escape from emotional and mental pain, negative life experiences, and boredom (Anderson, 1993). For some SY, substance use has drawn them to the street; for others it is the only thing that makes life on the street bearable (Backe & Katz, 1996).

Injection Drug Use. There are no published reports about overall injection drug use (IDU) in Winnipeg. The percentage of IDUs in major Canadian cities may exceed that of small cities. In their cross-Canada study King et al. (1998) found that approximately 9% of SY injected. Half of those injecting shared needles. About one in five Winnipeg female prostitutes had injected with used needles (Campbell & Heinrich Research Associates, 1994).

In 1991, of Toronto SY IDUs, 10% had injected in the past six months. One quarter of IDUs shared needles (Read et al., 1993). Most shared with a friend, others shared needles with someone with HIV or with someone in prison. Of those who shared needles 12% shared with 10 or more persons while 44% shared with only one person. Of those who shared needles half reported always cleaning them, although some of the techniques employed were ineffective. This compares to a Halifax SY sample of whom 17% used needles, with 72% of that group sharing needles (Anderson, 1993). The reason for these vastly different findings may be related to the influence of needle exchange programs. No reports discussed other possibly contaminated shared equipment such as

cotton filters, mixing water, cookers and alcohol swabs.

The risks of IDU and of sharing needles increases with the age of the SY (Smart & Adlaf, 1991; Smart et al., 1990; Smart et al., 1992). Older youth use injection drugs significantly more often than younger youth (Adlaf et al., 1996). In a 1993 study of Northern California SY, Clements et al. (1997) found that IDU within the past 30 days was related to: being over 18 versus being 18 or less; having unstable housing; drinking alcohol daily; subsisting by dealing drugs, prostituting, and/or stealing; and being sexually active in the past 30 days.

Table 10
Factors Associated with Injection Drug Use

Sample	Indicator and Findings
Street youth Age 12-23 Northern California (Clements et al., 1997)	Those using injection drugs in the last 30 days: - over 18 versus being younger OR=1.95 - having unstable housing OR=3.82 - drinking alcohol daily OR=2.59 - subsisting by dealing drugs, prostitution or stealing OR=2.13 - being sexually active in the past 30 days OR=1.79

IDU carries risks of serious infection such as HIV, hepatitis B and hepatitis C. Other risks include: tolerance for the injected drug requiring ever-increasing doses to feel the same effect, abscesses, poor appetite, heart palpitations, nausea, fatal and near fatal overdoses, and mental health problems such as depression, anxiety, paranoia, and suicidal ideation. IDUs also report physical discomfort on "coming down" from a hit, and use other drugs to help them cope with this. Most believe that it would be good for them to reduce or

quit use of drugs and have already tried this. Most feel better or somewhat better when quitting or cutting down (Kipke, Unger, Palmer & Edgington, 1996).

Pregnancy

SY have high rates of pregnancy, high birth rates and often do not live with the children they bear or father despite wanting to do so (Campbell & Heinrich Research Associates, 1994; Ensign & Santelli, 1998; Jackson & McSwane, 1992; Read et al., 1993; Anna Travers, Shout Clinic, personal communication, 1995). For females, pregnancy may increase risk of homelessness (Robertson et al., 1990). Pregnancy occurs in circumstances that are far from ideal.

Factors which may lead to unfavourable health outcomes include an environment characterized by: inadequate nutrition, high rates of drug and alcohol use, minimal or no prenatal care as very few services cater to this population, high rates of sexually transmitted infection, and high rates of violence. Alcohol and drug use may be dramatically curtailed during a known pregnancy (Ray, 1993). The most sensitive time for fetal development is in the first trimester—the period when many females, let alone street youth, would be unaware of pregnancy.

Ray (1993) reports that most SY mothers adjusted relatively well to motherhood, having made significant changes in their lives. Half of mothers identified being "upset over the responsibilities of being a mother." Half also continued relationships with the baby's father, and a little more than a quarter

said that the father was someone they could depend on. SY mothers relied mostly on friends, followed by family and partners. SY mothers identified many stresses in their lives. Many street mothers (40%) rated their health as fair or poor, and three quarters were concerned about the health of their baby. More than half of street mothers were depressed.

Table 11
Pregnancy, Fatherhood and Children

Sample	Indicator and Findings
Female prostitutes Ages - all Winnipeg (Campbell & Heinrich Research Associates, 1994)	File audit data - pregnant 18% Survey data - have children 61% Survey data - live with children 32%
Street youth Age 14-25 Toronto (Read et al., 1993)	They or partner had birthed or fathered a child 40% Have children with them 10% Females currently pregnant 26% Pregnant females wanting to keep child 92%
Shelter youth compared to school-based inner-city clinic youth Age 12-17 Baltimore (Ensign & Santelli, 1998)	25.3% compared to 13% ever pregnant
Street youth attending primary care clinic Age < 25 Toronto (Anna Travers, Shout Clinic, personal communication, 1995)	5th most common diagnosis made during clinic visits

SY often do not protect themselves from pregnancy. While most Winnipeg runaways reported being sexually active while on the run, only half used some form of birth control (Social Planning Council of Winnipeg, 1990). In

their cross-Canada sample, Radford et al. (1989) found that fewer SY were concerned about becoming pregnant than their same aged peers (30% vs. approximately 45%).

Sexual Debut

Sexual debut, or the beginning of sexual intercourse, may be a health risk or a health problem in its own right. Legally, intercourse before the age of 12 is called rape and always signifies sexual abuse. Radford et al. (1989) report that 21% of SY had experienced sexual intercourse before the age of 12. Half of those who had sex before the age of 10 reported "being raped".

As a health risk, early sexual debut increases the risk of sexually transmitted infection (STI). The risk of STI increases with the number of lifetime partners. A relationship between early sexual debut and increased number of lifetime partners among SY was established in a cross-Canada study (Radford et al., 1989). In the same study the median and mode for sexual debut was 14 years of age. Of a Toronto sample, half had sex before the age of 14 (Read et al., 1993). Coercion or rape was the first sexual experience of 14% of Toronto SY. Sexual debut is earlier and sexual activity is the norm among SY (Anderson et al., 1994).

Sexually Transmitted Infection

SY are considered a group at high risk for HIV and other STIs. In addition to the injection drug use and early sexual debut already discussed, other contributors to the risk of STI include: incidence and duration of infection,

frequency of sex, type of sexual activity, and number of partners. Little information about the rates and risks of sexually transmitted infection (STI) exists for the Winnipeg SY population, and none of it is current.

SY have a high *incidence of STI.* Radford et al. (1989) identify reasons for concern: 22% of SY had contracted an STI, and 5% had contracted more than one. Half of gay and bisexual youth had a history of STI. A Toronto clinic serving SY found that STI was the third most common diagnosis made (Anna Travers, Shout Clinic, personal communication, 1995). One third of Winnipeg runaways knew they had an STI (Social Planning Council of Winnipeg, 1990). Over a third of Winnipeg male prostitutes (35%) report having had an STI (Village Clinic, 1997).

Not being tested could prolong *duration of an STI* in an asymptomatic carrier. Less than half of the 63% of Winnipeg runaways reporting HIV risk behaviour while on the run recognized they had put themselves at risk of contracting HIV (Social Planning Council of Winnipeg, 1990). Of Winnipeg male prostitutes only 85% had been tested for HIV and 75% for STI (Village Clinic, 1997). In their cross-Canada studies King et al. (1998) and Radford et al. (1989) found that approximately half of SY had never been tested for STI while 3% were not sure. While most people who knew they had an STI were tested and treated, only three quarters attended for a follow-up visit.

Risk of infection increases as *frequency of sex* increases. Of sexually active Toronto SY more than half said they had sex at least once a week (Read

et al., 1993). Of 79% of sexually active Cleveland adolescent runaways, the mean number of sexual encounters in the last month was 4.2, and in the last six months it was 18.7 (Zimet et al., 1995).

Type of activity can also increase risk of STI. For example, a Toronto sample of gay male SY who had anal intercourse had high rates of hepatitis (Wang, King, Goldberg, Bock, Milner & Read, 1991). Anal sex was more than four times as frequent among a multi-city American street youth sample than a domiciled comparison group (Ensign & Santelli, 1998). California SY's sexual activities in the last 30 days include high rates of vaginal and oral sex, and small but significant rates of anal sex among men and women. Of those who had vaginal sex only a quarter always used a condom. Males used condoms more than females. Of all sexually active youth, only a quarter thought their behaviour put them at risk for HIV. This alarming denial of risk occurs despite more than half worrying about getting HIV and believing they will get it in the future (Clements et al., 1997).

According to the Social Planning Council of Winnipeg (1990) study, Winnipeg runaways may have a similar pattern of behaviour. Although 85% report having had sex while on the run, only 39% used condoms sometimes and 28% all of the time. Canadian studies unfailingly report that a minority of SY consistently use safer sex.

Of Winnipeg male prostitutes half always use condoms while working, and slightly more than half (55%) always use condoms with their partner. Only

35% consistently use condoms for pay and pleasure (Village Clinic, 1997). Female prostitutes infrequently use condoms with their boyfriends (Campbell & Heinrich Research Associates, 1994). These findings are consistent with an Ottawa study (Caputo et al., 1994a), which reports that prostitutes may engage in risky expressions of intimacy, using condoms with customers but not with boyfriends or girlfriends. As well, young prostitutes often are bribed into not using condoms (Radford et al., 1989).

A Canadian study of persons who had successfully left the street determined that 40% had been tattooed while on the street (Caputo, Weiler, & Anderson, 1997). Non-professional tattooing also carries a risk of various chronic STIs.

A study of California SY carried out in 1993 argues that gender-specific approaches to risk reduction must be encouraged (Clements et al., 1997). They found that 73% of SY had discussed condom use and sexual behaviour with partners. Half had generally good experience with condoms, and two thirds agreed that safe sex was completely accepted by friends. The same study found that females less likely to use condoms for vaginal sex did not have stable housing. Males infrequently using condoms for vaginal sex were likely to be daily users of marijuana. Factors found to enhance condom use for vaginal sex among females were good experiences using condoms and having other partners. Factors enhancing condom use for vaginal sex among males were usually carrying condoms, having received condoms in the past 30 days and a

high perceived peer norm.

Table 12
Sexual Risk Behaviour

Sample	Indicator and Findings
Street youth Age 12-23 Northern California (Clements et al., 1997)	Sexual activities in the last 30 days: - vaginal sex 98% - used condom every time for vaginal sex 23% - males using condoms every time 43% - females using condoms every time 29% - oral sex 71% - anal sex among men 7% - anal sex with women 3% - think behaviour puts them at risk 27% - worried about getting HIV 62% - believe they will get HIV in future 59% Decreased condom use based on: - housing stability in females OR=0.3 - daily use of marijuana in males OR=0.36 Increased use of condoms for vaginal sex in females based on: - good experience using condoms OR=3.95 - having other partners OR=2.98 Increased use of condoms for vaginal sex in males based on: - carrying condoms OR=4.61 - having received condoms in the past 30 days OR=3.86 - a high perceived peer norm OR=2.16

SY use condoms more frequently with those who are unknown to them (Anderson et al., 1996; Radford et al., 1989; Read et al., 1993). Anderson et al. (1996) found that the most consistent predictor of condom use among SY was having a condom on their person. Factors associated with risky sexual practices include being on the street instead of in a shelter, not having basic

needs met, and experiencing child abuse (Johnson et al., 1996).

Large numbers of partners also increase risk for STI. After excluding prostitutes, a cross-Canada study found that, to date, SY had an average of 21 lifetime partners (King et al., 1998). High rates of hepatitis were found in a Toronto SY with a large number of heterosexual SY partners (Wang et al., 1991). Drug and alcohol use is related to increased numbers of partners (Koopman et al., 1994; Radford et al., 1989).

Dental and Periodontal Health

Data related to Winnipeg SY's oral health are unavailable. While dental care is not a publicly insured service, it is essential to health. Barriers to accessing preventive and other dental care include: not having insurance, not being on welfare, an unstable lifestyle which makes it difficult to book and keep appointments, distrust of people in positions of authority, some health care providers' discomfort serving SY, and worry by SY that they will be given discriminatory and substandard service (Lee et al., 1994).

A study comparing homeless youth in North York, Ontario to their non-homeless peers identified serious hygiene problems and poor dental and periodontal health (Clarke, Locker, Murray & Payne, 1996) as did a study of downtown Toronto SY (Lee et al., 1994). Most SY in North York and Toronto had moderate to severe gingival inflammation. Increases in gingival problems were associated with years on the street in the Toronto sample. North York DMFT (decayed, missing, filled teeth) scores of 3.28 and Toronto scores of 5.7

are substantially higher than the score of 1.7 of the Ontario Health Survey comparison group. The Toronto study found that DMFT scores significantly increased with age and years on the street.

In North York 12% of homeless youth needed urgent dental care for pain or infection. Toothache was far more common for homeless youth (18%) than for Ontario Health Survey respondents (13%). Temperature sensitive teeth were 50% more common in homeless youth than reported in the Ontario Health Survey (32% vs. 21%). Homeless youth had three times as many sore or bleeding gums as Ontario Health Survey youth (41% vs. 14%). Three times as many homeless youth (18%) had pain in the jaw compared to Ontario Health Survey youth (6%).

The same urgent need for dental health care was found in the Toronto sample. Problems were common: 40% had pain when chewing, 13% had pain that kept them awake, and 45% reported bleeding gums. Three quarters said they needed dental treatment or advice now. Of the 51% who suffered no tooth pain, 38% had tooth decay and 40% had calculus or were in need of periodontal treatment.

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periodontal treatment.

Table 13
Dental and Periodontal Health

Homeless youth Age 16-25 North York (Clarke et al. 1996)	Indicator and Findings Moderate to severe gingival inflammation 77%
Homeless youth Age 14-25 Toronto (Lee et al., 1994)	Moderate to severe gingival inflammation 88% Years on the street compared to gingival health score : 0 to <1 - 1.1 1 to <3 - 1.1 3 to < 5 - 1.5 5 + - 1.6 DMFT score compared to years on the street: 0 to <1 - 4.5 1 to <3 - 4.4 3 to < - 5 5.2 5 + - 7.2 Mean DMFT by age: 14-18 - 3.7 19-22 - 5.6 23-25 - 8.3

Most Toronto youth (72%) brushed their teeth at least daily but only 6% flossed daily. A need to focus on basic day-to-day survival does not support attention to dental hygiene. Poor dental hygiene coupled with inadequate nutrition and physical injuries fosters poor dental health (Lee et al., 1994).

Only 41% of North York homeless youth used any dental services in the year studied, and of those, 86% sought help only when in pain. Only 22% of Toronto SY had seen a dentist in the past year, 59% in two years. Most (54%) did not see a dentist because of cost, 18% because of fear.

Determinants of Health and Illness Prior to Running Away and Street Involvement

The causes of running away and street involvement include various types of abuse, alcohol and drug use by youth, school problems, and discontinuous and unstable living arrangements. Factors influencing running away and street involvement may be interrelated and directly or indirectly affect health.

At the individual and family level, causes of running away and street involvement are understood and consistently portrayed in the literature. The reasons for initial street involvement can have long-term health consequences. Several non-discrete factors create a risk of street involvement, and all of these create conflict with caregivers (Radford et al., 1989; Read et al., 1993; Runaway and Homeless Youth Study Committee, 1994; Young et al., 1983). However, conflict with caregivers is a proximal event, not the underlying cause of running away. But it should be noted that runaways and street-involved youth may experience little warmth and support from parents (Young et al., 1983: Adams & And, 1985). What are believed to be the most significant underlying initial causes of street involvement can be collapsed into the following experiences of youth: (a) sexual, physical and/or emotional abuse or neglect; (b) discontinuous and disrupted living arrangements; (c) school problems (Runaway and Homeless Youth Study Committee, 1994); and (d) alcohol or drug use. While authors may focus on one or more "determinants of" or

"antecedents to" street involvement or running away, there appears to be no conflict among authors in proposing rationales for street involvement or running away behaviour.

Abuse. The finding of higher levels of abuse among SY has been repeatedly detected in post-facto correlational studies. High rates of sexual abuse (Adlaf et al., 1996; Gary, Moorhead & Warren, 1996; Greenblatt & Robertson, 1993; Janus, Archambault, Brown & Welsh, 1995; Kennedy, 1991; King et al., 1998; Kurtz et al., 1991b; McCormack & And, 1986; Rotheram-Borus et al., 1996; Sherman, 1992; Smart et al., 1992; Warren, Gary & Moorhead, 1994); physical abuse (Adlaf et al., 1996; Anderson, 1993; Gary et al., 1996; Greenblatt & Robertson, 1993; Janus, 1995; Janus, Burgess & McCormack, 1987; Kennedy, 1991; Kurtz et al., 1991b; Sherman, 1992; Smart et al., 1992; Warren et al., 1994); and emotional abuse, including being neglected abandoned or being forced out; (Gary et al., 1996; Janus et al. 1995; Kennedy, 1991; King et al., 1998; Russell et al., 1992) have been reported by youth. The risk of running away increases when more than one type of abuse occurs (Widom, 1995).

Whitbeck et al. (1997) compared the views of parents/guardians and runaway youths on their perceptions of abuse and neglect. Overall, this study supported the finding that abuse was a major antecedent to street involvement. Although there was disagreement about the intensity of the abuse, the runaways' reports of abuse and neglect accurately represented their home

situations.

Parental abuse, which Halifax SY report as a reason for leaving home, includes being kicked out and being physically or sexually abused (Anderson, 1993). Half of Winnipeg SY had been sexually abused. Winnipeg SY also reported family problems before the last running episode which included physical fights between parents, between parents and siblings, and between the youth and his/her parents (Social Planning Council of Winnipeg, 1990).

Table 14
Abuse

Sample	Indicator and Findings
Runaways Age 11-21 Winnipeg (Social Planning Council of Winnipeg, 1990)	Reported being sexually abused 49% Reported family problems before running away: - physical fights between parents 42% - physical fight between parents and siblings 27% - physical fight between youth and his/her parent 67%
Prostitutes Age =or > 13 Winnipeg (Elizabeth Fry Society, 1985)	Sexually or physically abused as a child 60% Neglected or verbally or emotionally abused 27% No abuse as a child 12%
Out-of-the-Mainstream Youth Age 10-24 Halifax (Anderson, 1993)	Parental abuse as reason to leave home: - being kicked out 16% - being physically abused 14% - being sexually abused 8%

A 1985 Winnipeg study of female prostitutes by the Elizabeth Fry Society and the YWCA found that most reported being sexually or physically abused as a child. A quarter had only been neglected or verbally or emotionally abused. Only 12% reported no abuse as a child. Most sexual abuse had been at the

hands of a family member (Elizabeth Fry Society, 1985).

Various studies found that a history of sexual abuse was more common among prostituting SY (Radford et al., 1989; Rotheram-Borus et al., 1996; Sherman, 1992; Silbert & Pines, 1983). Running away is associated with initiation of prostitution. However, in studies with control groups Nadon (1991), Seng (1989) and Widom (1995) find no evidence to support a direct causal relationship between sexual abuse and prostitution. Females report higher rates of sexual abuse than males, although both are high (McCormack & And, 1986).

In addition to the increased risk of street-involvement, abuse is associated with other outcomes. Compared to their non-sexually abused counterparts, sexually abused Toronto female runaways are more likely to report: feeling worried or tense, feeling nervous or jittery, "going crazy", confused feelings about sex, trouble with school officials and employers, participation in physical violence, and experiencing arrest and trouble with the law requiring incarceration. Sexually abused Toronto male runaways differ from their non-sexually abused counterparts by frequently reporting being worried or tense, and having a fear of adult men (McCormack & And, 1986).

Alcohol and Drug Use. A proportion of SY populations identify their own use of drugs or alcohol as contributing factors in leaving home (Robertson et al., 1990; Smart et al., 1990; Smart et al., 1992). Most Winnipeg runaway youth identified their own alcohol abuse as an issue prior to running (Social Planning

Council of Winnipeg, 1990).

Table 15
Alcohol and Drugs as Antecedents to the Street

Sample	Indicator and Findings
Runaways Age 11-21 Winnipeg (Social Planning Council of Winnipeg, 1990)	Identified own alcohol abuse as an issue prior to running 69%
Homeless Age 13-17 Hollywood (Robertson et al., 1990)	Identified use of drugs before becoming homeless as a contributing factor 18%
Street youth Age =or< 24 Toronto (Smart et al., 1990)	Identified own drinking as a contributing factor to their leaving home 15%
Street youth Age =or< 24 Toronto (Smart et al., 1992)	Identified own drinking as a contributing factor to their leaving home 21%

Alcohol and drug use also contribute to abusive and unstable home environments. Winnipeg runaways reported that 90% had homes where alcohol and drug abuse had occurred. Winnipeg SY also reported that 52% experienced alcohol abuse by a parent and 36% by a sibling (Social Planning Council of Winnipeg, 1990). Two thirds of Toronto SY and Montreal homeless aged 18 to 30 identified alcohol problems in the family and a third of Toronto SY said that alcohol use was a contributing factor to their leaving home. Montreal homeless also reported high rates of drug use among parents (11%) and siblings (62%) (Lamontagne et al., 1988). Two fifths of Toronto street youth

identify drug problems in their families prior to leaving, but only 18% in 1990 and 9% in 1992 said that family drug use was a factor in their leaving (Smart et al., 1990; Smart et al., 1992).

Discontinuous and Unstable Living Arrangements. Homelessness among youth may be a continuation of residential instability, and thus running away and homelessness can be viewed as part of a process, not as discrete events (Robertson et al., 1990). Homeless children often have high rates of involvement with child protection services (Rotheram-Borus et al., 1996) and histories of previous incarceration (Smart & Adlaf, 1992). Inadequate social support resulting from unstable living arrangements has profound effects on health.

Winnipeg runaways reported running most recently from various residential settings, but infrequently from one or both parents (Social Planning Council of Winnipeg, 1990).

The majority of Winnipeg runaways last ran from child protection placements. Most runaways from child protection placements in Winnipeg ran because of dissatisfaction or problems with the placement (Social Planning Council of Winnipeg, 1990). Kufeldt, Durieux, Nimmo and McDonald (1992) found that half of Calgary youth interviewed on the street were on the run from child protection agencies. Half of Calgary long-term runners and a third of short-term runners were involved with child protection agencies (Runaway and Homeless Youth Study Committee, 1994). Running from government care may

be the most important antecedent for Aboriginal street involvement (Gilchrist, 1996).

Table 16
Unstable Living Arrangements of Runaways

Sample	Indicator and Findings
Runaways Age 11-21 Winnipeg (Social Planning Council of Winnipeg, 1990)	Ran most recently from: - group home/receiving home 28% - locked facility 15% - foster home 14% - both natural parents 13% - single mother 11% - natural mother or stepfather 8% - adoptive home 4% - various other living arrangements 5% - child protection placements 59% Running due to dissatisfaction or problems with the child protection placement 73%
Safe house users Age 12-17 Calgary (Kufeldt et al., 1992)	On the run from child protection placements 46% Long-term runners involved with child protection 53% Short-term runners involved with child protection 30%

Of Montreal homeless aged 18 to 30, two thirds came from homes where parents were separated, divorced or dead (Lamontagne et al., 1988). Being adopted and being part of a reconstituted family may be related to street involvement. SY coming from adoptive parents accounted for 14% of a Calgary SY sample (Runaway and Homeless Youth Study Committee, 1994) and for 3% of a Halifax sample. Reconstituted families accounted for the background of 42% of Calgary and of 25% of Halifax SY compared to a national average of approximately 7% of reconstituted families (Anderson, 1993; Runaway and

Homeless Youth Study Committee, 1994).

A history of incarceration is also a common among SY. Smart et al. (1992) found that 48% of Toronto SY had lived in detention centres. Incarceration contributes to a history of discontinuous and disrupted living arrangements. Radford et al. (1989) expected only 8% of their Canadian sample would be youthful offenders but ended up with a total of 16%. When residential patterns are frequently disrupted, it is believed that youth loose or are unable to develop effective supportive relationships which may greatly influence their mental health.

School Problems. School problems are widespread among SY. Problems at school and at home influence each other. School problems may cause conflict with parents and home problems may influence school performance (Radford et al., 1989). When residential and school relationships are both disrupted, youth may loose any remaining social support, greatly affecting their health.

The extent of SY attendance at alternative schools is unknown, but homeless youth are known to have higher rates of attendance at alternative schools than non-homeless youth (Kurtz et al., 1991a).

Of Winnipeg runaways reporting running away from home, half reported arguments with parents over grades, and even more argued over skipping school (Social Planning Council of Winnipeg, 1990). Two thirds of Winnipeg runaways were still attending school. Winnipeg statistics compare favourably

to a cross-Canada study where most SY (two thirds) left school (Radford et al., 1989) and to a Halifax sample where about half of SY dropped out (Anderson, 1993). Most Winnipeg and Halifax SY dropouts left school before completing grade nine (Anderson, 1993; Social Planning Council of Winnipeg, 1990).

The most common factors affecting Winnipeg SY dropping out of school include disliking school, getting along poorly with teachers, and getting along poorly with other students (Social Planning Council of Winnipeg, 1990). The most common reasons for dropping out of school given by a Halifax sample of SY were not being interested, not doing well academically, not getting along with teachers, being expelled, and not getting along with students (Anderson, 1993). Aboriginal SY may leave school because of racial harassment (Gilchrist, 1996). A Canadian study of persons who had successfully left the street found that most respondents (75%) had a negative experience of school. Most felt they did not fit in, nor did they bond with the school environment (Caputo et al., 1997). Most of an Ottawa street youth sample (80%) had been suspended at least once (Caputo et al., 1994a).

Not surprisingly, school problems and educational failure have been shown to persist well past adolescence. In a cross-sectional retrospective study, most runaways studied by Olson et al., (1980) permanently dropped out of school, some received a diploma, and none went on to college. Repeat runaways had an educational trajectory much poorer than that of one-time runaways. Runaways did much more poorly educationally than their non-

runaway siblings. Runaways, particularly repeat runaways, recalled achievement and behaviour problems in school.

Table 17
School-Related Experiences

Sample	Indicator and Findings
Runaways Age 11-21 Winnipeg (Social Planning Council of Winnipeg, 1990)	Youth still attending school 62% Those having run away from home report: - arguments with parents over grades 50% - arguments over skipping school 58% Factors affecting dropping out of school: - disliking school 32% - getting along poorly with other students 18% - getting along poorly with teachers 21%
Out-of-the-Mainstream Youth Age 10-24 Halifax (Anderson, 1993)	Reasons for dropping out of school: - not interested 22% - not doing well academically 15% - not getting along with teachers 15% - not getting along with students 9% - being expelled 12%

Determinants of Health and Illness After Running Away and Street Involvement

Once a youth reaches the street, aspects of street life can negatively affect health. As previously noted, one of the most significant of these determinants of health is substance use. The literature on SY is unanimous in identifying the most pressing needs of SY as access to basic and fundamental survival resources such as food, shelter, sleep and safety. However, there is a lack of research on how SY meet these basic needs. SY are frequently unable adequately to address these basic needs. When basic needs are not adequately met, additional illness may result.

Substance use, abuse, school problems, discontinuous living

arrangements, nutrition, shelter/sleep, and violence are not discrete issues, but interact with each other and with other determinants of health.

Nutrition. Inadequate nutrition is a problem for SY. Nutrient needs are high during periods of rapid physical growth in adolescence and young adulthood. As previously noted, many female SY become pregnant. Inadequate nutrition puts their health and that of their fetus at risk (Council on Scientific Affairs, 1989; Strasser, Damrosch & Gaines, 1991).

Over a third of Winnipeg runaways reported they had gone without food for more than a day while on the run (Social Planning Council of Winnipeg, 1990). This fact contrasts favourably to Toronto surveys which report that most SY had gone without food for an entire day, that 9% were unable to find food most of the time (McCarthy & Hagan, 1992), and that most did not get enough food (Read et al., 1993). Inadequate funds for food and lack of access to cooking facilities makes safe and nutritious meal preparation very difficult (Jackson & McSwane, 1992). Winnipeg SY say they live on junk-food, eat inadequate quantities of food, or do not eat at all at least twice a week when food or money runs out (Backe & Katz, 1996).

Information collected before the proliferation of food banks and soup kitchens found that Winnipeg SY received food most commonly through friends and through illegal activities. Of youth who never experienced hunger, two thirds met their food needs through informal helping networks and a quarter by illegal means (Social Planning Council of Winnipeg, 1990). After the

proliferation of food banks in the last few years, 32% of Winnipeg male prostitutes say they rely on food banks, friends and family, or eat out. Only 64% eat at least one meal a day (Village Clinic, 1997).

Table 18
Nutrition and Food

Sample	Indicator and Findings
Runaways Age 11-21 Winnipeg (Social Planning Council of Winnipeg, 1990)	Had gone without food at least once 38% Received food through friends 51% Received food through illegal activities 17% Of youth never experiencing hunger, met food needs through: - informal helping networks 65% - illegal means 25%
Homeless youth Age = or < 19 Toronto (McCarthy & Hagan, 1992)	Had gone without food for a day 76% Unable to find food most of the time 9%
Street youth Age 14-25 Toronto (Read et al., 1993)	Do not get enough food 70%

Depression and drug use have a role in suppressing appetite. Typically, SY find food at soup kitchens, drop-in centres, homes of curb-kids, at hostels, or from food banks. Others steal food or eat discarded food (McCullagh & Greco, 1990). If money becomes available, youth often feast on high calorie fast foods "low in variety and high in cholesterol, fat and/or salt" (Strasser et al., 1991, p. 68).

The nutritional problems of the chronically homeless such as vitamin and

other deficiencies may contribute to psychiatric symptoms and immunodeficiencies. The effects of illness may be compounded by substance abuse (Strasser et al., 1991), inadequate sleep, and nutritional problems. For example, more San Francisco SY (11%) had anemia than a comparison population.

Hunger is related to length of time spent on the street and actually living on the street rather than in a shelter (McCarthy & Hagan, 1992). Youth are fed in shelters and while on the street may have difficulty finding opportunities to acquire food.

Shelter and Sleep. There is little literature which focuses on the sleep and shelter experiences of SY. Homeless persons experience erratic and inadequate sleep (Daly, 1990). If youth are lucky enough to be sleeping in shelters with rooms, they are likely not affected by sleep deprivation. However, some youth sleep in shelters with dormitories. Winnipeg's crisp winters and warm weather insects are not very hospitable to those wishing to sleep outdoors. Depending on the time of year, youth may sleep in public places such as parks, garages, under bridges, and in heated bus shelters (Oki, 1990). Of Toronto SY, 67% do not get adequate sleep and are tired (Read et al., 1993).

Kufeldt et al. (1992) found that a third of Calgary youth would have stayed with a friend if the youth shelter had not been available. Almost half (49%) of female Calgary youth under 16 identified friends as their alternative

option. However, over a protracted period of time, friends may not be able to provide food and shelter, and the same may be true of relatives. Many Winnipeg runaways do not know about the availability of shelters before they run, and may never learn about them.

McCarthy & Hagan (1992) report that Toronto SY under 19 years of age spend nights in a type of nomadic existence moving frequently between friends and relatives, walking the streets, "hanging out" in shelters, hotel and motel rooms, and sleeping in public places and "squats". This nomadic existence held true for those new to the street and for those who were on the street for longer periods of time.

Studies done before the establishment of two Winnipeg shelters for adolescents found that 62% of Winnipeg SY usually sleep at the homes of significant others, 20% sleep on the street only, 12% sleep with significant others and on the street, and 6% usually sleep in other settings such as rented accommodation or other combinations of shelter. About a quarter of Winnipeg youth felt that their sleeping accommodations were unsafe (Social Planning Council of Winnipeg, 1990). A very small number of Winnipeg SY slept outside in makeshift cardboard shelters throughout the mild winter of 1997/98.

A study of Los Angeles youth involved in prostitution found that, compared to other homeless youth coming to their clinic, more prostitutes stayed with friends, often for sexual favours. Prostitutes more than twice as often reported living on the street, and did not use shelters or relatives as

places to stay (Yates, MacKenzie, Pennbridge & Swofford, 1991a). About 17% of Winnipeg female prostitutes are homeless (Campbell & Heinrich Research Associates, 1994).

Violence. Violence on the street is frequent and has obvious mental and physical health effects, including death. While information about violence related to Winnipeg SY is almost nonexistent, there is much anecdotal evidence that violence is a major issue, particularly for those involved in prostitution.

The violence that youth have run from in their home of origin is often replicated on the street. More than half of Toronto runaway youth were victimized by friends, casual acquaintances, and persons in institutions (i.e., both clients and those in authority). Close to a third of youth were violently assaulted by persons involved in crime and by someone with whom they were intimate. Half of runaway youth were threatened with a weapon and punched with a closed fist. The variety of serious abuses suffered by youth while on the street is extensive. Many youth abused on the street do not disclose this to anyone (Janus et al., 1995).

Cumulative time spent on the street increases the likelihood of witnessing serious violence, of being victimized by sometimes extreme violence, and of perpetrating violence (Kipke et al., 1997a). Death of street family may become a major issue for Aboriginal and other SY (Gilchrist, 1996). Padgett, Struening, Andrews and Pittman (1995) noted that homeless New York adults suffer levels of victimization and injury up to thirty times the rate of the

general population.

Table 19
Violence While on the Street

Sample	Indicator and Findings
Runaways Age 16-21 Toronto (Janus et al., 1995)	Runaways reporting abuse by: - casual acquaintances 58% - friends 58% - persons within institutions 58% - those in intimate relationships 32% - persons involved in crime 29% Threatened with a weapon 51% Punched with a closed fist 56% Males who did not disclose abuse on the street 31% Females who did not disclose abuse on the street 26%
Homeless youth vs. those imminently homeless Age 13-23 Hollywood (Kipke et al., 1997a)	Likelihood of a youth homeless for more than 3 years witnessing: - physical attacks OR=3.30 - sexual assault OR=3.66 - someone seriously hurt after violent event OR=5.99 - someone being killed OR=6.64 - someone dead in the community OR=5.41 Likelihood of a youth homeless for more than 3 years experiencing being: - sexually assaulted or raped OR=2.35 - chased OR=4.25 - threatened with serious harm OR=3.41 - seriously hurt after an attack OR=2.18 - slapped, punched, hit, burned or beaten up OR=3.59 - attacked or stabbed with knife OR=4.55 - shot at OR=4.72 - shot at and hit OR=3.19 Likelihood of a youth homeless for more than 3 years perpetrating a: - knife attack or stabbing OR=11.45 - shooting OR=4.06

Of the three quarter of criminally victimized Ottawa SY (73%), 28% had

been physically assaulted and 11% had been sexually assaulted (Caputo et al., 1994a). Caputo et al. (1994c) reported that of the one third of Saskatoon youth who were victimized, 40% had been physically and 30% sexually assaulted.

A 1985 Winnipeg survey of female prostitutes found that 28% had been physically assaulted since prostituting and half had been physically and sexually assaulted (Elizabeth Fry Society, 1985). By 1994 there was an increase such that 86% of prostitutes reported physical violence including: customer violence at 54%, pimp and partner violence at 70%, and police violence at 19% (Campbell & Heinrich Research Associates, 1994). The above-noted increase in violence may also be a reflection of sample differences. According to a study of Los Angeles youth, those involved in prostitution were seen more often for rape than other homeless youth coming to their clinic (Yates et al., 1991a).

Theoretical Models of Access to Health Services

Various models of access to health services can be found in the literature. The Behavioral Model of Health Services Use has been widely used (Andersen et al., 1975; Andersen & Newman, 1973). The Aday and Andersen framework (1974) is a more comprehensive model. The Society for Adolescent Medicine (Klein, Slap, Elster & Schonberg, 1992) has also suggested a framework for analysis of equity in access to health services.

The preceding literature review has identified a variety of population characteristics, health issues and determinants which are related to health care

use. Some of these characteristics, health issues and determinants are known to affect health care use in large geographically-based heterogenous populations. Their relevance to SY populations is unknown.

Antecedents to health problems and concerns such as sexual orientation, involvement in prostitution, length of homelessness, pregnancy, and injection drug use should also be incorporated into the model since they may predispose SY to make use of health services.

The Behavioral Model of Health Services Use

The Behavioral Model of Health Services Use, a theoretical framework for analysis of equitable access to health care, has been widely used (Andersen et al., 1975; Andersen & Newman, 1973). The model concerns itself with population characteristics and how these relate to health services use. The Behavioral Model has been developed to assist in determining what factors influence a population's access to the formal health system.

The model sorts population characteristics which affect use of health services into three groups: predisposing factors, enabling factors, and perception of need. Predisposing factors are personal factors which precede an illness episode or desire to seek health services, but which in themselves are not a reason to seek health services (e.g., sex, age, race, involvement in prostitution, length of homelessness, education). Enabling factors are the means by which persons acquire health services (e.g., income, insurance, regular provider of care). Need (comparative, normative, or expressed) is

determined for populations, by direct measures or by a review of the epidemiologic literature such as is provided in the previous section. In the Behavioral Model of Health Services Use, general perceptions of health can be determined by quantitative surveys and the assessment of these perceptions is compared to other populations or to some standard by professionals.

Characteristics of health services use are the major outcome variables of interest in this model and include factors such as type, site, purpose and time interval. Type refers to the kind of service provided (e.g., tertiary care, primary care) and who provided it (e.g, physician, nurse, outreach worker). Site refers to the actual place at which the service was provided. Purpose refers to whether the health services were related to prevention, acute illness or chronic illness. Time interval has three sub-factors: (a) the possibility of entering a health service and time required to enter a health service, (b) volume of service or number of contacts within a given time interval, and (c) continuity, which involves linkage and coordination of services around health issues.

A basic assumption of this framework is that "access equity" should be a response to perceived and evaluated need, rather than flowing from predisposing or enabling criteria such as income, insurance status, or distribution of community resources.

A weakness of the Behavioral Model is that measurement indicators should be amended to conform to subsequent research (Andersen et al., 1983). The authors also over-emphasize traditional health providers (e.g., physicians,

dentists, and hospitals) as points of access to health services. The model does not emphasize the context in which SY live as affecting access to health services.

Andersen et al. (1983) have decreased the number of indicators in the original Aday and Andersen model to those that appear to be most relevant in an American context. The large number of indicators in the original model had created cumbersome and complicated analyses.

Table 20
Behavioral Model of Health Services Use

Population Characteristics				
Predisposing Factors *e.g., gender, age, race, involvement in prostitution, length of homelessness, education*	Enabling Factors *e.g., income, insurance, regular provider of care, distribution of community resources*	Need Factors *perceived or comparative* *- always measured collectively*		
Health Services Use				
Type of service *- primary, secondary or tertiary care* *- who provided care*	Site *location at which service provided*	Purpose of Service *related to prevention, acute illness or chronic illness*	Time Interval *- possibility of entering a service* *- time required to enter service* *- service volume in a time period*	Continuity *involves linkages and coordination*

There are now more entry points to the health care system than there were twenty years ago. While it remains true that physicians are still

gatekeepers of the health care system, other gatekeepers must be reflected in a current model.

Aday and Andersen Framework

The Aday and Andersen framework (1974) is a more comprehensive method for analyzing equitable access to health services. At the most general level, the Aday and Andersen model proposes that health system characteristics and population characteristics are process indicators or indicators of potential access. Health services use and satisfaction with services are outcome indicators. The Aday and Andersen model views the areas of potential access (characteristics of the health system and population characteristics) and realized access (use of health services and consumer satisfaction) to health services, as flowing from and affecting health policy decisions.

In the Aday and Andersen model, characteristics of the health system affecting use of health services include resources and organization. Resources include volume and distribution of labour and capital. Organization of services includes entry into the health system affected by issues such as travel time, office waiting time, and eligibility criteria. Organization of service also affects the structure of the service, that is, what happens to the individual once within a service, affecting who the individual sees and how they are treated. Health system characteristics are usually beyond the direct control of individuals using particular services. Policy makers are typically more aware of system

characteristics than of other factors associated with access to health care (Andersen et al., 1983).

Table 21
The Aday and Andersen (1974)
This model assumes parts of the Behavioral Model of Health Services Use.

	Process indicators (potential access):	Outcome indicators (realized access):
Health Policy	**Population Characteristics**	**Health Services Use**
financing	**Health System Characteristics**	**Satisfaction with Services**
education	*resources*	
manpower	*- volume and distribution of labour*	*- perception of convenience*
organization	*- volume and distribution of capital*	*- coordination*
	- organization	*- cost*
	entry into the system	*- provider courtesy*
	travel time	*- information about dealing with health issue*
	office waiting time	*- quality of care*
	eligibility criteria	
	What happens to the individual once they are in a system?	
	Who sees individual?	
	How are they treated?	

Consumer satisfaction is determined by the individual's perceptions of: convenience, coordination, cost, provider courtesy, information provided about dealing with the health issue, and quality of care. Consumer satisfaction presupposes use of health services. Hence, the consumer satisfaction aspect of the model, while important, is less significant than use itself. In overview then, policy makers may view the two additional elements of the Aday and Andersen model as less important than the two core elements it shares with the Behavioral Model of Health Services Use, i.e., population characteristics and

health services use.

The Behavioral Model of Health Services Use and the Aday and Andersen model of access to health care are complex and relatively comprehensive if viewed as tools for analysis of equity in health care, a principle of primary health care. These models have limited use in measuring other elements of primary health care such as: client participation in health, emphasizing illness prevention and health promotion, use of appropriate technology, and integrating health with social and economic development (Stewart & Langille, 1995).

Society for Adolescent Medicine Framework

An entirely separate analytic framework for determining access to health care is proposed by the Society for Adolescent Medicine. The Society proposes that access to health care be evaluated on the basis of the following criteria: availability, visibility, quality, confidentiality, affordability, flexibility and coordination (Klein et al., 1992). The means of measuring these criteria are not provided. The Society for Adolescent Medicine's model is a simple but inadequately developed and tested framework for evaluating access equity.

The Behavioral Model of Health Services Use As An Analytic Framework

The Behavioral Model of Health Services Use (Andersen & Newman, 1973) is a useful theoretical framework for organizing a review of the available literature regarding access to health services by SY. Use of health services is the result of many interrelated factors, only some of which are known. It is quite

likely that elements affecting health services use in large geographically-based populations differ from those affecting SY populations. The current state of knowledge is inadequate to identify or rank the most important factors affecting SY populations' uses of health services.

Finally, it should be reiterated that the development of the original and subsequent models was based on heterogenous geographically-based non-street-involved populations. While the Behavioral Model has been used as a theoretical framework in studies of homeless populations, there is no reason to infer or assume that the original or revised criteria are those most relevant to SY populations, or even to assume that the model itself is appropriate for analyzing SY access to health services. The absence of qualitative data in development of the model, particularly in relation to SY, brings into question face validity.

The remaining portions of this chapter will use the broadest concepts of the framework of the Behavioral Model to organize the most salient findings in the literature regarding SY access to health services.

Predisposing Characteristics

Predisposing factors are personal factors which precede an illness episode or desire to seek health services, but which are in themselves not a reason to seek health services. The preceding literature review has identified numerous predisposing factors at length. A brief discussion of predisposing factors follows.

Length of Homelessness

Health care pales in significance to other issues as perceived by SY. For example, Toronto SY identified basic needs as "their most immediate problems" more frequently than medical needs (47% vs. 7%) (Read et al., 1993). In another Toronto survey, SY said the "most important problems facing SY today" include, among others, in decreasing order of importance: homelessness, violence/crime, drugs, health, money, and alcohol (Smart & Adlaf, 1991; Smart et al., 1990; Smart et al., 1992). Again, health is viewed as secondary in importance. According to a Halifax study, entrenchment in street life improves knowledge of health services but reduces use (Anderson, 1993). Length of homelessness is likely to be negatively correlated with health services use.

Gender

Gender has been found to be a significant predictor of health services use in many studies (Andersen et al., 1983). Women of child-bearing age are more likely to attend for obstetrical care (Rew, 1995). Given the high rate of pregnancy among street youth, being a female may be a factor in use of health services. Non-street-involved older American adolescent females were much more likely (OR=6.6) to be seen for illness care than younger males (Ryan, Millstein, Greene & Irwin, 1996). On the other hand, of Toronto SY, females had less trust of agency workers (Read et al., 1993).

Sexual Orientation

Sexual orientation has not been studied as a predictor of SY use of health services. However, the disproportionately large number of SY who belong to sexual minorities, and the mental health and sexually transmitted infection risks associated with sexual minority status should be a positive predictor of health services use. Sexual behaviour with someone of the same gender and self-identification as a sexual minority should not be confused with each other. Because many SY have grown up in homophobic environments, it may be difficult for SY to self-identify as belonging to a sexual minority. A history of sexual experience with someone of the same gender may be something that more SY will acknowledge. Same-sex sexual behaviour may or may not have a relationship to health care use.

Age

While old age and childhood are typically the greatest predictors of increased utilization (Aday, 1973), differences in use have also been noted between adolescents of varying ages (Ryan et al., 1996). Of Toronto street youth slightly more than half said they trust agency workers. Most trusting were street youth aged 20-25 years. Younger street youth had less trust (Read et al., 1993), making it less likely that they would attend for health care.

Race

Winnipeg is a city with a large Aboriginal SY population. Unfortunately, nothing is known about differences in health services use by Aboriginal and

non-Aboriginal SY. While race has been found to be an important predictor of health services use in large heterogenous populations (Andersen et al., 1983), other studies have found race to be less important than system-related factors in providing equitable access (Orr et al., 1984).

Education

Education level of the head of the household has been found to be positively related to health services use in families (Andersen et al., 1983). Because SY may function outside of traditional families, or create their own, educational level may prove to have an association with health services use. Better educated non-street-involved persons make greater use of preventive care, and pregnant females with more education make earlier and greater use of prenatal care than do the less well educated (Rew, 1995).

Involvement in Prostitution

While many SY have health problems, those involved in prostitution seem to have the poorest health. Unfortunately, prostitution is common among SY. Winnipeg and Halifax SY reported that a third had sex for profit (Anderson, 1993; Social Planning Council of Winnipeg, 1990). A cross-Canada study of SY found that twice as many females as males prostitute. A third of youth only occasionally prostitute (Radford et al., 1989).

Prostitutes may have the highest rate of mental health problems. In a Los Angeles study, prostitutes were more than twice as likely to be seen for mental health problems than other homeless youth coming to their clinic (Yates

et al., 1991a). Compared to other homeless youth coming to their clinic, prostitutes reported only slightly higher rates of depression but had a much higher rate of suicide attempts, and were much more often found to be suicidal. Radford et al. (1989) report that female prostitutes were lonelier, had lower self-esteem, and had more thoughts of suicide than their other SY.

Prostitutes have more drug-related problems. A third of Canadian SY prostitutes are injection drug users (Radford et al., 1989). A Winnipeg study (Nadon, 1991) found that prostitutes used a greater variety of drugs compared to a non-prostitute comparison group. A Los Angeles clinic serving SY reported more frequent alcohol and illicit drug use, a history of injection drugs 5.9 times as often as those uninvolved, and more frequent use of cigarettes (Yates et al., 1991a).

The same Los Angeles clinic found that those involved in prostitution compared very poorly to other homeless youth coming to their clinic. Those involved in prostitution had earlier sexual debut, with almost a quarter having sex before the age of 10; had three times more pregnancies; used fewer family planning services; and were more often seen for many issues including uncontrolled asthma and infectious disease.

In administering the MMPI test to sexually exploited youth in California, Russell et al. (1992) found that most males indicated a concern about their sexual identity. Almost half of sexually exploited youth were depressed; and a third were at high risk for suicide.

If equitable distribution of health services is based on need, it follows that there should be greater availability of health services for those involved in prostitution as it is associated with so many health problems and risks.

Enabling Characteristics

Factors which allow action on a felt need are called enabling factors. Enabling factors are resources available to the individual or may be part of the community in which the individual lives. Relevant enabling factors are discussed below.

Regular Source of Care

Many studies have found that having a consistent provider has more predictive value than attending a consistent site in predicting use of health services (Andersen et al., 1983; Lambrew, DeFriese, Carey, Ricketts & Biddle, 1996). Among non-street-involved adolescents, health service use is highly dependent upon having a primary health care provider. New York adolescents able to identify a regular primary care provider saw a physician for routine health care 2.4 times more often than those who were unable to identify a regular primary care provider (Ryan et al., 1996). It is not known whether this finding would hold true for SY. Of additional interest, a study of Los Angeles homeless adults found that males, those with less than a high school education, and the long-term homeless were least likely to have a regular source of care (Morrissey, Calloway, Johnsen & Ullman, 1997).

It may well be that SY's expectations of traditional primary health

services differ from expectations of non-health-related services. Personal traditional health services may be sought from someone with whom an adolescent or young adult has no history, minimizing embarrassment when discussing sexual behaviour and drug use (Galbraith, Stevens & Klein, 1997). Fear of confidentiality leaks may discourage adolescents from receiving health services from private practitioners (Ensign & Gittlesohn, 1998; Marks, Malizio, Hoch, Brody & Fisher, 1983; Resnick et al., 1980; Rosenfeld et al., 1996). While a specific source of care, usually physician care, is an incentive for health care use in large heterogenous populations (Aday, 1973; Andersen et al., 1983; Lambrew et al., 1996), it may be a disincentive for SY if the specific source of care is a longstanding family physician.

Interval Before Appointment

Appointments may be a disincentive to someone whose life is chaotic. Appointment-based services are less likely to be effective with SY than are drop-in or street outreach services (Caputo et al., 1994a). Services should be open when they are needed (Anonymous, 1990; Caputo et al., 1994a). Standard agency hours of service may not agree with the times when youth need them and are motivated to use them. Many SY are unlikely to be able to attend regular appointments in traditional settings; consequently, they prefer "on demand" services. Interval before appointment has been found to discourage health care use in large heterogenous populations (Aday & Andersen, 1975; Andersen et al., 1983).

Affordability

Half (52%) of Winnipeg street youth said they needed health care while on the run, and of these, 17% did not receive health care because they had no identification or money or felt no one would help (Social Planning Council of Winnipeg, 1990). Affordability has been found to be strongly related to access to care in large and diversified American populations (Andersen et al., 1983) and among Baltimore SY (Ensign & Gittlesohn, 1998). Access to insurance was an important predictor of recent dental care among non-street-involved adolescents in the United States (Ryan et al., 1996) and in Canada (Lee et al., 1994). An on-site dispensing service may also be important because sending youth to a local pharmacy may be inappropriate for various reasons including lack of money and the reduced expense of on site dispensing (Jackson & McSwane, 1992).

Compliance with medication recommendations among SY is a complex subject worthy of study in its own right. There are factors other than affordability influencing medication compliance among homeless persons such as lack of privacy, lack of storage space, need to carry medication and understanding the need for medication (Nyamathi & Shuler, 1989). However, affordability remains a fundamental prerequisite for compliance with medication recommendation (Lamsam et al., 1996).

Location Where Youth Spends Time

Presence of SY at particular locations may also be related to health services use. Site of contact was an important factor in a multi-state study of health services use of homeless persons with a serious mental illness (Rosenheck & Lam, 1997).

Need Characteristics

Some of the comparative and expressed needs of SY have been reviewed in the previous epidemiologic analysis, particularly the following: depression, suicide, mental illness, substance use, pregnancy, sexually transmitted infection, dental and periodontal health, abuse. Discussed below are a few additional insights related to need characteristics of SY.

Self-Rated Health

Self-rated health has been found to be strongly related to health care use in large diversified populations (Andersen et al., 1983). The use of a four-point scale (excellent, good, fair or poor) is a standard method for determining individual perception of health. Non-street-involved American adolescents who perceived their health as "good" or "excellent" were 3.4 times as likely to have seen a physician for routine care as those with a "fair" or "poor" rating of their health (Ryan et al., 1996). Self-rated health was found to be inversely related to emergency-room use among New York homeless men and women (Padgett et al., 1995).

Pregnancy

While pregnancy is not one of the predictors of health services use

commonly used in large populations, the incidence of pregnancy among SY warrants further investigation. Pregnancy was related to 8% of recent visits to a doctor or nurse in a Halifax SY study (Anderson, 1993).

Prenatal care has the greatest benefit if targeted to at-risk women. SY should be considered at significant risk of low infant birth weight, and perinatal and neonatal mortality (Beal & Redlener, 1995). Homeless pregnant women often do not attend for early and comprehensive prenatal care, which increases the risk of poor birth outcomes and complications of pregnancy (Weinreb, Browne & Berson, 1995).

Pregnant adolescents risk getting late prenatal care or care that does not exceed that provided to adults. Pregnancy risks are the result of many factors including pregnancy-induced hypertension, preterm labour, and cesarean section. All of these risks decreased for adolescents who were provided with comprehensive care. Comprehensive care includes medical, educational and social services (Scholl, Hediger & Belsky, 1994). There is every reason to believe that adolescent street youth have a greater risk for undesirable pregnancy outcomes than do adolescents in general.

It is not uncommon for sexually active adolescents to delay contraceptive care. For example, the average American adolescent girl delays contraceptive care for 9 to 12 months after initiating sexual activity (Galbraith et al., 1997). Ryan et al. (1996) found that older non-street-involved adolescent females are more likely to attend for family planning than younger adolescents.

Mental Illness

The prevalence of mental illness and the tendency of marginalized populations to focus on basic needs warrants investigation of this issue.

Homeless mentally ill St. Louis adults of all ages, including those aged 18 to 25 years, were found to have poor rates of treatment in the current year and, consequently, relied heavily on in-patient care when symptoms became unmanageable. Inability to pay owing to lack of insurance was perceived as the most important problem, but was not found to be associated with use of mental health services (North & Smith, 1993).

Padgett et al., (1990) found that all services were used infrequently by New York homeless adults. The use of services for medical, mental health and substance use problems was more strongly related to need characteristics than to predisposing or enabling factors. North & Smith (1993) hypothesize that the perceived mental health needs of the mentally ill are displaced by the need to survive. Presence of medical conditions was related to use of mental health, drug use and medical services among these adults.

A multi-state research study found that there was a strong negative correlation between the number of days intoxicated and effective treatment of homeless people with severe mental illness (Rosenheck & Lam, 1997). Mental illness can cause overwhelming impairments of perception or judgment and thereby creates impediments to use of health care (Jackson & McSwane, 1992).

Sexually Transmitted Infection

Although SY may be sexually active, and may have a history of incest, molestation and rape, they are no more knowledgeable about the anatomy, physiology and psychology of sex than others their age. Health care providers must never assume that levels of sexual knowledge and maturity are consistent with activity (Deisher & Rogers, 1991; Gilchrist, 1996). Health education should be given particular emphasis in health care because many youth may have missed information they would have received had they attended school regularly.

Health Services Use

Secondary and Tertiary Care

Use of hospital beds by SY appears not to have been studied. Nor is use of medical specialists well studied. Male and female non-street-involved adolescents use various types of specialists similarly with the exception of gynecologists (Ryan et al., 1996).

SY use hospital emergency departments disproportionately more often than the rest of the population. Over one year, almost three quarters of a small Ottawa sample, and over half of Saskatoon SY used emergency departments. Over half of Halifax SY have made use of an emergency department, and 40% of a Toronto sample say they go to emergency departments or hospitals when they are sick. The rate of use of emergency departments is 75% higher in Ottawa SY and twice as high in Saskatoon SY as compared to high school

students (Anderson, 1993; Caputo et al., 1994a; Caputo et al., 1994c; Read et al., 1993).

Primary Care

SY use family or regular physicians less frequently than their non street-involved peers. The percentage of SY who mentioned seeing a personal or family physician over the past year was 50% in Ottawa and 62% in Saskatoon. Of Halifax SY, only 46% had ever used personal physicians; and only 27% of Toronto SY said they would seek care from a physician when sick. The rate of use of family physicians among SY is only 55% of that of high school students in Ottawa and 78% of that of high school students in Saskatoon.

SY who mentioned being seen at a community clinic included 39% of Ottawa SY and 44% of Saskatoon SY. Ottawa SY saw providers at community clinics at twice the rate of non-SY and 67% more frequently in Saskatoon. Only 10% of Halifax SY ever received care from a community clinic (Anderson, 1993; Caputo et al., 1994a; Caputo et al., 1994c).

Twelve percent of Toronto SY and 88% of Winnipeg SY have sought care at walk-in clinics (Read et al., 1993; Social Planning Council of Winnipeg, 1990). The reasons for the large differences in use of primary care providers are not known.

Refusal of Primary Care Services

For many SY long waiting periods for service may be perceived as barriers (Ensign & Gittlesohn, 1998), sometimes a barrier impossible to

overcome. There are often long waiting lists for specific and time-sensitive services such as sexual abuse counselling (Caputo et al., 1994c) and mental health services (Runaway and Homeless Youth Study Committee, 1994), including long-term mental health beds and treatment for those who self-mutilate (Caputo et al., 1994a). Manitoba has long waiting periods for inpatient addiction services. Waiting lists are a serious impediment to prevention or early intervention services.

An apparent Canadian trend is a move toward tighter rules and regulations regarding issues such as attendance and eligibility. Strict rules make it more difficult for SY to access publicly funded mainstream services (Caputo et al., 1994b; Caputo et al., 1994a). In order to be successful in dealing with SY, agencies need to lose their rigidity. SY may have no health cards or may not know their health number. As a result they may be refused care at many health care agencies (National Forum on Health, 1997). Of Saskatoon SY, 57% identified the need for care without identification (Caputo et al., 1994c).

Many SY serving agencies are specialized or have very tight service parameters leading to ever more discontinuous services. There are a number of ways in which continuous services could be delivered. These include loosening "eligibility criteria and service parameters within agencies as a whole" (Runaway and Homeless Youth Study Committee, 1994, p.109), and provision of services through generalist agencies which can take on a care

coordination function. In an era of cost restraints and resource limitations, agencies tend to develop more restrictive eligibility criteria and service parameters, thereby building further impediments to integrated and effective services. The opportunity for SY selectively to disclose relevant aspects of their current reality and history to various agency staff, and the piecemeal plans and interventions that result, can create a complicated, highly fragmented and potentially ineffective service patchwork.

Providing Continuous Services

A comprehensive continuum of services has something for everyone: for SY coming to or leaving the street; for those who can be reconciled with their family and/or community and for those who cannot; for those who will never experience profound homelessness and for those who are deeply entrenched in a street lifestyle. A service continuum would include: (a) outreach, including hot lines, street outreach, and advertising available services to those who are considering running; (b) short-term crisis shelter; (c) family reunification services, when possible; (d) comprehensive health and psychosocial care; (e) long-term shelter with long-term case management; and (f) networking among SY serving agencies and related sectors such as law enforcement (Yates, Pennbridge, Swofford & MacKenzie, 1991b). Shelter and outreach services can provide basic needs such as food or clothing, and additional preventive materials such as condoms. To the above list should be added: (g) mechanisms to address intercity, interprovincial and international issues related

to SY migrancy (Anonymous, 1990; Farrow, Deisher & Brown, 1991).

There is regular movement of SY between cities, provinces and countries. Of Winnipeg male prostitutes 55% work in other cities too (Village Clinic, 1997). A 1985 Winnipeg study of female prostitutes found that one fifth work in other cities (Elizabeth Fry Society, 1985). Of Toronto SY 54% moved in the last six months. "Of these, 65% had moved one to five times and 19% reported moving 10 times or more" (Read et al., 1993, p. 13). One fifth had moved from province to province in the last six months, and 7% had moved from the United States.

Service must have formal and informal continuity. Ideally, outreach programs and longer-term care should be part of an organized network providing a comprehensive continuum of services. There is currently a discontinuity between street-based services and longer-term and mainstream services. Outreach programs can make contact with SY but may have difficulty making successful referrals to mainstream services because of long waiting lists or inappropriate services. SY may fail in accessing mainstream services without long-term support (Caputo et al., 1994a). There are few services that provide the comprehensive support youth need to leave the street for addiction treatment (Caputo et al., 1994c).

Street outreach should be an important part of health services directed at SY. Street outreach may incorporate three functions: (a) distribution of risk reducing materials and messages; (b) delivery of services in street settings and

agency sites serving street-involved youth, and (c) provision of other services such as referral, case management and street-based health care (Anonymous, 1993). A three-site American study found that outreach programs reached between a quarter to a half of high risk youth (Anderson et al., 1996).

To summarize then, if SY have made some type of contact with a counselling or SY service it could be viewed as an indicator of structural continuity of care. Indicators of continuity of medical care include being able to identify a regular health care provider and a low number of visits to non-regular health care providers (Aday et al., 1975). High use of emergency departments may also be an indicator of fragmented, episodic and illness-focused care (Bindman, Grumbach, Osmond, Vranizan & Stewart, 1996; Jezewski, 1995).

Purpose for Health Care

Purpose for health care is meant to differentiate visits for preventive, curative or chronic care. Almost all existing literature on use of health services by SY assumes curative visits and rarely singles out preventive interventions. A rare and indirect reference to prevention is that a fifth of Halifax SY said that they had seen a doctor or nurse for a general check-up (Anderson, 1993).

Any future study of SY should take seriously the preventive recommendations of the Canadian Task Force on the Periodic Health Examination (1980 & 1994), which are based on published findings and can be applied by a variety of health care providers. The Task Force has identified prevention-focused recommendations. Many of these recommendations apply

to the health issues of SY or to antecedents of street involvement.

A common theme across most Task Force recommendations is the encouragement to raise, at the very least, relevant issues with at-risk clients. It may well be that traditional providers of health care are not the best placed to influence these difficult issues. Based on what is known from the preceding literature review, the preventive recommendations apply to a large proportion of SY. The Task Force has recommendations on many issues including depression, suicide, substance abuse, pregnancy, sexually transmitted infections, dental and periodontal health, child abuse and neglect, and nutrition.

Chapter Summary

Demographic characteristics and trends of Winnipeg SY were described. Because demographic information specific to Winnipeg was not always available, alternative sources of data were used if facts were so consistently reported that similar trends would likely be found if Winnipeg data were available. The most significant comparative and expressed health needs and health risks were identified as: depression, suicide, other mental illness, substance use, injection drug use, pregnancy, sexually transmitted infection, and dental and periodontal health. Some of the identified determinants of health for SY include those that precede street involvement, namely: sexual, physical and/or emotional abuse; substance use problems; discontinuous and disrupted living arrangements; and school problems. Other identified determinants of health result from running away or street involvement: nutrition,

shelter, sleep and violence.

The Behavioral Model of Health Services Use was used as the framework to organize the literature review. An exhaustive review of relevant literature regarding SY population characteristics and characteristics of health services use was undertaken and may have given the impression that the field is so well documented that quantitative testing is in order.

Because the Behavioral Model of health services use was not built upon observations of SY populations, relevant factors may be missing and other factors may be irrelevant. It is possible that the entire model is inappropriate to study SY's access to health services. There is need for a qualitative inquiry as a foundation from which to construct or validate factors influencing SY's access to health services. While the study will identify possible factors associated with health services use by SY, it is not the purpose or intent of this thesis to validate the Behavioral Model of Health Services Use.

Chapter 3

Method

This chapter describes and provides rationale for the research design, methods and ethical considerations of the study, which was to identify factors associated with access to health services as perceived by SY.

Research Design

This study is a mini-ethnography (Dobson, 1986) in that the focus of the study is not all SY culture, but rather, a focus on a particular question in the context of a culture. That research question is: What are the factors associated with Winnipeg SY's access to health care? The question is addressed with a rich understanding of the context, structure and function of relevant commonalities and differences in SY culture or subcultures. The research reflects the perspectives of street youth culture and presents these perspectives in ways meaningful to the informants, and hopefully, to health care providers, those involved in the policy process, and others in the community at large (Fetterman, 1989; Thorne, 1991).

Ethnographies focus on thought, behaviour (Fetterman, 1989) and other patterns of the population they study: in this case, SY perceptions of access to health care. Ethnography is a method to learn about cultural health beliefs and practices (Robertson & Boyle, 1984). This learning occurs through an exploration of a group's language and their perceptions of reality.

Ethnography originates from the field of anthropology, which has as its

quest the understanding of cultures. Ethnography means a portrait of a people. Its strength is its ability to generate an understanding of a group from the perspective of the insider (Lipson, 1994). The study answers the research question by reflecting the setting and life situation of SY. It is therefore a descriptive study (Artinian, 1988). The area outlined by the research question is unmapped territory.

No Canadian study of SY's experience of access to health care has been published. It is premature and possibly erroneous to assume that the factors influencing access to health services for SY are the same as they are for large heterogenous geographically-based populations. Many variables related to health care access in large populations are known. Few such variables have even been systematically identified for SY populations. This study was designed to elicit related qualitative and descriptive information.

Various other methods of qualitative enquiry are inappropriate. For example, phenomenology is not designed to shed light on shared cultural experiences, beliefs and values that probably underpin SY's access to health care. Ethnography was chosen because it gives primacy to the subjective reality of a group rather than to that of individuals (Kleinman, 1992). Ethnography also incorporates an etic perspective in that the researcher recognizes the "otherness" of the population being studied. If culturally-based behaviour was always immediately understandable to those outside of it, there would be no need for ethnography.

Grounded theory is designed to determine emergent theory by uncovering underlying social processes that shape human action. Any method of research, such as grounded theory, which requires repeated or lengthy access to the same participants may be problematic. Repeated or lengthy contacts cannot be assured because of the chaotic nature of the lives of many SY.

The strength of an ethnography as a research method is its holism. It values both emic and etic perspectives (Hughes, 1992). It has strong internal validity in that it can accurately represent the perceptions and life situations of SY. In this study accurate representation is made more likely by the researcher's involvement with the population and intensive data collection techniques. As well, validation by triangulation and continuous data collection contribute to internal validity (Robertson & Boyle, 1984). Transferability of data is possible if all hypotheses related to the study as well as a "careful description of the time, place, context, and culture in which those hypotheses were found to be salient" are accurately presented so that transferability decisions can be made by others (Lincoln & Guba, 1989, pp. 241-242).

1. However, owing to a small and local sample, ethnography's limitations may be its transferability to non-similar contexts. In this study localized aspects of the health system may influence findings, as may characteristics of the SY participants or of the weather. The study sample is not designed to ensure representativeness of SY. Like all

other methods of qualitative inquiry, observations and recognition of patterns are dependent upon the skill, ability and experience of the researcher.

Sample

As discussed previously, criteria governing eligibility for enrollment in the study were based upon a definition of SY used by numerous other Canadian studies. Use of a definition of SY similar to that which has been used across Canada limits the study to those who are street involved and may make the findings more easily understood by those familiar with SY research.

SY who fit the criteria and volunteered to participate in the study were interviewed. The primary criterion for being a youth is being aged 12 to 24. All youth who make use of a SY-serving agency are considered SY. If a youth's experience matched three of the following four criteria they were also considered SY:

(a) leaving school before completing grade 12 and not working full time,

(b) living away "from their family (or guardian) for at least 2 days during the past year",

(c) running or being "thrown out of their home at least once",

(d) being "homeless (i.e., without a place to stay) at least once".

Potential participants were approached by staff of agencies which had agreed to support the study. For reasons of interviewer safety, persons

manifesting volatile or highly unpredictable behaviour were not approached, nor were those with severe emotional withdrawal (Padgett et al., 1995). Purposive sampling was the main method used for securing the sample. Purposive sampling is based on the belief that the researcher's knowledge can be used to select subjects so that variety in selected geographic areas and gender and age typicality are assured (Polit & Hungler, 1995). Purposive sampling is meant to maximize respondent variety and to ensure heterogeneity, not representativeness. The sample for interviews was recruited through SY-serving agencies for reasons of interviewer safety and because third party recruitment reduces undue pressure on SY to participate in the research.

A limitation of the resulting non-probability sample may be its lack of transferability to the entire Winnipeg SY population (Kalton, 1983). Because the recruitment strategy draws from SY who are being served, it is possible that the study may under-identify factors which are barriers to service and more completely identify factors which facilitate service. Despite this, information gleaned from a purposive sample may be used to inform service planning and further research because some basic demographic data are collected which may assist in comparing serviced and unserviced populations. Because the sample is non-random and small, it had a greater possibility of becoming obviously non-typical. To ensure some degree of visible balance, no less than one third of the sample were to be male or female, and no less than one third of SY were to be above or below the age of majority.

The season during which formal interviews occur may have an affect on the type of sample recruited. Large numbers of transient youth move between eastern and western Canada through Winnipeg in the summer. Many of youth originating in Winnipeg also seasonally leave Winnipeg. Whether youth who travel interprovincially differ from each other or from geographically stable SY appears never to have been studied, and is therefore unknown.

The majority of the sample was recruited in winter and two interviews were done in the spring. SY populations are more transient during seasons other than winter. Four informants reported that since being street involved they travelled out of or within the province. At least some of Winnipeg's street scene moves into malls in the winter. The street scene is significantly shaped by very cold winters where youth are unable to sleep and spend much time outdoors.

For this focused mini-ethnography it was expected that between 10 and 15 informants would be required for formal interviews to achieve informational redundancy (Sandelowski, 1995). The number of informants was to some extent based upon their ability to verbalize thoughts, feelings and experiences. All thirteen initial interviews of approximately one hour occurred within one of six participating agencies with the exception of the last participant, who was interviewed in a park because the agency had closed. All 13 youth were recruited through agencies, 12 through agencies dedicated at least in part to working with street youth. Participating agencies provided services including,

but not limited to: shelter, youth drop-ins, counselling, family reintegration, recreation, street outreach, condom distribution, needle exchange and provision of various kinds of practical assistance such as meals, food banks and clothing.

Follow-up telephone interviews with three informants early in the interview period further clarified and confirmed the analysis as it related to them or those who had been interviewed before them. The reasons why later informants could not or chose not to be reached for clarification and confirmation of analysis are unknown. The last two informants were requested to comment on the framework and factors which emerged from analysis of all previous data. These two youth also participated in the same interview.

Observations of SY, their interactions with each other and with workers during street outreach activities, were another aspect of this mini-ethnography. The purpose of these observations in a public area was to provide insight into the cultural beliefs, knowledge and practices of SY culture(s) relative to access to health services. Information such as SY responses to the approach used by outreach workers, types of discussions that relate to access to health services, and other observations possibly related to access to health services were noted. The effect of the proposed observations was to generate additional relevant data from a second source, thus providing opportunities for data triangulation.

The option of observing SY during health care encounters was discarded because of legal and ethical implications associated with attending actual

health care visits. The option of observing SY at fixed SY-serving agency sites was also dismissed because of ethical concerns and because it was felt that access issues are raised less frequently in these sites than during outreach activities. Observation opportunities were limited by the only two agencies doing regular outreach to two outreach sessions each. A potential limitation of this study is that prolonged engagement with the SY population was not possible through street outreach observations. The timing of these outreach sessions was negotiated based upon availability of the researcher and the agency's experience of times when a large number of contacts were likely.

I was permitted to participate in two separate outreach sessions with each of two agencies. One agency dealt primarily with street-involved young adults and another worked primarily with young SY. During these four sessions I observed interactions between six workers and approximately 50 SY. On average, outreach sessions lasted about four hours. Observed outreach sessions occurred in malls, on streets, and in pool halls. Outreach was not as rich a source of information as expected in that few opportunities for observing youth discussing or accessing services presented themselves. Agencies declined further opportunities for outreach observations at the same time that I recognized outreach observations were not providing rich data. Findings based on observation are congruent with interview findings. The number of outreach opportunities is not believed to have affected the richness of collected data or depth of analysis possible.

Recruitment

The researcher contacted various SY agencies for opportunities to interview SY. Only outreach-oriented SY agencies were approached for opportunities to observe SY interacting with each other and with outreach workers. Only one participant who was observed was previously interviewed. See the agency recruitment letter and "Overview of the Study" in Appendix 1.

Youth were recruited for interviews or observations through SY-serving agencies which agreed to participate in the study. A sample letter introducing and summarizing this study and requesting agency participation is found in Appendix 1. The complete proposal or portions thereof were made available to agencies to meet the requirements of their access policy or to improve staff participation in the research process. Telephone contact and in-person meetings were made with agency managers and assigned staff for the purposes of eliciting participation and recruitment.

The researcher never directly approached SY to participate in observations or interviews. Agency personnel approached potential SY participants to determine their interest in participating in the study. A script to introduce the study was developed for use by agency staff. See Appendix 3. The number of youth who refused to participate when agency personnel approached them was not requested. All interview participants agreed to take part in the research.

When an agency not specifically serving SY expressed an interest in

participating, a few close-ended demographic questions were asked by agency personnel to confirm youth's eligibility for enrollment. Participants were asked about their gender, age, ethnicity, days lived away from family or guardian in the past year, number of times they ran away or were thrown out in the last year, their educational attainments, whether they worked full time, days spent homeless or without a permanent or fixed address in the last year, and last contact with health care providers. The researcher confirmed and noted eligibility for enrollment before initiating the main part of the ethnographic interview.

The researcher interviewed participants from various geographic areas of the city as population-based evidence has shown geographic variability (Zimet et al., 1995). It is the experience of other studies that SY found only in street sites have different characteristics and make different use of health services as compared to SY using agencies. This variation in characteristics between agency youth and street-based youth may not apply in Winnipeg in winter, since in this city street-based survival is impossible in winter. This study recruited all participants from youth drop-ins, SY-serving agencies, and shelters.

A second option of recruiting informants by word of mouth was not necessary. If snowball recruitment was to have been required, information about the project (Appendix 5) was to be passed by one SY to other potential participants along with the researcher's phone number.

Many SY have been abused, most often by men. Finding locations in agencies for interviews that provided privacy while still allowing informants to feel safe was essential. Examples of agency settings that were acceptable to SY are a glassed-in interview room or a private room with the door open. For reasons of perceived and actual safety, during all interviews the researcher stayed in a public place open to observation.

It is a generally accepted practice to provide monetary or food incentives for SY participants. The Tri-Council Working Group (1998) acknowledges that provision of incentives may be appropriate with certain groups. A current study of Winnipeg injection drug users provides a $20 incentive for participation. Past program evaluations provided monetary incentives to Winnipeg SY populations. The vast majority of documented North American studies involving SY provided monetary incentives ranging from $5 to $20. Participants in interviews for this study were provided with an incentive of $10. This incentive was provided upon completion of the main part of the interview.

SY-serving agencies were asked to provide opportunities for observation during street outreach. See Appendix 1. Consent was requested of all youth at the beginning of each observation. Only about five out of 50 youth refused to consent to observations. Although SY were not asked why they refused, it seemed that refusal was based primarily on the desire for the shortest possible encounter with the outreach service and a lack of trust in strangers. Requests for consent to observe SY during street outreach contacts were succinct

because street outreach activities rarely extend beyond a few minutes. A consent process was also carried out with outreach personnel before observing their interactions with youth in street outreach contexts. All outreach personnel agreed to participate. See Appendix 5 and 6 for samples of both consents. Only four opportunities for outreach observation were granted by agencies. Opportunities for outreach observations were limited by one agency because outreach activities are, almost by definition, relationship-building opportunities. Additionally, as the research progressed, another agency's clientele changed, so that they served mostly adults older than the ages of interest to this study.

Data Collection

The data collection tools in this ethnography were interviews and observation. The main instrument used in ethnography is the human being.

The first step in ethnographic studies is to spend time orienting oneself to the culture by living in it (as much as this is possible) in order to learn its basic structure, function, relationships, demographic parameters, historical information, and so on (Fetterman, 1989). It was possible to abridge my orientation process because over the last fifteen years I have spent much time working with SY, most recently with young adults. Because living cultures are not static, I needed to reacquaint myself with the situation of younger SY. This orientation through observation occurred through the outreach activities and formed part of the data collection process.

I kept a journal from the beginning to the end of the study. The journal

includes salient field observations, thoughts, insights, ideas, possibilities, guesses and arrangements which occurred during data collection and analysis. Fetterman (1989) states that the most important part of fieldwork is to observe, ask questions, and write down what is seen. All relevant observations from the field, my own thoughts, intuitions and feelings, were entered in the journal. Upon permission from SY, interviews were tape-recorded and transcribed.

Participant Observation

Participating in a culture allows one to understand how dominant ideas and values relate to behaviour (Thorne, 1991). An essential part of any ethnographic study is participant observation (Hughes, 1975). Eventually people being studied forget the researcher and lapse back into familiar behaviours and patterns (Fetterman, 1989). Time for observation may be too short for participants to forget the researcher's presence. SY-serving agencies providing outreach services were requested to provide opportunities for the researcher to observe SY interactions with each other and with staff. See Appendix 1.

There are limitations to collecting participant observations in this study. The researcher cannot be a complete participant (Jackson, 1975). Age differences and fundamental characteristics of SYs preclude the possibility of becoming a complete participant observer, no matter how non-judgemental the researcher may be. However, participation may include interacting with those people whose culture is under observation (Dobson, 1986) and observation of

activities (Robertson and Boyle, 1984). Another limitation to collecting participant observations is that, for reasons of safety and to maintain the participant's confidence, all observations occurred in public places.

This study used the participant-as-observer mode of observation. Jackson (1975) identifies the participant-as-observer role as one where:

> the observer and the observed are aware that theirs is a field relationship, and this mutual knowledge minimizes problems of role-pretending. Relationships approach intimate [sic] and the observed may share secrets which he would otherwise keep to himself; nevertheless, the roles are well defined and no one is betrayed (p. 552).

Because one of the main purposes of outreach activities is to connect SY with services, observations were made about factors influencing access to all kinds of services, including health services. As field notes were analyzed concurrently with data collection, observation should have been considered complete when many redundancies were observed and saturation was achieved (Adler & Adler, 1994). Contrary to expectations, outreach sessions were not rich sources of observed data. Availability of only four outreach sessions reduced opportunities to confirm observed redundancies. The researcher stayed attentive to mundane and unusual details including symbols, outcroppings and folk tales, within both the culture and its environment (Fetterman, 1989).

Interviews

In keeping with ethnographic methodology, a semistructured interview was used to determine what SY experience, feel, believe and think about access to health services. Data were collected by taking notes during outreach sessions and by tape-recording interviews. Each interview continued until the area under study, i.e., SY perceptions of access to health services, was discussed to the satisfaction of the investigator and participant. By mutual agreement, interviews were usually an hour in length because informants became visibly restless, even though they might have had more to say. They were often not used to sitting and attending for any length of time. Informants were asked to allow follow-up interviews to confirm findings and to clarify information.

Bauman and Greenberg (1992) identified five characteristics of an ethnographic interview, and these have been employed in this study: (a) Interviews should facilitate an emic perspective. (b) The researcher is the pupil and the informant is the expert. It is necessary for the researcher to avoid assumptions. (c) Everyday experience and descriptive data are the focus of an ethnographic interview. (d) Interviews are relatively unstructured and nondirective. (e) The informant's language is itself data. It is a window on the informant's reality, its structures and categorizations.

Shared understandings of culture were found in the informants' language. Data emerged from the informant's personal context. If necessary,

the conversation was directed toward the researcher's field of interest using the informant's own words and concepts. Data were collected in person by the researcher only, thereby making it possible immediately to probe, clarify and confirm any unusual observations or responses. Follow-up interviews were requested of all participants to clarify and confirm findings related to their interviews, but only three contacted the researcher again. Two additional final interviews were meant to gather additional data and to confirm the overall findings and framework.

Informational redundancy from interviews occurred relatively quickly. One informant minimally responded to questions, and another informant seemed occasionally to have difficulty expressing coherent thoughts. About a third of this informant's interview could not be coded.

Interviews were not so structured as to conform data to the way the researcher thought rather than dealing with issues from the perspective of the SY (Fetterman, 1989). Some street youth were still at the stage of operational thinking, having difficulty with abstract thoughts. Other SY had difficulty with conversation. It was therefore useful to ground the interview questions in the language of the participants' experience. Semistructured interviews usually allow greater breadth than more formal interviewing methods (Adler & Adler, 1994).

Some of the grand tour questions used in the interview were based on health issues most likely to affect SY, as described in the preceding literature

review. The main health issues of SY were used to prompt youth to describe their experiences of use or non-use. Asking SY about concrete health issues generated a great deal of useful data. Abstract and more general questions were not as useful in some situations.

After first providing informed consent, prospective informants were screened for their eligibility to enroll in the main interview. The main interview was introduced by giving SY a sense of the purpose of the interview. Each informant was asked to talk about: times they used a health service; times they did not use a health service when they thought they should have; street terms they felt they were associated with; defining criteria for these labels; and how their association with these terms affected access to the health system. They were then asked about the times that someone raised the issues of depression, suicide, mental illness, substance use, pregnancy, sexually transmitted infection, abuse, and dental and periodontal health. See Appendix 8.

Semistructured interviews provide participants with an opportunity to tell their story and to situate their perceptions in context, to demonstrate how they think and how personal and cultural values shape their perceptions of the past (Fetterman, 1989). Participants were prompted to provide information related to the research question. At the close of the interview, participants were invited to speak about anything else that they wished to contribute or discuss, provided with appropriate referrals if necessary, and given the monetary incentive. See Appendix 8 for the interview guide.

Data Analysis

The purpose of an ethnography is a rich descriptive analysis of a cultural phenomenon. The researcher must therefore constantly strive to provide an in-depth analysis. An ethnographic analysis reduces or distils great quantities of data (Mackenzie, 1994). Data were to have been analyzed concurrently with data collection (Fetterman, 1989). Through continued review of journaled field observations and transcripts, most patterns were explored while the researcher still had access to study participants (Robertson & Boyle, 1984). A residual but significant amount of analysis was completed after interviews were terminated. A number of factors could have benefited from more data to fully be able to explain the differences within them. These are highlighted in the findings.

Before data were analyzed, field observations and notes were taken and interviews were recorded and transcribed. The stages of interview analysis used in this study include: (a) writing notes and memos at each interview and during observations, (b) making notes about transcripts and field observations on first reading, (c) openly coding transcripts or notes, (d) collapsing codes into categories, (e) removing repetitious categories from a complete category list, (f) assuring transcripts are adequately represented by the category list and adjusting the category list if necessary, (g) cutting out coded sections of transcripts and putting them together under appropriate category headings and subheadings, (h) beginning the write-up of each category section, (i) referring back to the original text if the context or meaning of coded text ever requires

clarification, (j) determining if and how examples from the interviews and/or field notes relate to the literature (Burnard, 1991).

Fetterman (1989) identifies triangulation as basic to ethnographic research. Triangulation is the process of comparing information from one source with another. Triangulation of observations and interview data confirms whether patterns indeed exist. Triangulation assists the researcher to test the quality of the information, to understand the role of the participant in the situation, and to contextualize the situation. In this study triangulated data originated from multiple informants, and between interview and observational data, although this was very limited.

Negative cases are of particular interest to the ethnographer. Much can be learned from trying to make sense of these special cases (Adler & Adler, 1994; Guba & Lincoln, 1989). No negative cases were found.

Data were analyzed independently of the framework of the Behavioral Model of Health Services Use. It was not the purpose of this study to determine if factors associated with SY's access to health services are congruent with the Behavioral Model of Health Services Use. Because the Behavioral Model of health services use was not built upon observations of SY populations it is possible that the entire model may be inappropriate.

Simple statistics were applied to enrollment data to provide a description of the participant sample. See tables 21 and 22.

Evaluative Criteria

The proposed research was measured against the standard of trustworthiness as outlined in Guba and Lincoln (1989). Trustworthiness includes standards of credibility, fittingness, auditability and confirmability. The standards of trustworthiness parallel the quantitative standards of internal validity, external validity, reliability and objectivity.

Credibility occurs when human experiences are depicted in a manner such that people whose experience it is will recognize it as their own (Sandelowski, 1986). Credibility is achieved by: (a) prolonged engagement, (b) persistent observation, (c) peer debriefing, (d) negative case analysis, (e) progressive subjectivity, and (f) member checks (Guba and Lincoln, 1989). Prolonged engagement was achieved through extensive previous experience working with SY. Persistent observation was achieved by initial and subsequent interviews with the same or with other SY as well as through four outreach observations. The small number of street outreach observations made available to the researcher is not believed to compromise prolonged engagement as a criterion of credibility. Peer debriefing was carried out with the thesis chair-person on three occasions. No negative cases were found. What appeared to be incongruent findings were analyzed, and these findings which did not initially fit were combined into higher-level factors. A few findings did not fit at all. Progressive subjectivity is a way of avoiding findings that the researcher would expect to find. Progressive subjectivity was achieved by

carefully archiving the history of the analysis and discussing this analysis with the thesis advisor on a few occasions. Member checks were carried out with three youth. Because most informants were not located again, two SY peers were given the opportunity to respond to the factors and frameworks which emerged from the analysis of the various transcripts. When member checks occurred, the overall feeling of SY was that the findings fit with their experience.

Robertson and Boyle (1984) also bring attention to the importance of triangulation in achieving validity. The responses of various informants and of various data types such as observations and interviews were compared to each other to check for consistency.

Transferability is a standard of trustworthiness which assures that readers will know the context in which the findings were obtained. Thick description and triangulation are the major methods by which to ensure transferability. Descriptions of the entire context of this study, including time, place and culture (as much as this was possible), are carefully outlined in this chapter. Because the study only observed SY for a period of a few winter and spring months it was important that the possible consequences of this were reported (Adler & Adler, 1994).

Sandelowski (1986) identifies three threats to transferability. Becoming enmeshed with participants is a threat that can be avoided by consciously focusing on how researcher and informant influence each other. A strong threat in this study was an "elite bias". SY were not all articulate. It was especially

important for the researcher to avoid interviewing only well-spoken participants. The "holistic fallacy" occurs when data are presented as patterned or congruent, but either do not represent all the data or represent them poorly. To avoid this threat it was important to ensure that data were collected until the saturation point was reached from all possible sources. Because a bulk of the data was analysed after the data collection ceased it was found that a number of factors had not reached saturation. Also important was the rigorous application of analytic methods. Data which did not fit nicely were also presented.

Burnard (1991) suggests how transferability can be strengthened: by asking others familiar with category generation processes to generate categories after reading a sample of the study transcripts and of field notes. If differences exist, categories are adjusted. The thesis advisor was asked to generate categories for transcripts. Member checks or modified member checks were carried out by confirming findings in second interviews with three of the same participants or in later interviews with several different participants. The final framework was checked with two informants and was modified slightly as a result.

The researcher has adhered to the criteria in Sandelowski's (1986) list of decisions regarding the study which must be described, explained or justified in order to ensure dependability:

1) how the researcher became interested in the subject matter of the

> study, 2) how the researcher views the thing being studied, 3) the specific purpose(s) of the study, 4) how subjects or pieces of evidence came to be included in the study and how they were approached, 5) the impact the subjects or evidence and the researcher(s) had on each other, 6) how the data were collected, 7) how long data collection lasted, 8) the nature of the setting(s) in which data were collected, 9) how the data were reduced or transformed for analysis, interpretation, and presentation, 10) how various elements of the data were weighted, 11) the inclusiveness and exclusiveness of the categories developed to contain the data, and 12) the specific techniques used to determine the truth value and applicability of the data (pp. 34-35).

Field notes documenting the above-noted decisions were maintained throughout the data collection and analysis process. A document detailing how codes were incorporated through to the final analysis was also maintained. As there was very little opportunity for prolonged engagement with any youth an aspect of Sandelowski's criteria of dependability only minimally reflected in the field notes was how participants and the researcher influenced each other.

Confirmability is a standard of trustworthiness that was achieved by ensuring that the data could be tracked to their source. Tapes, transcripts and journal entries regarding observations and other raw data will be kept for seven years as required. However, since nothing can be studied without being in some way changed by the study itself, it is recognized that study findings are as

much a reflection of the researcher as of the group or phenomenon studied (Sandelowski, 1986). Confirmability therefore was achieved when credibility, transferability and dependability were also realized.

Ethical Considerations

The potential for unique ethical difficulties in this study was due to SY's age, vulnerability and marginalization, low social status, relatively low rates of education, unfamiliarity with social research on the part of some, involvement in criminal activity, and the fact that most studies of SY pay participants. All these factors were taken into account. There was no obvious harm that could emerge from participating in the study. And there is a strong possibility that this study will have a positive effect given that decision makers are currently looking for evidence to change the health care system to conform with the principles of primary health care.

SY are an extremely vulnerable population. SY must function independently without the benefit of much or any adult experience, positive social supports, a valued social role, legitimate economic opportunities, an unequivocal ability and right to choose for themselves, and personal or social stability. These are only a few of the many limitations within which most SY function. Given their many needs and few resources, SY often involve themselves in self-exploitative activities such as prostitution, survival sex, drug dealing, panhandling and petty crime, thus further compounding their vulnerability.

In conformity with requirements of the University of Manitoba, ethical approval was obtained from the Faculty of Nursing Ethical Review Committee before implementing this study.

The research respected the principles outlined in the Canadian Nurses Association (CNA) 1994 document entitled Ethical Guidelines for Nurses in Research Involving Human Participants. Participants' needs were respected in that no judgement was made of their use of harm reduction services such as needle exchange and condom distribution. It was anticipated that participants' conceptions of health and values regarding health and other matters would be different from those of the researcher. The Canadian Code of Ethics of Nursing (Canadian Nurses Association, 1991) identifies the responsibility of the nurse to accept the clients' values, including their right to live at risk. This responsibility was particularly relevant to this study in that street involvement is frequently associated with early, frequent and unsafe sex, unsafe drug use, gang involvement, and other risky lifestyles and lifestyle choices.

Choices regarding all forms of participation were respected (CNA, 1994). All SY, SY-serving agencies, and agency personnel were given full disclosure regarding the study before being invited to participate. Since not all SY are literate, at the very least SY needed oral disclosure. All participants, whether adults or children, provided informed consent for interviews and for participant observation before participation in the study (Robertson & Boyle, 1983). All agency personnel provided a written consent.

SY being approached during outreach activities are in a relatively unique situation. The consent process used during outreach observations reflected this reality and was not so ungainly as to get in the way of outreach activities. Outreach activities are frequently a few seconds or a few minutes in length. Their purpose is to build connections between isolated and needy youth and the range of available services. See Appendix 4 for the abridged consent procedure used during outreach activities. The outreach staff person introduced the researcher to the SY and requested their consent to participate. All questions about the observation or the study were answered in full by the researcher or the staff person.

For SY interviews, only oral consent was required. Written consent was optional. Potential participants were offered the option of not signing the consent, thus remaining entirely anonymous. They were also offered the option, where possible, of having a worker sign to attest that oral consent was given. All interview participants chose to sign the consent form. Many SY may be fearful or highly suspicious because they may be running from home, child protection authorities or the law. In order to ensure that oral consent was informed, the meaning and purpose of the consent form was reviewed orally with each participant, and a copy of the form was offered to each. The consent form included the telephone number of the thesis committee chair and was respectful of possible low literacy levels. See Appendix 5 for the consent form.

A child's parent or guardian is normally required to provide consent for

anyone under 18 years of age. However, SY are, by definition, disconnected from parents or guardians. SY have either made a personal decision to leave the parental home or they have been ejected from it. SY are emancipated minors. Requiring the consent of parents or guardians was necessary and would have made this research impossible. The research could only be done with the participation of SY, it exposed them to minimal risk, and the potential benefits of the research would be available to them (Tri-Council Working Group, 1998).

Agency staff were asked to introduce the researcher and the reasons for his presence at the beginning of any period that provided opportunities for observation. They were to inquire of the potential participant whether it was acceptable to have the researcher listen. If SY interacted with staff for an extended length of time, staff were asked to confirm the acceptability of the researcher's continuing to listen in.

A financial incentive of $10 was provided for only the initial SY interview. This level of incentive for Winnipeg SY was not coercive. It reflected payment for involvement in past and current studies. The study itself did not subject participants to an undue level of risk (Tri-Council Working Group, 1998). An example of a concurrent study providing a $20 incentive is the Winnipeg Injection Drug Use study. Most studies of SY reported in the Canadian and American literature include financial incentives and/or food vouchers. The provision of fast food vouchers may have been viewed as paternalistic by SY

and may have encouraged poor eating habits. This was therefore ruled out.

Because of possible involvement in illegal activities and general distrust of adults and of the system, it was thought that some SY might have been unwilling to identify themselves using their true names. Although signed consent was presented as one of a number of options, all youth chose to sign the consent forms and no youth gave an obviously fictitious name. Not requiring written consent where this is culturally unacceptable is in conformity with the Tri-Council Working Group (1998). It was believed that some youth might be so heavily involved in criminal behaviours and environments that they would be reluctant to use accurate identifying information. The Tri-Council Working Group recommends that in the event of verbal consent, an agency worker could be asked to confirm consent in writing, or that a written notation could be made in the field notes regarding circumstances of the verbal consent. These written notations would have been made immediately following the verbal consent. Another option could have been to tape-record the consent process. Individuals would not have been approached to participate if they were incapable of consent, for example, at times when they were seriously impaired owing to substance use.

Although experiences of child abuse, child neglect or planned criminal activity are not the interest of this study, there was a remote possibility that such issues could be raised by SY. The interviewer forewarned SY of his requirement to inform authorities if such issues were broached. Children who

were not emancipated minors were not approached for this study.

The following information was included in the consent form provided in Appendices 5 and 6 to ensure that participants' rights were respected:

nature and purpose of the study

identity of the researcher sponsor or sources of funds

purpose, extent and duration of participation

data to be collected from participant...

use to be made of research data during the study and after its completion

inconveniences, potential risks, and potential benefits for participants/others

freedom to withdraw at any time without fear of recrimination

procedures to ensure privacy, anonymity and confidentiality where indicated

method of contacting the research[er]... about any concerns that may arise (CNA, 1994, p. 7)

approval by the Ethical Review Committee, Faculty of Nursing, University of Manitoba

right to refuse to answer any and all questions

All participants were offered a summary of the findings, which will appear as a short report to be posted at participating SY agencies.

Confidentiality and anonymity were maintained (CNA, 1994). By virtue of signing the consent form, participants were not anonymous to the researcher

but remain anonymous to the readers of the study's results. Confidentiality was assured by providing opportunities for interviews to occur where the interview could not be overheard by others. Data that could have identified a specific person or persons were not shared. Reported findings were slightly modified to conceal the identity of informants (Robertson & Boyle, 1983). All field data, notes, recordings and transcripts will be kept in locked storage for seven years.

Because of the researcher's listening ear and because of the often very close relationship between the informant and the researcher, qualitative research methods may lead to disclosure of extremely personal information, making the informant feel manipulated. The researcher's tact and discretion in this regard did not require the termination of any interviews. No new boundaries needed to be established within the research process or relationship (Ramos, 1989), while some referrals were required to assist informants. When a participant identifies needs for information or assistance which arise as a result of the interview, it is the researcher's responsibility to ensure that the participant can get the help required (CNA, 1994). The researcher was aware of common resources for information and referral, and informed three youth about how to obtain appropriate dental services.

Chapter Summary

This chapter has described and provided a rationale for the research design, methodology and ethical considerations of a study seeking to identify factors associated with access to health care as perceived by SY. The

research design is a mini-ethnography. Interactions between SY and between SY and staff were observed in outreach-based street settings. The sample for interviews was drawn from fixed-site and outreach-based SY-serving agencies. In addition to simple demographic information, data collection included observations and semistructured interviews. Data were analyzed using a modified version of Philip Burnard's (1991) model. The study was conducted in a manner that is in accordance with the standards of trustworthiness proposed by Guba and Lincoln (1989). Unique ethical challenges arising from the social conditions and culture of SY were addressed through adherence to accepted ethical research standards.

Chapter 4

Findings

In this chapter the study findings are presented. The chapter describes participants, discusses participant affiliation, proposes an analytic framework, and discusses specific factors within the analytic framework associated with access to health services.

Description of Participants

In this section the sample is described. Thirteen SY resident in Winnipeg were interviewed. Except for the last two informants interviewed in early spring of 1999, interviews and observations occurred in the late winter of 1999.

Interviewed SY participants differed widely in affiliation, age, gender, race, days lived away from home or guardian, times thrown out or having run from home, days homeless, time since last contact with a health provider, and current school attendance. Little variation was noted in educational attainment, or employment status. Only three youth under 18 were still attending school. One youth disliked the study question regarding race as he felt we were all "humans" and identified himself as "other". Only one SY was located through an agency which did not specialize in serving SY. See Tables 22 and 23.

Overall, interviewed male youth experienced "more days homeless or without a permanent or fixed address in the last year" than did females (mean = 182 versus 55), and reported larger intervals of time since the "last contact with a health care provider" (mean = 82 versus 18).

Table 22
Information About Interview Sample: Continuous Variables

Category	Range	Mean	Median	Mode	Standard Deviation
Age (n=13)	14 - 24	17.8	17	17	2.55
Highest year of school finished (n=13)	6 - 11	8.6	9	9	1.44
Days lived away from family or guardian in last year (n=7, only those under 18 in last year)	7 - 365	168.8	180	90	131.90
Times thrown out or run from home in last year (n=8, only those living with others)	1 - 120	15.0	2	2	38.98
Days homeless or without permanent or fixed address in last year (n=13)	7 - 365	133.2	105	60	110.09
Last contact with health care provider in days (n=13)	today - 240	34.6	14	14	70.20

Table 23
Information About Interview Sample: Categorical Variables (n=13)

Age (n=13)	(18 or >)=6	(<18)=7
Located through street youth agency	Yes=12	No=1
Location of Interview	Agency=12	Park=1
Still going to school	Yes=3	No=10
Working full time	Yes=1	No=12
Gender	Male=8	Female=5
Race	White=7, Metis=4, Other=1, Part Aboriginal/Part White=1	

Some demographic characteristics from the Social Planning Council (1990) study of homeless children and youth are compared to the current study's interview sample to determine similarities. While both studies used convenience samples, it may be helpful to determine if sampling differences could have influenced the study findings. The Social Planning Council age ranges were younger than those of this study (10 to 21 vs. 14 to 24), as were the mean, median and modal age (16 versus 17). The mean, median and modal "years of education completed" were also one year lower in the Social Planning Council study (grade 8) compared to this study (grade 9). These differences in age and years of education completed may be due to the higher age cut-off used in this study. This study enrolled more males than females while the Social Planning Council experienced the reverse. This study did not enroll any status Aboriginals, or non-Aboriginal visible minorities while the Social Planning study did. These last two sample differences may be due to this study's small sample size and the fact that no efforts were made to purposively sample for ethnic heritage. It is possible that because no status Aboriginal respondents were included in interviews the study's findings may have been affected. However, Aboriginal youth, probably some with Indian status, were included in outreach observations. Taking into consideration the higher age cut-off in this study, it appears there is considerable similarity in both convenience samples in age, and completed education.

Identity

The researcher was interested in determining if its participants' identification with a particular sub-group was consciously associated with access to health services by the SY themselves. SY used terms to describe themselves based on their identification with a subculture, their interaction with a near group, labels imposed by others, and their description of personal traits.

Most youth were initially unable to recognize how their affiliation or association with a label affected access to health services. Later in the interviews facilitators and barriers to health services use did come to light, but these associations were usually recognized by the researcher, not the SY.

Six youth described an identification with a subculture. Three identified with "punks", two identified with "street kids" and one identified with "gangsters". Terms used to describe being a "punk" were "punk rocker", "street punk", and "punk". Being a punk involves an orientation toward marginality and nonconformity from the mainstream, including conspicuously nonconformist dress. Being a "street kid" involves "panning" and spending much time "on the street". The youth who identified as a gangster said what is required to be a "gangster" is "do(ing) bad stuff the gang wants me to do."

Only one youth was able to describe how being a punk affects access to health services. Stigmatization by services and an attitudinal orientation toward refusing help were described as hindering access to services:

Everyone looked at me funny if I walked into a place or something

> because of my appearance. We'd go somewhere off the street and they didn't use their real ID (identification) most of the time... They just don't like going there because it was a doctor and they were there to help you. They don't want help from anyone.

A "street kid" verbalized a concern about not having a fixed address: " No one can get a hold of you if there is a problem because you have no address." The youth involved in gangs was unable to identify any access issues or concerns.

In addition to the individuals who participate in the subcultures referred to above, some youth described themselves as interacting with groups with whom they do not identify. Two youths said they previously or currently "hang out with gang members" but are not gang members themselves. Two youth mentioned previously participating in groups using substances. One was a "sniffer" who said that to be a sniffer you needed to sniff solvents occasionally. Another youth said he was friends with a group "that drank and did coke." One youth developed a changeable pretense of group identification in order to avoid problems on the street: "I'm just trying to be somebody I'm not. I get intimidated by... other groups. So you become that group." None of these youth were able to identify any way in which their group associations affected access to health services.

A number of youth reported labels assigned to them by others. One youth characterized herself as "learning disabled" which she described as having trouble reading and speaking. She mentioned that her physician was aware of

this and kept it in mind when helping her. A doctor labelled one youth as "clinically antisocial" and his parents reinforced this label which the youth described as "not liking people", and "I always wait for them (most other people) to phone me." This is a youth who also self-identified as a street kid. One male was labelled by family and service providers as schizophrenic, but he was sure this label was wrong: "You get judged by something you are not." He complained about inappropriate and frequent hospitalizations. Dealing with the schizophrenia label had become his life preoccupation.

Some SY used other self-descriptive terms. One youth previously involved in gangs described herself as a loner and as homeless, terms not further described. Someone who considered himself a "street kid" and was labelled "clinically antisocial" also called himself "different" or "weird": "I like being different. I don't want to be like everyone else." Although similar to the beliefs of punks, this young man had an orientation toward nonconformity which was not associated with affiliation with that street subculture. Another youth called himself a "street kid" but gave no indication that street kids are a group with whom he self-identified or with whom he interacted. He described being a "street kid" as "being on the streets" with "no place to go." Finally, one youth self-identified as gay, that is, attracted to someone of the same sex. He said that he "hustled" like other gay kids, that is, prostituted himself for money.

The "different" youth felt he was unable to fit in with the residents of a shelter, and he never made use of the same shelter again. The gay youth had

significant insights into how being gay was associated with needs and access to health services. He listed two health needs related to being gay: sexually transmitted infections and more and different drugs (different from those most street youth are involved with because of the gay "rave scene"). He also mentioned that access to health services was directly affected by a "safety factor." By safety factor he meant the risk of gay bashings in places, including service agencies, where street youth are allowed to congregate. Sometimes agencies do not create or enforce loitering rules. Other youth "find out who the (gay) kid is. Most of the time it's obvious.... You get yourself beaten... because you're gay." Fearing the reaction of other youth he said: "Personally, like whatever I am, I'm not going to talk about it" (openly in agencies).

Joining with and being affiliated with a group was obviously important for some SY: "These people were on the street for a long time and I did what they did so I fit in." Three SY seemed to view themselves as outsiders or loners. Two of these did not psychologically identify with any group, and the remaining SY did so only minimally. Overall, SY 18 or older seemed to find it less important to self-identify with a street label than did younger SY. A few youth reported reduced intensity of identification with a group identity over time.

Despite the fact that no youth used the term "street youth" to describe themselves, not one reacted to or questioned the term as the population under study.

Analytic Framework

Youth identified factors affecting access to health services which fall into five major categories: (a) helping system characteristic, (b) provider characteristics, (c) street youth characteristics, (d) social environment, and (e) satisfaction. See Table 24 for specific factors within each of the above categories. These categories are discussed in detail below.

Table 24
Factors Associated with Access to Health Services by Winnipeg SY

a) Helping System Characteristics	b) Provider Characteristics	c) Street Youth Characteristics
- Affordability	- Caring relationships	- Knowing about services
- Immediacy	- Providing continuous service	- Crisis orientation
- Practical assistance	- Respect for client control	- Non-acute physical and emotional conditions
- Safety	- Age & Gender	- Deferral of care
- Tailored services		- Substance use
- Imposed services		- Environmental constraints
- Proximity		- Internal motivators
d) Social Environment - Family - Friends and acquaintances		e) Satisfaction

There are many linkages between categories within the above-noted framework. For example, the characteristics of helping systems will affect how providers do their work, and some providers and health systems have already adjusted their services to address the unique characteristics of street youth. Interrelationships between factors are mentioned in the following text.

Helping Systems Characteristics

The structure and function of the health care system affected access to health services. The factors which can facilitate access to health care include affordability, immediacy, practical assistance, safety, and tailored services. Imposed services, more often than not, acted as barriers to use of health services. Proximity, more often than not, facilitated access. Each of these factors is detailed below.

Affordability

Affordability is the opportunity to make use of health services which are available only on direct payment of fees or indirect payment of fees through insurance. On the one hand, because health services are covered by universal provincial health insurance plans and private extended health benefits, fee-based health services were not restricted for many SY. On the other hand, most SY described significant problems related to affordability of health care: not having or knowing a provincial health insurance number, having insurance from another province, incomplete coverage for all services, and out of country travel without insurance. Dental care seemed to be particularly affected by issues of affordability. Many services for SY are not fee based (e.g., counselling, shelter, food banks, outreach) and were not affected by affordability.

Access to provincial health insurance cards or knowing one's provincial health insurance number was repeatedly identified as a facilitator of access to basic medical and nursing care. Not having access to a health card prevented

one youth from getting needed services:

> This one time, I was like super sick and I couldn't talk or anything and I didn't have or find my medical number yet. I didn't know it. And talking to my parents wasn't what I'd like to be doing. I started to get sicker.

Losing a health card, which may happen often because ID has a value on the street, can be a serious inconvenience. "It takes a lot of work. When you lose your ID you gotta go to replace it and you need your ID to get your health card."

Travel by SY can create opportunities for inter-provincial disputes about responsibility for payment of health services and, in so doing, delay or eliminate access. For example, one youth experienced significant delays in needed surgery after moving to Manitoba. Both provincial insurers disputed responsibility for the surgery. The SY had almost despaired of getting the treatment by the time he was admitted to hospital:

> And the health care system there wouldn't let me see treatment. When I came back here they said I couldn't get treatment because it happened in another province.... So they told me to go back there for treatment. I couldn't get treatment there because I hadn't been there for three months.... Some of us are not on social assistance. We can't afford the treatments we need to get. So we can't go to surgery if you need it. If you don't have the money, you can't get it.

Concern was raised about the payment of Alberta provincial health insurance premiums once a youth reaches an age when parents are no longer responsible

for paying monthly premiums.

Although no foreigners were interviewed, one youth, after travelling to the United States, said he was very concerned about the affordability of American medical care should he have needed it. Another youth expressed concern that his "friend from California" was not covered for health services.

Youth with extended benefits such as those on social assistance, under the care of child protection services, or whose parents had extended family health benefit plans were not as concerned about affordability. However, for some of them, access to non-insured extended health benefits was raised as a concern: "Welfare won't pay for the ambulance bill." A youth receiving social assistance could not get dental braces.

Dental care, often neglected for long periods of time, seemed to be particularly affected by issues of affordability. SY not living at home were often not sure if they were still covered under parents' extended benefit plans. Some SY on social assistance or those terminated from social assistance who had no other means of income identified affordability of some non-insured health services as a concern. "See that's (dental care) the hardest one for me. Unless you're working you don't get... dental benefits." "I'm on assistance now and they still refuse to pay for... anything past cleaning."

Immediacy

Immediacy is the opportunity to use services without delay. Most SY talked about the importance to them of immediate health services. Immediacy is

enhanced by short or non-existent waiting periods, outreach which provides instant services, flexible agency hours, and walk-in and on-call services.

SY use outreach services in varying degrees. Outreach services provide immediate counselling, informational, and referral services, as well as practical material assistance such as provision of snacks, providing condoms or exchanging needles in various settings in which a number of SY can be found.

Youth appreciated agencies that provided non-standard hours during the times when youth experienced a need for these services. Flexible hours, even late into the night, are important for providing services such as meals, a place to warm up, clothing banks, and shelter.

A range of walk-in services such as shelters, emergency and basic medical care, and counselling were frequently mentioned as useful. Some youth expressed their preference for walk-in services: "At some points it's really hard for me to make an appointment because I never know where my day takes me. So I just go and get it over with while I can, when I want to." Many youth have or reported having had material impediments to keeping appointments such as not wearing watches or owning alarm clocks.

Waiting periods, especially long ones, were described as a deterrent to access. One youth reported: "If I can't get health [care] within half an hour I've got other things to do during the day. I'm going to leave." About emergency room services a youth similarly reported: "I usually don't wait there over an hour," implying he would leave.

Immediacy is related to the factors of proximity and crisis orientation. Many SY will use services that are close and therefore immediate. Immediacy is required because many youth tend to use services when they experience crises.

Despite the preference many youth have for immediate services, some youth said they had no trouble making and keeping appointments. But they too used immediate services. One of these youth said she wished her physician had a call service so she could get more immediate service. Another youth used a walk-in service to refill a prescription. There was not enough data to understand why some had no trouble keeping appointments but others did not.

Practical Assistance

Practical assistance is the opportunity to receive assistance with material needs. All SY used services or providers who supplied necessities for survival such as food, meals, a place to warm up and sleep, clothing, injection drug supplies, needle exchange, and condoms. These services were highly valued. Most youth also reported using non-survival related services such as haircuts, showers, laundry, telephone, dispensing bus tickets for appointments, job and apartment finding, personal banking services to cash cheques, assistance with applying for independent living, and prescription of the morning-after pill.

One practical need mentioned but not met was the need for clean socks: "I have no food, no place to crash. Nothing. No clean socks. Ask any street kid and clean socks are like the most important thing."

Meeting survival needs is often the greatest priority for SY. The medical

system was used by one youth to meet survival needs. He described getting prescriptions from various doctors, selling the filled prescriptions and buying fast food with the realized income. Another SY described that her priority was to use money to eat rather than to see a dentist: "I'd rather have the money in my pocket for something to eat, personally."

While receiving material goods or services is viewed by youth as important in itself, associated contact with providers creates opportunities for initial and ongoing contact: "My friend asked me if I wanted something to eat and so I got to know them (a counselling service) like that."

The availability and quality of material assistance given may be a deciding factor in the use of one agency over the other. One SY weighed variations in goods and services provided between similar services: "All they give you there is peanut butter and crackers. At least there you can have a shower."

Safety

Youth expected and appreciated services that provide an environment that minimized risk of physical and emotional harm. Youth needed protection from each other, from family and friends, and from providers. The six facilities in which the study was carried out made provisions for the safety and security of their clients, creating environments with less danger and fear than they might experience on the street or in their homes. When creating a safe environment for youth means barring other SY, safety considerations may reduce accessibility for those who are barred. Safety is a particularly important factor in settings such

as shelters or services which serve or hope to serve many SY.

A gay male identified how some agencies have reduced the likelihood of peer-initiated violence by stopping youth from "hanging out" for extended periods of time when they have nothing to do:

> I've had a lot of problems with gay bashings. I've had a lot of problems because of people using that certain place as a hangout.... When they find out somebody's gay they do a gay bashing.... They find out who the kid is.

One youth described not feeling safe with unknown providers within a group residential setting. He expected child protection services to "put me somewhere where I'd feel safe. But I didn't feel safe because I had no proof of who these people were or anything."

An informant gave an example of how one shelter provided protection from a family member: "My father has stalked me ever since he kicked me out.... He can't get in here. He can't harm me anymore."

Agency safety policies can also reduce accessibility for some youth: "If you get charged with different things like sexual assault, like my friend did, they would not let him stay there.... He'd be endangering people. So he'd be stuck out on the street. There's nothing else there for him."

Tailored Services

Access to services may be enhanced when services are tailored to address the needs of all SY or to SY sub-groups. Most of the six facilities from which the sample was recruited catered to unique populations. Youth chose to

use services which served populations of SY with whom they identified, or with whom they felt comfortable, and avoided agencies believed to serve groups of youth with whom they did not identify or with whom they felt uncomfortable.

Some respondents interviewed from each location defined themselves differently from youth in other locations. Various groups of SY "hang out" in different parts of the city. Street hang-outs for sniffers, hustlers, female prostitutes, transsexual prostitutes and punks differ. Inner city and suburban youth are very distant from each other. Despite having basic similarities, SY are a highly varied population. Two youth made comments to the effect that they were aware of these differences: "I usually didn't like people that did that (sniff)." The importance of providing service opportunities for varied SY populations was well expressed by one youth who compared two shelters:

> Well some of the kids (at the other shelter) didn't really make me feel welcome. The staff didn't make me feel welcome because I wasn't like everybody else.... Like here I always felt like I was welcome. I always feel like I fit in.... I like to fit in enough to feel welcome.

Most youth talked about initiating contact with agencies they knew were in existence to serve SY. This result may be an artifact of this study's recruitment strategy. It is possible that a study which avoided recruiting in SY-serving agencies might have different findings. Nonetheless, a service with a reputation of making a special effort to include SY was mentioned as facilitating access for others: "When a lot of street kids come to Winnipeg... (they go to this) walk-in

clinic where they actually hold kind-of-like meetings (related to SY) there." This occurred despite the fact that this clinic is not reserved for SY.

Imposed Services

Imposed services refers to services forced on youth regardless of a SY's personal choice. Most informants mentioned situations where the system forced them to get service. Some questioned the value of these services. Various government agencies including courts, police, drug detoxification services, in-patient psychiatric services, the public trustee, and child protection services forced services on SY. The child protection system evoked the most consistent and strongest negative responses from SY. Fear of unwanted imposed services kept some youth from initiating needed services.

Some youth reported being apprehended by police and brought back to a child protection services shelter, being picked up and confined when intoxicated or for public mischief, and having police apprehend and transfer them to psychiatric services. Some youth were locked into psychiatric wards. One youth lost control of his finances to the public trustee. Another youth was expecting a court order to attend an addictions program. Child protection services forced youths into foster care, to attend counselling, and to stay in specific residential settings.

Imposed services are related to the factor of "respect for client control". Respect for client control is a provider characteristic while imposed services is a characteristic of the helping system. In most cases youth experienced a loss of

personal control when forced into services. A young woman who was required to accept ongoing supportive counselling in the community provided an example where client control was respected. This young woman was given the option of choosing from among three workers.

Youth were frustrated by imposed services when expected outcomes did not materialize. One previously pregnant teenager who generally avoided medical care reported that her child protection services worker persuaded her to get prenatal care. Despite this, the baby was apprehended after birth. A 17-year-old father was required by child protection services to work on various concerns and was still disallowed from seeing his child after two years.

Some youth described how they sabotaged various types of imposed services, virtually guaranteeing their ineffectiveness. A youth who was driven to counselling sessions ran away. A teen who had been forced to live in a residential setting actually spent most days living in a squat with other street kids. The young woman who was locked into a psychiatric ward resisted participating in that structured and controlled setting. These services did not involve or motivate youth. Being forced into a service was a disincentive to active participation.

The mere mention of mandated child protection services evokes very strong negative responses in some SY who have experienced that system. SY think that child protection workers should provide adequate emotional support and non-abusive treatment. A number of youth expressed strong aversion

toward using child protection workers to assist with ongoing concerns because the SY experienced a history of not perceiving emotional support or because of a history of perceived abuse at the hands of child protection workers or their designates. One teenager who spent more time away from his group home than in it, explained his relationship with group home staff:

> I feel like I'm being cared for, I just don't feel like I'm being cared about.... You see, social workers... if they weren't getting paid they wouldn't be doing the job. So living for years with a feeling like that kind of triggers somethin' into rebelling.

One youth described his reasons for not trusting child protection services based on his experience of abuse. He described how a worker forced him to do physical work he should have avoided because of a previous injury. He was told he needed to work in order to be fed and to avoid being locked in his room with the power shut off. SY leave unsuccessful placements for the street: "I try to be as independent on the group home as possible. I try to get as far from CFS (child protection services) as possible." Once youth are out of the system and on the street, it is more difficult for them to connect with services than it is when youth have the structure and support of stable residential settings.

SY want control over their own lives and they want services which provide legitimate choices which respect their autonomy. Fear of being forced into unwanted and unpleasant situations is a disincentive to participating in and seeking care of all kinds. As an example, a youth with no involvement with the

child protection system was stabbed but did not seek medical care until the following morning when her drinking would no longer be obvious. She was concerned that child protection services might become involved because she was "drunk". A system that provides legitimate options seems to lead to satisfaction and increased use of services. For examples, being "able to drop in at 2 a.m." is valued while "being dragged back to a group home" by police is scorned. As one participant remarked about a mental health service: "But in my head it's like they are trying to run my life.... I don't like people telling me what to do and when to do it. I never have."

Proximity

Proximity refers to distance from services. Most SY mentioned the closeness of a health care provider to where they normally hang out as facilitating access, that is, nearness to hangouts, schools or a parent's home. Proximity is a factor in using many types of health services including walk-in clinics, emergency rooms, and SY serving agencies. One youth described his reasons for using a particular health service: "I was concerned at the time and there was a walk-in clinic right across the street." Outreach services are especially effective with some SY at creating access. In describing her use of service one youth reported: "It's whoever I run into I guess. I run into (outreach worker) three times a day at least when I'm downtown." Multi-service sites, places where youth can get a variety of services in one location, are effective in creating access based on proximity, whereas, distance from health care

providers is viewed as a disincentive to access. One SY said, "I have a family doctor, but he's way out and I have no way of getting there."

Five SY were able to access some services through school while they were still in attendance. As they left or were expelled from school, their opportunity to use school services was lost or diminished.

Access to health services can also be reduced by an inability to get to them. SY often reported that they deferred needed medical care, including emergency department services, until transportation was available. The way most SY get to most places most of the time is by walking or by taking the bus. One youth explained his deferral of health services this way: "My leg started to swell up really badly and I didn't know if I could get to a health care or walk-in or not.... Finally I got some friends to carry me." When SY used non-public vehicular transport to get health services, they were driven by friends, bosses, parents or ambulances. No youth mentioned not attending distant health services because of a lack of transportation, but some did mention distance as a reason for not using a service.

Proximity is related to the factor of immediacy. If the service is right there it is more easily accessed. In some cases proximity was a deterrent to accessing health services. One informant described the closeness of the city to a rural residential addictions treatment centre as a disincentive to completion of the program. It was too easy to cave in to temptation and leave. Successful completion of residential addictions treatment programs may be influenced by

unique factors.

Access to health services was profoundly affected by structural and functional characteristics of the health system. SY gave examples of how affordability, immediacy, practical assistance, safety, tailored services, imposed services, and proximity affected access to health services. There are many interrelationships between characteristics of helping system and provider characteristics, the area which is discussed next.

Provider Characteristics

The second major category affecting access to health services is that of provider characteristics. Provider characteristics found to facilitate access to health services include: caring relationships, providing continuous services, and respect for client control. There was disagreement about the importance of provider age and gender. Provider characteristics are discussed in the section below.

Caring Relationships

A central factor encouraging accessible services is the development of a caring relationship between a SY and a provider. Most youth, in one way or another, raised the issue of caring relationships with providers or a strong connection with a caring service as a very important factor in accessibility of services, particularly supportive and counselling services. If youth raised this issue they were either profoundly committed to or profoundly dismissive of the service as a result of the caring relationships they had developed or failed to

develop.

Some youth made comments about providers whose heart was in their work:

> It depends on if the person actually has a heart and actually wants to go into that particular trade or profession or wants to give the care to that person and take the time to do it properly.... Those people who really love you, they are the proper ones. Instead of making a little bit of money off you, those are the ones who really care.

Some youth had developed significant relationships with particular providers. Youth mentioned that in the development of the relationship: "you slowly learn to trust them." "On the street you think no one really cares about you. You find when people do care about you that's when you start coming to get help and getting off the street."

Youth who had a remaining or renewed significant emotional attachment to family did not, to the same extent, rely on or hope for providers to bond with them emotionally. The importance of family to SY became obvious as every young person talked about her or his family without prompting. Some youth gave examples of how they lacked caring and respectful family relationships which precipitated their street involvement. The expectation of being cared about and of emotional connectedness with providers was most obvious in youth who had poor relationships with their families of origin.

Comments about these providers were that they took extra steps, often

outside the parameters of the work or agency setting, to show kindness and a personal emotional investment in the SY. Youth also determined if a worker was caring when a worker: used common courtesy, maintained confidentiality, accepted differences, honestly disclosed personal information, acknowledged uncertainty, and was sensitive to the likes and dislikes of youth. These perceived qualities earned the respect and loyalty of SY. Some comments about a particular provider were:

> She gives me a lot of hope.... That's something a lot of people don't have.... She is the best thing that ever happened to me ever since I've been on the streets.... She does care.... And I respect her very much.

Another youth gratefully recalled the generosity of a provider who drove him to a treatment centre hundreds of miles away in his own car and who provided other unexpected services such as buying him winter clothing and using his banking card to cash cheques. A young woman talked glowingly of her consistent physician who took her to lunch and talked with her daily during the period when she was sleeping on the streets, and of a worker who calls even though "her work doesn't know that she does it every day."

To express the importance of the bond with providers some SY used family or intimate terms. A youth said, "She explains a lot of stuff to me, she's helping me with a drug and alcohol problem.... She's taking me to AA.... She's like my best friend. She's really nice." Yet another grateful SY recounted a provider's efforts to reach out to her street-brother: "She didn't think he had

anywhere to go for Christmas... and she invited (him) along (to her family).... I think that's totally cool." Recounting the provider's relationships with others: "She's like their mom or big sister. The mom they've always wanted." The family endearment of "mom" was also bestowed on a worker by another young man.

The contraposition to the above statements is that many youth were very dismissive of providers who do not genuinely care for them. They expressed an acute awareness of the commodification of service, the exchange of services and time for money, salaries or contracts. Although youth did not specifically state this, they are apparently disappointed when no effort is made by staff to develop relationships based on generosity or a mutual emotional commitment. "They were lying to me pretending they cared but they don't. People can see it. They may look interested but they are actually not. They are doing it to get their salaries or whatever." Another youth said:

> She said "I get paid for the amount of time that you are here so you better be here so I can get paid" and that sort of thing.... Like I was being used for money.... So I said like, screw it, and just left.

A male reported that he avoided child protection workers because while he "felt cared for" he did not feel "cared about", noting that workers wouldn't be there if they were not paid.

From the perspective of SY other provider behaviours that help build caring relationships include: being non-judgemental; acknowledging uncertainty; courtesy such as introducing oneself by name and reading the youth's file before

a meeting; keeping personal information confidential, particularly related to sexuality; exceptional efforts to provide treatment; and sensitivity to the particular likes and dislikes of youth.

Several youth stressed the importance of being non-judgemental as a foundation for a relationship: "I have my nose piercing and my eyebrow ring.... These guys never put me down." Several youths perceived adults prejudging them and not taking them seriously. One youth said: "They looked at you funny. You got laughed at and told to leave." Another youth expressed how being "the only kid there" may have influenced receptionist services in a waiting room:

> I was sitting there forever. And I was the only one in the office and finally everyone was going ahead of me coming in and going, and I didn't understand.... That kind of stuff happens a lot with teenagers, and not just with street kids.

SY also extended trust to providers who shared their personal experiences of street life or other struggles. One youth described his experience of the development of a trusting relationship based on personal disclosure by the provider:

> You need to know the person, see what they are actually like. Instead of hiding things they do, being open and honest about it. That's a good way to build trust. Like... I was talking to him about doing drugs, and he even admitted to doing them. Like that was a good thing. I know I can trust him. I can tell him things. There are other people who say they have

never done it before. I don't know if they are going to turn you in or not. You just can't trust them. Seeing other people say it's all perfect and everything, it's too good to be true. It just goes in one ear and out the other.

A few youth raised the importance of the consistent availability of one provider in the development of a caring relationship. One young woman said:

I have been talking to her ever since I was squeegeing, ever since I was panhandling. I would see her all the time. But the people at the other place are always changing. They'd be there one summer and the next summer they'd be totally different. And they are not really there in the winter. She is always there for me.

Not all youth rely upon particular providers. A few youth seemed to count on an entire organization, even for emotional support. "If I really needed someone to talk to I'd go to a close friend of mine or I'd come to talk to someone here." Another youth later clarified this reliance on an entire organization noting that "the service is the people in it." Youth who relied on particular providers seemed not to rely on the support of entire organizations. The data was inadequate to identify reasons for this difference between informants.

There were a few youth who were emotionally independent of providers and organizations. One youth who met the study inclusion criteria still lived at home. Another rarely connected with services of any kind. One youth wanted to develop a relationship with a provider or an organization but failed. To the

question "Do you find that the people here are talking to you about your issues or are you having to manage them all by yourself?" the youth responded, "It's no worries.... They don't care."

In summary, for most youth, caring relationships with a provider were a very important factor in accessing health services, particularly supportive and counselling services. Expectations of being cared about by providers were most important to youth with poor relationships with families of origin. Youth were generally dismissive of providers who commodified services. Providers who showed generosity and an emotional investment in youth encouraged the development of caring relationships.

Providing Continuous Services

Providing continuous services refers to use of consistent service providers, coordinating services for SY, creating standing appointments or contractual arrangements regarding service use or intensive referral efforts. The provision of continuous services enhanced access to health services for most SY.

Young or marginally street-involved youth with at least one viable parental relationship reported consistent use of family doctors. The term "family provider" refers to a provider who regularly cares for other family members. In fact, a few SY reported being referred to specialists by family doctors. A 14-year-old's report of the kind of intimate family knowledge only a family practitioner could have is similar to other SY reports:

> The doctor was talking about depression because my older brother had it when he was my age or something like that. And then they just gave him some pills to help him out. He was just wondering if I was feeling depressed or anything.

Some SY reported having previously seen family doctors. The reasons expressed for no longer seeing a family doctor were: fear of broken confidences, non-proximity, or a recent move to the city.

The importance of coordinated services was discussed by many SY. A youth recounted how she appreciated being consulted in the move from the adolescent to the adult psychiatric system. Another female reported how her high school counsellor talked to her elementary school counsellor to find out "what I was going through." The same female said she was very pleased that her family doctor calls the local walk-in clinic to find out what has happened during encounters she has informed him about. If effectiveness and satisfaction increases because of coordination, continued access is more likely.

Providers who consistently advocate with the system on behalf of a SY were consulted repeatedly, "It's just like 'cause she sticks up for me in a lot of things... from being in a group home to trying to get my independent living."

Inadequate access to treatment may occur because of the discontinuities inherent in constant travel. A young man told a complicated story of multiple use of emergency psychiatric services in many provinces and cities. He was admitted to many hospitals, and experienced redundant and unnecessary

investigations owing to a lack of continuity in service provision in the many provinces and cities in which he stayed. He said: "It's so confusing, that. It's ten different, it's a hundred different stories every time I tell it." This youth was repeatedly assessed, but never adequately treated for his mental condition.

Contractual arrangements and standing appointments also increase access to services for some youth. Some youth are able to keep standing appointments which provide an opportunity for ongoing contact with a provider. Some youth find adherence to contractual arrangements with an agency improves access to health services. A number of youth had standing appointments to see therapists or physicians. Two youths had voluntarily signed written contracts about how they would use services. One contract required a youth to seek service when emotionally distraught. Another contract limited a youth to services provided by only one medical provider as he had a history of fraudulently seeking prescription medication. These contracts seemed to be acceptable to both youth.

Intensive efforts to link youth with services are more likely to meet with success than merely informing youth of the availability of services. Access to services is enhanced when health providers call to collect information about options and to arrange appointments. To illustrate, in one case a youth was walked to an agency and driven to another. In another case an ambulance was called for a youth.

Merely informing youth of the availability of a service may not be sufficient

to promote access. One youth did not attend the service he was referred to after an attempted suicide. In this case, other than telling him he should make an appointment, no special efforts were made by the referring agency. However, another youth did make a link to a health centre after merely been told about it. Clearly, not all SY need the same intensity of referral efforts. The rationale for these differences cannot be determined from the limited data available.

For referral efforts to be appreciated, the referral should give SY choice and as much control as possible in the situation. For example, one youth felt betrayed when an ambulance was called to take him to psychiatric help.

In summary, continuous services enhanced access to services and included use of consistent service providers, coordinated services, the creation of standing appointments or contractual arrangements regarding service use.

Respect for Client Control

Respect for client control refers to the efforts of providers to ensure that clients have a significant degree of control in health care encounters and in decisions arising from these encounters. There are two important interrelated factors in ongoing access, a significant degree of client control during and after the encounter with a provider, and information on which to base decisions. "Respect for client control" refers to the behaviour of individual providers while "enforced services", outlined above, concerns itself with helping system characteristics. Even providers who work in mandated agencies can provide services which are respectful of client control.

Youth complained about providers who pressured them to provide information and to answer questions. Some SY complained about the control some providers exercised: "There is less pressure (here). Those (other) people keep asking you question after question after question."

Numerous teens resented the efforts of others to initiate counselling, and refused to participate. SY refused to participate in both community and hospital settings. On the other hand, youth who felt some degree of control in encounters with providers reported feeling satisfied. Youth appreciated the counsellor who waited for the youth to initiate discussions and "let time do its work... when I bring it up." The youth who felt she "could have changed therapists if I wanted" also appeared to appreciate this. Perceptions of who was or was not in control seemed to affect the involvement of youth in counselling services.

A prerequisite to being able to make an informed decision is getting and understanding information. Being informed about the medications one was on was appreciated. The counterposition of this is that a number of youth recounted stories about physician visits where they were not clearly informed about the nature of the care, or where no understandable explanations were provided. "Everyone is rushed. They give you a prescription but don't even tell you what is wrong with you." One youth mentioned that an acquaintance of his was given an incorrect diagnosis by a physician. Finally, one youth complained about poor information in that male providers expect male clients to understand explanations "in three or four words. And that is that."

Youth appreciated a choice, and when there is only one option to a problem, they appreciated being able to offer informed consent. Even when providers were able to propose only one service, it was suggested that they present it as an option:

> They'll explain it to you. Ask you if you want the help.... Explain that you have rights and that you can do this if you want to. And if you don't want to, you don't have to.

Youth responded well to offers of several options for service, whereas youth did not respond as well when workers provided only one alternative to the status quo. Promoting client control is particularly important in mandated services. Upon being asked how a provider gave him hope, one youth replied, "She discusses options with me and she gives me a broad view of what I can do."

Age and Gender

Age and gender of providers was mentioned as important by several youth but no consistent response was provided regarding these issues. Reasons for various findings regarding age and gender are unknown as saturation of data was not reached.

When age of provider was mention there was no consensus about providers' ideal age.

> Like when I was raped I talked to someone my age, but I find that now it's a lot easier to talk to older more experienced people than younger because they don't know exactly what is going on or anything.

Another youth reported that she goes to walk-in clinics because they have younger doctors, because older doctors had "older beliefs." A male SY said that males over 40 were often "old-fashioned" or "conservative". On the other hand, he suggested their effectiveness and acceptance depends more on "their talent and experience," and described a very effective worker in his twenties. He proposed having workers of various ages in the same office.

Opinions were likewise contradictory about the gender of the ideal provider. However, saturation of this factor was not reached. There was some evidence that gender was an important provider characteristic for about a quarter of all youth. Youth who had a gender preference chose females over males. The reasons for choosing female providers varied. A previously sexually abused gay male reported that his preference was for females although he "could do just as well with both." Another male reported that "women tend to care more. They actually sit you down and explain things to you. The guys, just, you're a male, you should understand this in three or four words. And that's that." One female said:

> I've always found it more difficult to talk with guys than with girls.... And ever since my father beat me and put me in the hospital I've always been scared to talk to a guy.... Guys don't go through the exact same thing we do. The pregnancies and stuff like that.

Even a female who said that gender was not an important factor to her, confided exclusively in female staff. However, no youth volunteered that they would

refuse to accept or seek service from a male provider. Further development of this factor was not possible due to limitations of the data.

Street Youth Characteristics

SY characteristics are the third major category of factors associated with access to health services. Characteristics which facilitate access to health care include knowing about services and crisis orientation. Experiencing a non-acute physical or emotional condition usually, but not consistently, facilitated access. Factors which act as barriers to health care access included deferral of care, substance use, environmental constraints, and various internal motivators. Each is outlined below.

Knowing About Services

Knowing about services is almost always a precondition to using them. Some youth expressed a lack of knowledge as to where to go for certain types of services (e.g., dental services). When services exist and knowledge of these services is lacking, access is compromised. One youth suggested that a list of commonly needed services be made available for distribution. Knowing about services is particularly germaine to those who travel. A few youth reported having trouble receiving services in other provinces because they did not know where services were or how to get to them. For example, one teen said he did not know where to find walk-in clinics in another city.

Youth listed a range of services that they knew about and had used including those directed at:

(a) supporting basic needs (e.g., shelter, food, clothing, distribution of other goods, and provision of preventive materials such as condoms and needles), (b) traditional health services such as: primary care (i.e., family and walk-in doctors), secondary care (e.g., obstetricians, cardiologists, pediatricians) and hospital care (i.e., in-patient and emergency departments), (c) psychosocial services (e.g., hot lines, family reunification services, in and out-patient psychiatric services, various drug treatment options, long and short-term supportive counselling, and school-based counselling), and (d) outreach services (i.e., street outreach).

Knowing about a service is related to proximity. SY are more likely to know about services in areas with which they are familiar.

Crisis Orientation

Crisis orientation refers to the tendency of SY to access services during crises. Crises are reported to precipitate use of health services. Violence-related injuries were the most cited reason for use of crisis health services.

Crisis visits to an emergency department ensued for several reasons, for example, after ignoring a minor illness which progressed to become serious, an attempted suicide, and unconsciousness during an asthmatic attack. Visits to an emergency department followed after being hit by a car, and after involvement in an occupational accident resulting from food preparation in a travelling fair. Many SY also reported involvement in violence with others as a reason for receiving emergency room services. These altercations included violence

toward others, being raped, or more often being beaten up themselves. Some youth sustained repeated violence-related injuries.

Youth reported using services other than emergency departments after incidents of violence. A school called Child and Family Services after learning that a youth's mother had given her a black eye. Another youth received many emotional support services when her father who had previously physically assaulted her resumed stalking her.

Street violence is ubiquitous. One female recounted:

> I was there one time and all I did was ask for spare change and a drunk came by.... He was starting to tell me to suck his dick and all that and shoved his (silence) in my face and I stood up and said sorry and pushed him away, because that was just disgusting. Then he had a bottle in his hand. I ducked so it didn't hit me. He meant it to and... his friend took him away.

Crises which did not necessarily require use of hospital emergency departments may lead to use of other health services. One teenager called a teen hotline after attempting suicide by overdose. A few youth reported initiating use of counselling to deal with personal crises such as miscarriage, eviction from home, and serious depression.

Crisis orientation is related to immediacy in that when there is a crisis, SY are very anxious to be served quickly. Despite the high use of health services during crises, use of health services was not universal. A sexually abused

female did not explain why she never attended for any type of health care despite having contacted police. More data would have been helpful to uncover why some youth experiencing crisis used health services while others did not.

Non-Acute Physical or Emotional Conditions

Most non-acute physical or emotional conditions such as pregnancy, disability and physical and emotional illness were associated with repeated use of health services. The presence of non-acute physical or emotional conditions is especially relevant to accessing traditional health services. Youth reported regular or non-emergent care for chronic depression, ongoing cardiac concerns, asthma and HIV. For example, a participant with a learning disability said she makes use of her doctor because he understands her disability "a lot." Another youth reported only emergency care for serious asthmatic attacks. Another youth engaged in many emergency visits and longer-term hospitalizations for unspecified mental health concerns. Not all youth with chronic illnesses, however, attended for care. One youth with chronic asthma refused to attend for care because she disliked doctors and another youth who eventually found out about his HIV infection had been concerned about the possibility of having it for years before he was tested and started being treated. Despite ongoing examination of the data, it was not possible to uncover all of the factors which influenced participants' use or non-use of services.

For example, all three currently or previously pregnant females described frequent appointments for health care during pregnancies. They recognized the

importance of adequate prenatal care to the health of their expected child. Two females set up and kept their own appointments for prenatal care. However, the third teen who never attended for her own health care visited a clinic frequently but only for tests related directly to the health of her son. She refused tests related to her own health. The reason, in her words: "Cause it's my boy. It's my son. It's my baby." While pregnancy facilitated access to health services, on its own it was not sufficient as she needed the assistance of her worker to link her with a health service. This youth's appointments were arranged by a child protection worker. Further data collection and analysis may have uncovered additional factors influencing use or non-use of services in non-acute situations.

Deferral Of Care

Deferral of health care refers to putting off getting needed health care. Many SY often put off attending for health care even though they recognize the need for assistance. SY defer care for various reasons: they fear health practitioners or practices, they fear physical or emotional discomfort, they do not want to learn about chronic or serious illness, they have a high threshold for pain, or they fear being made fun of by others.

> One youth who did not like doctors described her procrastination:
>
> I was really sick.... If I had waited any longer, I had pneumonia or something. I didn't really care at the time. I was like, I will get better. I guess I should have gone before that. If I had waited any longer I'd probably be hospitalized.

Eventually her prolonged illness and extreme discomfort motivated her to attend.

A common reason for deferral of care was fear of health practitioners or practices. One informant seemed particularly fearful of needles and disliked touch of any kind. Two youth had an outright fear of physicians: "I don't like doctors. They smell funny... and give me this weird feeling." Another youth said, "I still have a phobia about going to the dentist and I'm not going until I need it.... I haven't been since I was 11 years old."

SY of both sexes were ambivalent about getting sexuality-related services they knew were needed. On the one hand they knew they were at risk and on the other they wanted to avoid physical and emotional discomfort. A male explained how knowing about recommendations did not translate into action:

> I just think about it, that I should go to a doctor about this. Go check it out. But I haven't just yet. I was planning to do that some time this week. But I don't know. It's like I've had sex with a lot of girls, not to brag or anything. But I should have been checked out more than once. But I just haven't.

Women more often than men identified emotional discomfort as a disincentive to sexuality-related care. Being "lectured at" by health care providers about sexuality related issues created discomfort for one female. Another female talked about how she avoided getting a needed sexually transmitted disease check because she was worried she would find out it was she who gave the infection to her boyfriend:

> It was scary because we found something... and then I worried that it was

> me that gave it to him. And I thought, oh no. I just didn't want to hear. Like if I had given it to him. I couldn't go. I couldn't deal with it.... I don't know if I would have gone right away. I think I would have put it off.

Fear of physical discomfort, particularly discomfort associated with sexuality-related procedures led to ambivalent or negative comments regarding future access. Sexually transmitted disease testing in males was described as uncomfortable and embarrassing. A female reported speculums as "really cold. I really don't want to keep putting it off, but I don't like that stuff at all." A male said:

> I went to the doctor to see whether I had AIDS or not. They basically shoved it (a swab) like an inch into me (my penis). I got extremely turned off by going to the doctor for that kind of attention.

These finding highlight the inter-relationship between deferral of health services and satisfaction.

There seems to be a weak to non-existent relationship between getting adequate medical care, knowledge of personal risk, and knowledge of medical recommendations for HIV, pap and sexually transmitted disease testing. In fact, when youths of both sexes volunteered information about the need for testing, particularly HIV testing, they often also acknowledged deferring it. A few youth said that they avoided testing because they did not want to find out they had a chronic or serious illness. One male eventually found to have HIV said:

> A few years back I went through a period where I didn't have the best

> health.... But I didn't get it checked out for four years because I thought I (had HIV).... So there is a lot of that because you are so young and you don't want to know things.

Many youth on the street may have a higher threshold for enduring pain and discomfort before seeking help than non-street involved youth. This higher threshold is in some cases due to the relative priority placed on pain and discomfort compared with getting basic survival needs such as food or shelter. Contributing to the higher threshold for pain and discomfort may be the use of substances. Some SY reported being unmotivated and deferring services because of the effects of substance use. One young man with multiple social problems and who drank and used cocaine while on the street explained:

> I don't really care if your body's sore or not. It's just that you get in a frame. You're all bruised up and you're hurting. It's just another thing.... Like if something is wrong with their leg and we can walk on it, it is sort of fine to us. If we can't walk, then we need help... I had reconstructive surgery on my knee. I just went to physio and had it fixed. But as soon as I was on the street I didn't care.

One youth cited deferring care because of the fear that others would react negatively to a physical appliance. Another youth was so fearful of experiencing a disparaging reaction to dental braces that she refused to get them made: "Then other people would have another reason to put me down and make my self-esteem even lower."

Substance Use

Substance use frequently creates motivational barriers to obtaining needed health care. Almost all youth mentioned using substances. Substance use is ubiquitous among SY. SY described how it caused them to put off receiving services. Drugs and alcohol may be used daily or more often. A youth described motivational barriers to accessing services:

> Basically me and most street kids, usually, if we're sick we are usually too high.... Lately I've been hard core into the drug scene.... Everyone knows pot is a depressant, and I've smoked a lot of that so the motivation is completely demolished.

Particularly difficult addictions were those to cocaine. A few youth using cocaine said that cocaine addiction brought them to or kept them on the street. Seeking health services was simply not a priority for those with this addiction. During outreach observation a young prostitute explained how her life centres around her addiction; "You don't care if you're sick when you're using crack. You just care about breaking" (i.e., turning a trick).

One youth viewed the social-legal consequences of substance use as a barrier to access. A teen refused to seek help immediately after being stabbed while drunk because she was concerned that the hospital would notify child protection authorities.

A few youths experienced negative health effects of substance use and sought help. One youth said he got help "for chemically induced depression a

couple of times... and that is from drinking or something." Only one youth, someone involved in solvent abuse, mentioned getting addictions treatment. Although he attended a few treatment programs, he gave in to his cravings for solvents and never completed the programs.

Environmental Constraints

Most SY experienced environmental constraints which reduced opportunities to access services during times of street-involvement. These environmental constraints included a lack of commonly expected physical resources, difficulty attending to personal hygiene, unstable living patterns, and unconventional dress and adornment.

Some SY faced significant environmental limitations to arranging and attending care: no telephone, no fixed address, no watches in a peer culture with no watches, and no alarm clocks. Phone booths frequently do not have yellow pages to locate phone numbers or addresses of services.

Some SY report having no opportunity for daily showers or changes of clothes: "A lot of street punks are too dirty to sit in a chair beside someone." Inadequate hygiene creates difficulty in getting health care:

> A lot of people when you go to a nice doctor's to make an appointment. You go there and you're all dirty from being on the street. People think you stink. I understand that. If I stink, don't sit near me. You don't want to.... They'll just leave. We are humans too. We need to see a doctor too.

Unstable living patterns, common to those on the street, lead to difficulty arranging and attending for health care. Those SY with multiple environmental limitations to arranging care also seem most likely to report prioritizing time toward activities which meet their basic needs: "There are so many things that are happening, that come up. You just can't have an organized life." One youth explained that "not having an address or a permanent place to live makes it difficult for health providers to get a hold of me if something is wrong." On the other hand, SY who have some kind of residential stability or a connection with home and parents seem to be more capable of arranging care. One young man told me of how recently moving in with his organized girlfriend helped him to get to the health services he needed.

Unconventional appearance may frighten or otherwise create provider discomfort. Some SY also wear unconventional clothing, sometimes by choice, and sometimes by necessity. Clothing may originate from clothing banks, and be worn until it wears out. Unusual hair styles and colours, body piercing, use of heavy chains as jewellery, old and heavily used clothing, and unconventional clothing were noted during outreach activities and in interviews with youth. SY referred to unusual appearances as a potential barrier to acceptance by providers. Hygiene is obviously related to the potential for developing caring relationships depending on the understanding of the provider.

Internal Motivators

Internal motivators are incentives or barriers to the use of health services

within the SY themselves. The experience of pain was an incentive to using health services. Barriers to accessing health services are fear of pain, depression, and a lack of trust in others. Each internal motivator is described in some detail below.

The Experience and Fear of Pain. The experience of pain stimulated health services use, while the fear of pain was a deterrent to heath care use. A number of youth mentioned visiting a physician because of experiencing pain.

Fear of pain was the main deterrent to the use of dental services. Even recommended dental care was not attended because of fear of pain.

> I refuse to go to a dentist and that. I think that I should see a dentist soon because it's pretty bad just. *"You are saying that your teeth are bad?"* Very bad. It's like, I should get braces too. I don't know like I'm scared cause they have like picks and the gouge. *"Is it the pain?"* It's the pain and the fear, it's both.

The absence of pain was used as a measure of dental health and used to justify not using dental services. One SY reported his dental health as "good" because "my teeth don't hurt." Another was told by a physician to visit a dentist for extreme oral pain, but did not because "it doesn't hurt anymore." Fear of pain leads to deferral of care.

Depression. Depression was repeatedly discussed as decreasing the motivation of those involved in street life, which in turn inhibited use of resources. Depression was often implied and many youth acknowledged that they and most

of their friends and acquaintances were depressed too. Depression is "true for me and all my friends that I knew.... 'Cause they had nowhere to go.... When you have nothing it's who cares anymore?"

Depression is often very severe. Before seeking help one youth had attempted suicide.

Although common, depression is not often talked about on the street. Two male informants told me of their reluctance to discuss depression or suicidal thoughts with others, one of whom only recently received counselling for depression when he was "forced" to attend for help by friends. Both youths recognized a personal link between depression and substance use. Describing his reluctance to discuss depression with others, one youth provided insight into the importance of having all providers actively ask about depression:

> I don't talk about suicide with anybody. I usually just think about it on my own.... A lot of other street kids I know will just do anything. They don't even care about dying. *Is that true for you too?* Yes, yeah. It's not like I'm in a rush for it or anything, it's just, I don't really care. Like, oh, I've got to go today, I've got to kill myself. It's not like that or anything. A lot of people fantasize. A lot of people I know anyways.

Without provider exploration, depression may remain hidden and services to address it may go untapped. Depression is also likely related to substance use.

<u>Lack of Trust in Others.</u> Many youth, particularly punks, mentioned lack of trust as a pervasive trait of SY. Lack of trust in others but especially in adults

may be a significant barrier to health services. One of the most cynical comments came from a female questioned whether she trusted her physician: "I don't trust anybody. You got to learn, you don't trust nobody." Another female echoed these sentiments as she described her active avoidance of helping systems and the absence of a significant relationship with any provider.

Youth, particularly those involved in the economy of drugs and sex and those who were abused as children, may be particularly distrustful of those on the street and others whom they do not recognize and have not learned to trust. One under-aged young man who had involvement in the drug trade told me that when the study was introduced to him, the first question he asked was, "Can I trust him (the researcher)?" He said his concerns were:

> If I tell him I smoke a joint or something is he going to turn me in to the cops? If I have a bunch of dope in my pocket is he going to keep me there and stall me and phone the cops and have them show up even before I leave? Or (will he call) CFS (Child and Family Services) or something?

Lack of trust is related to the opportunity for development of caring relationships. Trust is not freely given on the street; rather, it is earned in small measure over a long period of time.

Internal motivators influence access to health services. The experience of pain encourages health services use. Fear of pain, depression and lack of trust in others inhibits access to health services.

Social Environment

Access to health care is influenced by the social environment around SY, which includes family, friends and acquaintances. Each of these factors is described below. Crisis orientation is very much related to the undesirable influence of family and friends and acquaintences.

Family

Family may facilitate health care access for some youth while the family histories of others may create a need for use of health resources.

Violent or abusive families may have a role in precipitating health service use. Some youth cited family problems as a reason for receiving ongoing counselling. Some youth have experienced rejection by their nuclear family and still find their family burdensome and emotionally problematic. As an example, one youth feared for her safety as a result of her physically abusive father's persistent stalking behaviour. In addition to receiving shelter, this youth also was involved in ongoing counselling related to her father's continuing behaviour.

Four SY reported family-initiated contact or family problems as a reason for initial or ongoing contact with the mental health system. One youth attempted suicide by overdose after a serious argument with his father whom he had recently met: "Like too many things happened too fast and I couldn't handle them." Another young man intermittently involved with the mental health system in many different provinces said his entire family believes he is schizophrenic. He wished that doctors "would call my parents (and tell them) that I wasn't

schizophrenic. I could get my life back on track. I'm only 19 years old."

Family of origin may be particularly important in creating opportunities to access health services for a small number of young or minimally street-involved youth. Some youth with at least one viable parental relationship expected their parents to organize appointments, transport them, pay for health insurance, pick up medication, provide information, and provide emotional support and encouragement.

> I still visit my mom, and she drives me down there and stuff like that. Picks up my medication when I need some. It's pretty much how I get there, whatever.

Even a heavily street-involved youth made a rare call for assistance from a phone booth during a medical emergency and was picked up and transported to an emergency department by her father.

SY with little connection to their families of origin were the only ones who mentioned belonging to or creating "street families." In a few situations these street families included a provider. The quality of these family relationships encouraged access. One SY over the age of 18 calls his counsellor in another province whom he still contacts from time to time "mother".

Surprisingly, two young men reported that their fathers had introduced them to youth-serving shelters. The reasons for this were not clarified. One youth reported that his family paid his Alberta health care premiums, thus making it possible for him to get health care when he needed it.

Despite the abovementioned situations, biological family played no role whatever in assisting current access to health services for about half of SY.

Friends and Acquaintances

Friends and acquaintances influenced the use of health services by providing information, encouragement and transportation. In some situations, friends and acquaintances also encouraged violence, leading to the need for health services.

A number of SY were initially introduced to services by friends who accompanied them there. Sometimes SY were forced to attend for health services by friends. A teenage male who suffered serious bouts of depression reported: "Sometimes my friends brought me down here to talk with them.... They just wouldn't leave me alone until I agreed to come down here.... I have good friends." On the other hand, some SY were discouraged from attending for addictions treatment because they would no longer be fun to be around: "They're just all against going to get treatment.... They don't think I should."

Boyfriends and girlfriends may be especially influential in encouraging or pressuring each other to get checkups for sexually transmitted diseases. A teenage female described how her boyfriend pressured her:

> We discovered it (symptoms) on him... and I got really scared and then I was worried that it was me that gave it to him. Like he said, "You and me are going to the doctor's."... I don't know if I would have gone right away. I think I would have put it off. He said "I'm going tomorrow."

The encouragement of friends was not always effective however:

> They were gonna take me to the hospital.... (And I said,) "You can't do that to me because you don't have my permission. I mean I'm not unconscious or anything. So you can't." And I didn't go.

SY with gang affiliations sometimes participate in violence which leads to injuries. The resulting injuries may or may not precipitate health care use. One gang member said she would be reluctant to use health services if she was hurt as a result of gang activity, but did not explain why. One young man with gang friends described how he was beaten up on the street and how he sought help at an emergency department.

During outreach observations it was noticed that if workers made contact with a few youth it facilitated access to a wider group of their peers. In other situations, when one youth agreed to visit a facility, another youth would be more likely to tag along.

Acquaintances too, may play an important role for travelling SY or those new to the street. SY may ask their peers about available services.

Satisfaction

Satisfaction is the perceived difference between the services which were experienced and the services which where expected. Satisfaction is both an outcome and facilitator of future service use. Satisfaction with health care encounters facilitated repeated use of services, while a history of dissatisfaction became a barrier to future access.

Expectations, characteristics of the helping system, provider characteristics, and characteristics of being a SY all influence satisfaction. Youths made many comments about the types of activities or approaches they valued or disliked in providers. Implicit in comments about satisfaction was its relationship with the likelihood and rapidity of future access. Expectations of service providers varied a great deal among informants. Satisfaction seemed to result when personal expectations were met or exceeded.

The variance between the expectations youth had of child protection workers - whether they actually cared for and about them - and the reality of that relationship left most youth dissatisfied. The expectations youth had of outreach workers or physicians were never that exacting. Youth also reported that experiences with a type of providers (e.g., physicians, dentists, counsellors) affected future use of the same provider type.

A number of informants who had positive experiences with services seemed to use those services again. Familiarity with services was variously described: "I've used this service before," "'Cause they know me there", I'm a "regular here so it's easy to talk to them about lots of things", and "'Cause that (service) knows my name." By contrast, those who had poor experiences with health systems were reluctant to use them. One youth reported how he had lost five close family members in the last two years at the hands of doctors, and how he was now reluctant to use their services.

Successes in dealing with health problems, often depression-related, were

followed by repeat visits for similar concerns by a number of youth. However, three youths described how their poor experience with psychiatric services made it less likely for them to use these again. As an example:

> When I was living at home I was seeing a lot of psychiatrists, really a lot. It just made me feel ten times worse. So I've always had a phobia of going again.... I was made to. Now I am never going to go on my own, unless it's for drug rehab or something like that.

Another youth said, "I've been to a psychiatric ward.... I've been on Prozac.... I left there more screwed up than I came in. A lot of people do.... It totally turned me off!" One youth described how friends "who have tried it (suicide) and stopped like so many times", did not find services to be helpful. It is likely that this youth's potential access to services would be affected by the experiences of friends. Another SY reported: "When I'm in the hospital, my mind goes all really fast and I don't think on what I want in life.... It's not a helpful place for me. The outside helps me out a lot more."

One youth who continued to use hospital services despite dissatisfaction with them went against the general trend. He had lingering doubts about having a mental illness and talked about previous and future encounters with the health system despite dissatisfaction that after many hospitalizations "doctors can't diagnose a certain illness" and can't "solve the problem." To understand the motivation behind this type of variation it would have been helpful to have had a larger sample.

Chapter Summary

SY used terms to describe themselves based on their identification with a subculture, their interaction with a near group, labels imposed by others, and personal traits. Most youth were initially unable to recognize how group affiliation or association with a label affected access to health services.

Factors affecting access to health services fall into five major categories: (a) helping system characteristics, (b) provider characteristics, (c) street youth characteristics, (d) social environment, and (e) satisfaction. Specific factors can either hinder or enhance access to health services. In table 25 factors facilitating and inhibiting access to health services are outlined. The table excludes factors for which there was no general agreement about whether it facilitated or inhibited access to health services (i.e., age and gender, non-acute physical and emotional conditions). It would be helpful to have collected more data to better explain variation within some factors.

Health care system factors which facilitate access to health care include affordability, immediacy, practical assistance, safety, and tailored services. Imposed services, more often than not, act as barriers to use of health services. Proximity, more often than not, facilitates access.

Provider characteristics found to facilitate access to health services include: caring relationships, providing continuous services, and respect for client control. There was disagreement about the importance of provider age and gender.

Table 25
Factors Facilitating and Inhibiting Access to Health Services

	Facilitating Factors	Inhibiting Factors
Helping System Characteristics	*Affordability* *Immediacy* *Practical assistance* *Safety* *Tailored Services* *Proximity*	*Imposed services*
Provider Characteristics	*Caring relationships* *Providing continuous services* *Respect for client control*	
Street Youth Characteristics	*Knowing about services* *Crisis orientation* *Internal motivator (experiencing pain)*	*Deferral of care* *Substance use* *Environmental constraints* *Internal motivators (fear of pain, depression, lack of trust in others)*
Social Environment	*Families* *Friends and acquaintances*	
Satisfaction	*Satisfaction*	*Dissatisfaction*

SY characteristics which facilitate access to health care include: knowing about services, crisis orientation and the internal motivator of experiencing pain. Experiencing a non-acute physical or emotional condition usually, but not consistently facilitates access. SY characteristics which act as barriers to access include: deferral of care, substance use, environmental constraints, and various internal motivators (i.e., fear of pain, depression, and lack of trust in others).

The social environment around SY, including family, friends and acquaintances enhances, or in some cases mitigates against, access to services.

Satisfaction is both an outcome and facilitator of service use. Satisfaction with health care encounters facilitates repeated use of services, while dissatisfaction does the opposite.

Within this framework all categories and most factors are interrelated.

Chapter 5

Discussion

The research findings are discussed in this chapter. The chapter begins with a discussion of health service access issues based on SY identity. Then each of the major categories of the framework emerging from the data are considered: helping system characteristics, provider characteristics, SY characteristics, social environment and satisfaction. Recommendations which arise from the study are listed. Frameworks for evaluating SY access to health services are reviewed and SY needs in relation to access are discussed. This chapter concludes by identifying this study's contribution to a model of access to health services.

Access is the potential for and actual entry into not only the first encounter, but the potential for and actual entry into every subsequent encounter with the health system. If access to services is to be equitable, that is, based primarily on the needs of the population served rather than on those of providers or systems, then it follows that access to health services should be greater for SY. The preceding literature review confirmed that SY have higher levels of health problems compared to rates among non-street-involved youth, when it was possible to compare these rates. In the preceding literature review, where comparisons were not made, the rates of health problems among SY were demonstrably high in their own right. In identifying factors which affect SY's access to health services, this study's findings can be used to improve equitable

access to health services.

Identity

How youths identify themselves may be related to how they access the health system. This study neither intended nor was able to identify all significant SY subcultures and the influence of subcultures on access. The study determined three ways other than membership in SY subcultures that youth self-identified: through association with near groups, by the labels that others gave them, and by describing their own personal traits. The factors affecting access to health services associated with various types of youth may be important in planning and delivering health services.

Only some SY were able to consciously link self-identity to issues of access to health services. While most SY were at first unable to explicitly verbalize how their affiliation with terms describing their identity affected access to health services, these associations were sometimes implied throughout the course of the interview.

About half of SY identified with one of three SY subcultures: punks, gangsters, and street kids. There are almost certainly more than three SY subcultures, but they were not identified owing to the study's small sample size and possibly the recruitment process itself. Some youth who identified with a subculture also used other types of self-identification. SY under 18 found it more important to self-identify with a subculture or street-label than did older SY. Some SY reported reduced intensity of identification with subcultures or street-

labels over time. Perhaps maturation reduces the desire and need for group affiliation.

Kipke et al. (1997b) provide evidence of the heterogeneity of the SY populations in a large city (Hollywood) sample characterized by sub-groups with different norms, values and beliefs. According to Kipke, peer affiliation influences service use. The current study's sample size did not allow for the identification of all or even most sub-groups that are on the street. For example, it was not large enough to distinguish patterns between those on the street for long periods of time and those who had recently become street-involved. Additional studies with SY sub-groups may assist in clarifying the issues associated with access for various sub-groups. It may well be, however, that there is less group diversity among SY in a medium-sized city like Winnipeg because of the smaller number of SY and the high likelihood of SY interacting with each other in service sertings and in street contexts. No research has identified or compared the factors associated with access among SY groups of differently sized cities.

About half of SY did not identify as members of a subculture; and even among those who did, a relationship between participating in the subculture and access to health services was infrequently noted by the SY themselves. SY who self-identified through their association with near groups never consciously made the connection between that association and their access to health services. It is difficult to be critically self-aware at the best of times, but particularly when youth

are in the midst of the stressful circumstances of the street. Reid and Klee (1999) in a study of 15 to 25 year old homeless people in Manchester, England found that the "homeless" label seemed to make some people unwilling to use services specifically for the homeless. While no participant mentioned this or appeared uncomfortable with the term SY in the title of the study, it is unknown if the term "SY" has the stigma associated with it in Canada.

All cultures and subcultures, as well as the contexts in which they operate, change over time. To ensure access, providers should make efforts to stay abreast of the unique access issues of SY subcultures. If health services and providers focus efforts exclusively on overall barriers to and facilitators of access for SY rather than on the unique needs and capacities of specific groups, services may risk becoming inaccessible to those whose primary self-identity is as part of a SY subculture.

Although this study did identify a few specific factors associated with access for some SY subcultures, the sample size was not large enough to identify all major factors for each group. Although half the participants did not express any sub-group affiliation, an attempt to delve more deeply into the access issues of specific SY subcultures might be a logical step for further research.

SY who talked about labels given to them by others and those who used other self-descriptive terms were often able to identify how being associated with these terms affected access to health services. Providers may find it helpful to

talk with youth about labels given to them by others and about other self-descriptive terms in order effectively to explore an individual's access to health services.

It is important that services which need to remain accessible to a wide range of SY (e.g., shelter, needle exchange, condom distribution) avoid identifying themselves with any single group of SY. Agencies suggest the inclusivity or exclusivity of their services to potential users by: their location, the diversity of staff, which groups of SY make the greatest use of their service, and how services are marketed. For some services accessibility to all groups of SY may be important because a mid-sized city like Winnipeg has limited potential to develop tailored or unique services for sub-groups of SY. Remaining accessible to all SY is most important for specialty health services which cannot be duplicated.

This study did not set out to identify all aspects of informants' group affiliation, nor to establish how access to health services is affected by group affiliation. The study did find that non-subculture-specific self-identity is important to how SY access services. This research identified common factors associated with access to health services regardless of sub-group affiliation. Awareness of commonalities across all sub-groups of SY is particularly useful in a mid-sized city because of financial restrictions on the development of multiple tailored services.

A discussion regarding identity was also made in the introductory chapter.

It was argued that researchers needed to be more consistent in defining SY. Interpreting research in which a multiplicity of definitions are used will remain difficult. How might the findings of this research apply to SY in other settings? Do the criteria used in this study adequately define SY? A selection of definitions of street-involved youth used in Canadian research is briefly reviewed below and compared to those of this study's inclusion criteria. See Table 1 for some of the specific criteria used in some other Canadian studies. The following studies are mentioned in addition to those in Table 1: Anderson (1998) defines SY as those who have left home in the past, are thinking of leaving or have decided to leave; are not employed or under-employed; dropped out of school or have school problems; regularly use substances; and use services for out of the mainstream youth. The Community Street Youth Task Force Report (1990) identifies homeless youth as depending on non-traditional sources for survival and acceptance. The Social Planning Council (1990) defined homeless youth as those who currently or previously left home. Age criteria for enrollment varied widely but usually stopped at or before 24 and started at or after age 10. The ages of youth eligible for enrollment in this study are in step with those of other studies and are perhaps more inclusive. Most of the participants in this study would have met most or all of the criteria for enrollment in the other studies mentioned above or in Table 1. The strong impression left after carrying out this research is that the inclusion criteria used in this study were effective in identifying SY.

The confusing multiplicity of definitions of what characterizes SY is a matter of great concern. It is important to start using consistent definitions and terms for what is essentially a similar population or there will continue to be legitimate questions about the applicability and transferability of findings.

Helping System Characteristics

Several factors of helping systems were identified as facilitating access to health services. These included affordability, immediacy, practical assistance, safety, and tailored services. Imposed services were more often than not seen as a barrier to access, while proximity more often than not facilitates access. In the following section, factors associated with access to helping systems and recommendations to improve access are discussed.

Affordability

The issue of affordability emerged from the study and was anticipated in the literature review. Affordability is a very significant barrier to or facilitator of access. Affordability is a major impediment to the principle of universality of access to health services among Winnipeg SY.

Some of the issues emerging from the study which relate to affordability were often also identified in other SY research: knowing a health number or having a health card (Caputo et al., 1994c; National Forum on Health, 1997; Social Planning Council of Winnipeg, 1990); and having insurance for non-government-insured health services such as dental care (Lee et al., 1994; Ryan et al., 1996), pharmaceuticals (Jackson & McSwane, 1992), or other non-insured

services such as physiotherapy. Extended health benefits (for pharmaceuticals, dental care, etc.) were sometimes available through parents' insurance plans, to a more limited extent through government financial assistance (i.e., welfare), or through child protection services.

Issues of affordability are mediated by the sociopolitical environment. In Canada, for example, major issues of affordability differ from province to province. These differences apply to payment of required medicare premiums, public insurance of pharmaceuticals, and public coverage for purchase of prostheses, dental procedures and other health supplies and procedures. Getting dental services was particularly difficult for many youth because they were unable to afford them. Not providing public insurance for dental services is a puzzling social policy decision.

Because personal identification is like currency on the street, its loss may have serious implications for access to a variety of health services. Simple replacement of identification is not always an adequate solution to this problem. One possible solution is for SY-serving agencies to encourage youth to memorize their insurance numbers and for the same agencies to provide secure storage for identification or to offer to place insurance information on file to prevent loss. Shared electronic client files are another option for storing and retrieving insurance information. Shared electronic files are in the conceptual stage for all Manitoba health services.

Some youth did not know they were eligible for services, and some did not

know how to get the services they were eligible for, particularly dental care. Providers must guard against assuming youth know about how to make use of the health system. To ensure equitable health services for all, alternatives to fee-based services must be available and should be well publicized to SY populations. Not raised as an issue by informants of this study is that medications can be frequently stolen or lost on the street. Efforts must be made to improve accessibility to pharmaceuticals, dental care and other non-insured services.

Transient populations, many of which have demonstrably high needs, should be assured of unrestricted and continuous access to health services. Youth who engage in interprovincial travel may be misinformed about residency requirements and how this affects their eligibility for traditional health services. Provincial health insurance services should establish agreements and processes to circumvent involving potential health system users in disputes about liability for costs. Traditional health providers and SY-serving agencies should be prepared to advocate for youth whose eligibility for health services is uncertain. Non-insured foreign SY face particular challenges as they may fear being turned over to immigration officials if they attend for care using legitimate identification. Use of false identification compounds their need to remain hidden. Basic health care is often viewed as a right in Canada and should also be extended to these youth, if for no other reason than to assist in the control of communicable diseases. One way around this predicament is to fund select centres to provide

basic health services to those street 0youth without insurance.

Immediacy

Immediacy is the opportunity to receive services without delay. What constitutes delay is highly subjective and, for SY, often very short. This study and Ensign and Gittlesohn's (1998) study of Baltimore homeless youth found that as waiting time before appointments and waiting time within an office increased, accessibility decreased. As the study uncovered, the importance of immediate availability is influenced by the tendency of many SY to defer needed care, and to ignore problems until they either resolve themselves or reach crisis proportions. These findings were foreshadowed in the literature review.

Immediacy is related to the factors of proximity and crisis orientation. Many SY will use services that are close and therefore immediate. Immediacy is required because many youth tend to use services when they experience crises. There is a need to have services available when the motivation to use them is high. A high motivation to use services may be short-lived and transitory. Getting treatment for substance use problems is particularly difficult (Reid & Klee, 1999) when, in addition to long waiting lists for residential treatment, there are also waiting lists for initial detoxification. Once a SY is heavily reinvolved in substance use a motivated moment may not reoccur until years later.

Outreach on streets, in malls, and in agencies where SY congregate, creates gateways into helping systems. Youth in this study highly valued outreach services. Street outreach should remain an important part of health

services directed at SY. Street outreach may incorporate three functions: (a) distribution of risk reducing materials and messages; (b) delivery of counselling services in street settings and agency sites serving street-involved youth, and (c) provision of other services such as referral, coordination of care, and street-based health care (Anonymous, 1993). Street outreach provides immediate services.

Interestingly, although youth talked about the value of outreach, observation of outreach encounters did not yield large amounts of useful data. This may have been because youth did not know or trust the researcher and censored themselves, or because the benefits of outreach activities accrue over time and are not very noticeable within a short time frame.

Outreach agencies and workers must be well connected with a range of services to create formal and informal continuity. Ideally, outreach programs and longer-term care should be part of an organized network providing a comprehensive continuum of services. Without planned and formal interagency service continuity, outreach programs can make contact with SY but may have difficulty making successful referrals to mainstream services because of long waiting lists or other inappropriate responses.

Services should be open when they are needed (Anonymous, 1990; Caputo et al., 1994a). Standard agency hours often are often not in accord with the needs of youth and the times when they are motivated to use them. SY need flexible hours to meet basic needs and appreciate flexible times for drop-in

services.

In this study appointments were viewed as a disincentive to access services for some SY, while for others appointments enhanced access. For SY who cannot keep appointments, "on-demand" services such as walk-in clinics, street outreach or drop-in services are preferred. Agencies could poll SY or experiment to determine when SY are most interested in making use of their services. Agencies and providers that build flexibility into their schedules, that leave a portion of their available time and resources unbooked to deal with walk-in clients, provide opportunities to reach and serve SY who might otherwise choose not to be helped.

SY seeking service based on immediacy may create fragmented health service utilization. The delivery of health services may become fragmented when no after-hour call service exists, where the youth is requested to come back repeatedly for potentially refillable prescriptions, and where SY attend various walk-in clinics or emergency departments. In the face of SY's desire for immediate services the following suggestions may avoid fragmented services: after-hour call services, refillable prescriptions where appropriate, and the generation of routine reports to family physicians.

Extended waiting room delays are uniformly disliked and may be perceived as a serious barrier to accessing services, especially because SY often only see a provider when problems have become crises. Volume management and increasing staff resources during times of greatest demand

may decrease waiting delays.

Practical Assistance

The importance of services to meet basic survival needs was often identified as the greatest priority of SY. That basic survival needs might be identified as an important factor was fully anticipated in the literature review. SY appreciate and often need concrete assistance in meeting basic needs. Opportunities for adequate food, drink, shelter, clothing, hygiene, a safe environment, basic medical and dental care, and needed pharmaceuticals are essential for life and quality of life. To avoid fatal illnesses condoms and, in some situations, new syringes are needed. Some youth reported an inability to get the abovementioned services.

Not all youth in the study were served by social services or by child protection services. Some youth had just run away from home, while others, because of substance abuse and for other reasons, had been cut off from the formal helping systems. Even if youth are receiving financial assistance, finances may be mismanaged or inadequate. Last resort facilities, such as Winnipeg's Main Street Project, cannot be used by those who are minors or those who perceive them to be unsafe.

Meeting basic survival needs is the greatest priority for many SY. Basic needs must be met before higher level needs can be addressed. Some SY in this study abused the health system to meet basic needs. Other youth avoided using costly health services to use the money saved to buy food. Services that

provide for basic needs should be available and marketed to SY throughout the city. SY also appreciated a wide variety of non-survival-related services and goods. The availability and quality of material assistance may be a deciding factor in the use of one agency over another. In meeting SY's practical needs efforts should be taken to ensure that SY receive quality goods and services. Providing for the basic and non-survival needs of SY is a way to encourage contact with helping systems and can be used as an inducement to develop relationships with providers and agencies and encourage trust.

Safety

Youth expected and appreciated services that provided an environment free from physical or emotional harm. Youth need protection from each other, from family and friends, and from some providers. Schaffner's (1998) research found that SY leave their homes for what is perceived to be a safer environment.

Youth who are street-involved face a high risk of violence (Campbell & Heinrich Research Associates, 1994; Caputo et al., 1994a; Caputo et al., 1994c; Elizabeth Fry Society, 1985; Janus et al., 1995; Kipke et al., 1997a). When SY do not feel safe in SY-serving agencies, they feel betrayed. Client safety planning should continue to be a key feature among SY-serving agencies. Unfortunately, given the lack of private rooms in these services some youth are excluded in order to create a safe environment for others. It is very important for SY-serving agencies to continue to provide services free of danger and fear (Ensign & Gittlesohn, 1998; Runaway and Homeless Youth Study Committee,

1994). As mentioned previously, there are sub-groups of SY some of whom are threatened by other groups, such as gays, lesbians, and youth who are stalked. Client safety for these sub-groups can be enhanced by creating, where necessary, no-loitering policies or specialized agencies or locations to meet their needs.

Tailored Services

The six facilities in which this study was carried out provided services to slightly different groups of SY. Although there were overlaps in clientele among agencies, differences were noted in the populations served. While it seems that on the surface all SY-serving agencies cater to a similar population, SY do not see it that way. SY can be very aware of their differences and allegiances. Some of these allegiances or differences can create conflict between groups of SY (Runaway and Homeless Youth Study Committee, 1994). "One size fits all" services may not be the most effective way to reach all SY, particularly groups of SY who are on the bottom of the social pecking order (e.g., "sniffers"), or groups who fear for their safety from other SY (e.g., gay youth). Russell et al. (1992) also described homeless youth as sensitive to the appropriateness of services for special minority populations. Providers should be especially sensitive to the antagonisms and alliances between SY sub-cultures. A cost-benefit analysis of the appropriateness of proximally distinct and tailored services for gay youth, solvent abusers and other vulnerable SY populations may be timely.

Mainstream health services not identified as exclusively SY-serving but

which develop a reputation as generally making an effort to serve SY may, through this reputation, attract SY.

Imposed Services

Imposed services refers to forced services regardless of a SY's personal choice. Numerous youth described how they sabotaged various types of mandated services such as those resulting from their involvement with child protection services, virtually guaranteeing poor results and dissatisfaction. Power struggles with inflexible systems are to be expected as youth seek independence and a sense of control over their own lives. The findings of this study point to the importance of services establishing policies and practices which, whenever possible, work with SY to address the SY's issues as the SY defines it and as the SY wishes to approach it. This concept of client empowerment should be applied in child protection services, residential settings, mental health services, and all other services serving SY. Providers in mandated agencies could use an empowering approach.

SY in this study viewed mandatory reporting to child protection services as a barrier to accessing health services. The majority of Winnipeg runaways last ran from child protection services placements, and most of those ran because of dissatisfaction or problems with the placement (Social Planning Council of Winnipeg, 1990). Satisfying SY or marginally street-involved youth is critical when services are mandated. A youth dissatisfied with a child protection services placement may view the street as his or her only remaining option.

When this occurs making contact with any service becomes a threat to the youth as the service is required to report the youth to child protection services.

Imposed services are related to the factor of "respect for client control". Respect for client control is a provider characteristic while imposed services is a characteristic of the helping system. SY want control over their own lives, they do not want to be controlled. They want services which provide legitimate choices and which respect their autonomy. Fear of being forced into unwanted and unpleasant situations is a disincentive to participating in and seeking care of all kinds. Child protection services might consider the development of formal links with other youth-serving agencies in order to serve more effectively those youth who have little remaining trust in the child welfare system, or those who have broken these ties completely. Youth-serving agency personnel could take on functions normally the purview of child protection services. Youth may still be able to develop a trusting and effective relationship with a provider in a youth-serving agency when this has become highly unlikely or impossible with child protection personnel directly (McCullagh & Greco, 1990).

Proximity

Proximal health services are more likely to be used. The types of transportation normally available to SY, walking and public transit, obviously restrict travel to distant services. Proximity is related to the factor of immediacy as overall, proximal services are more easily accessed.

Services near to areas where SY congregate should make special efforts

to modify services to meet their needs. Marginally street-involved youth are more likely to make use of local services near their homes. Service providers near to where marginally street-involved youth live also need to recognize and be able to respond effectively to them.

SY who have been expelled or drop out of school may lose access to some youth-oriented services that are available only in school settings. When placing services in communities consideration should be given to where they are most likely to serve those most in need. Schools may not be the most appropriate location for many services, particularly counselling services. School counselling services, however, may be the only counselling services which have an understanding of the local dynamics of a youth's neighbourhood.

Those involved in health system planning and most service providers have control or influence over the structure and function of helping systems. They should closely consider how to improve access to health services based upon the factors discussed above.

Provider Characteristics

Provider characteristics are important in creating accessible health services. Provider characteristics are closely linked to those of the helping systems in which they work. Providers can encourage or obstruct access to services in the face of health systems that are or are not accessible. Provider characteristics found to facilitate access include: caring relationships, providing continuous services, and respect for client control. There was disagreement

about the importance of provider age and gender. These characteristics are further discussed and recommendations are made in the following section.

Caring Relationships

Most SY informants emphasized the importance of caring relationships with providers or a strong connection with a caring service as a very important factor in accessibility of services, particularly counselling and supportive services. If youth raised this issue they were either profoundly committed to or profoundly dismissive of the service based on the caring relationships they had developed or failed to develop. Youth with remaining or renewed emotional attachment to family did not, to the same extent, rely on or hope for providers to bond emotionally with them.

Providers were considered caring if they took extra steps, often outside the parameters of the work or agency setting, to show kindness and an emotional investment in SY, were courteous, maintained confidentiality, were accepting of differences, honestly disclosed information about themselves, acknowledged uncertainty, and were sensitive to the likes and dislikes of youth. Youth said that providers who did not care commodified services by merely exchanging services for money (e.g., salaries, contracts). In this respect SY's comments were partially consistent with McKnight's (1995) view that "care cannot be produced, provided, managed, organized, administered or commodified" (p. x). Consistent availability of a provider and the traits defined above were important in developing a caring relationship. A few youth relied upon the caring of providers

in an entire organization while a few SY were emotionally independent of any providers or organization.

The importance of SY's relationships with providers is an interesting finding, particularly because SY are thought of as having taken steps to distance themselves from conventional society and because some SY claim to stand in opposition to it. Rosenfeld et al. (1996), who studied urban youth in Boston but also included some SY as part of their sample, identify the approach of the health care provider as the most important factor in seeking, receiving and returning for primary care. The Runaway and Homeless Youth Study Committee (1994) of Calgary concurs with the importance of the nature and relationship with the helping person as one of the most important factors in use of and satisfaction with a range of services.

The findings from this study and from the literature indicate that SY disengage from families, schools and other social institutions for many different reasons. Social bond theory (Hirschi, 1969) would suggest that most SY (e.g., runaways, gang members, substance users, those with non-normative sexual orientations, and others) have loose or deficient moral, emotional or psychological ties to conventional society. A social bond exists where the individual has something to lose by being released from it. A social bond is based on the attachment or belonging a person feels to a social order (Brennan, Huizinga & Elliot, 1978). As outlined in the literature review, some SY's social bonds have been broken in one way or another. For others the social bond was

never strong to begin with.

Most SY are attracted to the street through the possibility of establishing positive relationships and finding safe environments. In some cases new and less socially acceptable social bonds replace those of families, child protection services, schools, and other community settings. In situations where there is no history of positive relationships with parents or guardians, youth develop their own social bonds. Many youth in this study mentioned the importance to them of their street "family". Street families are groups of street-involved peers who create emotional bonds and opportunities for safety and connectedness. Street families can be positive or negative forces in the lives of SY. Providers can also create an environment of safety, acceptance and a sense of belonging.

Schaffner (1998) found that adolescent runaways resist running and usually run only as a last resort. Adolescents run to gain freedom from situations they experience as abusive and to establish opportunities for finding love and protection elsewhere. Schaffner found that, paradoxically, running away is a search for connection, a search for nurturance and protection. The search for connection, nurturance and protection was also evident in this study. Youth looked for connection, nurturance and safety on the streets. Most SY leave home during adolescence, a time of heightened desire for independence (McGoldrick & Carter, 1982). Establishing autonomy is a developmental task of adolescence, and insecure attachment to parents or guardians makes this task very difficult (Allen, Moore and Kuperminc, 1997; Galambos & Ehrenberg, 1997).

Some youth find a degree of safety and nurturance with services and providers. Providers are predictably available in place and time. Other youth find nurturance in newly created families or, sometimes, with families of origin. Relationships with street family are unlikely to be long-lived due to the instability of the street.

Informants were articulate as to how provider relationships can create opportunities to develop trust, and how building on that trust can establish an emotional bond between the youth and the provider. That bond with a provider could be described as an anchor in a sea of instability. The effective provider is perceived as someone who can be counted on to lend a hand. Informants implied that valued relationships with providers were based on friendship and support. In effect, providers became an important and sometimes the central person in the SY's community. In the absence of family and community support these youth found support and nurturance in relationships with providers who were willing to give of themselves emotionally and in other ways.

McKnight (1995) argues that professional care cannot replace the relationships and support of real community and that "the basic definition of 'unprofessional conduct' is 'becoming involved with the client'. To be professional is to distance" (p.47). In contrast to McKnight's comments, SY said that they valued most highly those providers who developed emotional bonds with them. In effect, those providers became "friends" and an important part of the SY's supportive community.

The relationship with a trusted provider has powerful significance to many SY and is deeply felt. Given that family relationships have been problematic for many of these youth, it is not surprising that deeply trusted providers were referred to using familial terms like "mother" or "sister".

Stigma has the potential to get in the way of developing effective relationships between providers and SY. Although the term stigma was never used by any informant, SY experienced its effects and articulated problems which arose from being stigmatized. Some SY are obviously different in hygiene, adornment and dress, in how they congregate on the street and go about acquiring money or other goods and services. Stigma reduces in our minds "a whole and usual person to a tainted, discounted one" (Goffman, 1963, p.3). Stigma creates some degree of ambivalence in responding to SY. In this study SY said they were sometimes treated with sympathy or pity, at other times as a threat, or they are blamed for their own misfortune. These responses are neither appreciated nor useful to SY. Perhaps it is more difficult for health care providers to be courteous if they are uncomfortable serving SY. SY worry that they will be given discriminatory and substandard service (Lee et al., 1994). SY seek out and need respectful reciprocal relationships.

In this study SY implied that providers who were able to be non-judgemental and respectful were more likely to be successful in establishing effective relationships. In this and previous studies the perception that they are being treated unequally because of their youth is a barrier to access for SY but

also to non-SY (Ginsburg, Slap, Cnaan, Forke, Balsley & Rouselle, 1995; Rosenfeld et al., 1996). SY described perceiving services as not taking them seriously because they are youth. All services should review practices, including those of reception, so as not to appear to discriminate based on age.

Maintaining confidentiality was important as a foundation in the construction of caring relationships for youth in this study. Adolescents and SY may be insecure in the confidentiality of their health information and avoid seeking help from a known provider. This study's findings are congruent with earlier studies that health services for sexuality or drug issues may be sought from someone with whom an adolescent or young adult has no history so as to minimize embarrassment (Galbraith, Stevens & Klein, 1997). Fear of confidentiality leaks keeps adolescents from receiving health services from private practitioners (Ensign & Gittlesohn, 1998; Marks et al., 1983; Resnick et al., 1980; Rosenfeld et al., 1996). While a specific source of care, usually physician care, is an incentive for health care use in large heterogenous populations (Aday, 1973; Andersen et al., 1983; Lambrew et al., 1996), it may be a disincentive for SY if the specific source of care is a longstanding family physician. Conspicuous provisions for confidentiality may create confidence in accepting health services for personally sensitive concerns particularly those related to sexuality (Ensign & Gittlesohn, 1998). Practitioners can show sensitivity to these issues with proactive assurances of confidentiality concerns about information leaks so as to avoid non-continuous care and provide greater

opportunity for development of caring relationships.

SY in this study afforded increased credibility to those who were able genuinely to share their street experience or other life struggles. SY volunteered without prompting that they would find help to be credible from someone who acknowledged using substances. They preferred to be served by people who have experienced what they have experienced on the street or providers who are honest about their own past struggles.

The Calgary Runaway and Homeless Youth Study Committee (1994) found that positive qualities of helping persons, as described by youth, were empathy, genuineness, acceptance, attentiveness, respect, commitment, trustworthiness, action orientation, and competence. With the exception of the last two qualities, all other qualities were reflected in the comments of at least one of the SY involved in this study. Empathy was described as the most important of these qualities in the Calgary study. McKnight (1995) asserts that it is impossible to teach professionals to care, and that caring is not something that can be taught in a curriculum. The quality of the relationship with a provider that SY seemed to value most was the bond of mutual emotional commitment. Education programs should inform future providers about the importance of effective relationships which are fundamental to providing accessible services to SY. While it may be impossible to teach someone to care, it is possible to disuade someone who is not suited to working with SY from doing so.

That some youth said they relied on an entire agency's staff for support is

a surprising finding. While a few youth were intensely appreciative of the good working relationship they had with a single provider, others had no single person to whom they turned within an agency, instead soliciting the help of a number of different service providers. Clearly these study participants felt comfortable in how they gained needed support from agencies. The reasons for SY's preferences for individual providers or an entire agency staff could not be uncovered in the data collected.

Providing Continuous Services

Providing continuous services refers to use of consistent service providers, coordinated services, or the development of standing arrangements for services or appointments. Continuity increases use of traditional medical services and enhanced access to counselling and supportive services. Because effectiveness and satisfaction may be reduced after discontinuous services, youth may be reluctant to use them again. Some SY in the study were able to attend occasional appointments successfully. Other youth found they were able to attend standing appointments. Yet others were willing to participate in negotiated services on an "as needed" basis. Providers should explore what arrangements will work to enhance continuity for any one SY.

Youths with at least one viable parental relationship were more likely to report consistent use of family doctors. In agreement with the literature, this study found that SY with a consistent provider or SY who used a consistent site for services, access health services more frequently (Andersen et al., 1983;

Lambrew et al., 1996; Ryan et al., 1996). Some SY recognized the need for someone to coordinate the services they use.

Decreased access and continuity of service may result when SY use inconsistent providers of service such as walk-in clinics or hospital emergency departments. SY may not be knowledgeable enough to coordinate their own care. When youths reach the streets they have an increased need for continuity of care while at the same time, for reasons discussed earlier, they may no longer see the primary care provider they saw as a child. Other opportunities for discontinuous services may arise when SY use more than one Winnipeg SY-serving agency. Regular formal communication between all major Winnipeg SY-serving agencies will increase continuity, if not for individual SY, then at least for the population of SY as a whole.

In keeping with the literature on urban youth (Rosenfeld et al., 1996), continuity of service is viewed as important. Youth prefer what is familiar to them. Services should encourage furnishing consistent providers for SY. If long-term primary care providers are unavailable, or if they refer youth to others, providers should make every effort to coordinate that youth's care. As previously noted, allaying concerns about confidentiality may keep SY from attending various physicians or clinics for sexuality-related care, thus improving continuity. Continuity of service can be an important part of the development of caring relationships.

This study found that intensive referral efforts were more likely to meet

with success than merely informing youth of the availability of services. When providers call ahead to collect information about options and to arrange appointments the likelihood of SY actually following through on the referral increases. In their referral efforts providers should be respectful of the clients' wishes for control.

This study supports previous findings that Winnipeg SY travel frequently outside of the province. Some SY with an extensive history of interprovincial travel were heavy users of the health system. In some situations SY did not know the name of their primary physician or the addresses of the services they have used, making it difficult to retrieve health records in a timely manner. Where SY have used health services during their travels it is important that existing health information be efficiently transferred to avoid expensive duplication of effort and to provide the best possible service. Unfortunately, at present there exists no easy way to transfer health information quickly from one province to another for highly transient SY with or without serious health problems. Youth who travel between locations in Manitoba may also have a need for easy transfer of health information. There exists no intraprovincial or interprovincial network of SY-serving agencies which might create mechanisms for the speedy transfer of health or other relevant information. The findings of this study reinforce the need to consider some kind of formal interprovincial mechanisms to transfer SY health information (Anonymous, 1990; Farrow et al., 1991). Such a network might also provide SY who plan to travel to another city

with information about health services available there.

Respect for Client Control

Respect for client control refers to the efforts of providers to ensure that clients have a significant degree of control in encounters and in decisions arising from health care encounters. The results of this study are congruent with earlier studies in that youth appreciate making decisions or having an influence on decisions that affect them (Runaway and Homeless Youth Study Committee, 1994). "Respect for client control" and "imposed services" are highly related factors. Respect for client control is a provider characteristic while imposed services is a characteristic of the helping system.

While some may argue that a certain level of paternalism is unavoidable with under-age clients, there are often ways to provide voluntary services that do not have the appearance of provider control. Control is a flash-point for many SY. Life circumstances that have led youth to the street have often not been in SY's control and the reality of street life implies limited control. A youth in this study suggested that providers can and should present youth with positive suggestions in the form of options, even when those options are very limited.

Based on the study findings, the potential for success in counselling and mental health services seems to be particularly sensitive to voluntary participation. Giving some degree of control over the counselling situation encourages involvement. Behaviours which are based on client empowerment should underpin the practice of all providers, particularly those providers working

within mandated services which are almost universally viewed with suspicion by SY. If SY do not experience some degree of control within mandated services they are likely to become dissatisfied and terminate relationships or run to the street thereby substantially reducing access to many services.

SY in this study wanted providers to give them an adequate amount of information in a way they could understand so that they can make decisions about their own health. Providing adequate and understandable information is particularly relevant to traditional medical services. SY liked to have their health issues explained to them. Time spent with a provider has been found to be related to medical care use in large and diversified populations (Andersen et al., 1983). Presumably providers who spend more time with clients spend more time explaining care.

When providers need information from SY, they should avoid sounding inquisitorial. Much information can be gleaned using an interview based on a conversational style. For all providers patience and the ability to acknowledge small improvements or changes are virtues. As one youth so aptly said: "Let time do its work."

Age and Gender

Although only some SY identified provider age and gender as significant to them, it remains quite possible that provider age and gender are important variables related to access to health services, which can be predicted in certain populations and under certain circumstances. Similar studies with urban youth

(Rosenfeld et al., 1996) found that gender was important to some youth. This study's inability to determine overall preferences may be because saturation was not attained. As no consistent pattern regarding concern about the age and gender of providers was determined, this issue may benefit from more study. Effectiveness of services may be dependent upon age and gender of provider. If available, this information might affect decisions about staffing and approaches providers use.

Street Youth Characteristics

Two SY characteristics which facilitated access to health care were knowing about services and crisis orientation. Experiencing a non-acute physical or emotional condition usually facilitated access but this was not consistently found. Characteristics which acted as barriers to health care access included, deferral of care, substance use, environmental constraints, and various internal motivators.

Helping systems and providers can compensate for some of the characteristics of youth involved in street life which would otherwise limit access to health services. SY's knowledge of available services can be expected to be compromised because some have been uprooted from their homes and neighbourhoods (Reid & Klee, 1999) and because some travel to distant places. SY are beginning to use the health system independently. They may not know about services or how to use them effectively. Providers can inform and refer youth to appropriate services either directly, through outreach services, or

through brochures or posters.

Youth travelling to other cities may find themselves not knowing about where to get needed services. Street-based outreach which provides information about available services should be active throughout the year in all provinces. Indoor locations where SY converge should continue to be used for outreach where appropriate. Street-based outreach should be particularly active and visible in the summer when more SY travel to and through Winnipeg.

Some SY experience non-acute physical or emotional conditions which increase their use of traditional health services. Well documented in the literature is the high number of SY who become pregnant, who have chronic viral infections, or who experience chronic depression and other mental health problems. Some of these illnesses continue on well past youth. In this study only some youths with non-acute physical conditions used more services. Reasons for these differences in felt need cannot be explained at this time because there was insufficient data in this factor to reach saturation. Effectiveness or appropriateness of health services use in situations of non-acute physical or emotional conditions were not investigated in this study. To be effective, health systems may wish to place more emphasis on prevention of and early intervention with chronic conditions such as HIV, viral hepatitis and chronic mental health problems.

SY used services more during crises. Violence-related injuries were the most cited reasons for use of crisis health services. Providers should be

prepared to ask questions about and discuss prevention of street violence in order to prevent further injuries. There are multiple implications of a crisis orientation on practice. Crisis orientation is related to immediacy in that when there is a crisis, SY are very anxious to be served quickly. To serve SY effectively, counselling, medical and supportive services must be structured to allow for a crisis response. Not successfully addressing crises decreases the likelihood of further use of a service. Services and providers will need to balance their responses to avoid enabling help-seeking only during crises and to encourage more proactive approaches to addressing ongoing concerns. Youths seeking help during crises give providers an opportunity to develop the foundation for caring relationships with SY, and to discuss prevention if appropriate. Because access may occur primarily during medical, mental, or social crises, a completely portable history and service record would be beneficial to provide the best services. The provincial government should prioritize the development of a central repository of youth's history and service records. Providers in various agencies could selectively access these files by electronic means. Shared electronic files are currently in the conceptual stage for all Manitoba insured health services.

SY in the study deferred getting needed care even though they may recognized the need for assistance. Some SY reported being unmotivated and deferring services because of the effects of substance use. SY deferred care because they fear health practitioners or practices, fear physical or emotional

discomfort, do not want to learn they have a chronic or serious illness, have a high threshold for pain and discomfort, or fear being made fun of by others. It may be that like homeless adults some SY defer use of health services until their ability to function at a basic level is compromised (Shiner, 1995). Rosenfeld's (1996) findings concur with this study's that youth negatively perceive providers who are rushed, who do not provide explanations of treatments or of prescriptions. Like SY in this study, Russell et al. (1992) also found that some homeless and sexually exploited youth were not willing to receive counselling services.

Some of the reasons for deferring care can be addressed in the structure of health services and in the comportment of providers. Practitioners who really listen and who, in the words of one of the youth, "let time do its work" are more likely to make inroads with SY. Traditional health practitioners can reduce the fear associated with their role and with medical practices by being more visible in locations where youth congregate, particularly in multi-service sites. To increase accessibility of needed sexuality-related testing may require that traditional providers spend considerably more time explaining what they are doing and why they are doing it during visits but also, whenever possible, to give youth information in advance of visits.

As reported in the literature, substance use and abuse is ubiquitous among SY (Council on Scientific Affairs, 1989; Radford et al.,1989; Yates et al., 1988). This study found that substance use creates serious motivational

impediments to getting care. Some SY described how substance use caused them to put off receiving services. Substance use is also related to depression and suicide attempts (Greene & Ringwalt, 1996; Smart et al., 1992). SY should be informed about the relationship between substance use and depression. To capture the motivated moment which may not recur for a long time, particular efforts need to be made to provide immediate detoxification or in-patient treatment for those needing help with addictions.

SY's experience of environmental constraints created barriers to access. These constraints included having no phone, no fixed address, and no alarm clocks; difficulty attending to personal hygiene; unstable living patterns; and unconventional dress and adornment. Because most SY do not have stable addresses, SY-serving agencies can provide the required consistency for mail and telephone communication for times when providers want to contact a youth. To compensate for SY's not having watches, agencies can provide walk-in services. Some agencies have facilities for SY to be able to attend to personal hygiene. Good personal hygiene makes it more likely that they will be treated respectfully by patrons and providers in traditional health care settings. Providers should recognize that being perceived as judgemental about unconventional clothing and personal adornment is a barrier to access.

The experience of pain was found to be an incentive to using health services. Lee et al. (1994) also found that the majority of SY used dental services only when in pain. The barriers to using health services were a fear of

pain, a lack of trust in others, and feeling depressed. This study's findings about the effects of depression are in harmony with Garland and Zigler's (1994) study of school-based 10 to 19 year olds, in which children with depressive symptoms and depressive attributional style were more likely to have negative attitudes toward seeking help. All health providers who depend upon a trusting relationship with SY for successful intervention should strongly consider creating opportunities to develop trust by spending time in locations where SY congregate. For youth on the street, trust is not freely given but earned in small measure, over often long periods of time. Traditional health practitioners may be able to minimize the influence of the fear of pain by developing trusting relationships with SY.

Social Environment

Some factors associated with access to health care were related to the social environment around SY, including family, friends and acquaintances. Families facilitated health care access for some youth, while the family histories of some youth created a need for use of health resources. Although families sometimes had a very important role in accessing health services for some youth, for others they played no role at all.

Violent or abusive families may have a role in precipitating health service use. Some youth cited family problems as a reason for receiving ongoing counselling or contact with the psychiatric system. Although on face value it is counterintuitive, family of origin may be particularly important in creating

opportunities to access health services for a small number of young or minimally street-involved youth. Youth with at least one viable parental relationship had parents who organized appointments, transported youth, payed for health insurance, picked up medication, or provided information, emotional support and encouragement. This finding is not unique to this study. "Youth who are homeless and from less than ideal family situations remain in contact with and continue to seek advice from parents and other family members" (Ensign & Gittlesohn, 1998, p.2097). Snell (1991), in an American study, found that most street males involved in prostitution reported high levels of emotional support from family when needed. Families may encourage or discourage counselling (Russell et al., 1992) or other services whether they are needed or not. Providers should recognize, and where appropriate, support relationships with family as they may strongly influence health services use.

Friends and acquaintances affected use of health services by providing information, encouragement and transportation. In some situations, friends and acquaintances also encouraged violence, increasing the need for health services. Acquaintances may play an important role for travelling SY or those new to the street. These youth may ask peers about available services. Peer pressure can influence access to services. When some youth use a service, others may not be far behind. As this study found, sometimes SY were pressured or forced to attend for health services by friends or intimates. Providers should recognize, and where appropriate, support relationships with

friends, for such relationships may strongly influence use of health services. The encouragement of friends was not always effective, however.

Satisfaction

Satisfaction is the perceived difference between the services which were experienced and the services which were expected. Satisfaction is both an outcome and facilitator of service use. Satisfaction with health care encounters facilitated repeated use of services, while a history of dissatisfaction became a barrier to future access.

Expectations, characteristics of the helping system, provider characteristics, and characteristics of being a SY all influenced satisfaction. Youths made many comments about the types of activities or approaches they valued or disliked in providers. Implicit in comments about satisfaction was a relationship to future access. Expectations of service providers varied a great deal among youth. Satisfaction seemed to result when personal expectations were met or exceeded. Russell et al. (1992) had similar findings in their study of homeless and sexually exploited youth.

Youth described satisfaction with services in a general way and did not provide enough detail to determine which components of satisfaction, if any existed. Krowinski and Steiber (1996) propose that, at its most fundamental level, satisfaction is a positive appraisal of the provider's service based on the user's expectations. This study described satisfaction in similar terms, as the variance between experienced and expected service. This definition falls within

the contrast model of satisfaction (Pascoe, 1983). SY implied or expressed satisfaction as a factor affecting health services use throughout the interviews.

The variance between the expectations youth had of child protection workers – whether they actually cared for and about them – and the reality of that relationship, left most youth dissatisfied. Youth were most dissatisfied with child welfare workers and seemed least dissatisfied with physician services. The reasons for this finding are unknown but may be important to determine in future work since increased satisfaction will likely lead to ongoing accessibility of services. The following may be some of the possible reasons for differences in satisfaction between the services of child protection workers and traditional medical staff:

1. Child welfare workers are familiar to youth and their role is understandable to them, while medical services are less familiar and more difficult to understand. If they do not understand health services, users may be forced to assume that the "doctor knows best". The assimilation model of satisfaction (Pasco, 1983) posits that readily understood services have a lower level of satisfaction than those which remain mysterious.

2. The timing and nature of involvement with child protection workers and the workers themselves are rarely chosen by the SY; the opposite is likely true of medical practitioners. SY seek and are able to get symptom relief from medical practitioners, often during times of crisis or during illness events. Child protection workers provide help to manage the activities of daily living.

3. Child protection workers may have a better contextual understanding of SY and may be more likely to challenge SY's behaviour. Child protection workers may challenge SY more frequently or their challenges may be taken more seriously by SY.

4. Because SY also yearn for and value connection, they can be easily frustrated in the expectations of those whose role they perceive includes the establishment of emotional bonds. Expectations that emotional bonds will be built are not usually placed upon traditional health providers, but when positive bonds are formed they are a pleasant surprise.

Clearly satisfaction is an important factor influencing ongoing accessibility. It is important for providers to clarify the expectations of SY and the limitations of their own professional roles in initial meetings with SY, and to remind them regularly of these limitations. While youth may be frustrated by the expressed limitations of professionals, in recognizing these limitations they may be able to establish attainable expectations.

Recommendations Arising From the Study

This section outlines the recommendations for health care providers, SY-serving agencies, health system policy, education of health care providers, and research which arise from this study's findings. These recommendations arise directly from the issues and concerns raised by SY in their discussions about access to health services.

Recommendations for Health Care Providers

To improve SY's access to health services providers the following recommendations are put forward:

1. Establish services based on the principles of empowerment. That is, providers should work with SY to address the SY's issues as SY define them and as SY wish to approach them. Providers should give SY legitimate options which respect their autonomy. This is particularly important for providers working within mandated agencies and in the capacity of counsellor.
2. Respectfully offer advice and information about the health system and how to use it.
3. Be sure all SY understand the health information they need to:
   - establish a comfort level for use,
   - be able to offer fully informed consent, and
   - follow through with recommendations.
4. Use all contacts with SY, particularly when providing goods or services and crisis services, as opportunities to build trust and develop personal relationships.
5. Be patient, build opportunities for small successes, "let time do its work".
6. Investigate the role and influence of family and friends in the lives of SY, and foster relationships with families and friends where this is useful and improves access.
7. Determine the type of service delivery arrangement that would provide the

most continuity and offer it to SY. These arrangements may include occasional appointments, regular appointments (usually at the same place, time and day), and contracts to seek help under certain conditions.

8. Encourage youth to memorize their insurance numbers.
9. Be prepared to advocate for youth whose eligibility for health services is uncertain.
10. (In the case of physicians) provide refillable prescriptions where this is possible and desirable.

Recommendations for Health Care Providers and SY-Serving Agencies

To improve accessibility of health services for SY, health providers and SY-serving agencies should carry out the following activities:

1. View referrals as part of the intervention process. This may entail extra effort in referring. Youth are not likely to follow through on a referral unless intensive work is completed by a provider.
2. Provide responsive after-hour call services.
3. Emergency departments, walk-in clinics and specialists not acting as the SY's primary provider should routinely send a report about health visits to the SY's primary provider.
4. Services located near areas where SY congregate should make special efforts to be prepared to meet the needs of SY.

Scheduling and time management:

5. Explore the best times to provide services to the greatest number of SY.

6. Create opportunities to provide walk-in service by scheduling unstructured time into the work-day.
7. Be structured to successfully address crisis situations and at the same time start to address prevention or early intervention.
8. Keep SY from waiting by staying on schedule if services are appointment-based.
9. Encourage the best plan for continuous services, selecting from options which include: as-needed contact, intermittent appointments, regularly scheduled appointments, and contracts to seek services under certain conditions.

The development of personal relationships between SY and providers:

10. Provide opportunities for repeated contacts with the same providers.
11. Develop an environment that is welcoming and accepting, starting with reception staff.
12. Encourage policies and a service environment which are non-judgemental, acknowledge uncertainty, are courteous, respond to the likes and dislikes of youth, and encourage providers to be honest about themselves and their past struggles.
13. Provide confidential services and programs. Conspicuous and meticulous provision of confidentiality is especially important in dealing with sexuality-related concerns.

Recommendations for SY-Serving Agencies

In order to improve accessibility of health services for SY, SY-serving agencies should consider the following recommendations:

1. Avoid identification with any single group if the services need to remain accessible to a wide range of SY (e.g., shelter, needle exchange or condom distribution).
2. Carefully consider their location so as to be near where SY congregate, but not in an area that is exclusive to any group.
3. Print and distribute a list of commonly needed services.
4. Provide secure storage for personal identification or offer to file insurance information in the event that personal papers are lost.
5. Continue outreach services which provide immediate counselling, information, referral and practical material assistance in all major setting where street youth congregate.
6. Continue providing basic survival goods and services (e.g., food, drink, shelter, clothing, hygiene, and a safe environment).
7. Continue to provide flexible hours for services which address basic survival needs.
8. Continue to emphasize safety and security in SY-serving agencies.
9. Ensure that quality goods and services are used to meet SY's basic and other practical needs so as to give SY the message that they are valued.
10. Be creative in providing physically separated shelter for SY who may be a risk to the safety of others in a shelter (e.g., separate entrance to private

room).

11. Take extra precautions such as no-loitering policies to protect vulnerable SY (e.g., gay youth, or solvent users).
12. Establish policies which empower SY (particularly important for mandated agencies).
13. Recruit and retain staff who are able and wiling to develop effective caring relationships (especially important for staff with counselling and supportive roles).
14. Establish and participate in regular formal communication with other major Winnipeg SY-serving agencies to improve services, if not for the benefit of individual SY then for the benefit of SY populations as a whole.
15. Whenever possible, provide multiple services at the same site.

Recommendations for Health System Policy

Health policy decisions should reflect the following recommendations to improve accessibility of health services for SY:

1. Provincial insurance should be extended to address basic corrective and preventive dental treatment, pharmaceuticals, vision care and other essential non-insured services.
2. Provincial health services should prioritize the development and implementation of shared electronic client files for storing and retrieving all SY health information.
3. Provincial health insurance services should establish agreements and

processes to circumvent involving potential health system users in disputes about liability for costs.

4. Provincial insurance services should select appropriate providers and fund them to provide basic health services to those without insurance.
5. Child protection services and SY-serving agencies should investigate the development of formal reciprocal agreements which would delegate responsibility for SY who have run away from child protection placements to providers in SY-serving agencies.
6. Funders should consider the placement of local services outside of schools so that they become accessible to school drop-outs.
7. A service should be developed whose role is to provide addicted SY with immediate detoxification and in-patient treatment.

Recommendations for Health Service Provider Education

Education of health care providers should:

1. Provide information about and prepare providers to intervene in issues important to SY (e.g., substance use, depression, violence).
2. Encourage providers to learn about and intervene in the context of the SY's social environments, including their families, friends and SY subcultures.
3. Develop primary care providers in all communities and neighbourhoods who will effectively work with adolescents and young adults who are street-involved.

Recommendations for Health Research

Based on the review of the literature and the findings of this study, it has become apparent that there are various questions that would benefit from further research. Future research should:

1. Use consistent definitions and terminology to describe this population.
2. Use pre-existing standardized criteria for recruitment into SY research.
3. Explore differences in patterns of access to health services based on length of street involvement.
4. Identify issues associated with access to health services among and SY who self-identify with a street subculture, SY who associate with sub-cultures but do not self-identify as participating in them, and SY with no group affiliation.
5. Identify and compare factors associated with access among SY in cities and communities of different sizes.
6. Develop a cost-benefit analysis of the appropriateness of proximally distinct and tailored services for gay youth, solvent abusers and other vulnerable SY populations.
7. Study how provider age and gender are related to SY's accessing health services.

Frameworks for Evaluating SY Access to Health Services

There is some similarity but also considerable difference between the framework arising from this study and frameworks in the literature review

presented earlier. Moreover, the specific factors associated with access to health services identified in the current study and those of the previously reviewed frameworks differ considerably. See Table 26 for a comparative overview of the Behavioral Model of Health Services Use (Andersen et al. 1975; Andersen & Newman, 1973), the Aday and Andersen (1974) framework, and the framework developed from the findings in this study.

SY in this study did not limit themselves to discussing access to traditional health services. For SY health services include practical assistance, outreach, and psychosocial services including child protection services. Consequently the findings of this study are applicable in a variety of settings. The Behavioral Model and the Aday and Andersen framework, outlined earlier, are focused on traditional medical services. SY do not limit their conceptions of health and health services to traditional medicine. SY's broad view of health and health services means that they use various routes into the broader health system. This broader view of health has some implications for integrated health services. To provide effective access, providers and agencies should maintain strong links with other health services.

The Behavioral Model was employed as an organizing framework for the preceding literature review. This framework has some things in common with that framework developed in this study. Both frameworks make some reference to health system and population characteristics. The Behavioral Model and the Aday and Andersen model identify comparative and normative need as a factor

influencing health services use. Comparative or normative need was not identified as an overarching category in this study, although felt need was often expressed by SY. This is an interesting difference which will be further discussed later. This study raises the issue of satisfaction, which is not highlighted in the Behavioral Model. However, many of the specific factors identified in this study could fit within the Behavioral Model.

The Aday and Andersen (1974) framework builds on the Behavioral Model but also makes reference to satisfaction, health system characteristics, and population characteristics. The Aday and Andersen model views access as arising from and affecting health policy objectives. In comparison, this study views access as flowing from and affecting the experience of SY. In the Aday and Andersen model, satisfaction and health services use are viewed primarily as indicators of realized access, not of potential access. In this study satisfaction and the experience of health services use (which include both helping system characteristics and provider characteristics), are strongly linked to future access.

The Society for Adolescent Medicine (Klein et al., 1992) suggests that access be evaluated based on affordability, coordination, and confidentiality. Both frameworks have the first two factors in common. In this study maintaining confidentiality was described as a component of the development of a caring relationship. The Society also suggests that the following elements should be used to evaluate access: availability, visibility, quality, and flexibility. These specific factors did not emerge from this study's data, although aspects of these

are found in the data.

Table 26
A comparison of the Behavioral Model of Health Service Use (Andersen et al., 1975: Andersen & Newman, 1973), The Aday and Andersen (1974) model, and the model arising from this study.

Behavioral Model	**Aday & Andersen Model**	**This Study's Model**
Population Characteristics *predisposing factors* *enabling factors* *need factors* Health Services Use *type of service* *site* *purpose of service* *time interval* *continuity*	Health Policy *financing* *education* *manpower* *organization* (POTENTIAL ACCESS) Population Characteristics *predisposing factors* *enabling factors* *need factors* Health Services Use *type of service* *site* *purpose of service* *time interval* *continuity* (REALIZED ACCESS) Health System Characteristics *resources* *organization* Satisfaction with Services *perception of convenience* *coordination* *cost* *provider courtesy* *information about dealing with health issue* *quality of care*	Street Youth Characteristics *knowing about services* *crisis orientation* *non-acute conditions* *deferral of care* *substance use* *environmental constraints* *internal motivators* Social Environment *family* *friends & acquaintances* Helping System Characteristics *affordability* *immediacy* *practical assistance* *safety* *tailored services* *imposed services* *proximity* Provider Characteristics *caring relationships* *providing continuous service* *respect for client control* *age & gender* Satisfaction

It should be noted that this study's findings are based on the stories of actual experiences of SY. The majority of empirical literature on access to

services compares population need with service usage. Numerous other studies seek to uncover perceptions of what would or would not be useful if a hypothetical problem were experienced rather than what was helpful or not helpful when someone actually needed or tried to use a service (Offer & Schonert-Reichl, 1992).

The epidemiologic model in Chapter Two was highly dependent upon studies which identified comparative need (e.g., comparison of SY to non-SY health status). Some examples of expressed need were also provided. The interview questions were based upon needs identified through the epidemiologic literature review.

The epidemiologic approach uses professionals to identify preponderantly biomedical or social needs. Professionals and observers outside the population of SY define a problem (McKillip, 1987) or a deficit (McKnight, 1995) as reflected by normative, comparative or expressed need. McKnight argues that, for the most part, when professionals identify a need they see it as a problem. Need identification generally leads to four conclusions: a) the problem is in the client; b) the professional knows what the problem is; c) the professional can explain the problem best; and d) the professional knows when the problem is resolved. These conclusions disempower the people about whom these conclusions are drawn. SY in this study were very clear that they wanted to be in control, and that is probably very healthy. Providers can and should let SY take and keep control of their own health care and health care encounters.

Although questions were not asked about "need" and SY did not use the terminology of "need", that is what they talked about. Felt needs of SY informants were very different from those identified through the epidemiologic literature. Their most important felt needs were essential goods and services for survival, safety, and being cared about. Although there is a considerable amount of incompatibility between professionally defined and SY defined need, this is not to say that SY did not recognize the relevance or importance of some illnesses and other problems. How then, should we proceed to improve access to health services for SY when faced with conflicting perspectives or needs? There is probably no right answer. I am proposing what I hope are a few "righter" answers.

Funding for health services is a policy decision that needs to take access into account in order to attain its objectives, which are often concerned with improving health status. Health status objectives are based on normative or comparative need analysis. Unfortunately, most traditional medical service funding is based strictly on use (expressed need). Use-based funding is not necessarily related to desirable outcomes for funders or for SY. In line with epidemiologic thinking, policy decisions should reflect choices that decrease premature mortality and morbidity, as well as reducing long-term use of health services and resulting costs. Decisions about access to health services should support these goals, which in turn would almost certainly reorient existing funding provided to SY populations.

McKnight (1995) suggests that needs cannot legitimately be addressed without involving the individuals themselves, their peers, and their political, social and economic environment. Providers of health services should tailor health services to the context of the lives of SY. This study has provided a framework for access to health services that encourages the development and delivery of services within a context that is meaningful to SY. Health-related agencies should support a working environment that uses this approach to services.

This Study's Contribution to a Model of Access to Health Services

There are unique contributions of this study to the development of a model of access to health care when compared to mature models like those of the Behavioral Model of Access to Health Services and that of Aday and Andersen (1974). This model emerged from an analysis of the experiences of youth themselves and is grounded in that experience. Consequently, it views access as emerging from the relationship of SY with health providers and helping systems within the lived context of SY. The implications of this study are that providers, agencies and health systems must be responsive to the unique and changing realities of SY. It challenges the perspective that overall health policy decisions are the sole fulcrum for creating an accessible health system.

Two other related unique contributions of this study are that it is based on a broad conception of health and takes into account wider determinants of health which also affect access to health services. The broad conception of health is based on SY's understanding of health and health services which extend well

beyond the biomedical view of health on which the previously mentioned models are based. The concept of health implied by SY informants addressed felt biomedical needs, as well as basic survival needs, interpersonal or relational needs, and needs for physical and emotional comfort. This study's model also takes into account wider determinants of health such as SY's physical and social environments and how they promote or limit access to health services.

The final major contribution of this study to a model of access to health services for SY is its accentuation of the importance of provider characteristics which can enhance or inhibit access. Given that most SY have difficult or absent relationships with families of origin and have lost connection with others in their communities of origin, nevertheless, through the development of emotional bonds with a trustworthy adult provider SY are able to establish strong connection to health services.

In sum this framework provides the most appropriate approach for understanding access to health services for Winnipeg SY for the following reasons: (a) it views access as emerging from the relationship of SY with health providers and helping systems within the lived context of SY; (b) in conformity with SY's own understanding of health and its determinants, the framework takes into account a spectrum of health services and determinants; and (c) it accents the importance of provider characteristics which can enhance or inhibit access.

Chapter Summary

Health service access issues based on SY identity were discussed and an appeal was made to standardize how SY are defined. Factors associated with system characteristics, provider characteristics, SY characteristics, social environment, and satisfaction were discussed. Knowledge of the factors associated with each of these categories can and should be used to improve access. Recommendations arising from the study were made. The relevance of other models for evaluating SY access to health services was discussed. The study's unique contributions to a model of access to health services were outlined.

Conclusion

This study has identified factors associated with Winnipeg SY's access to health services. A framework for understanding SY access to health services was developed based upon these factors. This research has created an opportunity to make recommendations about improving access. This study's findings provide guidance on ways to monitor and improve access to nursing and other health services. This research should inform the creation of more equitable access to a range of respectful health services for SY.

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Appendices

Appendix 1: Introductory Letter to Agencies

Italicized sections of this letter were sent to agencies having a street outreach service.

Regarding: A request for your agency's formal agreement to participate in a study to determine factors affecting street youth's access to health care.

I am a Master of Nursing student from the University of Manitoba carrying out a thesis titled Factors Affecting Street Youth's Access to Health Care. I hope that the findings of the study may be helpful in improving services for young people who find themselves on the street. The study involves two parts: (1) observation of street youth and staff during outreach activities, and (2) direct interviews of street youth. I request your agency's help to *observe street youth and staff during outreach activities, and to* recruit youth for interviews. A short description of the study is attached.

I wish to spend time observing how youth interact with each other and with staff during outreach activities. These observations will provide me with the opportunity to refamiliarize me with the street youth scene, provide a context for information obtained through interviews with youth, and allow me to collect some direct information about factors associated with access to health care. Youth and your agency's staff would be asked for consent to be observed. Please see Appendix 2.

I would like to interview up to 15 street youth throughout the city, only some of whom will be recruited through your agency. The first part of the interview which determines eligibility for enrolling in the study takes less than 5 minutes. The complete interview will take about an hour and will gather information about factors related to access to health services. Participants will be paid $10 for completing the second part of the interview. If participants are willing, they may be approached for additional interviews although no additional monetary incentives will be provided.

Participation in the study and in the interview by clients of your agency is totally voluntary. Youth can choose to be interviewed or observed, or not to be interviewed or observed. Youth can refuse to answer any questions they do not want to answer. Youth can stop and withdraw from the interview whenever they like. Agencies *and workers in them* also have the right to withdraw from the study whenever they like. Your agency will not be identified in the final report.

The interview is confidential within the exceptions required by law. Any detailed information regarding child abuse or neglect must be reported in conformity with the Child and Family Services Act (Government of Manitoba, 1993). Any planned crimes that would harm someone, and of which authorities are not aware, must also be reported. Participants are forewarned about these exceptions and confidentiality is therefore not expected to be an issue.

Recruitment of participants for interviews will be through agency sites, in street settings and through word of mouth. Your agency's staff would be asked to introduce the study to street youth clients and give them an opportunity to participate or to decline participation. Please find a recruitment script which can be used by staff attached.

All agencies participating in the study will be provided with a summary of findings to be posted in the agency for the benefit of staff and of street youth participants.

The study is in the process of being approved by the Ethical Review Committee of the Faculty of Nursing, University of Manitoba. The researcher is working with three advisors including Sid Frankel of the Faculty of Social Work and Paul Fieldhouse of the Faculty of Nursing. You can reach the thesis committee chair, Karen Chalmers of the Faculty of Nursing at 474 - 9317.

I have many years of experience working with street-involved youth both in Winnipeg and in Toronto. I was involved in the development of services for street youth in Winnipeg and helped establish and managed the Shout Clinic, a health centre for street youth in downtown Toronto, during its formative years.

For further information about the project, you can reach me at xxx-xxxx or xxx-xxxx at home. I will be calling you shortly to respond to any questions you may have and hope that we can develop a mutually agreeable arrangement.

Sincerely,
Horst Backé

Appendix 2: Overview of Study

This overview was distributed to street youth agencies and to agency personnel to assist them to make decisions about participating in the study.

Overview of the Study:
Factors Affecting Street Youth's Access to Health Care

This study will determine some of the factors affecting access to health services by Winnipeg street youth. There is much evidence that as a group, street-involved populations have poor health compared to their same-aged peers. It is recognized that traditional health care is one of many factors affecting health, and in most cases, probably one of the least important. Despite this, health care services have a practical importance, particularly for a population with numerous health problems. To understand and influence health care use patterns of street youth it is important to identify the factors influencing their use.

This is the first study in the country that focuses on access to health care by street youth. Very little is known about access to health care by street youth populations. It is hoped that the findings of this study will be able to inform the larger Winnipeg needs assessment being carried out by the Winnipeg Community and Long-Term Care Authority. The study has been approved by the Ethical Review Committee of the Faculty of Nursing, University of Manitoba.

Two methods of data collection will be used. It is important for the researcher to immerse himself in the culture of street youth as much as is possible. Connecting youth to appropriate services is often one of the main purposes of outreach activities. Street youth and their interactions with outreach workers will be observed during outreach activities to provide opportunities to learn about factors affecting access to health services. Other than taking the researcher along, workers are not expected to do anything differently from what they normally do during outreach activities. The researcher would like to participate in about 10 to 20 outreach shifts, ideally split between more than one outreach service. The researcher is open to various scheduling suggestions. It is understood that outreach workers have the right to ask the researcher not to observe certain situations. Agencies and outreach workers can withdraw from the study at any time. The voluntary participation of youth, agencies and workers will be respected at all times.

The second method of data collection is through interviews. Interviews of street youth who agree to be interviewed will be noted or tape-recorded. A total of 8 to 15 youth will be interviewed, some possibly more than once to clarify and confirm information given in a previous interview.

This study will provide descriptive data, some of which have never been collected. It is hoped that this study will provide some baseline information about factors which may be used to improve access to health services.

Appendix 3: Agency Personnel Recruitment Script

Recruitment Script for Interviews

- A graduate student from the Faculty of Nursing, University of Manitoba is studying factors affecting street youth's access to health services. His findings may be used to improve health services for young people on the street.

- If you agree, the interviewer, Horst Backé, will first ask you a few questions to find out if you are the type of person he needs for the interview. He will interview some of these people for about an hour. If you are the type of person he needs to interview and you choose to participate, you will be paid $10.

- All information you give is confidential. The information collected about you personally will not be shared with this agency or with anyone else.

- The interviewer will be here at ____. If you wish to set up an appointment to see him at some other time, please call him at ___-____. He can see you here or set up some other place to meet. I can also call him to see if he is able to come by to see you.

- I can give you a sheet describing the study.

- Are you interested in participating in this study?

- I will first ask you a few questions to be sure you can enroll in the study. The interviewer will ask you some of these questions again.

1. What is your age? **[All participants must be over 11 and under 25.]**

[Persons are eligible for enrollment if they are also enrolled in a SY serving agency - or - if 3 out of the 4 conditions in the questions below are met.]

2. Have you finished grade 12?
   Are you still going to school?
   Are you working full time? **[Condition satisfied if grade 12 is incomplete and not working full time nor going to school]**

3. How many days did you live away from your family or guardian in the past year? **[Condition satisfied if at least 2]**

4. **[Ask only if under 19 years of age]** How many times were you thrown out or did you run away from home in the last year? **[Condition satisfied if at least once]**

5. How many days were you homeless or without a permanent or fixed address in the last year? **[Condition satisfied if at least once]**

Appendix 4: Script to Ask for Consent for the Researcher to Observe

The consent script is short in keeping with the reality that most outreach contacts are a few minutes in length. Agency outreach staff will say to street youth:

"Horst Backé is a student researcher from the University of Manitoba Faculty of Nursing. He wants to learn more about access to health services by people on the street. He is joining me today. Is it OK for him to listen in on this conversation? If you don't think its OK he doesn't mind stepping away."

In the event that the interaction being observed is prolonged, the agency staff person should confirm consent by asking:

"Is it still OK for Horst to listen in?"

Appendix 5: Interview Consent or Disclaimer

Information About the Project
Horst Backé is a Master of Nursing student from the University of Manitoba studying factors affecting street youth's access to health services. Horst is looking for people aged 12 to 24 for his study. The study is part of his education and may be used to improve services for young people on the street.

The first part of the interview will find out if you are eligible to take part in the study, and is less than 5 minutes long. The full interview takes about an hour and will ask information about you, your use of health services and the nature of the health services offered to you. You will be paid $10 for completing the second part of the interview.

Your participation is totally your choice. You can choose to be interviewed or you can choose not to be interviewed. You can refuse to answer any questions you don't want to answer. You can stop and withdraw from the interview whenever you like.

The interview is confidential within the limits of the law. One exception is a situation which involves harming or neglecting a child - unless Child and Family Services is already involved in the situation. Information about adults taking advantage of anyone under 18 years of age must be reported. Any planned crime that would hurt someone must also be reported. No questions regarding these exceptions are part of the interview.

If you agree, the interviewer may tape record the interview. Otherwise he will take notes. These recordings and/or notes will be kept in a locked place for seven years and then destroyed. No one will be able to find out any personal information about you because you took part in this interview. Your name will be removed before any information you give may be shown to the interviewer's advisors.

The study has been approved by the Ethical Review Committee of the Faculty of Nursing, University of Manitoba. The researcher is working with three advisors. If you have any questions or concerns about the project you can contact them through Karen Chalmers, Horst's advisor at the Faculty of Nursing, at xxx-xxxx.

If you wish, the interviewer can help you get information about health services after the interview is finished. You can reach the interviewer, Horst Backé at xxx-xxxx. Within the next six months a short summary of the study's findings will be posted in participating agencies.

If you wish to take part in the study, you have the right to sign the consent form yourself. If you do not wish to sign the consent form, then the researcher may ask someone else to sign the sheet to show that you have consented to take part in the research. You do not need to sign to take part.

I agree to take part in this study _____
Signature (Optional)

(Staff can sign on behalf of a participant if that staff person has witnessed the explanation and verbal consent of the participant.)

Appendix 6: Staff Consent to Participate

Horst Backé is a Master of Nursing student from the University of Manitoba studying factors affecting street youth's access to health services. Horst requests permission to observe your interactions with street youth during outreach activities. The study is part of his education and findings may be used to improve services for young people on the street.

If you agree, Horst will observe your interactions and then take notes after outreach interactions. Horst is looking for information that will help him to determine factors associated with street youth's access to health services. These notes will be kept in a locked place for seven years and then destroyed. All observations will be treated confidentially. Only Horst's research advisors may have access to the information you provide, although your name will have been removed . When the study is written up, you and the youth will not be named or identified. No one, including your employer, will be able to find out any information about you because you participated in this study. Your employer will not be informed if you participated or did not participate in the study.

Your participation is totally voluntary. You can stop and withdraw from the study whenever you like.

The study has been approved by the Ethical Review Committee of the Faculty of Nursing, University of Manitoba. The researcher is working with three advisors, Sid Frankel of the Faculty of Social Work and Paul Fieldhouse of the Faculty of Nursing. If you have any questions or concerns about the project you can contact Karen Chalmers at 474 - 9317, Horst's main advisor at the Faculty of Nursing.

You can reach the interviewer, Horst Backé at xxx-xxxx. Within the next six months a short summary of the study's findings will be posted in participating agencies.

If you agree to participate in the study, please sign the consent form.

I agree to participate in this study _____
Signature

Appendix 7: Demographic Questions

The following close-ended questions will be asked:
[Questions 1, 2 and 4-7. Person included in study if 1 and 2 criteria satisfied. Person also included in study if 1 and three of 4 - 7 criteria also satisfied.]

1.	**What is your date of birth?** **What then is your age?** **[Must be over 11 and under 25 to satisfy criteria, note age]**	**Criteria Satisfied** ☐ _____
2.	**[Do not ask] Is informant located in a street youth serving agency?**	**Criteria Satisfied** ☐ 0 = no 1 = yes
3.	What is the highest grade or year of regular school you have ever attended? Did you finish the (NUMBER) grade? **[If grade 12 completed]** How many years of education have you completed after grade 12?	Grade completed _____ Years completed _____
4a.	**[Criteria satisfied if incomplete grade 12 and not working full time or going to school]** Are you still going to school?	**Criteria Satisfied** ☐ 0 = no 1 = yes 8 = no response/uncertain 9 = n/a
4b.	Are you working full time?	0 = no 1 = yes 8 = no response/uncertain 9 = n/a
5.	How many days did you live away from your family or guardian in the past year? **[Criteria satisfied if at least 2]**	**Criteria Satisfied** ☐ _____
6.	**[Ask only if under 19 years of age]** How many times were you thrown out or did you run away from home in the last year? **[Criteria satisfied if at least once]**	**Criteria Satisfied** ☐ _____
7.	How many days were you homeless or without a permanent or fixed address in the last year? **[Satisfies criteria if at least once]**	**Criteria Satisfied** ☐

[If criteria not satisfied, stop interview and thank youth. If criteria satisfied let youth know you would like to move on to next part of interview.]

8.	**[Note sex by observation - If in doubt ask]** Please tell me your sex: male, female, or transsexual?	1 = male 2 = female 3 = transsexual/transgendered 8 = no response/uncertain
9.	What is the group which best represents your race: White, North American Aboriginal, Metis, Black or Asian? **[Note group if 'Other' selected]**	1 = White 2 = North American Aboriginal 3 = Metis 4 = Black 5 = Asian 6 = Other _____ 8 = no response/uncertain
10.	When did you last contact a health care provider? By health care provider I mean someone whose role it is to help with emotional, physical or mental health concerns.	_____ **[In months]**
11.	Location of interview	Street Based _____ Agency Based _____ Other _____

Appendix 8: Interview Guide

This study will use a semistructured interview. Grand tour questions are listed below. Informants will be prompted to provide information relating to the study question throughout the interview. The following general points and questions will be expressed to participants:

Thank you for agreeing to speak with me. I look forward to learning from you. The purpose of this interview is to find out what sorts of things affect your ability to get health care when you need it. I am also interested in what keeps you from using health care when you you need it.

- Please tell me about the last time you used a health service. By a health service I mean a service which can help you with emotional, physical or mental health concerns.
- Could you tell me about the time you used a health service before that? (and before that?)

Please tell me about a time when you did not use a health service when you think you should have (and before that?)

- Some of the many terms used by young people on the street to describe themselves include words like: street youth, runaways, homeless, hustlers, and gangster. What words or street labels do you feel describe you?
  - What about you makes you fit this label?
  - Does being associated with these labels affect your ability to get health care?
  - If so, how?

If there is time in the interview, the researcher may ask:

- Please tell me about the last situation when a health care provider talked with you about:
  - depression,
  - suicide,
  - mental illness,
  - substance use,
  - pregnancy,
  - sexually transmitted infection,
  - abuse (sexual, physical or emotional),
  - and dental and periodontal health.

The interview will conclude with:

- Is there anything else that you want to tell me?
- Is there anything else that you want to discuss?
- Would you be willing to answer a few questions at another time, once I have had a chance to think about what you have told me today?
  - If so, how would I contact you?