FINAL REPORT:
The Experiences and Perceptions of Street-Involved Youth Regarding Emergency Department Services

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Funding is gratefully acknowledged from the Alberta Centre for Child, Family and Community Research
Introduction

Street-involved (SI) youth are among the groups most vulnerable to poor health outcomes in adolescence. Many SI youth turn to the street for a range of reasons, including neglect and abuse, or they may have been forced to leave home by their parents or caregivers (Calgary Homeless Foundation, 2009; Department of Justice, 2012; Higgit et al., 2003; Smith, Saewyc, Albert, MacKay, Northcott, & The McCreary Centre Society, 2007; Worthington, MacLaurin, Huffey, Dittmann, Kitt, Patten, & Leech, 2008). Along with an exit from home, access to traditional healthcare such as a family doctor is often compromised, resulting in SI youth necessarily accessing emergency department (ED) services for both emergency and primary care. As part of a larger examination of ED systems of care relative to SI youth, this paper reports on a community-based participatory action research project that examined ED access by and experiences of SI youth.

Background

Caputo, Kelly, & Weiler (1997) identify four categories of SI youth: (i) ‘curbsiders’, who mainly live at home and maintain family connections; (ii) ‘runaways’ who have left home but may return; (iii) ‘throwaways’ who were asked to leave home, but at some point may be invited to return home; and, (iv) ‘entrenched’ youth who have lost all connections with their home and family. Other literature similarly confirms such heterogeneity among SI youth (Backé, 1999; Woods, Samples, Melchiono, Keenan, Fox, & Harris, 2002; Ensign, 1998; Harris, Samples, Keenan, Fox, Melchiono, & Woods, 2003; Woods et al., 1998; Woods, Samples, Melchiono, & Harris, 2003). Canadian studies indicate that Aboriginal youth are disproportionately represented in the SI youth
population (Higgitt et al., 2003; Smith et al., 2007; Backé, 1999). Many Aboriginal youth maintain ties with extended family when they leave their home reserves, often living with various relatives in urban centers. However, these youth remain classified as having no fixed address (Backé, 1999). As documented by Higgitt et al. (2003) and Smith et al. (2007), young people who are lesbian, gay, bisexual and ‘questioning’ are also over-represented among SI youth. Accordingly, Backé (1999) suggests that any evaluation of services designed for SI youth should specifically consider the complex needs of youth who are multiply-marginalized.

An accurate estimate of the total number of SI youth is difficult to ascertain since there is no universally understood definition of or parameters that delineate this population. As a result, they remain largely invisible in public discourses about pressing social problems (Backé, 1999). However, SI youth are a substantial component of urban homeless populations, and comprise several sub-groups including “youth who are homeless, intermittently homeless or at-risk of homelessness, and [those who use] the streets as their primary means of socialization and/or economic survival” (Woods et al., 2002, p. 499).

Estimated to number just over 650 in Edmonton and Calgary, Canada (the two largest cities in this catchment area with a cumulative population of approximately 2 million), homeless youth (i.e., under the age 18 years) in these regions represent approximately 11% of Calgary’s homeless population at (City of Calgary, 2008) and 13% of Edmonton’s homeless population at 279 (Homeward Trust, 2012). The results of a 2008 count of homeless persons in Calgary indicated that youth aged 13 to 24 years are one of the most rapidly growing sub-groups of homeless people (City of Calgary, 2008).
Daily challenges facing SI youth

For SI youth, uncertainty is inherent to daily life and requires a constant focus on meeting immediate needs for food, shelter and safety. Given the complexities often involved in maintaining daily survival, SI youth may ascribe low priority to their health needs. Moreover, SI youth are also reportedly more likely than non SI peers to engage in behaviors with negative health implications, including engagement in high risk sexual activity (e.g., unprotected sex for money, food, or lodging), with greater likelihood of a sexually transmitted disease (STD) and, among females, unplanned pregnancy (Ensign & Santelli, 1997). SI youth also report more alcohol and drug use than other adolescent populations, with many describing substance use as a way to ‘forget’ their difficult circumstances (Ensign & Santelli, 1997; Walters, 1999). They experience higher rates of severe injury than non SI youth, which renders them more likely to need emergency health services and other health resources (Ensign & Santelli, 1997). Additional threats to health safety include environmental dangers, victimization by peers and adults, and various forms of discrimination (Smith et al. 2007; Woods et al., 2002; McCreary Centre Society, 2008), all of which contribute to potential health difficulties.

Among SI youth, an estimated 42% meet the criteria for post-traumatic stress disorder (PTSD) (Valera, Sawyer, & Schiraldi, 2001), and many have learning disabilities that create barriers to negotiating the complex health care and other community systems (Smith et al., 2007). In addition to these many health risks, SI youth can experience a condition known as ‘street sickness’, which is a general malaise associated with persistent respiratory symptoms. Street sickness results in reduced immunity brought about by outdoor exposure, sleep deprivation, poor personal hygiene,
food insecurity, and poor nutrition (Higgit et al., 2003). Cumulatively, the challenges and obstacles faced by SI youth contribute considerably to patterns of health care seeking that are less than optimal, and leave them at substantial, ongoing health risk (Higgit et al., 2003).

Structural impediments and barriers

Notwithstanding their heightened risk for more serious and complex health needs relative to peers, SI youth are more likely to encounter external, structural accessibility barriers when they attempt to access health resources. Barriers include a lack of affordable transportation to and from a clinic/doctor’s office for routine health care (Karabanow, Hopkins, Kisely, Parker, Hughes, Gahagan, & Campbell, 2007) and a lack of valid health insurance (Ensign & Santelli, 1997; Kushell, Yen, Gee, & Courtney, 2007). SI youth reportedly fear the attitudes and reproach of health care professionals, which they describe as disrespectful and unsupportive. As a result of this perception, SI youth may be very ill before accessing healthcare (Karabanow et al., 2007).

Access and experience of ED services

Evidence documenting the circumstances under which SI youth will access an ED is inconclusive. Rosenfeld, Keenan, Fox, Chase, Melchiono, & Woods (2000) state that when faced with a chronic illness, youth seek hospitals for medical attention. In contrast, Ensign (1998) suggests that SI youth access an ED only when they are experiencing a health crisis. Overall, distinct patterns of health care use have been identified among various subgroups of SI youth (Woods et al., 2002; Woods et al., 1998; Woods et al., 2003; Rosenfeld et al., 2000). Factors including gender, age, ethnicity, sexual orientation, HIV status, high risk sexual behaviour, pregnancy, and prior diagnosis of a STD have
been found to influence health care utilization. Surprisingly, research suggests that SI youth continue to access hospital EDs for medical care even when youth-oriented walk-in clinics and outreach programs are able to provide requisite health care services (Woods et al., 2002; Harris et al., 2003; Woods et al., 1998; Woods et al., 2003; Rosenfeld et al., 2000; Resnick & Burt, 1996). Existing questions invite greater understanding about the experiences of SI youth accessing ED care as well as processes that contribute to those experiences.

**Methods**

To address these objectives, a community-based participatory action research (C-PAR) approach, using tenets of grounded theory, was conducted. C-PAR recognizes community stakeholders as partners and co-researchers in all aspects of the research process from conceptualizing to implementing the research (Dentith, Measor, & O’Malley, 2009). This approach embodies principles of equity, reciprocity, participation, respect and inclusion, and was deemed to be essential to our project given what we viewed to be a traditional disconnection and power disparity between ‘authority figures’ (e.g., health and community service providers, researchers) and SI youth. Team relationships were developed over a 1.5 year period with the following co-researchers: SI youth in greater Edmonton, ED service providers at key hospitals serving SI youth in Edmonton, relevant community service providers, administrators in ED care, and researchers.

C-PAR typically involves adult community partners, hence there is little to guide the inclusion of youth partners (Chen et al., 2007). Those who have partnered with youth—particularly at-risk youth—recommend balancing involvement in order to not
overwhelm participating youth and consider factors such as consent and confidentiality issues, a range of desired levels of commitment to a project, and power differentials between the youth researchers and the researched, particularly if the youth are involved in data collection and analysis (Chen et al., 2007). Our team sought to remain sensitive to these issues throughout the project.

Beyond C-PAR as a predominant approach, grounded theory offered a helpful focus in examining processes related to the delivery of ED care for SI youth. Through focus groups, the experiences, interactions, processes, practices and systems of ED care for SI youth were theoretically examined (Strauss & Corbin, 1998). This included social/interactional, procedural and organizational features of ED care relative to the experiences of SI youth, and associated key concepts, relationships, and perceived outcomes related to involvement in the ED environment.

**Recruitment and Sampling**

Data were collected through an initial convenience and subsequently a theoretical sample of SI youth. Youth and young adults (12-26 years of age) were eligible for inclusion if they had currently or recently (within the previous four months) utilized ED services. Recruiting SI youth occurred through health care and service providers who made referrals to trained research assistants located in two local urban EDs as well as in agencies serving SI youth in the community. SI youth were informed about the study and if willing to participate, informed consent was obtained. Institutional ethics review board approval was granted prior to study commencement.

**Data Analysis**
Focus groups were facilitated with groups of SI youth. They were approximately one hour in duration, and were transcribed verbatim. In keeping with C-PAR, regular planning meetings, including meetings at locations regularly attended by SI youth (e.g., youth drop-in centres), were facilitated throughout the project, and participants were invited to engage in the project as they desired (with the exception of reviewing data, given confidentiality issues). Of note, several SI youth enthusiastically engaged in the project temporarily and were informed of project updates through email. None of the youth chose to stay involved in the project throughout its entire duration (approximately three years from concept inception to study completion).

Grounded theory analytical approaches of constant comparison of data were implemented including open coding, axial coding and selective coding. Initial open consisted of a line-by-line review of data which determined discrete units of meaning. Axial coding subsequently determined properties and categories of data, and selective coding solidified the emergence of core categories through contrast, reflection, saturation and fit. NVivo 10 qualitative data management and analysis software was used, and any identifying information in transcripts was eliminated prior to analysis. Based in Grounded Theory, analysis comprised an iterative process in which codes and categories were checked and verified in subsequent data collection and future analysis. Through this approach including the achievement of data saturation, theoretical advancement was fostered.

Rigor

Rigor was achieved through established means including saturation, inter-rater reliability, triangulation, prolonged engagement, peer debriefing, negative case analysis,
and an audit trail (Lincoln & Guba, 1985; Padgett, 2008; Tuckett, 2005). Saturation comprised recruitment until sufficiency and exhaustion of emergent findings were determined. Inter-rater reliability was achieved through a portion of the data being blindly reviewed by independent coders, with subsequent consensus on emergent codes. Triangulation similarly was demonstrated through multiple sites of data collection and theoretical convergence of Grounded Theory and C-PAR. Prolonged engagement was reflective of extensive research team experience in this substantive area in part due to our participatory approach which included youth and service providers as team members. Inter-disciplinary practitioners on the team cumulatively brought decades of experience working with this population. Peer debriefing reflected periodic review of emergent findings among team and community members in which findings resonated with peer experience. Negative case analysis was achieved through theoretical sampling including explicit searching for non-conforming examples of apparent findings. This offered confidence in the emerging theory. Finally, illustrative text quotes were identified throughout the analysis process (and within this paper) in seeking to ensure referential adequacy.

The Sample

A total of 48 SI youth and young adults as well as 20 community agency staff, 17 health care providers, 2 security personnel, and 2 hospital administrators (total n=89), were interviewed. Youth interviewed ranged between 15 and 26 years old. A variety of current living situations among youth participants were described, including homelessness and sleeping in shelters, assisted housing programs, and newly acquired
housing (not a parent’s home). They reported a range in the number of ED/hospital visits, ranging from a few to 106 over the last 5 years, and averaged 2.5 ER visits in the past year. Youth identified multiple means for getting to the ED, including ambulance, attending alone, with friends, or with family. As noted, service/care providers were also interviewed; however, the focus of this report (due to length restrictions) is solely based on the perspectives youth experience. Please note that we are in the process of writing two manuscripts; one addressing youth experiences (largely presented herein) and another addressing the perspectives of health care providers and other hospital personnel.

We would be happy to further share this second paper, as available.

**Reasons for Youth Attending the ED**

Youth reported a wide array of reasons for attending the ED. These included: substance use (intoxication or other substance overuse, including injury due to violence when intoxicated), acute accidents or traumas (musculoskeletal injuries caused by recreational accidents, car accidents, dehydration, seizures, cardiac arrest), chronic ailments (pneumonia, mental health concerns including self-harm), and relational violence (physical altercation, partner abuse, sexual assault). Other identified reasons included supporting friends in the ED and pregnancy care.

**Helpful or Neutral Elements of the ED**

Several youth described their ED experience as generally positive, with some participants recognizing the benefit of health care professionals seeking to be helpful by supporting the youth. One participant stated that it was helpful, “being able to get everything off (my) chest. Just basically saying what’s all on my mind and everything.” Other positive aspects of care included the cleanliness of the hospital, and the food that
was provided during the ER visit. One youth reported that they were unable to speak due to injury, so staff sought another way of effectively communicating with the participant via pen and paper. Another youth reported that a nurse booked blood work in such a way that allowed the youth to spend the night in the ED sleeping which was appreciated due to exhaustion.

Beyond ways “of being” or positive interaction among ED staff that were thought to be beneficial and supportive, youth reported helpful tangible services while in the ED. The most prominent of these was being given medication. Specifically, youth reported receiving sample medication to avoid prescription costs, and some youth stated that a social worker obtained emergency medication for them.

Some support was appreciated, but deemed not helpful. For instance, one youth reported that a social worker tried to connect his girlfriend with local programs and services, but the couple had already explored these resources. Another youth reported that he was allowed to sleep in the waiting room due to the homeless shelter being closed in the middle of the night, but stated that the waiting room was very uncomfortable.

**Non-Helpful Elements of ED Care**

The majority of experiences reported by participants were negative. Areas of challenge included wait times, negatively perceived elements of care, broader systems-related gaps, and being treated inappropriately due to what youth perceived as their young age and marginalized social standing. Each of these themes is outlined below.

*Lengthy wait times*

A common source of a negative ED experience was the long wait time in the ED. Participants reported waits ranging from 1.5 hours to almost 24 hours. One youth
reported that “nobody has patience” for extreme wait times. Others described such waits using terms such as “ridiculous”, “boring”, and “bad”. Participants described fainting while waiting, and one adolescent described being periodically dosed with morphine during the wait to manage pain related to the injury for which he was seeking ED care. Another participant indicated the long waits as, “like living in hell for a day.”

Wait times were reportedly also lengthy and difficult for individuals who had been sexually assaulted. It was upsetting for these young persons to have to wait extensively just to go through reportedly uncomfortable procedures and exams. For many youth, the extreme waits sometimes resulted in exiting the ED without being seen or treated by a health care provider, leaving them further at health risk. One youth explained their experience in the ED after a sexual assault: “you… make it to the [the hospital], and then they have the fricking (sic) lady from [the police service] come and do the whole body examination and shit….I just didn’t really want to be there and then they had to convince me to try to stay in [local community] and then I didn’t want to and then all this real messed up shit [was happening].” In this case and others, personal dignity and choices were thought to be compromised by the treatment and associated processes of care.

Overall, youth felt that the triage system employed by the EDs lacked “effective process” such that needs were perceived to not be attended to in a reasonable time and manner. Participants felt that the current system did not prioritize care efficiently, especially for those individuals with less critical ailments or those who may otherwise be marginalized such as a SI youth and/or those facing other forms of stigma due to issues as intoxication, victimization, etc.
**Youth/staff interaction**

Many negative experiences were shared regarding the ED care received by SI youth. With regard to this care, health care providers in general were described as uncaring, impatient, judgmental, and lazy. Negative attitudes toward youth by ED staff were described, as were responses that were interpreted by youth as “holding power over youth”. As an example, ED staff were generally reported to not express concern or overt help if a youth did not have the ability to obtain medication for post-ED follow-up. One youth reported that when they inquired about the untenable fee for a needed prescription, the nurse’s response was, “get some money”. Participants reported that the courtesy phone in one ED if often turned off, causing some youth to be unable to connect with supports such as family and friends. One youth shared that when he and a group of friends went to visit a hospitalized friend, they were told by nurses that they could not see their friend and were subsequently escorted out of the building by security before visiting the friend.

According to youth, staff members demonstrate an intolerance for perceived inappropriate language use (despite this being common parlance among SI youth). One youth shared that she was told to “watch [her] language” while giving birth. Another youth who also is a parent reported feeling like she was being judged to be a bad mother and felt that staff were telling her how to parent her child. She stated, “you feel bad like you are the worst mom on the planet.” Instances were described in which staff members who were familiar with an individual SI youth due to previous ED visits, reportedly raised past negative ED experiences upon recognizing the youth at subsequent ED visits. As an example, a participant reported that a staff remarked remembering the youth being
high on drugs during her previous ED visit. Another youth reported specific ED staff members laughing at him for being intoxicated including some of his behaviors. This youth viewed this staff response as disrespectful and disingenuous to the aim of patient care. A participant stated that his care team quickly “walked away” from him once it was determined that the injury for which he came to the ED, was not life threatening. This withdrawal seemed to the youth to be disrespectful and humiliating. Several youth felt that ED staff wanted to get SI youth out of the ED as soon as possible. Several participants stated that some health care providers do not care if a youth has no place to stay upon ED discharge, with one reportedly telling a youth to “go find a bridge.” In another instance, a young lady who was in the ED with labor pains reported receiving demeaning comments inferring promiscuous behavior. The youth reported feeling insulted, shamed, and angry. In another case, a participant reported attending an ER due to several broken bones. The staff stated that they needed to give the youth a needle to calm him down, but the youth refused this due to an extreme fear of needles. The staff member’s response reportedly was to restrain the youth and administer the needle anyway. Overall, the youth felt that he had received a negative response and poor care. Generally, this poorer standard of care was thought to reflect varying degrees of negative stereotypes, disrespect and perceived infractions to patient-centred care.

Youth (minor) status downplayed

Participants under 18 years of age reported that they were treated as adults in ways that were detrimental to them. Youth reported that if admitted to hospital, they were sometimes sent to adult units of the hospital, often due to their street involvement being seen as incompatible with treatment according to their age. Accordingly, their “social”
status rendered them ineligible for a developmental level of care. A reported consequence was a frequent “failure” to involve parents or guardians because of the perceived independence of these youth. As an example, staff sometimes did not ask youth about their wishes related to calling family, a friend or an advocate. In one instance, a youth stated that the only reason his parents were aware of his serious injury was due to an online post the youth left via social media. On the other hand, some youth did not want parents or guardians knowing about their activities; however in this case (as in the former), these minors, based on their age, reportedly should have been given the option of parent/caregiver engagement.

**Negative Impact of Street Involvement on ED Care**

While a few youth reasoned that the treatment they received in the ED was similar to others (e.g., “They all have the same 5-hour wait that I’ve got.”), most youth felt that they experienced sub-optimal care due to their status of being SI. Generally speaking, youth felt multiple levels of stigma and marginalization related to attitudes and presumptions associated with their street involvement, lack of stable housing, young age and in some cases, cultural background.

Several youth stated that treatment was differentially experienced based on who accompanied the youth to the ED. One participant described coming into the hospital with several friends who were intoxicated and injured. He stated that the only care received by the group was to have their cuts covered, and then they were told to leave. Another youth shared that he and his friends were handcuffed in the ED, which was thought to negatively affect the way they were treated. While perceptions about the extent to which and nature of the treatment varied, participants often struggled and, in some
cases, circumvented the system or their presentation to increase the likelihood of receiving better care.

**Youth Response: Avoiding or Prematurely Exiting the ED**

As well as early discharge due to choosing to leave the hospital before care was administered, some youth reported also being discharged from the hospital prematurely, or exiting the premises during care typically due to frustration with care processes or staff responses. Many participants chose to avoid the ED for as long as possible. One participant stated that most SI youth “do not see doctors”. Word of mouth was described as important in street youth culture, and youth reportedly shared stories that discouraged ED access due to reports of negative experiences (e.g., wait times, staff response), as exemplified by a participant who reported that she avoided the ED because she has “heard too many bad stories”. Another youth described coming to a decision to opt for a Medicentre rather than an ED, or stay at home to heal himself which meant missing school. Unfortunately in several cases, these decisions reportedly had serious implications for the current and future health of the youth.

Generally, participants felt that a poor experience at a hospital left one less likely to return even if necessary. In one case, a youth with a broken limb, independently reset his break due to these issues, with long-term negative health implications. Alternatively, youth shared that youth would not be “scared” or ‘hesitative” to return to a hospital where they had a good experience.

**Broader System Gaps**

Beyond the ED, SI youth reported service gaps in the broader community which had a negative bearing on their care. For instance, long wait times associated with ED
visits sometimes impeded access to external services. For instance, youth explained that the long waits in the ED sometimes prevented them from reaching a youth shelter before it closed for the night. Youth alternatively reported that despite disliking the long wait times, they sometimes hoped for overnight ED stays if they were likely to be detained beyond the shelter’s closing time. One youth reported that if they missed the shelter, housing alternatives were negligible, often requiring youth to sit overnight in a 24 hour restaurant.

Challenges were also identified at a broader systems and community level. For instance, youth often lacked money; hence they could not afford elements of health care such as required medications. One youth who didn’t have sufficient money for medication, reported supplementing his income by selling drugs. Others reported owing hundreds of dollars to medical service providers (e.g., ambulance costs). Youth reported that if there was no money for medications, they were “out of luck”, with youth commonly forgoing needed medication or other cost-related follow-up.

Participants described that when living on the street, it is often difficult to safely store and keep personal items and important documents. Accordingly, youth reported losing government-issued identification that would enable them to access services, sometimes resulting in access being denied. One youth reported losing a needed care document given by a health service provider which resulted in negative health outcomes.

Youthful age, limited resources and a lack of system-management experience often created barriers for the youth, who tended to be unsupported as they attempted to navigate the health system. For instance, transportation was largely limited to public transit. In one instance in which a youth did not go to the ED to attend to a serious injury,
the youth justified this lack of service access stating, “the only reason that I can really think of (for not going to the ED) is because I had no transportation.” One participant stated, “the entire system is kind of dehumanizing.”

Several respondents commented on their sense of marginalized services for SI youth; one participant stated that homelessness should not mean that one does not access health care, and another youth commented that homeless people still contribute to taxes based on what they buy and should be treated equally. In making these arguments, youth participants generally appeared to vicariously comment on their negative experiences of feeling demeaned and marginalized in the community at large.

**Recommendations**

Youth offered recommendations to improve the service they receive in the ED. They suggested that SI youth need to feel welcomed to the ED and hospital which entailed greater understanding of street/youth culture, and a less negative response to SI youth in the ED. Related to this, participants suggested the need for the development of a broader orientation to health in which an ethos of patient-centered care was offered. They felt that with this approach, constructive ideas could emerge such as activities of distraction during waiting (e.g., use of video games, food availability), and new ways to achieve mutual understanding.

Overall, participants suggested that ED staff needed to be more respectful of and open to communication with SI youth. Part of this shift, according to one youth, would entail not attempting to discuss or remind youth of past negative experiences in the hospital. One youth relayed their positive experience in another agency, and suggested that this could translate well into the hospital: “[they] make you feel comfortable with
them so then you can start talking about the situation or what happened.”

Recommendations further included improved sharing with youth about, “what [procedures are] going to be done so [youth] are aware.” Youth suggested increased health care provider accountability for service.

Accordingly, participants believed that ED staff needed to better understand SI youth in order to increase engagement and meaningful conversation. One youth suggested that having someone to talk to while waiting would help youth to become less agitated and remain calm. Another suggested that more female doctors should be available, which would make the visit more comfortable for some female youth.

Reduced waiting times was a priority for youth. It was suggested that giving an estimated wait time for treatment would decrease uncertainty and potential agitation. Moreover, additional staff training in providing care to SI youth was recommended, with the aim of capacity building to proactively engage SI youth and enhance ED care and health care access more generally.

**Discussion**

Participants described a range of responses resulting from their experiences in the ED. Positive experiences resulted in SI youth being more inclined to access ED care in the future. Yet the overwhelming negative experiences of these youth reportedly discouraged care access. Specific implications of this diminished care for SI youth were: protracted and heightened health issues as well as insufficient treatment.

Overall, this study highlights SI youth as marginalized and in many cases struggling to accommodate, yet resistant to, the barriers and imposed system issues associated with the ED. Serious health implications emerged that further marginalized SI
youth and in some cases left them at risk for long term and serious health and psychosocial outcomes. Participants disliked what they perceived to be a lack of options for ED health service, but identified few options within the environment of current ED service delivery. A path forward is needed in finding more accessible ways of delivering ED care that is more amenable to SI youth.

Barriers were noted at clinical, ED programming and broader systemic levels. In the context of clinical care, participants recommended that care processes be more patient- and population-sensitive. Alternative models were presented offering heightened support including more consistent and coordinated care. Understanding and liaison at initial contact (providing an advocate) may provide a scaffolding of support to enhance SI youth’s experience and navigation through the ED and potentially into follow-up care, as needed. Additionally, educating SI youth on what to expect in the ED may help prepare them for the culture shift by entering the ED environment.

These findings invite a review of care processes, structures and staff/youth interactions as well as broader societal attitudes toward SI youth. Finding ways to mutually appreciate the strengths of SI youth in their daily survival and resilience could potentially re-locate youth to a position of greater equity in the ED encounter. To that end, supporting youth and ED staff in redressing systemic barriers seems critical in moving forward. Existing structural and attitudinal inequities that marginalize SI youth need to be replaced by service access pathways that are more palatable for the range of diversities among persons attending the ED, including SI youth.

Conclusion
Notwithstanding challenges related to pressing and complex demands in the ED and the unique pressures of serving SI youth in that setting, finding delivery approaches that do not further marginalize SI youth is critically needed. This invites new ways to navigate ED access which may include consultation with SI youth and their advocates in moving forward. Increased research may identify possibilities and strategies for advancing ED systems for greater ‘welcoming’ and patient-centered flow. Given the multi-layered challenges experienced by SI youth in the context of ED care, aims of improved service delivery, patient experience and health outcomes are indeed worthy of pursuit.
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