



ADDICTIONS FOUNDATION OF MANITOBA

Still without Shelter: A Description of Issues Faced by Street Youth in Winnipeg in 2007

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Addictions Foundation of Manitoba

The Addictions Foundation of Manitoba is responsible for providing rehabilitation and prevention services for Manitoba citizens relating to substance use and problem gambling.

VISION:

Manitobans living free from the harm of alcohol, other drugs and gambling.

MISSION:

To enhance the health of Manitobans by reducing the harm of alcohol, other drugs and gambling through leadership in education, prevention, and rehabilitation.

VALUES:

We believe our greatest asset is our staff, and acknowledge their contribution and passion in supporting the following organizational values:

- *The dignity and diversity of each individual;*
- *The capacity of clients and communities for change;*
- *Collaborative relationships with stakeholders, partners and the self-help community;*
- *Continuous improvement and best practices;*
- *A continuum of services and programs; and*
- *A safe and respectful work environment.*

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Last, we need to thank the youth who participated in this project by sharing their life stories with us –we are sure this was, at times, difficult. Only by gaining a better understanding of some of the issues they face and where they are coming from, will agencies such as the AFM be in a better position to develop services that meet their needs. Hopefully, this report will help to facilitate this understanding.

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EXECUTIVE SUMMARY

The purpose of the current report is to describe the characteristics and needs of street youth in Winnipeg, offering discussion and suggestions where possible for improving their situation and meeting their needs. A similar survey was conducted two years ago in Winnipeg and, although a small number of comparisons may be made, these should be made with caution as differences in methodologies in addition to any differences in the political and public context since the last study may have impacted the results. Where these comparisons are made, please exercise caution in making judgments about the data.

Street youth are known as heavy substance users, however, they are rarely seen at mainstream offices and are more likely to engage with services that reach out to them where they naturally congregate. They are more likely to be at risk for a variety of additional problems (e.g., mental health issues, criminal involvement, problems with family and friends) compared to their non-street living peers. This report offers the opportunity to identify the range of difficulties that these individuals face, with the intention of identifying areas in which we may be able to provide service, and thus, in the long run, assist these individuals in reaching their full potential within supportive environments free from the harms of living on the streets.

This street youth survey was conducted in Winnipeg during the summer of 2007. A total of 166 individuals completed both a questionnaire and an interview. The mean age of females was 18, and for males it was 19. Data collection occurred at two resource centers in central Winnipeg. The survey involved a range of questions, including demographics, questions about family background and history, and a number of standardized measures of substance use. The focus of the interview was on mental health issues, as these have been identified in previous research as significant problems for this population (e.g., Bodnarchuk, Patton and Rieck, 2006).

Results

Results indicate that the situation for youth living on the streets of Winnipeg has not improved since our first study in 2005¹. Mental health issues remain highly prevalent, and the use of drugs and alcohol and dependence on a variety of substances is still common. The results of the study are summarized below.

Family Background

- Over half of respondents had been placed in at least one foster home.
- Just over 40% had been physically abused in the year before they left home.
- Nearly 20% of females and 8% of males were sexually abused before age 8.

¹ It should be noted that the first study's data collection period was in 2005, but the report was not publicly released until 2006. Therefore, the reader will notice that this report makes reference to the "2005 study" but the actual report was released in 2006 (as noted in its citation).



- Nearly half of all participants said that they considered one or both of their parents/guardians as heavy drinkers.

Education and Employment

- Only 20% of street involved youth received a high school diploma.
- Less than 20% of participants reported regular work as a main source of income.
- Over 25% of participants reported their main source of income as welfare, EI, or other government support. The next highest sources of income were getting money from family or friends, panhandling, dealing drugs or doing drug runs, prostitution and theft.

Substance Use

- More than 80% of all participants are current drinkers.
- Two-thirds of all participants were classified as high risk drinkers or showed signs of alcohol dependence and/or abuse.
- About half of current drinkers had their first drink by age 12.
- 96% of respondents have tried marijuana in their lifetime, with half currently smoking daily.
- Excluding alcohol and marijuana, stimulants and crystal meth were the most frequently used drugs, with about 5% and 8% (respectively) of youth reporting to use these drugs daily.

Mental Health Status

- Most participants reported symptoms of more than one psychological disorder. Discounting the substance use disorders, the average psychological disorder per person is nearly 3.
- Over half report suicidal thoughts or tendencies, with 20% meeting criteria for high risk.
- After depression and suicide ideation, the most prevalent mental health issues are anti-social personality and psychotic disorders.

Criminal Involvement

- Participants report involvement in a variety of illegal activities including theft, assault, drug trafficking and vandalism.
- The average number of different criminal activities per person in the past year was more than 2.
- Over one third of females and nearly two thirds of males have spent time in a detention facility.
- More males than females reported involvement with the sex trade.

Conclusions

This new report shows that the circumstances facing street involved youth today are not very different from those they faced several years ago. They are still dealing with a lack of employment opportunities, a difficult family history, mental health and substance use disorders, and a general lack of social connections.



Integration into what is considered typical society is dependent on the ability to maintain social connections, keep focused on work, understand money and finances and have adequate and quality social and emotional support from family and friends. Unfortunately, the results of this study show that most of these youth report not having anyone in their life that could provide this type of support. According to the youth, many of their families are neglectful at best and abusive at worst, and certainly not giving them much support beyond basic care. Most drop out of school due to a lack of social networks, a variety of mental health disorders or simply not feeling like it is going to be beneficial to them. These mental health and self-esteem issues are then exacerbated by turning to substance use and criminal activities, affecting their ability to be employed due to lack of education, lack of social skills, or a criminal record. This sample represents a population that struggles to reach out for help and if it does not come to them, they will continue living their life moment to moment, with no sense of security or belonging. There is hope that with the appropriate help and supports, they can start to build a better life for themselves.

A note about past year comparisons

Though, on face value, this report shows similar findings to the 2005 study, some numbers do differ. The reasons for this can most likely be attributed to a different group of participants, with slightly different methodologies and different time periods. Also, in the previous report, there was an emergency shelter in which interviews were done that was not used this time. For these reasons, the numbers from the report two years ago are rarely directly compared with the numbers from this year, and when they are, they must be interpreted with caution as they are not representative of a significant change in circumstance, but rather a change in survey methodology.



INTRODUCTION

Due to a growing concern of substance use and abuse in Canadian youth, there has been a movement towards monitoring the prevalence rates of alcohol and other drugs on a provincial and national level. This monitoring has included special reports on the use of substances by youth (Canadian Centre on Substance Abuse, 2007) and attention to substance use by school-aged children. However, most monitoring approaches underestimate the use of alcohol and other drugs in the population, as at-risk populations (e.g., individuals who are incarcerated, street youth) are often not included in these surveys. Youth who have dropped out of school, or who are frequently absent from school, are not interviewed and street youth are not included in telephone surveys.

Adolescents without a fixed address are becoming more and more common on our urban streets, and these adolescents appear to have difficulty “fitting in” and achieving the usual milestones that reflect maturity and the developmental stages of transition into adulthood. Although there has been some interest in the plight of Canada’s homeless youth, much of the work to date is descriptive, trying to describe their current situation with a goal to identify precursors of their life on the street and some of the consequences (e.g., drug addiction and disease). What has been found is that street youth have a wide range of difficulties, and a wide range of family backgrounds that may have contributed to these difficulties. To overcome these obstacles requires skills that are beyond their current capabilities, and few are able to take the required steps to develop these skills.

“Street youth” is a term often used to refer to people, usually adolescents, who have run away from home, or have been “kicked out” of their homes for a variety of reasons. Street youth, while not necessarily a homogeneous group, are younger individuals who commonly do not have a permanent residence and spend a significant amount of time without physical shelter. In the literature on homelessness, the term “youth” has not been standardized, but often includes youth and young adults between the ages of 14 and 25.

Estimates of the numbers of street youth in Canada vary, ranging from 50,000 to 200,000 (McCormick, 2004). Although they are the fastest growing segment of the Canadian homeless population (Ayerst, 1999) we have little knowledge of their situations (Cauce et al., 2000).

Our understanding of street youth is further confounded by our surveying methodologies. Most of what we know from surveys does not allow us to make any causal statements about the issues that street youth face. This limitation is due to the fact that we rely on the youths’ perception of their issues in a snap-shot format versus following them over time. For example, several years ago Nancy Higgitt and her research team conducted a study from the perspective of street experienced youth. They discovered that street youth felt alienated from those support systems that are thought to keep youth anchored in mainstream society; and it is for this reason, overall, that many of them find themselves homeless (Higgitt, Wingert & Ristock, 2003). Although this snap-shot sample was small and potentially not representative of all street youth in Winnipeg, it was a significant



contribution² as it provided a rich description of the street youth experience, including their difficulties obtaining and maintaining various levels of support.

This means that services that can help, including programs at the Addictions Foundation of Manitoba (AFM), must be purposefully extended to these populations³. We must make an effort to reach out to them, if we want to impact positively on their lifestyle.

The AFM conducted a survey of over 150 homeless adolescents in 2005 and found a number of characteristics that make it difficult to reach out to these individuals. In addition to a very high prevalence of substance abuse disorders, many of these youth have symptoms of a number of different mental illnesses, and they struggle in their day to day relationships with family and friends. These issues can severely impair the ability to communicate and can lead to an environment of mistrust. In addition to the expected depression and anxiety, which may be related to their unstable living situation, they express the presence of a number of psychotic symptoms, related to both psychoses and/or schizophrenia. Many of these disorders will also be exacerbated by some of the substances that they use in addition to the growing number of stressors they face on a daily basis. Stimulants such as methamphetamine as well as hallucinogenic drugs are used by this population. Both of these drug classes can interact with existing mental health disorders to produce even greater negative impacts and make it difficult for them to access social services. The results from this report were consistent with other studies that also showed a disproportionately high degree of mental health issues in street involved youth (e.g., Adlaf & Zdanowicz, 1999; Cauce et al., 2000; Slesnick & Prestopnik, 2005).

The transition from youth to adulthood is not an easy one to make, even for those youth who have more than enough supports during this developmental phase. Youth living on the street experience similar challenges of young adulthood such as the need for education and employment, yet at the same time they often face very different circumstances and obstacles compared to their peers. Street youth are typically not well educated; rarely meeting the minimum requirement (such as a completed high school education) for entry-level employment. They often struggle to financially support a spouse or a child. Their contemplation of the future is one of hopelessness and lack of opportunity. Without shelter and regular income, they must develop different (socially less acceptable) means of supporting themselves and finding the security that most of us take for granted. With limited social skills and connections, an inadequate education, and few opportunities for employment, many of them resort to criminal activity frequently associated with gaining money, shelter or access to drugs. This includes petty theft, fraud, prostitution and drug dealing (e.g., Baron & Hartugal, 1998; Chen, Tyler, Whitbeck, & Hoyt, 2004; Janus, McCormick, Burgess, & Hartman, 1987). Again, in the 2005 Winnipeg street youth study, most of the youth were involved in a wide variety of petty

² It should also be noted that Wylie (2005) and Beaudoin, Larsen, & Wood (2005) have done significant work in this area in Manitoba; with their research focusing more on selected health issues.

³ The AFM Youth Outreach Project 2006-2008 in Winnipeg ended due to an end of funding for the position.



crime, including theft, fraud, drug trafficking, assault and vandalism. Often the results of this criminal activity are used to support a drug habit as runaways are about 10 times more likely to have a history of substance abuse than non-runaways (van Leeuwen et al., 2004). Their substance abuse may reflect an effort at self-medication to escape from the harsh reality of the daily stresses with which these youth cope. Further, evidence of troubled family history (e.g., Bodnarchuk, Patton & Rieck, 2006) suggests that they may be trying to forget some of their past, which may be a contributing factor to their current situation. Many young adults who become homeless have left conflict-laden, often violent, abusive, or dysfunctional home situations (e.g., Higgitt et al., 2003; Whitbeck & Hoyt, 1999).

These family situations frequently contribute to a person's decision to live outside. In the 2005 Winnipeg street youth survey we found that many had been physically abused, often reporting that they did not feel safe in their own home. Further, many were sexually abused, often at a very early age by someone familiar to them, suggesting that their caregivers did not protect them in the usual way that caring parents protect their children. Again, it is likely that this background contributes to the many difficulties that they now face. Many are involved in the sex trade. For some this offers the opportunity to make fast money. This may help support a drug habit, or may go towards paying off prior drug-related debts, or sex may often be used in exchange for shelter. Unfortunately, experiences of sexual exploitation at a very early age may create strong negative emotions that are then somewhat numbed through the frequent use of alcohol or stronger drugs. Thus, substance abuse and involvement in the sex trade are likely the beginning of a cyclic reaction to very negative experiences during early childhood, so that involvement in one may result in increased involvement in the other. A person may become involved in the sex trade out of need for food or shelter and drugs are used to cope with a negative self-image and the reality of the situation. The strength of addiction then causes an increased need for money and an increase in sexual exploitation to accommodate the addiction.

While we may try to develop programs for street youth in order to help them re-integrate into society, findings from the previous survey suggest that these youth experience various personality disorders and mental health issues which may contribute to the dangerous cycle of living on the streets. In 2005, two-thirds of respondents reported experiencing symptoms of a psychotic disorder in their lifetime. Psychotic disorders, when not treated and sometimes even with treatment, can limit an individual's ability to function on a daily basis. In addition, many street youth from the last survey met the criteria for anti-social personality disorder. People who exhibit symptoms of having an anti-social personality tend not to trust others; they have difficulty feeling empathy and at times can be irresponsible, irritable and aggressive. Not surprising, these individuals do not relate well with others. The accumulation of all of these issues and experiences may produce reactions from others that may not facilitate a caring response. By being irresponsible and uncomfortable (e.g., un-trusting) when dealing with social service representatives, they are likely creating more difficult situations for themselves. They may turn away offers for help, fail to meet deadlines or follow instructions, and generally not play the part of a "co-operative client". At the same time, this does not mean we



should not try to engage these youth in community services, but instead we should be looking for ways in which to improve our current services to better meet their needs.

The findings from the 2005 survey indicate a wide range of difficulties experienced by street youth. For many, these difficulties are intense and have developed over a long period of time. Although the 2005 survey contributed to our limited knowledge of street youth in Winnipeg, there were a few gaps identified. The 2005 report did not identify whether the individuals who participated in the survey were local residents or whether they were passing through; for example, taking a summer trip from eastern urban centre to the west coast. It is also important to determine whether the findings are robust, that is, are they reliable characteristics of the street youth population of Winnipeg? Re-doing the survey in 2007 will help to determine the level of stability of the findings, and help us to evaluate whether there have been any changes in general street youth situation. If a future study generates similar findings compared to 2005, we can be more confident that the results are representative of street youth in Winnipeg and that they are accurate and reliable. Unfortunately, we are not able to link the 2007 data with the 2005 data, due to the fact that both surveys are anonymous, thus individual identifiers were never collected. There is no way to tell if individuals from the 2005 also participated in the 2007 survey, and how their specific circumstances have changed.



METHOD

Sample

Participants were recruited through two youth resource centers in Winnipeg through visual advertising (e.g., posters) and by word-of-mouth with the help of the resource center staff. Street youth were defined as individuals who were between the ages of 14 and 25, who had recently spent time with no fixed address. There were no major limits on the amount of time that had been spent time in the previous year with no fixed address. Participants were still included if they had lived on the street or had no fixed address in the past, but were currently living at a fixed address. Both Manitoba residents and individuals who were just traveling through the province were included, as long as they were accessing the resources at one of the two youth centers involved.

Recruitment and screening were done by the youth center staff with whom the participants felt comfortable. Word-of-mouth within participants was also a major factor in recruitment. Participants were asked to refer others to the resource centers to participate in the study. A \$25 cash incentive was offered for completing a written survey and participating in a personal interview.

In total, 166 males and females completed the survey; however, seven individuals were excluded due to endorsing use of the fictitious drug “quabaline”. By endorsing this item, which could not be true, the rest of the questions could not be analyzed at face value and thus the responses of these individuals were eliminated.

Procedure

The participants were asked to complete a self-report questionnaire and a mental health screening interview. Both components were administered on-site at the resource centers or at a center-owned building nearby. The location was dependent on center schedules, as several rooms were needed to ensure privacy in the interview and adequate space for participants to complete the self-report. Due to the sensitivity of some questions in the verbal interview, male participants were questioned by a male interviewer, and female participants were questioned by a female interviewer. Self-reports were completed in a group setting with anywhere from 2 to 8 participants per group. The interview lasted an average of 20 minutes and it usually took about one hour for each participant to complete the questionnaire. All participants were made aware of the purpose of the study and were asked to sign an informed consent form.

Questionnaire

The questionnaire was comprised of several validated measures (e.g., AUDIT, CAGE-AID, etc.) as well as a series of demographic, health-related, and questions on social and behavioral functioning. The next section describes the validated measures used in this study.



Alcohol use Disorders Identification Test (AUDIT). The AUDIT is a brief ten-item measure of alcohol dependence. It was developed by the World Health Organization and has been shown to be a reliable and valid indicator of hazardous alcohol consumption. Questions refer to amount and frequency of consumption, and dependent behaviour and also ask about alcohol related problems. A score of 8 or greater suggests abuse or dependence.

CAGE - Adapted to Include Drugs (CAGE-AID). The CAGE-AID is a modified version of the CAGE, a four-item questionnaire designed to detect addiction. In the present study, the CAGE was adapted to measure cannabis dependence specifically, as this was the most common illegal drug that was used in the previous sample (e.g., in 2005). Questions refer to dependent behaviour (e.g., using cannabis first thing in the morning), as well as attitudes and feelings towards their own use (e.g., if they ever feel guilty about their use).

Leeds Dependence Questionnaire. The Leeds Dependence measure is a ten-item scale that is used to measure dependence that is not drug-specific. It is used here to supplement other measures. This measure includes questions about frequency of cravings (e.g., “do you want to take more drink or drugs when the effect starts to wear off?”) and attitudes (e.g., “do you find it difficult to cope with life without drink or drugs?”) and behaviours (e.g., “do you plan your days around drinking or taking drugs?”).

Other questions. Additional questions included demographic information (e.g., gender, financial, and education), experience growing up, mood, and health status. Also included were items about knowledge and use of harm reduction practices (considering both drugs and sexual behaviour), and involvement in criminal activities (self-reports of their friends’ involvement are also included).

Interview: The Mini International Neuropsychiatric Interview (MINI)

The MINI is a brief psychiatric interview that takes approximately 20 minutes to complete. It is a diagnostic tool based on the Diagnostic and Statistical Manual, 4th Edition (DSM-IV), and is comprised of several modules, each with a series of yes/no questions that indicate whether the interviewee may potentially meet the symptoms of a specific mental illness.

The interview is composed of questions concerning the most common mental illnesses such as depression, anxiety, post-traumatic stress disorder (PTSD), obsessive-compulsive disorder (OCD) as well as alcohol and drug dependence. An extra module was added to the MINI that assessed dependence specifically to prescription drugs. The questions asked were identical to the questions in the “non-alcoholic substances” section, only they referred to a variety of prescription drugs, rather than street drugs.



The questions were asked so that common symptoms were mentioned first, and affirming the presence of those symptoms led to more questions. If the answer to the most common symptoms was “no” then the youth was assessed as not having the specific disorder and the interviewer moved on to the next module. In the drug dependency module, participants were asked what drug they used the most frequently and the dependence questions were asked regarding that drug only.

Interviews were conducted in a private or semi-private (partially enclosed) room, while group questionnaires were being filled out in another room. Interviewers were trained in use of the MINI prior to starting the study. All interviews were conducted face-to-face and the youth were assured that their responses were completely confidential. The only exception to confidentiality was if the youth was deemed to be at high risk for suicide. Participants were informed about this before the interview began.

Data Analyses

All analyses were performed using the Statistical Package for the Social Sciences (SPSS) version 14.0 for Windows. All tests of significance were completed using an alpha level of .05 (the level of significance). The level of significance is the chance you take (in this case, 5%) that the difference you found was due to coincidence. In other words, when a significance difference is found, we attribute 5 times out of 100 that this is due to chance alone. Obviously, the smaller the level of significance, the greater the confidence in your results.



RESULTS

DEMOGRAPHIC CHARACTERISTICS

Gender

The study population consisted of 87 male (56.9%), 64 female (41.8%), and 2 transgendered (1.3%) youth. As 7 people did not endorse a gender, and most of the analyses in this report are gender comparisons, these people were excluded. Also, as 2 is an insufficient number to make meaningful (and valid) comparisons, the transgendered individuals were not included in any gender analyses. The mean age of females was 18, and the mean age of males was 19, however, as many respondents selected the option “22 and older” the actual mean is likely slightly higher.

Ethnicity

The largest percentage of respondents were First Nations (approximately 42% from each gender), followed by Caucasian (29%). The rest of the sample identified as Métis (21%), Asian (1%) or “Other” (7%). It should be noted in 2005 the majority of respondents identified as Caucasian (56% of males and 51% of females) and 16% (each male and female) identified as First Nations. Differences in the ethnic background of respondents from 2005 may be attributed to the location where subjects were recruited in addition to many other extraneous factors.

Education

Most of the participants in this study had not yet completed high school or had dropped out altogether. At the time of data collection, 79% of males and 81% of females were without a high school diploma. Very few females (6.3%) reported a post-secondary degree; likely reflected by both their youth and various other factors. No males in the sample indicated a post-secondary degree.

Occupation

In the past 12 months, 62% of males and 40% of females had held a job of some kind. Of these, 58% of males and 41% of females worked full time. Just over 80% of all the participants who held jobs did not have them longer than 6 months. For males, the most common source of income was through regular work (20%). For females, regular work was the main source of income for only 9%, while most got money from friends or family (25%). In spite of their current situations, many of these individuals are able to work, although most did not hold a job for longer than 6 months.

Home location/status

Most of the participants in the study had lived in Manitoba all their life (approximately 70%). Only 9% of females and 3% of males were just passing through the province on their way to some other place (based on interviews, this was largely people coming from the east heading to British Columbia). Many had not returned home since they first left. For example, 41% of males and 27% of females had never returned home to live since they first left. Interestingly, many of these youth never had a period of time when they would have considered themselves without a fixed address (22% of males and 30% of



females). The reasons for this might be that they still consider their permanent address to be at their home even though they don't stay there that often or perhaps they've always gone from one house to another and they consider that to be a fixed address. In the future, the question about residency should be made clear to the interviewee. Just over 21% of males had been without a fixed address for over a year, while only 12% of females reached this timeframe. This may be related to the fact that the males in this sample were, on average, slightly older. Approximately half of all participants had been homeless for at least a month in the past year.

Participants were asked whom they had lived with prior to leaving home. The most frequently cited response was "mom only" (33%). There were some gender differences; 20% of females lived with a biological parent and a step-parent, while only 6% of males had lived in this situation. Most of the youth respondents spent at least some time at friend's houses; with only 12.5% reporting not spending the night at a friend's place. Of those who responded, 65% spent at least some time at their parent's home, and 35% never spent the night at their parent's home. One in five males (20%) and 12% of females reported sleeping on the street "often".

Over half (54%) of participants had lived for some period of time in a group home. This makes some sense as some of the interviews were conducted out of a resource centre that also supports a group home, though this does not account for the very high number. There was no substantial difference between males and females. Just over half of participants (54%) had also spent time in at least one foster home. There was again no significant gender difference (about 5% more males were in foster home than females). Of those who had lived in a foster home, 76% had more than one placement (36% had more than 5). Again, there was only a marginal gender difference with 34.4% of males having had more than 5 placements, while 38.9% of females had more than 5 placements.

Participants were asked if their family had ever received welfare, public assisted housing, or employment insurance. Many people did not respond to some or all of these questions. It is expected that the reason for this is that the information was unknown. Approximately one half of all participants' families had received welfare. Only 18% knew that their family had received public assisted housing and 45% knew that they had not. Almost thirty percent knew that their family had received employment insurance and 44% knew they had not.

In summary, the demographics and background information of the respondents in this sample are consistent with other studies on street youth. Many have not graduated from high school with few going on to post-secondary education. Many of them come from difficult home life backgrounds, with a significant proportion of them having lived in group homes or foster homes. They appear to come from homes where their biological parents were not together (e.g., 1/3 lived with their mom only), and about 20% had been homeless for at least the previous year. The next section describes substance use among the street youth respondents.



SUBSTANCE USE

The literature has consistently found street youth using substances at a high percentage in addition to reporting histories of substance abuse. The 2005 report found that most of the youth respondents had used alcohol in the past year with a significant portion using it several times a week or more. Tobacco rates were quite high as well, with males being more likely than females to be heavy smokers. Not only are youth reporting use of these substances, but they are also more likely to be participating in the harmful use of these drugs. A significant percentage in 2005 were also injecting drugs, with females being more likely to engage in risky behaviors that go along with injection drug use (e.g., reusing needles and equipment). Females were also more likely to inject methamphetamine and several other drugs compared to male street youth. In addition, a separate section was added in the 2005 report exploring methamphetamine use as its occurrence tends to be significantly higher with street youth compared to their non-street living counterparts. Methamphetamine use was linked to risk for suicide, the use of other drugs and dependence. For this particular report we will summarize cigarette smoking, alcohol use, cannabis use, other drug use and prescription drug use. Although it is clear that methamphetamine remains to be a problem for this group (among several other drugs), there will not be a separate section on this issue in this report.

Cigarette Smoking

In contrast with general population studies that show about 26% of Manitoban youth (ages 15-24) smoke (Health Canada, 2007), 73% of homeless participants considered themselves regular cigarette smokers at the time of the interview. Of those who were not smokers, only 14% had never smoked regularly. Of those who currently smoke cigarettes, 53% of males smoke fewer than 12 per day, and 72% of females smoke fewer than 12 per day. The results are displayed graphically below (see Figures 1 and 2).

Figure 1. Non-smokers who used to smoke and never smoked by gender (%)

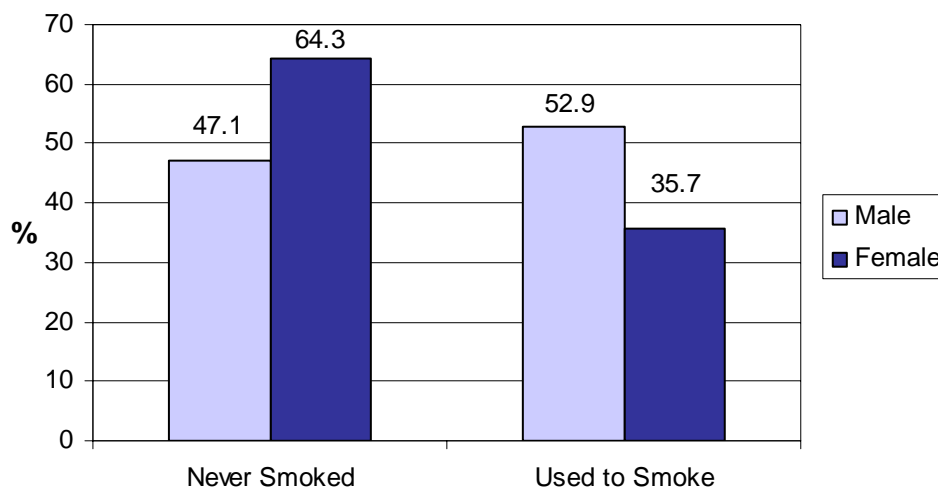
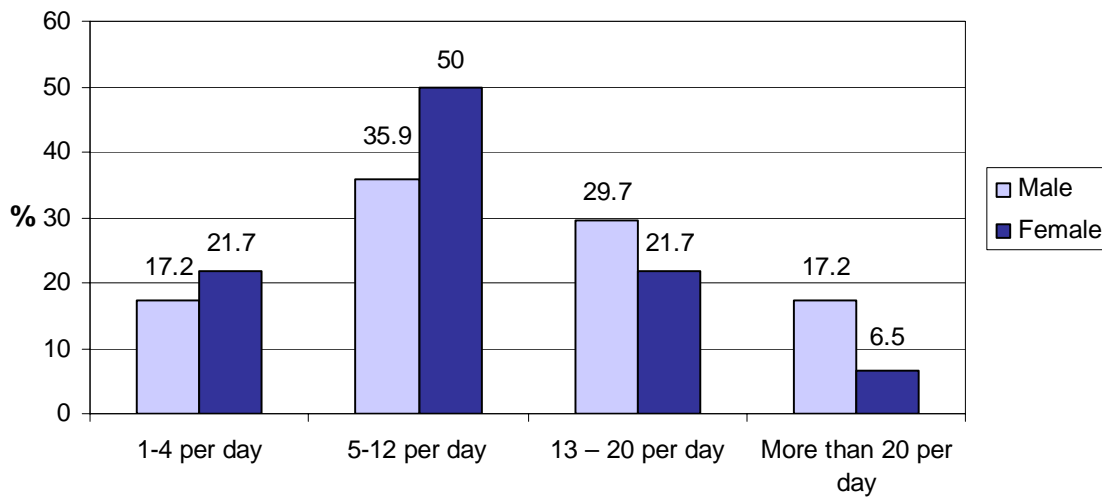




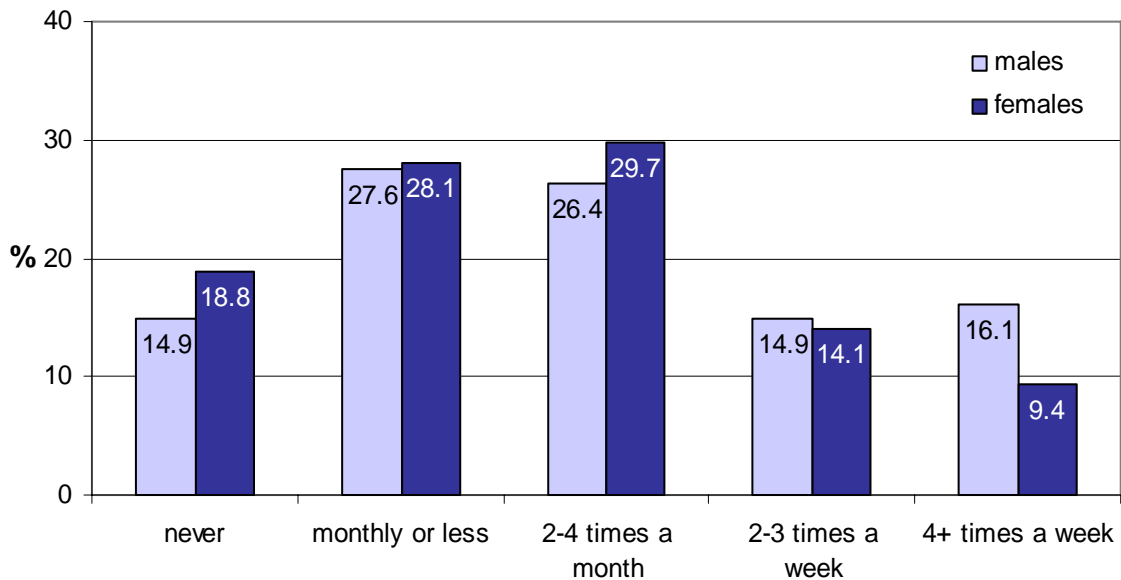
Figure 2. Usual number of cigarettes per day by gender (%)



Alcohol Use

Several questions were asked about alcohol use, the first of which was how often the respondent consumes a drink containing alcohol. This question was used to filter out those who do not drink when doing subsequent analyses using the Alcohol Use Disorders Identification Test (AUDIT). Those who said “never” to this question were not included in the analyses for alcohol abuse or dependence that are based on the AUDIT. The following figure shows how often male and female respondents drink alcohol.

Figure 3. Frequency of alcohol consumption by gender (%)





Males were less likely to respond “never” (14.9%) than females (18.8%), and the females were less likely to consume alcohol 4 or more times a week (9.4%) than males (16.1%). Males were, therefore, both more likely to drink, and more likely to drink more frequently than females. In addition, males also consume more alcohol than females on a typical day of drinking. Just over 44% of all males that drink alcohol said that they drink more than 10 drinks on a typical day. Only 23% of females drink this much, but since women are on average, smaller with a larger percentage of body fat, this difference is expected. These are both very high consumption patterns.

These rates of use are quite similar to the 2005 survey. For example, in both surveys about one-third of the respondents drank alcohol about twice a week or more frequently.

Age of first drink

The age at which youth begin to drink alcohol is an important predictor of subsequent drinking problems. In this sample, the average age that males first consumed alcohol is 13; the average age for females is slightly younger at about 12. Of those who “sometimes” drink, 23% of males and 12% of females had their first drink of alcohol before the age of 11. By age 12, almost half of males who drink had tried it (49%), and over half of females (55%). This suggests that most of the homeless youth that were interviewed are at risk for becoming alcohol dependent.

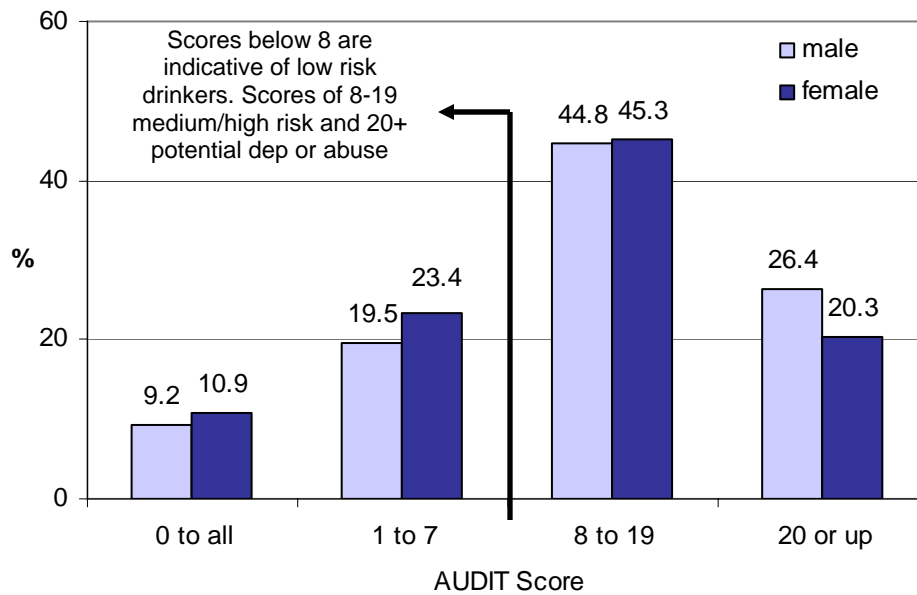
Results of the AUDIT questions

As noted earlier, the AUDIT is a frequently used measure that indicates alcohol abuse and/or dependence. The AUDIT is scored on a 40-point scale, with low risk drinkers scoring under 8. Those scoring from 8 to 19 are considered medium to high risk drinkers but are not yet showing signs of serious alcohol dependence. Any score above 19 is considered high risk or dangerous drinking, or signals dependence or abuse.

This population is highly involved in substance use as was shown in the 2005 street youth study. In this sample, 71.2% of males and 65.6% of females scored an 8 or higher on the AUDIT. This means that only a little more than 30% of the participants surveyed are non-problem or low risk drinkers. Only about 10% of participants did not answer yes to a single AUDIT question and as all participants answered these questions, it can be assumed to some extent that the people who did not score on the AUDIT are the few participants that do not drink at all. The following figure shows the AUDIT scores by gender.



Figure 4. High Risk Drinking Categories by Gender (%)



The following table shows the results of the individual AUDIT questions by gender. Gender differences are minimal for most questions except for “How often do you feel guilt or remorse after drinking?” Females are more likely to feel guilty at least some of the time; 49% said that they never feel guilty. On the other hand, 59% of males say they never feel guilty after drinking.

Table 1. Differences between males and females on the AUDIT items (%)

		Never	Less than Monthly	Monthly	Weekly	Daily
Unable to stop drinking once started	Male	45.9	23.0	12.2	10.0	10.0
	Female	44.0	26.0	18.0	6.0	6.0
Failed to do what was expected	Male	52.7	27.0	5.4	8.1	6.8
	Female	51.0	23.5	9.8	5.9	9.8
Have a drink in the morning	Male	68.9	9.5	8.1	4.1	9.5
	Female	65.4	9.6	11.5	3.8	9.6
Felt guilty after drinking	Male	59.5	18.9	6.8	10.8	4.1
	Female	49.0	19.6	19.6	9.8	2.0
Unable to remember events of the night	Male	37.8	25.7	14.9	17.6	4.1
	Female	38.5	25.0	21.2	11.5	3.8



		No	Yes, but not during the past year	Yes, in the past year
Drinking caused injury to self or someone else	Male	44.6	21.6	33.8
	Female	42.3	26.9	30.8
Been told to cut down by friend, relative, or healthcare worker	Male	58.1	14.9	27.0
	Female	59.6	21.2	19.2

The responses to questions about use and signs of alcohol dependence reveal the extent to which alcohol is an integral aspect of street youth's lives, and shows the beginnings of a pattern that causes concern. About 15 - 20% of homeless youth have signs of alcohol dependence. They drink in the morning, may often forget events from the night before, and are often (e.g., at least once a week) unable to stop drinking once they start.

As shown on the table above, 55% of males had caused injury to themselves or someone else in their lifetime, as a result of their drinking. Over half of these occurrences were in the past year. These numbers are approximately the same for females, with 58% causing injury to someone at some point in their life, and again, just over half of these being in the past year. In addition, 27% of males and 19% of females had been told by a health care professional in the past year that they should cut down on their alcohol consumption. Another 15% of males and 21% of females had been told this, but not in the past year. This means that 40% of all participants have been told to cut down on their drinking by a physician or concerned family member or friend and yet, in spite of these negative consequences and concerns, they continue to drink alcohol at a very high rate.

MINI Assessment of Alcohol Dependence

The Mini International Neuropsychiatric Interview (MINI) is a brief psychiatric interview that is based on symptoms of mental illness as identified in the Diagnostic and Statistical Manual of the American Psychiatric Association. It is used in the present context to obtain more detailed information about respondent's alcohol and other drug use problems, and to get a general overview of their lifetime history of symptoms of mental illness. Abuse is defined as a maladaptive pattern of use leading to impairment, presenting as one or more of the following with in the previous year:

- Failure to fulfill major obligations
- Physically hazardous use
- Legal problems
- Continued use despite social or interpersonal problems.

Dependence is more severe, and may include physiological dependence. A clinical diagnosis is characterized by three or more of the following:

- Tolerance (e.g., the need for more to get the same effect)
- Withdrawal

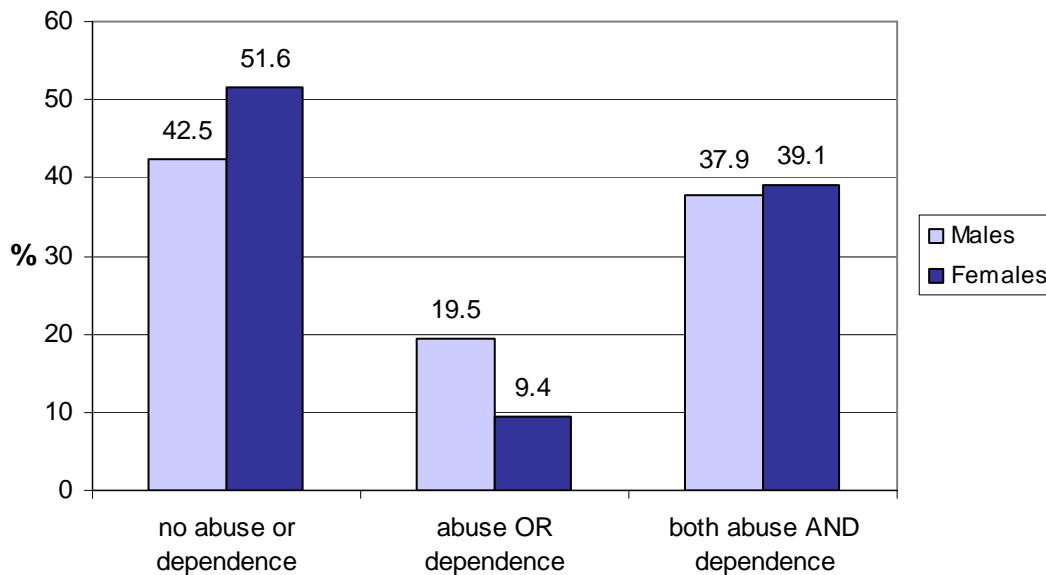


- Use more than intended
- Inability to control use
- Effort expended to get drug
- Important activities are replaced by drug use
- Drug use persists, despite physical or psychological problems

The result for the MINI dependence scale is similar for both genders. Almost two-thirds (64%) of both male and female participants answered 3 or more of the dependence questions positively; indicative of alcohol dependence. However, there was a gender difference on the abuse scale. More males (72%) than females (64%) were determined to be abusing alcohol. Males were more likely to be at risk while intoxicated and to continue drinking in spite of this creating a problem with family and/or friends.

The following figure shows the number of males and females from the entire sample that were assessed by the MINI as either abusing or potentially dependent on alcohol or as being potentially dependent *and* abusing or as neither.

Figure 5. MINI Alcohol dependence and abuse by gender (%)

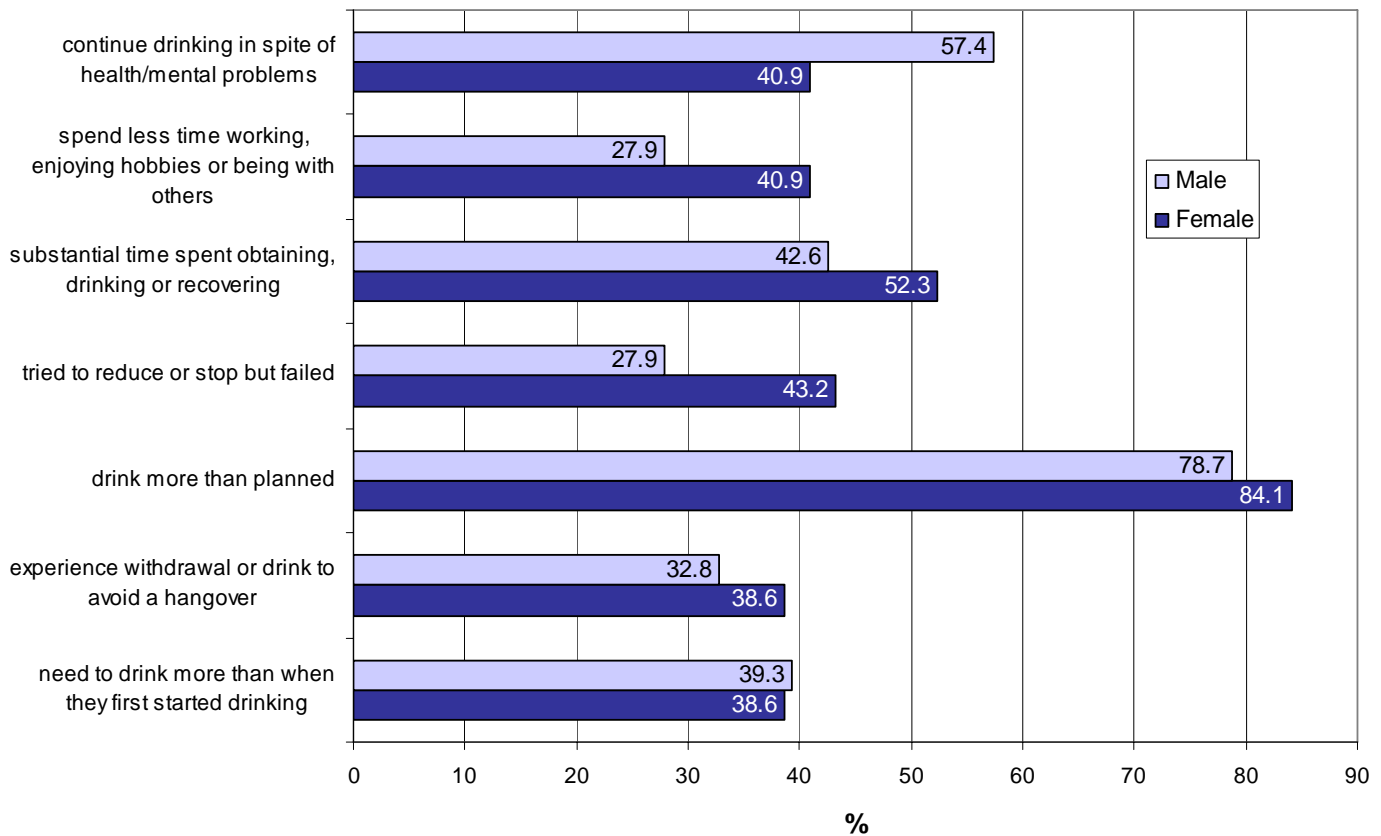


Participants who said that they had not had more than 3 drinks of alcohol within 3 hours on 3 or more occasions were not asked any further questions from the alcohol abuse or dependence scales. Of those who answered the questions on the MINI, 79% of the males and 84% of the females said that when they drink, they often find themselves drinking more than they planned. One third (33%) of males and 39% of females said that they feel withdrawal symptoms when they cut back on their drinking, or that they drink to avoid a hangover. Approximately 28% of males and 43% of females had tried to reduce their alcohol consumption or stop drinking altogether but failed. Over half (57%) of males and



41% of females continued to drink even though drinking caused them health or mental problems. Comparisons of the number of males and females who responded “yes” to the individual questions are shown in figure 6 below. At least three of these questions needed to be answered in the affirmative for the participant to be considered dependently involved with alcohol. Clearly, many of the participants in the street youth survey have many of the signs and symptoms of alcohol abuse and/or dependence, and there is no obvious gender difference.

Figure 6. MINI alcohol dependence questions by gender (%)



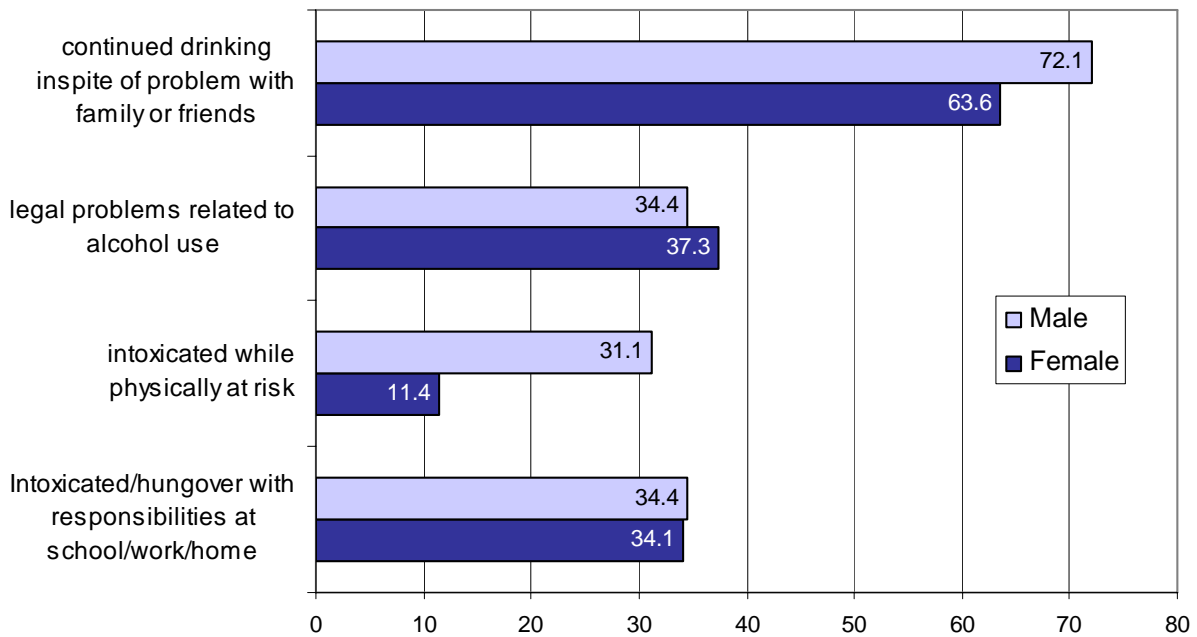
Participants were also asked four questions regarding alcohol abuse. These questions are listed below:

- 1) Have you been intoxicated or hung-over more than once when you had responsibilities at school, work or home, and did it cause a problem?
- 2) Have you been intoxicated more than once in any situation where you were physically at risk such as driving a car or operating machinery?
- 3) Have you had any legal problems more than once because of your drinking?
- 4) Have you continued to drink even though drinking caused problems with your family or other people?

Only **one** of these questions needed to be affirmed in order to indicate alcohol abuse. The results of these 4 questions appear in figure 7 on the next page.



Figure 7. MINI alcohol abuse questions by gender (%)



Cannabis Use

In the 2005 survey cannabis was the most commonly used drug in the street youth population. About 94% had smoked cannabis at some point. In this survey only 6 participants (4%) had never used it. Although some respondents use cannabis less frequently than others, almost half of the males (49%) and females (46%) smoke cannabis daily. An additional 10% of males and 17% of females also smoke cannabis at least once a week.

Furthermore, most began using cannabis at a very early age. Nearly 20% of males first used cannabis before the age of 11 and two-thirds of the male respondents (67%) had used it by the time they were 14. Females started using just a little later; with 9% having smoked cannabis before age 11. Approximately 75% of females had tried it by age 14, and of all the females who tried cannabis, all but one had done so before age 17. Over 80% of males and 71% of females reported at least one period of their life when he or she had used cannabis daily or almost daily for at least a month (which is one of the indicators of dependence).

Additional signs of dependence were also reported. For example, 24% of male participants who use marijuana had tried to cut down in the past 12 months but had been unable to, and 42% had never tried to cut down. Of the females who used marijuana, 19% had tried and failed, and 44% had not tried. This means a total of about 35% of participants had cut down their pot use in the past 12 months, but it is unclear whether they maintained the change.



Cannabis Dependence

Cannabis dependence was measured by responses to the items of the CAGE-AID. This is a 4 item measure that is commonly used to screen for marijuana dependence. Based on similar alcohol measures, the CAGE-AID asks about cutting down smoking, being annoyed by individuals about use, feeling guilty about use, and smoking first thing in the morning (an “eye-opener”). These are each signs of cannabis dependence, and, taken together, provide an estimate of potential dependence on cannabis. Table 2 shows the percent of male and female respondents answering “yes” to each of the CAGE-AID items, and the percent that would be considered potentially dependent on cannabis.

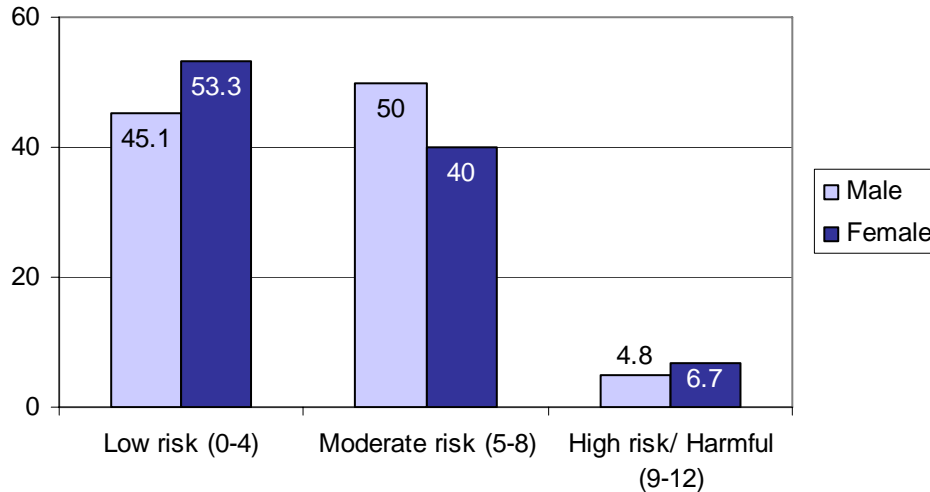
Table 2. CAGE-AID cannabis dependence questions by gender (%)

		Never	Rarely	Sometimes	Often
Have you ever felt you should cut down on your pot use?	Male	34.1	18.3	34.5	12.2
	Female	40.7	13.6	30.5	15.3
Have people ever annoyed you by criticizing your pot use?	Male	50.0	18.3	20.7	11.0
	Female	48.3	23.3	20.0	8.3
Have you ever felt guilty about your pot use?	Male	65.9	15.9	14.6	3.7
	Female	58.3	23.3	15.0	3.3
Have you ever smoked pot first thing in the morning?	Male	20.7	14.6	28.0	36.6
	Female	28.3	16.7	21.7	33.3

The overall average CAGE-AID score for males is 4.5. The mean for females is 4.3 and the difference is not statistically significant. These numbers are quite comparable to the 2005 survey, suggesting that there is no increase in the number of cannabis dependent street youth over the two years of these surveys – although we caution any comparisons made to the previous report. Table 2 shows that the number of “yes” responses to each question was quite similar for males and females. Although 35% of participants were “often” smoking pot first thing in the morning and over 60% had felt at some point that they should cut down on their use, almost 66% of males and 58% of females never felt guilty about using marijuana. The following figure (figure 8) presents the breakdown of the CAGE-AID scores by gender into low risk (0-4 points), moderate risk (5-8 points) and high risk /harmful use (9-12 points). Both the moderate and high risk categories are indicative of problematic use.



Figure 8. CAGE-AID scores by gender (%)



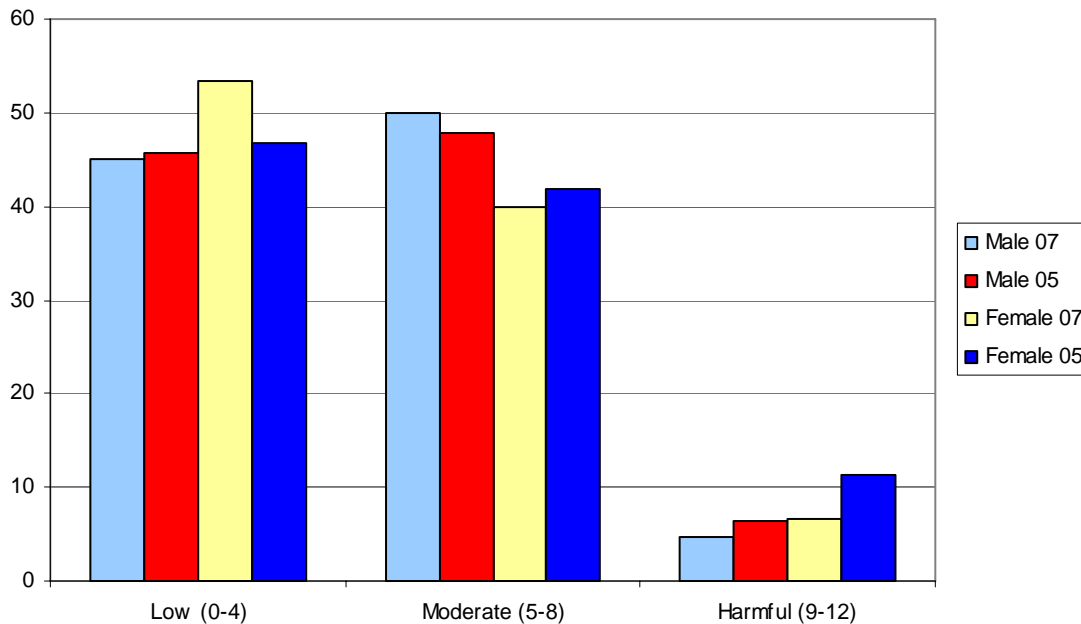
Participants were asked how often their friends smoke marijuana and 56% of males and 46% of females claim that their friends smoke marijuana at least 5 times a week. Only six percent of males and 9% of females say that their friends never use marijuana. This means that over 90% of the friends of participants use this drug, which is not surprising considering that most respondents use marijuana themselves. It is also not surprising, as many of their friends will also be homeless or marginalized (e.g., not working or going to school).

Comparison with 2005

The figure on the next page shows the CAGE-AID scores for males and females from the 2005 study and the current study. Results are largely consistent, though it appears that the current rate of high risk cannabis users has slightly declined. These numbers though showing a trend toward less cannabis use, likely demonstrate the difference in the sample from 2005 to 2007. Though cannabis use may be declining, the results are not supportive of that conclusion. As was stated in the beginning of this report, please interpret results with caution.



Figure 9. Gender by CAGE-AID score by year (%)



Other Drug Use

Self report responses

The self report measure that was used also asked about the use of a number of other drugs. In addition to alcohol and cannabis, a long list of substances, and the frequency of their use was included. The table on the next page provides a summary of male and female responses to these questions. It was anticipated that, similar to the 2005 study, street youth would again report using many illicit drugs including cannabis, crystal meth, cocaine, and stimulants. It should be noted that the past year prevalence of illegal drugs in the student population is usually quite low, with some students reporting to have never used other drugs in the past year.

**Table 3. Frequency of past-year drug use by gender (%)**

MALES					
	Never	< once a month	once a month	once a week	daily
cannabis	13.8	12.6	6.9	17.2	49.4
mushrooms	63.2	25.3	6.9	3.4	1.1
cocaine	67.4	20.9	7.0	2.3	2.3
crack	74.7	17.2	3.4	2.3	2.3
ecstasy	77.0	13.8	4.6	3.4	1.1
other club drugs	88.4	8.1	1.2	1.2	1.2
stimulants	83.7	11.6	0	0	4.7
hallucinogens	77.0	18.4	2.3	1.1	1.1
crystal meth	78.2	5.7	4.6	2.3	9.2
salvia	83.9	13.8	1.1	1.1	0
heroin	94.3	3.4	0	2.3	0
Inhalants	98.8	1.2	0	0	0
FEMALES					
	Never	< once a month	once a month	once a week	daily
cannabis	15.9	23.8	4.8	9.5	46.0
mushrooms	64.1	28.1	4.7	3.1	0
cocaine	60.3	23.8	11.1	1.6	3.2
crack	79.0	9.7	8.1	1.6	1.6
ecstasy	67.2	17.2	6.3	9.4	0
other club drugs	88.9	7.9	1.6	1.6	0
stimulants	82.5	9.5	1.6	0	6.3
hallucinogens	76.2	14.3	9.5	0	0
crystal meth	82.8	9.4	0	0	7.8
salvia	85.9	10.9	3.1	0	0
heroin	96.9	0	1.6	1.6	0
Inhalants	96.8	3.2	0	0	0



The most obvious observation is that few other drugs are used as frequently as alcohol and cannabis. No other drugs had been used by more than half of the sample in the previous year. Although magic mushrooms and cocaine had been used by about one-third of respondents, they are used relatively infrequently, that is, usually less than once a month. Stimulants and crystal meth were the most likely drugs to be used more frequently, with about 5% and 8% (respectively) using these on a daily basis. Overall, crystal meth is not commonly used by this population (or at least no more often than other drugs), however, when it is used it is more likely to be used more frequently. The 2005 report mentioned that it may have adaptive functions for street youth, as it is cheap, suppresses appetite and keeps the user awake for long periods. All of these characteristics may make this drug attractive to those living on the street. It should also be noted that the rates of regular crystal meth use (once a week or more) seem to have declined from the 2005 study (males – 34% to 11.5% and females – 28% to 7.8%; with the former percentages being 2005 rates and the latter 2007 rates). Again, we urge readers to view these comparisons with caution as this was not a follow-up study and the differences in the rates may be due to several factors, including the differences in the samples.

On a final note, it should not be forgotten that the Province of Manitoba in conjunction with many addiction and mental health agencies (including AFM), has taken great efforts to increase public awareness of substances (including crystal meth) and the dangers associated with them. Although it would be impossible to attribute the decline in regular crystal meth use over the two studies to the public awareness initiatives that have occurred in 2005 and 2006, it is important to include it in the analyses of the bigger picture.

MINI Assessment of Illicit Drug Use

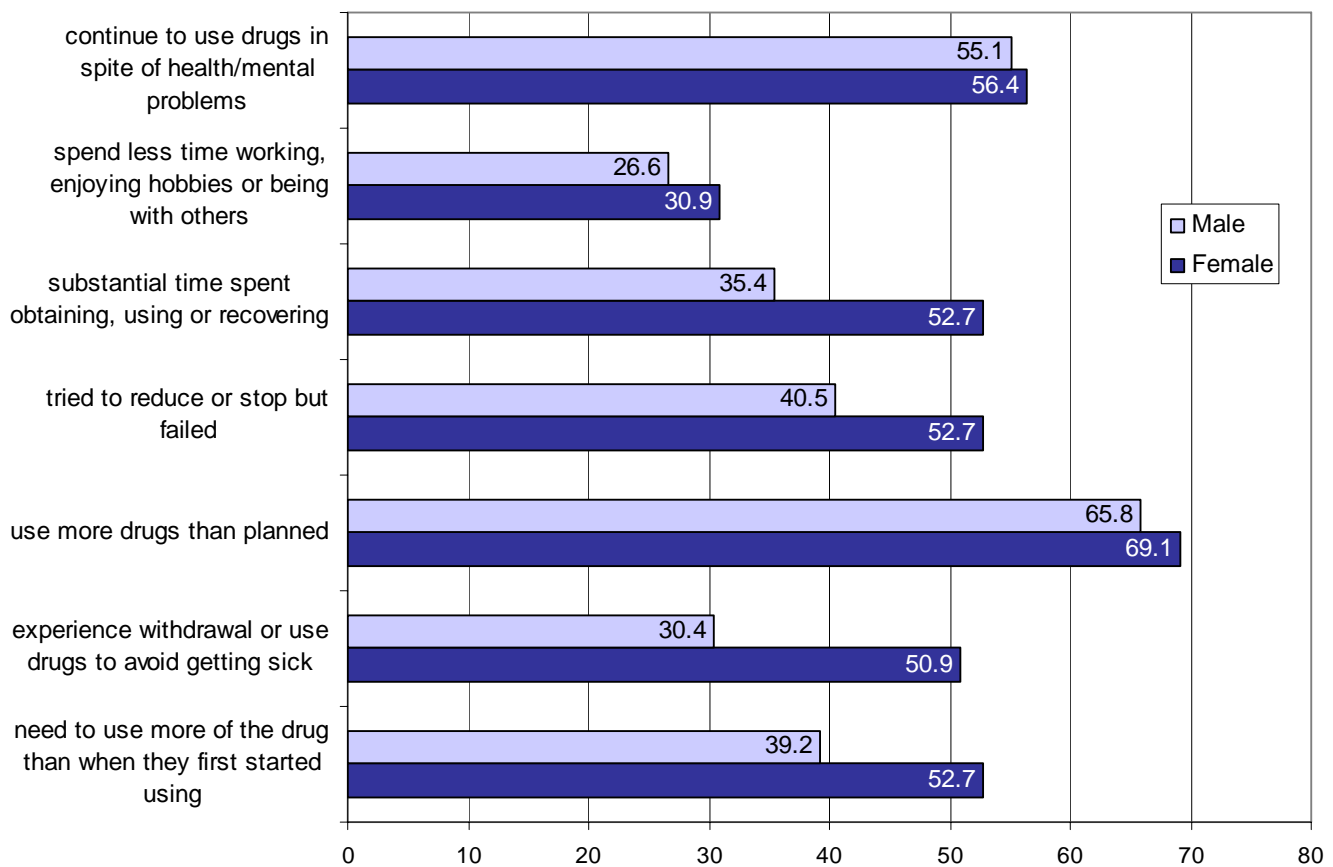
In the interview, 91% of males and 86% of females said that they had used at least one drug more than once in the past year to get high, feel better, or change their mood. Those who said that they did **not** use any drugs in the past 12 months were excluded in any further analyses of MINI items.

Participants were asked what drug they used the most so the remaining MINI questions could be asked in regards to that drug only. Since the self-report questionnaire provided data about cannabis use, participants who said that cannabis was their most frequently used drug were asked if they had another drug of choice. If they did, the MINI questions were asked regarding their second drug. This way information about the use and abuse of drugs other than marijuana could be obtained. At the end, an analyses of the total number of participants who were potentially dependent or abusing an illicit drug or who scored greater than 4 on the CAGE-AID (scores of 5-8 indicates moderate risk, scores of 9-12 indicate high risk/harmful involvement) was completed. A high percentage of both males (82.3%) and females (80.0%) scored high enough on either the MINI or the CAGE-AID to qualify as harmfully involved with a drug (other than alcohol).



The following figure displays the percentage of participants by gender that answered “yes” to the various drug dependence questions on the MINI. A few gender differences emerged from the analyses. Over half (53%) of females claim to spend substantial time obtaining, using or recovering from their drug of choice, while only 35% of males told us this. Likewise, over half of females and 41% of males have tried and failed to reduce their cannabis use in the past 12 months. This might mean that females have a harder time reducing than males, but it could also mean that fewer males have tried to cut down. Over half of the females (51%) experience withdrawal when they reduce use, or they use drugs to avoid withdrawal symptoms, while only 30% of males report these symptoms and behaviors. This could be related to the fact that more women may have trouble cutting down their use; they may be more affected by withdrawal symptoms, or they may experience these effects as being more severe than do males.

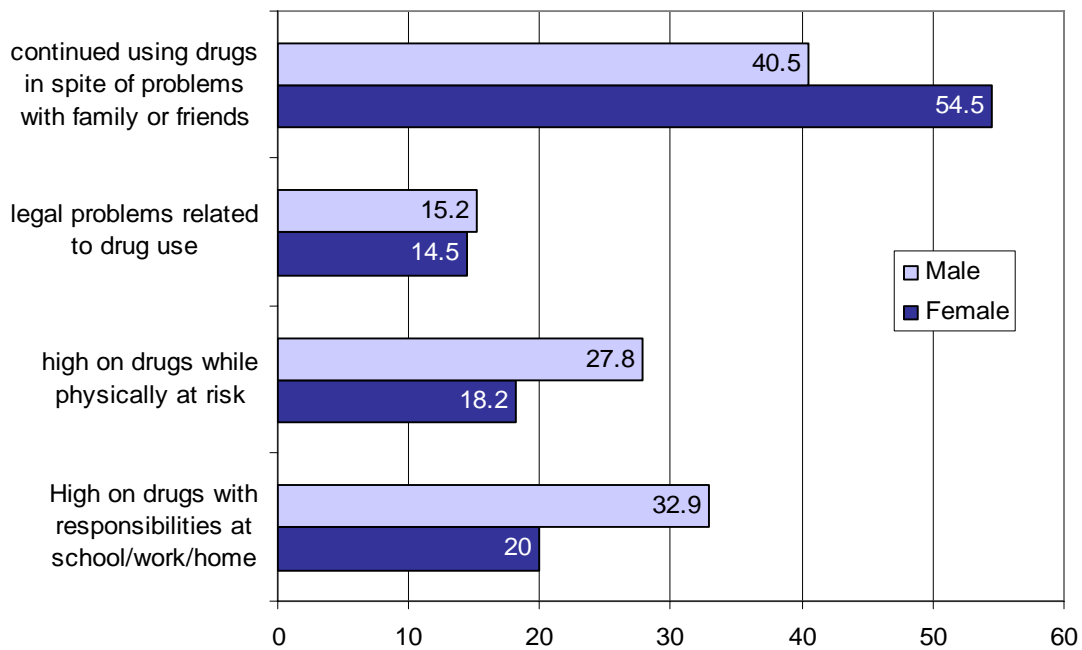
Figure 10. MINI drug dependence questions by gender (%)



The next four questions on the MINI regarding drug abuse are the same as those for alcohol abuse. Participants were asked if they had been high more than once when they had responsibilities at school, work or home (and if it caused a problem), if they had be high while in a situation in which they were physically at risk like driving or operating machinery, if they had had any legal problems in the past year resulting from their drug use, and if they had continued to use drugs in spite of causing problems with family or friends. The results of these questions are displayed in Figure 11.



Figure 11. MINI substance abuse questions by gender (%)

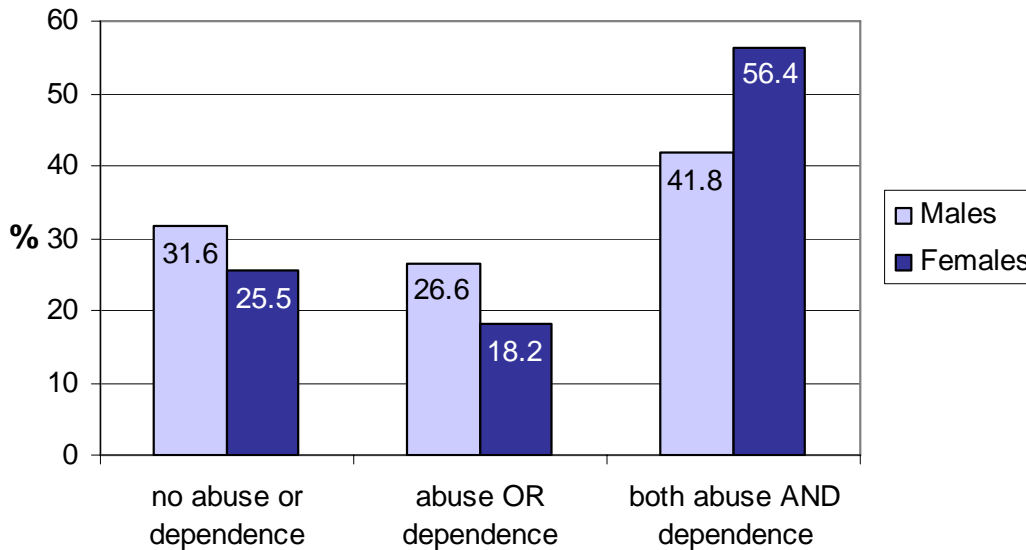


Again, a close inspection of this data revealed some gender differences. It seems at first glance that men may be less likely to be dependent on drugs than women, but more likely to engage in risky or problematic behaviour than women. Over one-quarter (28%) of men and only 18% of women answered that they had been high in the past year while in a situation in which they were physically at risk. About one-third (33%) of men said that they had been high when they had responsibilities at school, work or home and this had caused a problem in the past year. Only 20% of females reported being high while having responsibilities in their life. Males and females were equally likely to experience legal problems in relation to their drug use, and women (55%) were more likely than men (41%) to use despite interpersonal problems. This last point may be because males may not identify interpersonal problems as frequently as females.

Almost half (46.8%) of males who answered the drug use questions on the MINI can be classified as dependent users and 63.3% are classified as abusing drugs. For females the numbers are a little higher. Almost two-thirds (63.6%) of females appear to be dependently involved with a drug, while 67.3% are abusing a drug. About one-third (32%) of males had no MINI diagnosis, 27% appeared to be either abusing a drug or dependent on a drug, and 42% of males in the study were classified as both. About one-quarter (26%) of females did not appear to be abusing or dependent, 18% appeared to be abusing or dependent, and the rest (56%) appeared to be both abusing and dependent. The data is presented in the following figure.



Figure 12. Substance abuse & dependence on the MINI by gender (%)



Prescription Drug Use

There are some emerging data from the United States that suggests prescription drug abuse is on the increase, especially among young people. Often these drugs are mixed with alcohol to enhance the effect of both. Because there was some concern that this is a population that may be prone to abusing prescription drugs, we asked a detailed series of questions about prescription drug use and some of the social contexts in which they use prescription drugs.

In asking questions about prescription drug use it is always necessary to clarify that this is use beyond what is usually considered “medical use”. That is, we do not wish to confuse respondents who may be legitimately using a medication for its prescribed purpose. Thus the question was phrased as follows: “In the past 12 months have you taken any of the following drugs to get high, feel better or change your mood?”

Table 4 on the following page describes the frequency of prescription drug use by gender.

**Table 4. Frequency of past-year prescription drug use by gender (%)**

MALES					
	Never	< once a month	once a month	Once a week	daily
stimulants	86.9	6.0	2.4	1.2	3.6
hydromorphones	95.2	4.8	0	0	0
mepredine	91.7	7.1	0	1.2	0
morphine	86.9	10.7	1.2	0	1.2
oxycodone	81.7	9.8	7.3	0	1.2
presc. codeine	56.5	22.4	12.9	4.7	3.5
OTC codeine	85.7	7.1	3.6	3.6	0
methadone	94.0	3.6	1.2	1.2	0
fentanyl patches	97.6	1.2	1.2	0	0
tramadol	96.4	0	0	1.2	2.4
tranquilizers	86.7	9.6	2.4	1.2	0
other presc. drugs	91.7	6.0	2.4	0	0
FEMALES					
	Never	< once a month	once a month	Once a week	daily
stimulants	88.7	4.8	1.6	0	4.8
hydromorphones	93.7	3.2	0	1.6	1.6
mepredine	92.1	3.2	3.2	0	1.6
morphine	93.5	3.2	0	1.6	1.6
oxycodone	90.5	6.3	0	1.6	1.6
presc. codeine	69.4	16.1	8.1	3.2	3.2
OTC codeine	88.7	1.6	3.2	4.8	1.6
methadone	98.3	0	0	1.7	0
fentanyl patches	97.6	1.2	1.2	0	0
tramadol	96.8	1.6	0	0	1.6
tranquilizers	84.1	6.3	4.8	4.8	0
other presc. drugs	90.5	1.6	0	3.2	4.8



The frequency of prescription drug use is similar across genders, though females were slightly more likely to have never tried the various drugs. Most of the prescription drugs listed were not used frequently, if at all. This is in sharp contrast to the numbers using (and abusing) alcohol and cannabis. Prescription products with codeine were the most commonly used, with about 46% of males and 30% of females using in the previous year. Only one or two respondents used any of these on a daily basis.

The next set of analyses of prescription drug use includes only those who had used at least one of the above drugs. This includes a total of 44 males and 28 females. Participants who said that they sometimes use prescription drugs were asked how they obtained these drugs. The most popular avenue for obtaining drugs were from a friend or a relative (for free). Over sixty percent (61%) of both genders selected this option. Some noticeable gender differences can be seen in other categories. One-quarter of females say they stole the drugs from a friend or relative, while only 11% of males said this. Just under one-half (43%) of males got their prescription drugs from one doctor and only 18% of females got drugs this way. Nine percent of males got drugs from more than one doctor and 18% of females used more than one doctor. The results of this question by gender appear in the following figure.

Table 5. Where prescription drug users obtained their drugs by gender (%)

	Males	Females
Free - friend/relative	61.4	60.7
Bought - friend/relative	31.8	25.0
Stole - friend/relative	11.4	25.0
One doctor	43.2	17.9
More than one doctor	9.1	17.9
Bought - dealer/stranger	18.2	14.3
Other	4.5	10.7

As participants could select multiple responses for this question the summed total is greater than 100%. One female chose all the responses, but the majority (just over half) only selected one. Less than one-quarter (21%) of males and 18% of females chose two responses. Approximately 10% of participants chose more than three options.

Clearly the most common source of prescription medication is from friends and family. A substantial number (e.g., between 25% and 32%) also purchase them from friends and relatives. Males seem more likely to obtain prescription drugs from a physician, whereas females are more likely to steal them from family and/or friends. There is also a small percentage, about 16% who purchase prescription drugs from a drug dealer. However, as noted previously, the overall prevalence of prescription drug abuse by this population is quite low, about 10%, depending on the specific drug.



Also related to prescription drug use, participants were asked about patterns of use in regards to their own prescriptions. The following questions were asked:

- 1) “Do you take your prescriptions more often or in a greater dose than recommended by your doctor?” 34% of males and 33% of females said yes, while 23% of males and 26% of females did not know.
- 2) “In the past 12 months did you take your prescriptions with alcohol?” 41% of males and 56% of females said that they had done this at least some of the time.
- 3) “In the past 12 months did you take your prescription drugs with sleeping pills or sedatives?” 64% of males and 63% of females never did this. So, approximately 37% of participants did this at least some of the time in the past year.
- 4) “How often in the past 12 months did you take use prescription pain relievers or other prescription medication to get high?” Forty-one percent of males and 33% of females said “once or twice”, 18% of males said monthly or weekly, while only 8% of females said monthly or weekly. However, only 2% of males said “daily or almost daily”, while 11% of females use prescription drugs this frequently.
- 5) “In the past 12 months, have you gone to more than one doctor including emergency rooms, to get refills of prescription drugs?” Approximately 42% of males and 31% of females had done this at least once.
- 6) “During the past 12 months, were you ever unable to cut down on your use of prescription medication, even when a doctor asked you to?” Approximately 12% of males and 19.5% of females had tried but found themselves unable. Over one-half (53.7%) of males and 44.4% of females had never tried to cut down. Just over one-third (34%) of males and 37% of females had tried to cut down their use and were able to do so.

MINI Assessment of Prescription Drug Use

Prescription drug use was also included in the interview portion of this research. Less than one-quarter (21%) of males and 28% of females said that they had used prescription drugs to get high in the past 12 months. As before, only these people were included in the analyses of prescription drug use in the MINI. As in the alcohol and street drug sections of the MINI, people can be classified as dependent, abusive or both, in regards to their use of prescription drugs. Less than one-quarter (22%) of males and 44% of females appeared to be dependent on a prescription drug. In addition, 33.3% of males and 44.4% of females were abusing a prescription drug. Twenty-two percent of both males and females appeared to be either dependent or abusive (but not both) while 16.7% of males and 33.3% of females appeared to be both. Although prescription drug abuse is not highly prevalent in this population, a small number may be dependent on prescription drugs and this is a cause for concern.

Leeds Dependence Questionnaire

The Leeds Dependence Questionnaire (LDQ) is a supplementary measure designed to help understand some additional characteristics of an individual’s substance use that are not drug-specific. All questions on the LDQ are worded in a way that ensures inclusion of

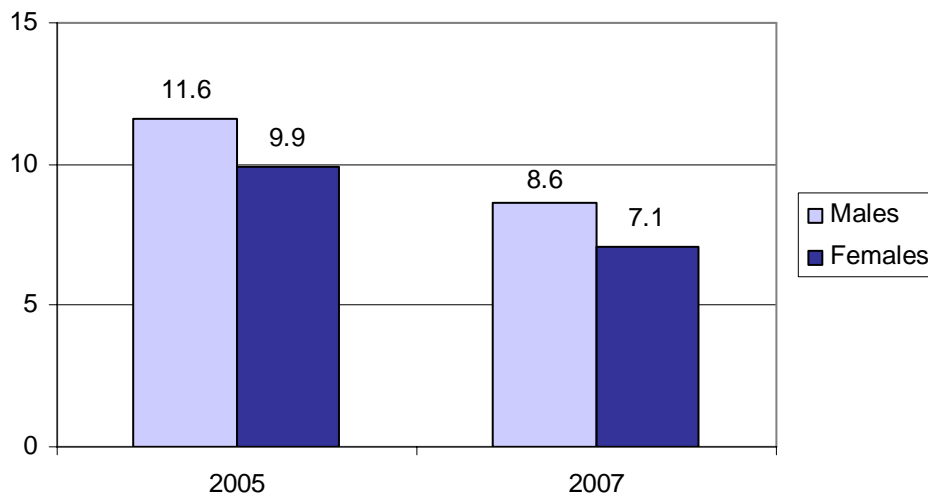


both drugs and alcohol, and participants answer the questions in regards to whatever they feel is their substance of choice. There are 10 questions on the LDQ and they are answered on a 4-point scale: “never”, ‘sometimes”, “often” and “always”. Answers yield 0, 1, 2, and 3 points, respectively, for a range of 0-40 points. When all participants were included, the average LDQ score for males was 8.6, and the average for females was 7.1. These scores are quite low considering how often the other scales (the AUDIT, CAGE-AID and MINI) assessed participants as harmfully or dependently involved. In terms of the overall distribution of scores, 14% of males and 16% of females scored 0 on all items, 51% of males and females score between 1 and 9 points, 27% of males and 32% of females scored between 10 and 19 points, and 8% of males and 2% of females scored between 20 and 29 points.

Comparison with 2005

As the LDQ was also used in the 2005 survey we are able to compare the average substance use scores across the two time periods. Analyses show that the scores in 2007 are lower than in 2005.

Figure 13. Comparison of average Leeds Dependence scores by gender and year (%)





FAMILY BACKGROUND

One of the more common findings from the research with street youth is widespread substance dependence and/or abuse and child abuse within the family unit. In the previous survey a significant number of street youth (35%) reported that their home was not a safe place to live, and over half reported physical and sexual abuse, often at a very early age (e.g., before age eleven). It was suggested in the report that their family background may have contributed to their current situation, due to the failure to provide some of the basic security required for normal development. We continue to examine the family background of street-involved youth in order to get a better picture of some of the difficulties that they may have faced growing up.

Parental Substance Use⁴

Many of the street involved youth told us that their parents used alcohol and other drugs. Approximately 55% of all participants said that their parents/guardians used alcohol, drugs or both at least once a month. As the parental questions about alcohol and other drugs were asked separately, they are reported below in separate sections. Approximately two-thirds of males (67%) and 59% of females said that at least one of their parents drank alcohol once a month or more. Just over 11% of males and 22% of females either did not respond to the question or said that they did not know the frequency of their parents' alcohol consumption. Approximately 9% of all participants said that one or both of their parents drank five times a week or more. Participants were also asked for their opinion as to whether either of their parents were heavy drinkers. Nearly 40% of males and just over 50% of females said that at least one of their parents is a heavy drinker. Just over one in ten (12%) participants said both of their parents drink heavily. Twenty percent of males and 11% of females said that their parents drink twice a week or more. This means that many of the participants consider once a week or less to be heavy drinking. In fact, 15.6% of males and females rated their parents as heavy drinkers, but also said that their parents drink less than once a month. This may also be related to the intensity of the drinking session (e.g., binge drinking) versus the frequency of drinking events.

One difficulty in understanding this data is that some of the females (9.4%) said that their parents were heavy drinkers but they also said that their parents NEVER drink. This appears confusing, but it may be that the respondents were considering their parents alcohol consumption at different times in their life. The question regarding frequency might be considered in the past tense ("how often would your parents drink alcohol") while the question about heavy drinking might be considered currently ("would you describe any of your parents/guardians as heavy drinkers?").

In terms of parents' use of other drugs, 14.5% of males and 12.7% of females did not know about their parents' drug use habits (other than alcohol). Many said that their parents never used drugs (59% of males and 51% of females). Only 26% of males and

⁴ As reported by the respondent.



37% of females knew that their parents used drugs other than alcohol, at least occasionally. The following table shows the frequency of parental alcohol and drug use by gender.

Table 6. Parental drug and alcohol use by gender of youth (%)

	ALCOHOL			OTHER DRUGS		
	Males	Females	Total	Males	Females	Total
Never	25.0	20.6	23.1	59.0	50.8	55.5
1-4 times a month	47.6	47.6	47.6	14.4	20.6	17.1
2 or more times a month	19.0	11.1	15.6	12.0	15.9	13.7
Don't know	8.3	20.6	13.6	14.5	12.7	13.7

Physical Abuse

As noted previously, physical abuse was often reported by street youth. Usually this abuse occurred in the home. As such, we wished to monitor these results over time in addition to exploring this issue in more detail. From what we know, the presence of abuse is one of the many contributing factors as to why some of them leave their homes. A greater understanding of this issue will hopefully contribute to improved outreach services that meet the needs of street youth.

The following table shows the percentage of male and female participants that said one or both of their parents or guardians committed each action at least once.

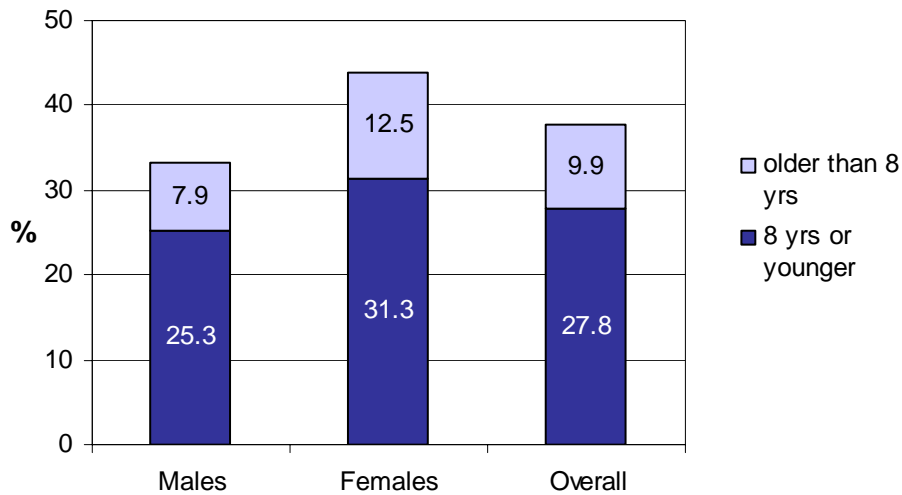
Table 7. Parental abusive behaviors by gender of youth (%)

	Male	Female	Total
Parents hit/shook/beat me	37.6	46.8	41.5
Parents threatened me with physical violence	32.5	39.3	35.4
Parents insulted me	50.0	57.4	53.1
Parents left me home alone	65.1	70.0	67.1
Parents were unable to provide food	29.8	29.0	29.5
Parents were drunk or high and couldn't take care of me	29.8	40.3	34.2

Females reported each of these behaviours more frequently than did males, except being unable to provide food, which was approximately equal. In addition, we also asked questions about how safe the respondent felt while living at home. Many reported that they did not feel that home was a safe place. For example, 15% of males and 28% of females said that they did not feel their home was a safe place. Over 30% of males and 44% of females claim to have been physically abused when they were growing up. Figure 14 shows that of those who were physically abused by a parent or guardian, around three-quarters said this happened for the first time before age 8.



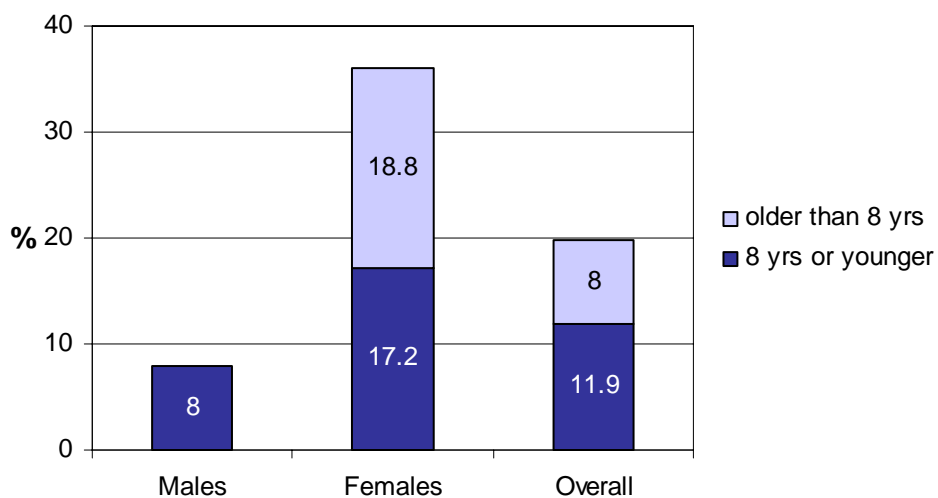
Figure 14. Physical abuse by gender of youth and age of first occurrence (%)



Sexual abuse

In the section on abuse, participants were also asked about their potential experiences with sexual abuse. Almost one in ten males (8%) and 36% of females said that they had been sexually abused when they were growing up. These findings are similar to the 2005 report, where a significant proportion of females reported sexual abuse compared to males (45% versus 12%). For males, every person said that this happened before age 8. For females, half said it happened for the first time before age 8, but the other half said the first time occurred anywhere from age 9 (8.7%) to age 16 or older (4.3%). These results are shown below in Figure 15.

Figure 15. Sexual abuse by gender and age of first occurrence (%)





MENTAL HEALTH

One of the main findings from the 2005 survey was the wide range of mental health concerns that street youth reported. Although we are unable to tease apart the causal nature of their multiple problems (e.g., do mental health problems cause an increase in drug use or is it the other way around, with drug use leading to significant issues or are there other factors involved?) almost all respondents had signs and symptoms of at least one major mental health disorder. Many had signs of two or more disorders. Although we recognized that these are not necessarily diagnosed conditions (**as only a trained psychiatrist or psychologist should make such diagnoses**), we did use DSM – IV criteria to evaluate the strength and recency of the symptoms that were reported. Thus we feel confident that these findings were reliable. A great concern was the high number that reported feeling suicidal. The MINI was again used to evaluate mental health.

Firstly, the following table shows each mental health issue that is addressed in the MINI and the percentages of participants who appear to meet the criteria for a diagnosis of the disorder, by gender.

Table 8. Psychiatric symptoms appearing to meet diagnostic criteria by gender (%)

	<u>Male</u>	<u>Female</u>
Major Depressive Episode ⁵		
Current	27.6	35.9
Recurrent	14.9	12.5
With melancholic features	25.3	26.6
Dysthymia	5.7	7.8
Suicidality		
Low Risk	26.4	31.3
Med Risk	5.7	6.3
High Risk	17.2	18.8
Any Risk (total)	49.4	56.3
Hypomanic Episode		
Current	14.9	4.7
Past	14.9	12.5
Manic Episode		
Current	11.5	7.8
Past	6.9	14.1

⁵ Only participants who met the criteria for a current major depressive episode were asked the questions regarding recurrences and melancholia; numbers within columns are overlapping and should not be totaled.



	<u>Male</u>	<u>Female</u>
Panic Disorder		
Lifetime	11.5	21.9
Limited symptom (lifetime)	10.3	18.8
Current	10.3	9.4
Agoraphobia		
With panic disorder	8.0	7.8
Without panic disorder	20.7	18.8
Social Phobia	16.1	18.8
Obsessive-Compulsive Disorder	13.8	14.1
Post-Traumatic Stress Disorder	13.8	14.1
Psychotic Disorders		
Current	20.7	25.0
Lifetime	31.0	40.6
Mood disorder with Psychotic features	5.7	10.9
Eating Disorders		
Anorexia Nervosa	1.1	1.6
Bulimia Nervosa	8.0	6.3
Anorexia Nervosa – binge/purge type	0	1.6
Generalized Anxiety Disorder	16.1	28.1
Antisocial Personality Disorder	42.5	37.5

The average number of disorders per person is 2.7. This does not include drug and alcohol disorders. With symptoms of alcohol dependence and abuse and drug dependence and abuse, the average number of disorders jumps to 4.7, which simply reflects the fact that many appear to have co-occurring disorders that include alcohol or other drug abuse and/or dependence.

There are also signs that many of these individuals have a high level of anxiety, with panic disorders and various phobias. In most cases, the prevalence rates are higher for females than males, which is consistent with the mental health issue literature.



Depression

The most obvious concern from the previous table is the high number of individuals with signs of severe depression. In addition many are at high risk of suicide, with almost half of the males and over half of the females showing some level of risk (low, medium or high) for suicide.

In addition to the interview evaluation of psychological distress, participants filled out the Center for Epidemiological Studies - Depression scale (CES-D). This is a 20-item scale with each item answered on a 4-point Likert scale. A score of 16 or more on this scale (out of a range of 0-60) is considered indicative of clinical depression, although it is important to remember that a high score through this survey is not the same as a formal diagnosis. The respondents are providing responses that, if they were provided in a psychiatric setting, could lead to a diagnosis of depression. In this street youth sample, 56% of males and 67% of females scored this high. The average CES-D score for males is 18.8, and 23.2 for females.

Of the 28% of males and 36% of females who, according to the MINI, are currently experiencing a major depressive episode, 50% of males and 35% of females said they had previous intervals of at least two weeks when they had felt depressed, but they also had intervals of at least 2 months when they did not feel depressed. Also, of those with a current depressive episode, most (88% of males and 74% of females) were experiencing melancholic features, including excessive guilt, loss of sleep, and weight loss.

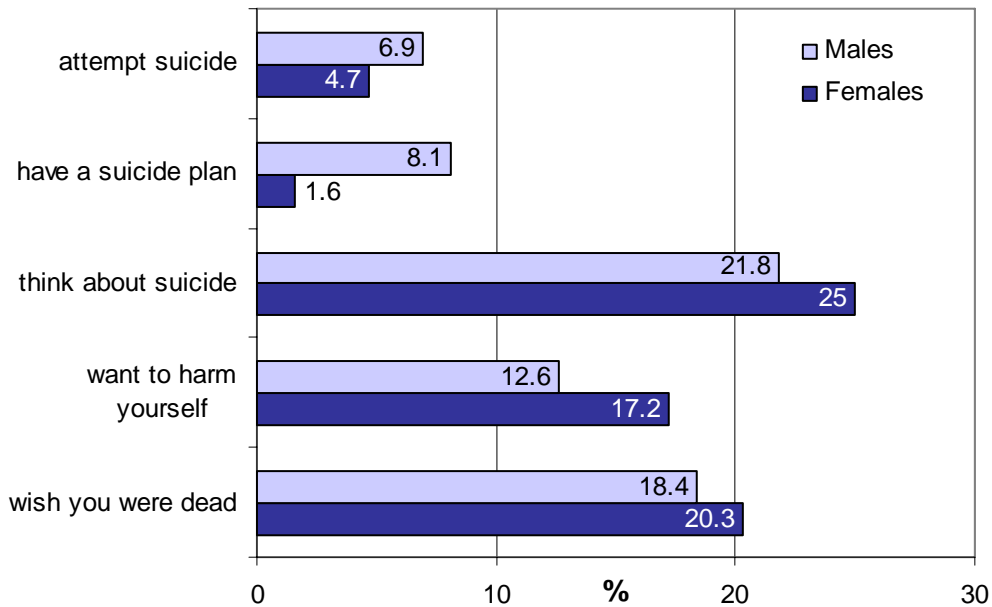
Participants who were considered as having a major depressive episode were not asked about chronic dysthymia, a disorder indicated by at least two years of general sadness. Thus only a small percentage of participants met the conditions for having dysthymia; 5.7% of males and 7.8% of females. This fairly low number is likely partially the result of people who met the criteria for depression not being asked the questions. It is possible that the people who were having a depressive episode had felt that way for much longer than two weeks and had not experienced two months free from depression for quite some time. These people may have qualified as dysthymic, had they been asked the questions.

Suicidality

Nearly 20% of all participants were considered to be at high risk for suicide according to the MINI. Having had one previous attempt at suicide did not place a person at high risk to try again. In the interview, we found that 44% of males and 52% of females had made a suicide attempt in their life. Participants were also questioned about suicidal thoughts, suicide plans and recent suicide attempts. The following table shows the results of the individual interview questions. These 5 questions were asked in regards to the past 30 days only.



Figure 16. MINI suicide-related questions⁶ by gender (%)



Comparison with 2005

The findings for suicide risk are quite different from the 2005 survey, where almost half of participants (46%) were identified as high risk.

Participants were asked about suicide in the 2007 self-report survey. Just over 40% of all participants left the section blank. Of those who declared having made a suicide attempt on the self-report, half made their first attempt when they were between the age of 13 and 15 years of age. One quarter made their first attempt before age 13 and only 10% were over 18 years old before they attempted suicide for the first time. Finally, participants were asked how many times they had attempted suicide in their life. Although 38% of males and 24% of females had only tried once, 22% of males and 32% of females had made 2 or 3 attempts, and over 40% of all participants (who answered these questions) who had ever attempted suicide had done so more than three times.

Again, compared with the 2005 survey, the rates of suicide attempts and thinking are much lower in this group. However, there are a large number who did not complete these questions (e.g., left them blank), thus the estimates may be quite conservative. We will need to understand better why this occurred, and plans to continue these surveys on a regular basis will help in this regard. That being said, the rates of suicidality for this group of youth is significantly higher compared to non-street involved youth.

⁶ Past 30 days.

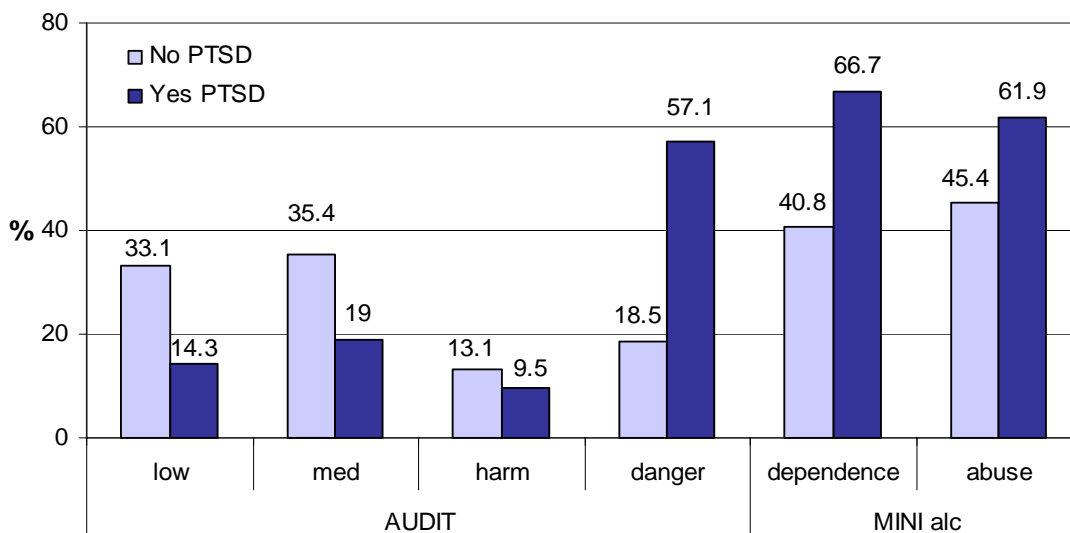


Post-Traumatic Stress Disorder

As part of our efforts to understand the psychological characteristics related to substance use, we also asked about post-traumatic stress disorders (PTSD). According to their responses in the interview, around 14% of all participants were considered to have symptoms of PTSD. Only about half of these were also considered as having the disorder based on the self-report. Participants completed the Modified PTSD Symptom Scale, a 17 item questionnaire reflecting symptom frequency and severity. One of the reasons for the inconsistency may be a fatigue effect. The PTSD scale was the last item on the self report and it is somewhat complex, requiring participants to both identify symptoms and rate the severity or impact of the symptoms. Some participants may not have understood the scale, other may have simply said no to all the questions in order to complete the survey more quickly. The MINI is likely more valid in this case than the self-report and therefore the following figure uses the MINI results as the index for PTSD.

As PTSD is commonly associated with substance use, the following figures show the percentages of participants who scored in the various levels of all the completed substance scales as a function of PTSD diagnosis on the MINI. As can be seen in Figure 17, the substance use scores are much higher in the PTSD population than in the non-PTSD population. For example, over 50% of respondents who had signs of PTSD were also in the extreme end of the AUDIT (e.g., dangerous use). Over 65% of those with PTSD also had signs of alcohol dependence, compared with about 41% of those with fewer PTSD signs. Likewise, over 60% of those with PTSD also had signs of alcohol abuse, compared with about 46% of those with no PTSD. The strength of this association could suggest that the PTSD may result in the need to use alcohol and the reinforcing effects of alcohol could contribute to a cycle of harmful use and/or dependence. Future work in this field is needed to look at this relationship more closely in order to help clarify the adaptive characteristics of alcohol abuse in this population.

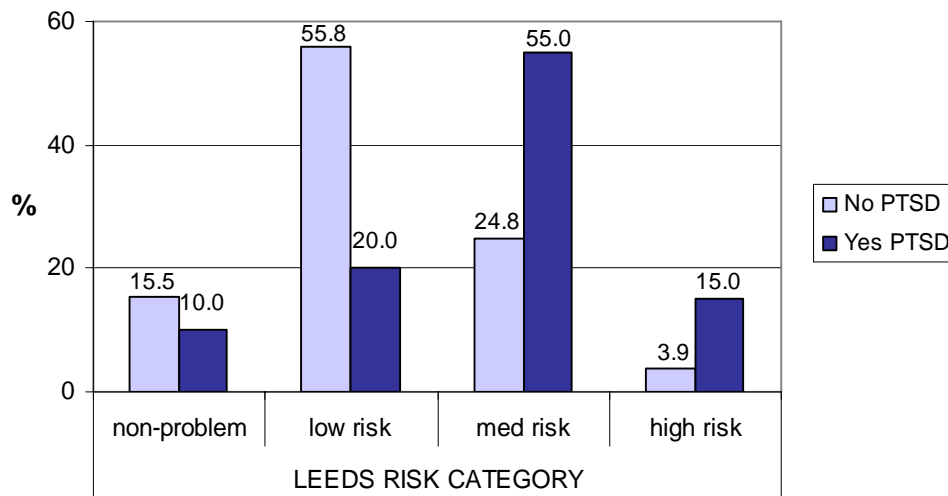
Figure 17. Percent of respondents with PTSD and their alcohol harm scores





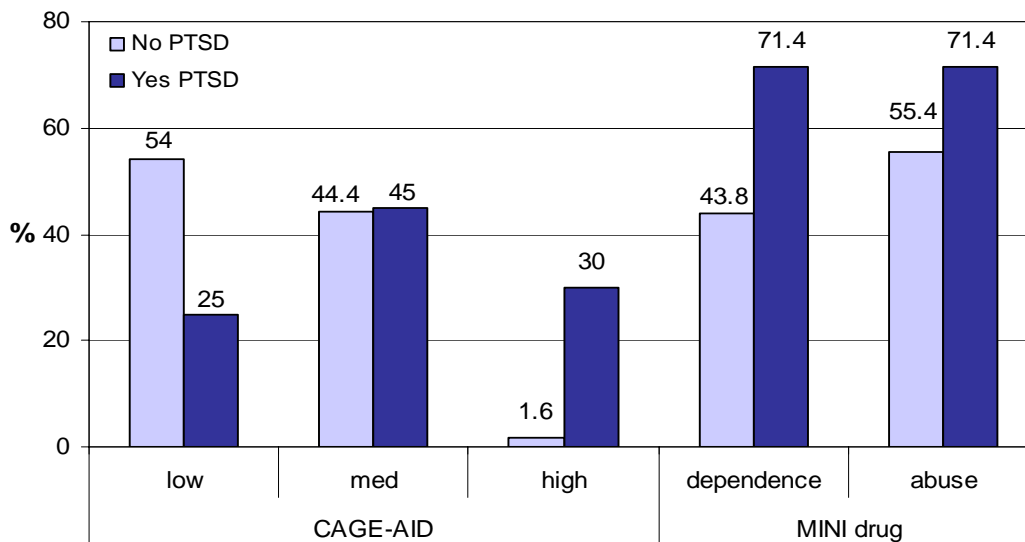
In addition to looking at the association of PTSD with alcohol abuse measures, we also compared those with PTSD and no PTSD on general alcohol and drug dependence, using the Leeds Dependence Questionnaire (LDQ). Most of the respondents with no PTSD were in the low risk category of the LDQ, whereas about 20% of those with PTSD were in this group. On the other hand, in the medium and high dependence categories of the LDQ there were more individuals with PTSD. Again, the causal direction is unclear; however, the strong association suggests that for this population there is a link between experiencing traumatic events and substance dependence.

Figure 18. Percent of respondents with PTSD and their Leeds Dependence scores



Last, we looked at those with PTSD and their cannabis and other drug dependence. A similar pattern emerges. Those with higher levels of PTSD are much more likely to also have high levels of dependence on cannabis and other drugs, and are also more likely to abuse other drugs.

Figure 19. PTSD by CAGE-AID and MINI drug dependence and abuse (%)



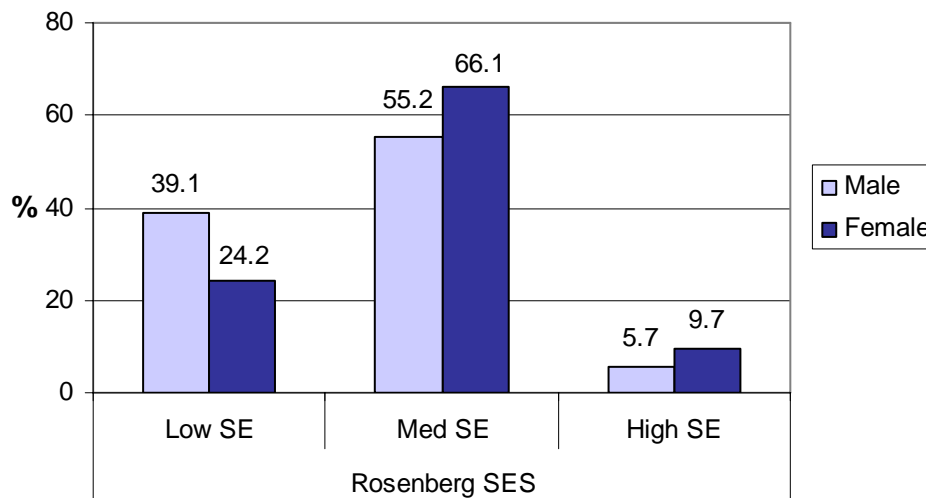


It may be that experiencing a traumatic event increases the likelihood that a person will become more harmfully involved with alcohol or drugs, or that people who are harmfully involved with a substance more frequently put themselves in a position to experience a traumatic event, or that some other third variable causes a link between these two things. More detailed questions about the functional nature of alcohol and other drug use in this population may help to clarify the nature of the relationships among, stress, traumatic events and substance use in this population.

Self-Esteem

The Rosenberg Self-Esteem Scale (SES) is a 10 item questionnaire, with 4 response options: strongly agree, agree, disagree, and strongly disagree. Scores can range from 10-40, with high scores indicating low self-esteem. The average score of the participants is 28.8, with a standard deviation of 5.7. Males scored 29.3 on average, while females scored slightly lower at 26.8. These scores are quite high⁷. When splitting the SES into three classes of low, medium and high self-esteem, only 5.7% of males and 9.7% of females have high levels of self-esteem. The following figure demonstrates these numbers.

Figure 20. Rosenberg self –esteem scores by gender (%)



Self Esteem was not found to be correlated with scores on the AUDIT or the CAGE-AID, however, there was a correlation between the SES and the Leeds dependence questionnaire (-.23). This suggests that those with lower self-esteem have more signs of substance dependence; however the relationship is not strong.

Alcohol use as assessed by the MINI was not related to self-esteem, and drug use was only mildly related. Participants with drug dependence and/or abuse scored a little lower on the self-esteem measure; again the difference was not significant.

⁷ The Rosenberg measure is scored such that high scores indicate lower levels of self-esteem



Anti-social Personality Disorder

Approximately 40% of all participants in this survey had symptoms indicative of an anti-social personality disorder (APD). APD is a recognized mental illness in the DSM-IV. These disorders are known to occur primarily in males and are associated with drug and alcohol abuse, suicide attempts and other complications (Lilienfeld, 1992). Aggressiveness, impulsiveness, and lack of emotion are characteristic of this disorder.

The MINI questionnaire is separated into two parts for this disorder. The first part includes questions about their behaviour before the age of 15 (Figure 21), the second set of questions focus on behaviour since age 15 (Figure 22). The following two tables show participant responses to each set of questions, respectively. The data is split by gender.

Figure 21. MINI APD group 1 questions by gender (%) before age 15

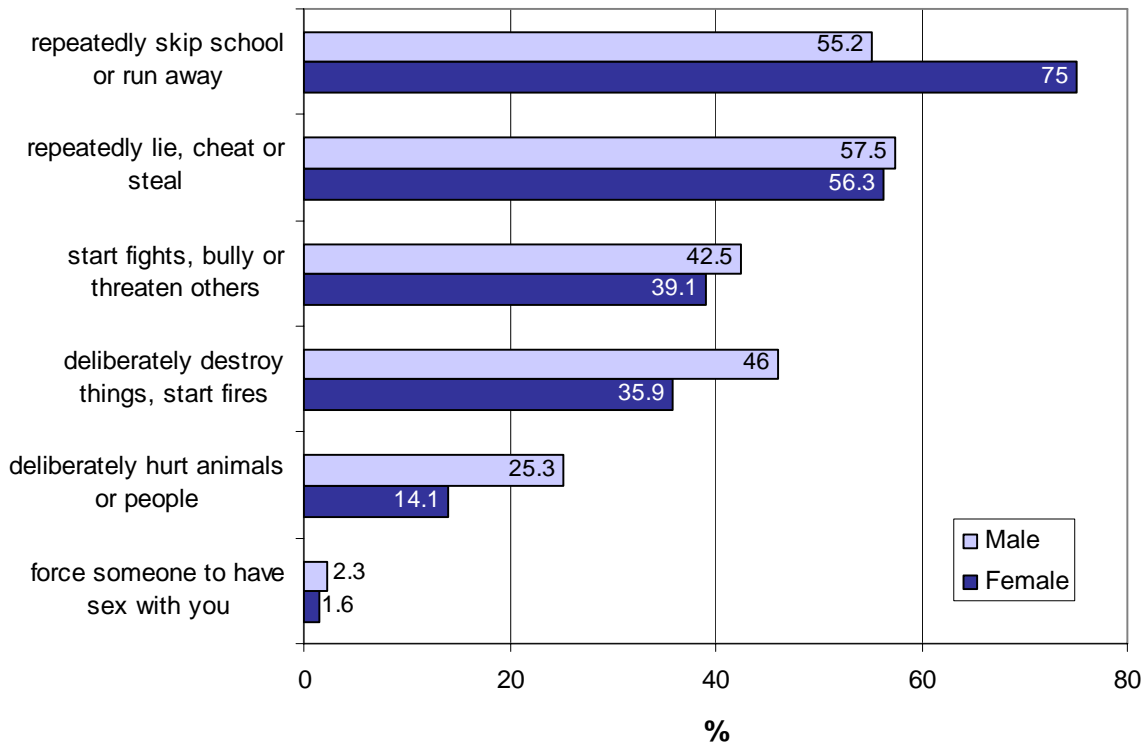
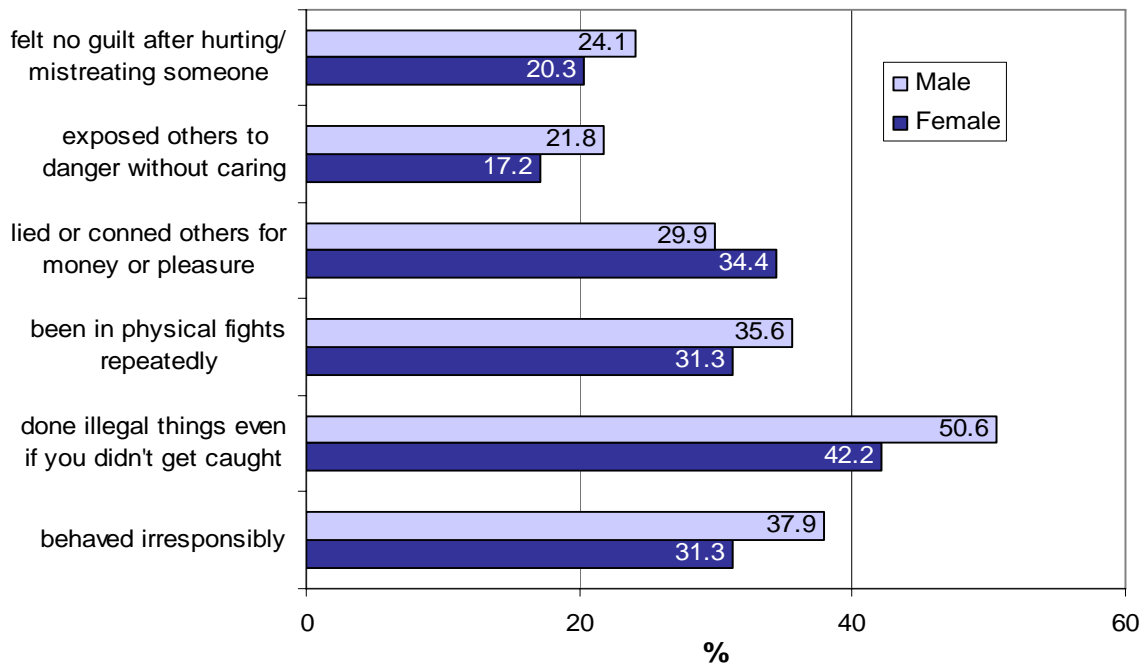




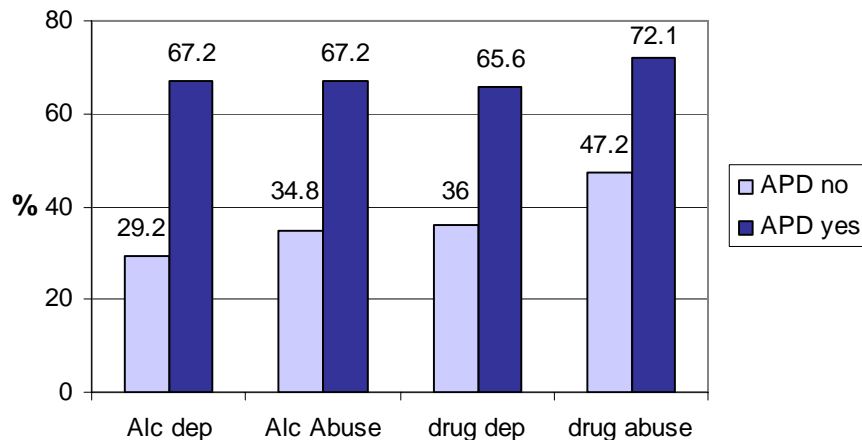
Figure 22. MINI APD group 2 questions by gender (%) since age 15



As expected, females answer yes less frequently across nearly the whole module, except for lying or conning others for money or pleasure, but the difference is quite negligible. Females are also more likely than males to skip school or run away from home before age 15. Males are more likely than females to deliberately destroy things, start fires, hurt animals or people, and to generally behave irresponsibly, including failing to pay back money owing, and being deliberately impulsive.

People with APD are also significantly more likely to be harmfully involved with both drugs and alcohol, with statistical testing showing significant differences between APD participants and non-APD participants on the AUDIT, CAGE-AID and the Leeds scale. Figure 23 below shows that youth who met the MINI criteria for APD are much more likely than those who do not meet these criteria to report substance dependence or abuse.

Figure 23. APD by MINI alcohol and drug use disorders (%)

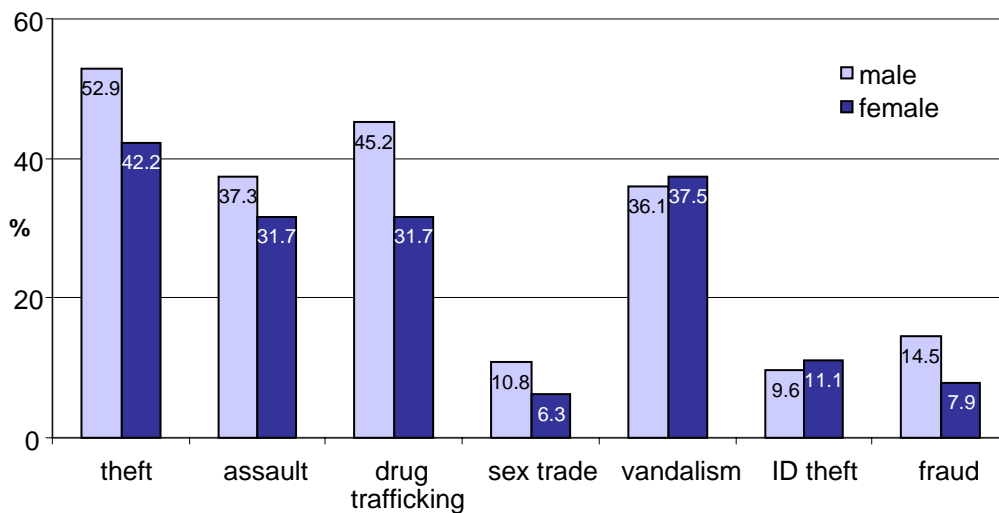




CRIMINAL INVOLVEMENT

Participants were asked about the various criminal activities that they have been involved with during the past year. The mean number, out of 8 listed activities, was 2.26, with a standard deviation of 2.0. On average, each participant had been involved in more than 2 illegal activities in the past year. Figure 24 below shows the full list and the percentage of participants who said “yes” to being involved in each one in the past year, by gender.

Figure 24. Percent of males and females involved in various criminal activities⁸



Comparison with 2005

Criminal involvement was also explored in the 2005 survey. Overall the rates in 2007 were about 10% lower, although the patterns were quite similar. For example, males engaged in illegal activities more frequently than females, and the most common activities in 2005 are still the most common activities in 2007 (e.g., theft, drug trafficking, assault and vandalism). Perhaps as a result of sampling differences, fewer women were involved in the sex trade in 2007 (7%) than in 2005 (19%). Again, please use caution when comparing the two studies (please see the last paragraph on page 8).

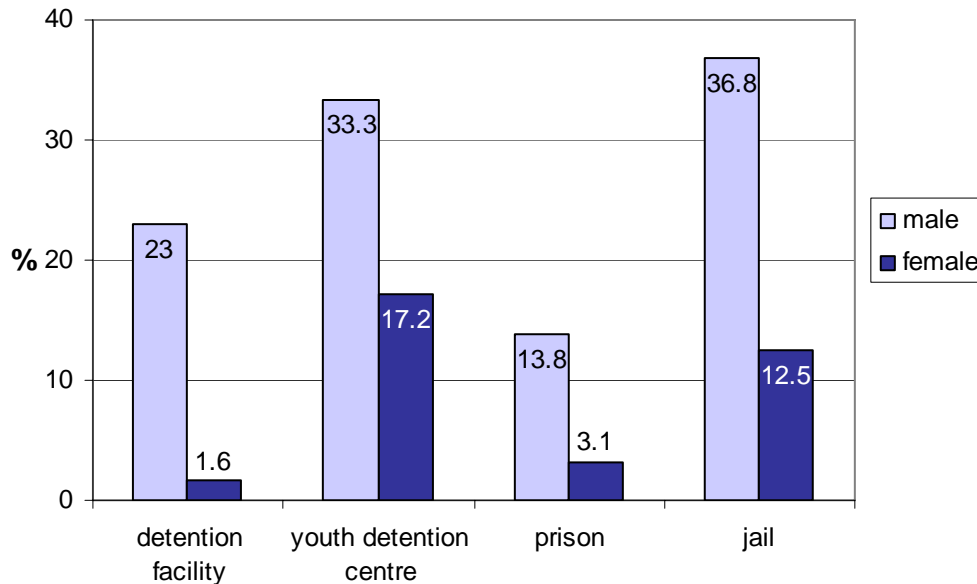
Males are more likely than females to be involved in almost all criminal activities, except for identity theft, in which both genders are equally likely to be involved. Figure 25 shows the percentage of males and females that have spent at least one night in some kind of detention facility or jail. Participants were told to select all that apply, so several people chose more than one response. Just over one half of males (53.8%) had spent the night in one type of facility, 19.2% selected two options, 21.2% spent the night in 3 of the 4 kinds of facilities and 5.8% claim to have spent time in all four. Of the females that selected at least one response, 90% selected only one. The remaining 10% had spent

⁸ Past year.



time in two different types of facility. Fewer males (37.9%) than females (65.6%) had never spent a night in a detention facility.

Figure 25. Percent of males and females who have spent time in a detention facility



Anti-social Personality Disorder and Criminal Activity

People with anti-social personality disorder (APD) were more likely to have spent time in a detention facility than those without the disorder. Of those without APD, 40% had spent time in a correctional facility, while 60% of those with the disorder had spent time in at least one. Also, the average number of types of criminal offences that participants without APD had been involved in is 1.74. The average number of offences in the APD population is 3.03. Also, the APD population is likely to engage in these activities significantly more frequently than people without this personality disorder. On a four-point scale participants were asked how frequently they have been involved with each offence. For ease of interpretation, each answer was worth a certain number of points (never = 0, rarely = 1, sometimes = 2, often = 3) and each person's points were summed for a total out of 24. For those without APD the average frequency was 2.87. For those with the disorder, the average frequency of offence was 5.40. Interestingly, of all the participants who selected at least one offence, the average frequency is still only 5.28, while the APD average jumps to 6.14 if only people who were involved in an offence are included.

The number of criminal activities is positively correlated with alcohol use in the AUDIT ($r = .33$, $p = <.01$) and the Leeds ($r = .48$, $p <.01$), as is the frequency of engaging in criminal activities [AUDIT ($r = .40$, $p = <.01$) and the Leeds ($r = .52$, $p <.01$)]. These



results indicate that there is a positive relationship between criminal activity and substance use.

As mentioned in the introduction, a similar survey was conducted with Winnipeg street youth in 2005. At that time the intent was to get a general picture of issues facing street youth. The present study builds on the information that was gathered in 2005 with the intention of comparing and identifying changes that have occurred within that population.



CONCLUSION

Similar to the 2005 study, we have found that street youth in Winnipeg continue to struggle with mental health and substance use issues in addition to their homelessness. Several of them have been abused by a family member, few have graduated from high school and most of them meet the criteria for high risk drinking. Almost all of the respondents have tried marijuana and many reported symptoms of more than one psychological disorder. Unfortunately, street youth are a very difficult population to reach, and engaging this group in social services has proven over time to be quite challenging. For a variety of reasons, they are not likely to show up for assessments or to keep appointments, and these behaviors become barriers to getting the help they need. There are other factors which make it difficult to engage these youth in community services, some of which are out of their control.

Given the nature of their various problems and concerns, the responsibility of this social issue remains with a multitude of stakeholders; this is everyone's concern. Piecemeal approaches that address separate issues will result in frustration and lack of engagement, resulting in continued alienation. Although outreach programs may facilitate the initial contact, a seamless system where most of their needs can be addressed simultaneously will be required.

Although this research has attempted to identify the social and psychological characteristics of street youth in Winnipeg, summaries such as we have developed here tend to suggest that this is a homogeneous group. We must remember that this group is not homogeneous; some are transient, moving their way across Canada, usually towards the West Coast. Some are Aboriginal and some are not, and in the case of the younger women (and men) are exploited by the sex trade. Many come from abusive homes. Many have mental health problems, which may or may not be exacerbated by the heavy substance use. Nevertheless, they are individuals, each of whom is likely looking for the same things that make other youth happy; safety and security and love and respect. Their paths towards these goals are paved with several obstacles, but the more we understand the various obstacles, the more likely we (as a community) are best able to work with them to meet their needs and help them reach their full potential.



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