The Cedar Project:
Surviving the Streets Without Shelter, Trauma and HIV Vulnerability Among Aboriginal Young People Who Use Drugs in Two Canadian Cities

by
Brittany L. Bingham
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Name: **Brittany L. Bingham**

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Examining Committee:

Chair: **Denise Zabkiewicz, Ph.D**
Assistant Professor
Faculty of Health Sciences

Marina Morrow, Ph.D
Assistant Professor, Senior Supervisor
Faculty of Health Sciences

Julian Somers, Ph.D
Associate Professor
Director, Centre for Applied Research in Mental Health & Addictions
Faculty of Health Sciences

Ronald Roesch, Ph.D
Professor, External Examiner
Director, Mental Health, Law & Policy Institute
Department of Psychology

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Abstract

Aboriginal scholars suggest that the legacy of colonialism is a key contributing factor to rising rates of homelessness among Aboriginal young people. This analysis examined factors related to sleeping on the streets for 3 nights or more and HIV vulnerability among Aboriginal young people who use drugs. A profile of these young people was created using data from the Cedar Project. Young people who reported sleeping on the streets for 3 nights or more were significantly more likely to reside in Vancouver, report HIV or HCV positive antibody status, have a diagnosed mental illness, and report being sexually abused or sexually exploited. Aboriginal females were more likely than males to report HIV or HCV positive antibody status, previous sexual abuse and previous sexual exploitation. Having a stable place to sleep is critically important to enhancing health promotion efforts and resiliency for Aboriginal young people who use drugs.

Keywords: Homelessness; Aboriginal young people; Canada; Cedar Project; HIV; historical trauma

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[1] Prince George Native Friendship Centre, Carrier Sekani Family Services, Positive Living North, Red Road Aboriginal HIV/AIDS Network, Central Interior Native Health, Vancouver Native Health Society, Healing Our Spirit, Q'wemtsin Health Society, Splats'in Secwepemc Nation.

[2] Centre for Health Evaluation and Outcome Sciences, St. Paul's Hospital, Vancouver, British Columbia, Canada.

[3] Department of Health Care and Epidemiology, University of British Columbia, Vancouver, British Columbia, Canada.

Table of Contents

List of Tables

1. Introduction

Homelessness[1] and Injection Drug Use among Aboriginal Young People

Homelessness among Aboriginal[2] people in Canada is an issue of immediate concern. Only 4% of the Canadian population is Aboriginal, however, over 10% of the homeless population is Aboriginal. Aboriginal homelessness rates are even higher in urban city centres and those who are at risk for becoming homeless often go unnoticed (Sider, 2005). It is estimated that close to 300,000 Canadians are homeless, either living on the street, in shelters or in other types of precarious housing (Rachlis, Wood, Zhang, Montaner, & Kerr, 2009). One third of Canada's homeless population is now comprised of youth,[3] with approximately 8,000 to 11,000 youth without a safe place to sleep each night (Rachlis et al., 2009). It is important to note that the homelessness statistics are often derived from the number of individuals who use shelters and therefore may be underestimated (Baskin, 2007). Many Aboriginal youth do not use the shelter system,

[1] The terms *homelessness* and *sleeping on the streets* will be used interchangeably for the purpose of this paper. The current study measures homelessness by asking participants if they have ever slept on the streets for three nights or more and implies a period of homelessness in their lifetime but does not measure chronic or absolute homelessness. The literature varies in its definition of homelessness and future research should establish measures of homelessness that captures the complexity of this problem.

[2] The terms First Nations, Indigenous, Aboriginal, and Native will be used interchangeably and will all be intentionally capitalized. This terminology will be used to define the first inhabitants in Canada, the United States, Australia and New Zealand. Cedar participants self identified as descendants of the First Peoples of Canada, which was inclusive of status and non-status First Nations, Metis and Inuit. It is not the intention to group First Nations peoples into one homogenous group. I value and respect the diversity of beliefs and attitudes that exist among First Nations people (van der Woerd & Cox, 2003).

[3] The terms *youth* and *young people* will be used interchangeably for the purpose of this paper. There are varying definitions of youth in the literature, the current study defines young people as being between the ages of 14 to 30 years and this range was chosen based on global health literature, which widely varies between the ages of 12-30.

leading to a significant concealed homeless population (Baskin, 2007). Youth who are not included in the official homelessness data include those who are in transition homes, detox facilities, overcrowded and inadequate housing. There are also youth who may stay with a family or friend or are at significant risk for becoming homeless (Baskin, 2007). There is a paucity of research on Aboriginal youth, especially on issues surrounding homelessness among Aboriginal youth. Aboriginal advocates suggest that rates of homelessness among Aboriginal youth are rapidly increasing (Baskin, 2007).

Factors contributing to homelessness are a lack of affordable and adequate housing, low income, poverty, addictions issues, mental health issues, domestic violence and most importantly the social structural factors including systemic racism and discrimination and the legacy of residential schools and colonization (Sider, 2005; Baskin, 2007; Reid, Berman, & Forchuk, 2005). Homeless youth are at risk for a number of adverse health consequences. It is not surprising that substance abuse and mental health issues have become a significant problem among street involved youth, most likely as a way to cope with the stress and harsh reality of living on the street (Rachlis et al., 2009; Ennett, Federman, Bailey, Ringwalt, & Hubbard, 1999). Furthermore, street involved Aboriginal youth face multiple barriers in accessing health services and challenges in addressing their health concerns.

Literature consistently reports that more than half of the homeless youth population has some kind of drug or alcohol problem. Among homeless youth in Vancouver, approximately 38% report Injection Drug Use (IDU; Rachlis et al., 2009). Injection drug use is one of the main risk factors for HIV among Aboriginal people,

accounting for almost 60% of all new infections between 1998 and 2005 (Public Health Agency of Canada, 2006; Barlow, 2003). Aboriginal people represent 5% of the population in BC and account for approximately 16% of new positive HIV tests in the province each year. Among the total female population, Aboriginal females account for 30-40% of all HIV cases. Among the male population in BC, Aboriginal males account for 10% of HIV cases (BC Provincial Health Officer, 2009). HIV among Aboriginal youth is on the rise, in 1998 youth accounted for 35% of HIV infections within the Aboriginal population and in 2005 youth accounted for 41% of new infections (Public Health Agency of Canada, 2006). Key risk behaviours associated with increased HIV prevalence among youth are needle sharing, sharing injection equipment (e.g., spoons, filters or water) often referred to as "indirect sharing," involvement in the sex trade, unprotected sexual activity and for young men, and same sex activity (Public Health Agency of Canada; Ennett et al., 1999). The life course of homelessness for street involved youth is associated with the risky behaviours they engage in. The longer the exposure to being homeless, and the more deprived the homeless circumstances the more risky the behaviours are (Ennett et al.). Therefore, HIV prevention efforts must focus on addressing issues of homelessness for these youth.

Aboriginal Trauma: The Legacy of Residential Schools

Linda Tuhiwai Smith, a Maori researcher, describes the common experience the world's Indigenous populations have shared:

> The world's Indigenous populations belong to a group of peoples. They share experiences as peoples who have been subjected to colonization of their lands and cultures, and the denial of their sovereignty, by a

> colonizing society that has come to dominate and determine the shape and quality of their lives, even after it has formally pulled out…Indigenous peoples represent the unfinished business of decolonization. (Smith, 1999, p. 7)

Although they are individually unique, Indigenous populations worldwide continue to feel the effects of colonization and cultural assimilation. It is imperative that when exploring issues of health among Aboriginal peoples that the unique historical context is also considered.

In Canada, the residential school system removed over 100,000 children from their families between 1874 and 1986 (Pearce et al., 2008). As recently as 1991, 13% of Canada's Aboriginal populations were residential school survivors (Dion Stout & Kipling, 2003). Attempts to "civilize" Aboriginal people became an official government policy in the 1840s. The government was attempting to prevent any interference with their plans to colonize Western Canada (Dion Stout & Kipling). There were 22 residential schools in British Columbia, which was more than in any other Canadian province. Residential schools used regimented behaviour, corporal punishment and strict discipline to teach Aboriginal children to be ashamed of their culture, language and Aboriginal identity. Aboriginal children in residential schools were subjected to many forms of abuse at the hands of school employees, including sexual abuse (Pearce et al., 2008; Dion Stout & Kipling). The disciplinary regime often involved verbal, sexual or physical assault and there are also documented cases of children being confined in dark closets, being beaten physically or having their heads shaved for speaking their native language (Dion Stout & Kipling). The residential school regime created a general climate of fear for the children and taught them to be ashamed of their culture as well as their family.

The impact of residential schools is felt at the individual, family and community level. Many individual survivors of residential schools adopted destructive patterns of behaviour and many died an early death as a result of suicide, violence or alcohol-related causes (Dion Stout & Kipling). The patterns of behaviour learned in residential schools were often brought back to families and communities creating a cycle of violence and abuse impacting future generations of children.

Intergenerational Trauma

Survivors of residential school often indicate that their experiences in the residential schools left them unprepared to become parents themselves. Being raised in an institutional setting with authoritarian care givers and a lack of emotional support left survivors facing difficulty showing affection to their own children (Dion Stout & Kipling, 2003). After being taken from their parents at young ages, survivors did not have the chance to learn child-rearing and parenting techniques from their own parents: “Like a pebble dropped in a pond, the effects of trauma tend to ripple outwards from victims to touch all those who surround them, whether parents, spouses, children or friends” (p. 33). The legacy of residential schooling in Canada is still felt by the youngest of Aboriginal generations. The trauma resulting from residential schools, whether direct or intergenerational, continues to have an impact on Aboriginal people, intersecting with their issues of mental health, drug use and risk taking behaviours leading to HIV vulnerability.

Child Welfare System

The residential school era was followed closely by the cultural assimilation policies of the child welfare system in Canada. In the 1950s, the federal government handed over control to the provinces for Aboriginal health, education and welfare. Each province was given payment for each First Nations child apprehended (Fournier & Crey, 1997). In 1959, only 1% of all children in care were First Nations and by the end of the 1960s close to 40% were First Nations. This number is shocking when considering that at this time, First Nations people only made up less than 4% of the national Canadian population (Fournier & Crey). The large numbers of Aboriginal children apprehended over that 30 years was dubbed the "sixties scoop" (Bennett et al., 2005). Once children were placed in foster care or adopted they rarely returned home and most were sent to live with non-Aboriginal families in other provinces or even in the United States. Children grew up with little understanding of their culture and were often the victims of discrimination in cities or towns where very few Aboriginal people resided (Bennett et al.; Fournier & Crey). Many children also suffered physical or sexual abuse at the hands of their foster parents or adoptive parents. Most children who were apprehended were taken from parents who had attended residential schools and were unable to care for their children or were being raised by elderly grandparents in the absence of their parents (Fournier & Crey). Some children were apprehended for legitimate reasons of abuse but many were apprehended because of impoverished living conditions or because they required medical care.

The removal of children from First Nations communities was devastating and many communities lost an entire generation of their children to the child welfare system (Bennett et al., 2005; Fournier & Crey, 1997). Generations of First Nations children who suffered the effects of the child welfare system are now dealing with issues of identity, searching for their parents, culture and communities, and trying to heal from the trauma of abuse.

Recent Developments

On June 11th, 2008, Prime Minister Stephen Harper publicly apologized to the victims of residential schools in Canada. He stated that the:

> Two primary objectives of the residential schools system were to remove and isolate children from the influence of their homes, families, traditions and cultures, and to assimilate them into the dominant culture. These objectives were based on the assumption that Aboriginal cultures and spiritual beliefs were inferior and unequal. Indeed, some sought, as it was infamously said, "to kill the Indian in the child." Today, we recognize that this policy of assimilation was wrong, has caused great harm, and has no place in our country. (CBC News, 2008)

He also acknowledged that the legacy of residential schools has contributed to many of the social problems that exist in Aboriginal communities today and that young people continue to suffer from this legacy. For many First Nations communities this was a first step in healing from the trauma of residential schools.

On April 29, 2009 at the Vatican, Pope Benedict XVI addressed the abuse and reprehensible treatment that Aboriginal children suffered at residential schools that were run by the Catholic Church (CBC NEWS, 2009). The Pope offered his "sympathy and

prayerful solidarity" to those who were caused anguish by some of the church members. The Pope acknowledged the suffering that residential school survivors still experience. The Catholic Church ran three-quarters of residential schools in Canada. The leader of the Assembly of First Nations, Phil Fontaine commented that the Pope's words were a significant statement and the fact that the word "apology" was not used does not diminish the significance of this event for residential school survivors (CBC NEWS, 2009).

Purpose of the Study

The purpose of this study was to create a profile of Aboriginal young people who use drugs and sleep on the streets in Vancouver and Prince George, using data collected from the Cedar Project. There is little research that investigates the unique experiences of Aboriginal young people who experience sleeping on the streets. This study acknowledges that young Aboriginal men and women who sleep on the streets have different life experiences and that gender differences are important. Socio-demographic and traumatic life experiences will be described using data from the only prospective study of young at-risk Indigenous peoples of its kind in North America.

2. Methods

Ethics

The Cedar Project study followed the guidelines provided in the *Canadian Tri-Council Policy Statement: Ethical Conduct for Research Involving Human Subjects*, and paid particular attention to Section 6.0 pertaining to research involving Aboriginal

participants. First Nations' investigators and community collaborators including Aboriginal AIDS organizations were involved in the conception, planning, design and implementation of the Cedar Project (Spittal et al., 2007). The Cedar project was approved by the University of British Columbia/Providence Health Care Research Ethics Board. This secondary analysis was approved by the Simon Fraser University Office of Research Ethics. The Cedar Project Partnership reviewed the results of this analysis and approved this paper for publication.

Study Design and Sample

This analysis used baseline data from the Cedar Project, an ongoing prospective cohort study involving 602 Aboriginal young people who resided in Vancouver and Prince George, British Columbia. Participants were eligible if they were between 14 and 30 years of age, self identified as Aboriginal, had smoked illicit drugs in the past week or injected illicit drugs in the past month, including, heroin, crack-cocaine, crystal methamphetamine or cocaine (Spittal et al., 2007). Saliva screens (Oral-screen, Avitar Onsite Diagnostics) were used to confirm participant's drug use. Participants were eligible to be involved if they had been residing in Prince George or greater Vancouver regions and if they provided written consent. Participants were recruited through community outreach, referral from health care providers and by word of mouth between October 2003 and July 2005. Most participants were recruited by word of mouth (39%) and outreach (32%). Other methods of recruitment were posters put up in various locations including community organizations and street corners (Spittal et al.). The recruitment goal in each location was approximately 300 "at-risk" youth. We define a

participant as at-risk if they have smoked or injected drugs in either of these locations. The recruitment goal was based on sample size calculations using an alpha level of 0.05 and a power of 80% to detect risk factors for prevalent HIV infection with an odds ratio as low as 1.5, provided the risk factor was present in at least 20% of participants. The power for detecting associations for HCV infection was higher because of its higher incidence and prevalence (Mehrabadi et al., 2008).

All participants met with an Aboriginal study coordinator who sought informed consent, confirmed participants' eligibility and explained the procedures. All participants were informed of the limitations of research confidentiality, including child welfare legislation regarding current sexual abuse and communicable disease reporting (Spittal et al., 2007). Participants completed an interviewer-administered questionnaire to elicit sociodemographic data and data on injection and non-injection drug use, injection practices, sexual risk behaviours and service utilization. All participants had the option of being interviewed by an Aboriginal person or by someone they trusted from the research team. Trusting the interviewer was of particular importance in smaller communities where confidentiality is a concern. Venous blood samples were drawn and tested for HIV and Hepatitis C antibodies and interviewers were blinded to the HIV and Hepatitis C status of the participants (Spittal et al.). All participants who were eligible had private interviews, including pre and post test counselling with trained nurses; participants were requested to return for their HIV/HCV sero-status test result at which time referral for HIV/AIDS and Hepatitis C care was provided (Spittal et al.). Although we actively encouraged participants to return for their results, it was not a requirement to participate in the study. Participants were given a $20 stipend for each study visit as compensation

for their time and to facilitate transportation. Study personnel worked with the young people to secure any support they requested. Some requests for help included addictions support and treatment, access to housing and traditional healing (Spittal et al.). This analysis is based upon data from the baseline questionnaires of all 512 participants recruited between October 2003 and July 2005.

Measures of Socio-Demographics

Cedar participants were asked "Have you ever been '*on the street'* with no place to sleep for more than three nights?" The terms "sleeping on the streets" and "homelessness" will be used interchangeably for the purpose of this study and implies that the young person was homeless for at least three nights or more but does not necessarily imply chronic or absolute homelessness. The participant may not have been homeless or sleeping on the streets at the time the survey was administered. There are various definitions of homelessness; the United Nations distinguishes between two different types of homelessness, absolute and relative. Absolute homelessness is a condition where individuals without physical shelter sleep outdoors, in vehicles, abandoned buildings or in other places that are not intended for humans in inhabit (Hwang, 2001). Relative homelessness is a condition where individuals have physical shelter but their shelter does not meet basic health or safety standards and does not protect them from the elements or offer safety and affordability (Hwang, 2001). The question used in the Cedar questionnaire does not establish whether participants were either absolutely or relatively homeless, however participants could be either at the time of the survey. The Cedar question on sleeping on the streets implies that at one point in the

young person's life they were unable to secure shelter and slept on the streets. Sleeping on the streets for three nights or more is an indicator of vulnerability. It is undisputable that young people are more vulnerable to various health related harms if they have had no place to sleep. Sleeping on the streets for at least three nights is also an indicator of young people's access to shelter and/or the severity of their street involvement. This question may still underestimate the number of young people who are homeless because it is not capturing young people who have relative shelter and have never had to sleep on the streets. It is acknowledged that young Aboriginal people face complex risk factors and vulnerability and that these risk factors cannot be measured adequately with our current instruments. However, the question under consideration provides justification to further investigate the vulnerabilities related to sleeping on the streets.

Other socio-demographic characteristics included age, location, gender, sexual identity, marital status and education level. Participants were asked if their biological gender at birth was "male" or "female" there was no category for "transgendered". Gender was defined as male or female. HIV and HCV antibody status are included. Participants were asked if they had been in jail since they started using drugs or if they ever had a doctor tell them they had a mental illness. Participants were asked if they had ever been denied shelter because of their drug use (yes vs. no).

Measures of Traumatic Life Experiences

"Sexual abuse" was defined in this study as any type of sexual activity that participants were forced or coerced into (including childhood sexual abuse, molestation, rape and sexual assault). Interviewers gave this definition to participants prior to asking

the question: “Have you ever been forced to have sex against your will and/or been molested.” Response options were yes, no, unsure/can’t remember, and prefer not to answer. In order to preserve the number of cases, researchers made the conservative decision to code participants who answered that they were unsure/can’t remember or preferred not to answer as “no” in the analysis (Pearce et al., 2008). “Sexual exploitation” was defined in this study as any type of sexual activity that participants were paid for by someone else.

“Historical Trauma” is defined as having at least one parent who attended a residential school and/or ever having been taken from biological parents into care. Participants were asked, “Do you know if your biological parents attended residential school?” and “Were you ever taken from your biological parents?” Response options were yes, no and unsure (Pearce et al., 2008).

“Suicidality” was measured by asking participants if they “ever seriously thought of taking their own life” (yes vs. no). Participants were also asked if they “ever attempted suicide” (yes vs. no) and the time since their last suicidal attempt. Participants were asked to describe the methods used in their last suicidal attempt. Answer categories included cutting, drugs/pills overdosing, hanging, jumping, firearms, drowning, poisoning, and other.

Analysis

Data from the baseline questionnaire of all participants recruited from the study’s commencement in October 2003 until April 2005 was analyzed for this paper.

Comparisons of categorical variables between individuals who reported sleeping on the streets for three nights or more and those that did not were conducted using Pearson's Chi-square test and Fisher's exact methods when expected cell values were less than 5. The continuous variable of age was analyzed using the Wilcoxon rank-sum test, and normally distributed continuous data was analyzed using Student's t-test. All reported *p*-values are 2-sided. All significant associations between variables at the 0.05 cut-off were entered into univariate analyses. A descriptive analysis was performed for the entire study sample. Pearson's chi-square was used to compare categorical variables. Statistical Package for the Social Sciences 16.0 (SPSS 16.0 Windows version) statistical software was used to run these analyses.

3. Results

Socio-demographic Characteristics

The mean age at study enrolment was slightly lower for participants who did not report sleeping on the streets for 3 nights or more (23 years old vs. 24 years old) (see Table 1) (N = 602). A total of 405 Cedar participants reported sleeping on the streets for 3 nights or more. Of the young people who reported sleeping on the streets 55% were male and 45% were female. There were 233 young Aboriginal people who reported sleeping on the streets in Vancouver and 172 in Prince George. Participants were significantly more likely to experience living on the streets if they lived in Vancouver. Of those who reported sleeping on the streets, 87% were straight and 13% were bisexual or gay. Young people who slept on the streets for three nights or more were more likely to have been

detained by the police and been in jail since they started using drugs. The majority of young people who reported homelessness also reported being single (76.5%), with only 23.5% common law or other. A high percentage (71%) of Aboriginal young people who slept on the street have also completed high school (Grade 10 or higher including other). Young people who slept on the streets for three nights or more were more likely to report HIV positive antibody status and HCV positive antibody status (see Table 1).

Table 1. Comparisons of Socio-Demographics Characteristics between Those Who Reported Sleeping on the Streets for 3 Nights or More (n=405) and Those Who Didn't (n=197)

Variable	No n (%)	Yes n (%)	*p* value
Age at enrolment visit			
Mean (SD)	22.6 (4.2)	24.0 (3.9)	**<.001**
Location			
Vancouver	65 (33)	233 (58)	**<.001**
Prince George	132 (67)	172 (42)	
Biological gender			
Male	89 (45)	222 (55)	**0.026**
Female	108 (55)	183 (45)	
Social/Sexual Identity			
Straight	181 (92)	354 (87)	0.069
Bisexual/Gay	15 (8)	51 (13)	
Marital status			
Single	150 (76)	309 (76.5)	0.926
Common law or other	47 (24)	95 (23.5)	
Education level			
Not completed high school (<gr10)	56(28)	117(29)	0.835
Completed high school (gr 10 and higher including other)	141(72)	283(71)	
HIV antibody status			
Negative	181 (96)	357 (90)	**0.007**
Positive	7 (4)	41 (10)	
HCV antibody status			
Negative	138 (76)	239 (62)	**0.002**
Positive	44 (24)	144 (38)	
Been in jail since started using drugs			
Yes	93 (47)	300 (74)	**<0.001**
No	103 (53)	105 (26)	
Ever been told by a doctor you have a mental illness			
Yes	45 (23)	137 (34)	**0.006**
No	151 (77)	266 (66)	
Ever denied shelter because of drug use			
Yes	24 (12)	138 (34)	**<0.001**
No	172 (88)	267 (66)	

Aboriginal young people who slept on the streets were also significantly more likely to have been told by their doctor that they have a mental illness. Participants were asked if they have "ever been denied shelter because of drug use," and young people who reported homelessness were significantly more likely to report this when compared to young people who have not slept on the streets.

Traumatic Life Experiences

Young people who slept on the streets for three nights or more were also more likely to have been taken from a biological parent at a mean age of 5 years (see Table 2). Young people who slept on the streets were also more likely to have been forced to have sex against their will, at a mean age of first forced sex of 7 years. Young people who slept on the streets were more likely to have been sexually exploited or paid for sex compared to those who did not report sleeping on the street, with a mean age of first sexual exploitation of approximately 16.5 years. Young people who lived on the streets were more likely to report having 20 or more lifetime sexual partners. Participants were asked if any of their parents attended residential schools, 187 youth who slept on the streets also reported that a parent went to residential school.

The Aboriginal young people were asked about suicidality in their lifetime. Among young people who reported sleeping on the streets (n = 405), 225 (56%) reported that they had seriously thought of taking their own life, which was significantly higher than those who did not report sleeping on the street (p = 0.041). Young people who slept on the streets were also significantly more likely to report they had attempted suicide in their lifetime (40% of homeless as compared to 31% of not homeless, p = 0.034).

Therefore, a total of 161 young Aboriginal people who slept on the streets had attempted suicide. Furthermore, youth who slept on the streets were significantly more likely to have engaged in self-harm behaviours in their lifetime (41% of homeless as compared to 32% of not homeless, $p = 0.028$).

Table 2. Comparisons of Traumatic Life Experiences among Those Who Reported Sleeping on the Streets for 3 Nights or More (n=405) and Those Who Didn't (n=197)

Variable	No n (%)	Yes n (%)	*p* value
Ever been forced to have sex against will			
Yes	76 (39)	211 (53)	**0.002**
No	118 (61)	190 (47)	
Age at first forced sex against will			
Mean (SD)	7.4 (4.0)	7.2 (4.2)	0.674
Ever paid by someone for sex			
Yes	69 (35)	186 (46)	**0.010**
No	128 (65)	217 (54)	
Age at first paid by someone for sex			
Mean (SD)	17.1 (3.6)	16.5 (3.6)	0.237
Lifetime sexual partners			
Less or equal to 20	118 (62)	177 (44.5)	**<0.001**
20 plus	74 (39)	221 (55.5)	
Ever injected drugs			
Yes	94 (48)	239 (59)	**0.009**
No	103 (52)	166 (41)	
Ever overdosed			
Yes	42 (21)	134 (33)	**0.003**
No	155 (79)	270 (67)	
Ever taken from biological parent			
Yes	116 (59)	274 (68)	**0.035**
No	81 (41)	131 (32)	
Age at first taken from biological parent			
Mean (SD)	5.7 (4.2)	5.3 (4.1)	0.316
Do any of your parents attended residential school			
Yes	89 (46)	187 (46)	0.861
No	106 (54)	216 (54)	
Ever seriously thought taking own life			
Yes	92 (47)	225 (56)	**0.041**
No	105 (53)	180 (44)	
Ever attempted suicide			
Yes	61 (31)	161 (40)	**0.034**
No	136 (69)	243 (60)	
Ever Self Harm			
Yes	63 (32)	166 (41)	**0.028**
No	134 (68)	236 (59)	

Drug Use

Among participants who reported sleeping on the streets for three nights or more (n = 405), 239 (59%) had injected drugs in their lifetime (Table 2). Young people who had slept on the streets were more likely to have injected drugs than those who did not report being on the streets (59% of homeless as compared to 48% of not homeless, p = 0.009) (see Table 3). Young people who had slept on the streets were also significantly more likely to have overdosed in their lifetime, with 134 (33%) reporting a previous overdose.

Gender Differences

Among participants who reported sleeping on the streets for three nights or more (n = 405), 222 were male and 183 were female. The following results only include responses for young people who reported sleeping on the streets. Males were significantly more likely to report a straight sexual identity and females were more likely to report being bisexual or gay (p = 0.017). Male participants were significantly more likely to report they were single and female participants were significantly more likely to report being common law or other (Table 3). Seventy-four percent of males reported they completed high school (Grade 10 and higher including other) and 67% of females also reported this level of education. Aboriginal females who slept on the street were significantly more likely to report HIV positive antibody status and HCV positive antibody status (see Table 3). Males were significantly more likely to report having been in jail since they started using drugs (p = 0.002). Among young people who reported

sleeping on the streets for three nights of more, 80 (36%) of males reported being told by their doctor that they have a mental illness compared to 57 (31%) of females.

Table 3. Comparisons of Socio-Demographic Characteristics Between Male (n=222) and Female Cedar Participants (n=183) Restricted to Participants Who Reported Sleeping on the Streets for 3 Nights or More

Variable	Males n (%)	Females n (%)	*p* value
Age at enrolment visit			
Mean (SD)	24.4 (3.92)	23.4 (3.76)	**0.012**
Location			
Vancouver	122 (55)	111 (61)	0.248
Prince George	100 (45)	72 (39)	
Social/Sexual Identity			
Straight	202 (91)	152 (83)	**0.017**
Bisexual/Gay	20 (9)	31 (17)	
Marital status			
Single	186 (84)	123 (68)	**<0.001**
Common law or other	36 (16)	59(32)	
Education level			
Not completed high school (<gr10)	57 (26)	60 (33)	0.104
Completed high school (gr 10 and higher including other)	163 (74)	120 (67)	
HIV antibody status			
Negative	206 (95)	151 (84)	**0.001**
Positive	12 (5.5)	29 (16)	
HCV antibody status			
Negative	155 (74)	84 (49)	**<0.001**
Positive	55 (26)	89 (51)	
Been in jail since started using drugs			
Yes	178 (80)	122 (67)	**0.002**
No	44 (20)	61 (33)	
Ever been told by a doctor you have a mental illness			
Yes	80 (36)	57 (31)	0.271
No	140 (64)	126 (69)	
Ever denied shelter because of drug use			
Yes	73 (33)	65 (36)	0.577
No	149 (67)	118 (65)	

Traumatic Life Experiences

Among young people who reported sleeping on the streets, 71% of females and 65% of males reported being taken from their biological parent, with the mean age of first being taken 5.1 for males and 5.5 for females (see Table 4). Young Aboriginal females were significantly more likely to report previous lifetime sexual abuse 136 (75%) of

females as compared to 75 (34%) of males, $p = <0.001$). The mean age that females were first forced to have sex against their will was 7.4 years compared to 6.7 years for males.

Table 4. Comparisons of Traumatic Life Experiences Between Male (n=222) and Female Cedar Participants (n= 183) Restricted to Participants Who Reported Sleeping on the Streets for 3 Nights or More

Variable	Males n (%)	Females n (%)	*p* value
Ever been forced to have sex against will			
Yes	75 (34)	136 (75)	**<0.001**
No	144 (66)	46 (25)	
Age at first forced sex against will			
Mean (SD)	6.7 (3.51)	7.4 (4.46)	0.239
Ever paid by someone for sex			
Yes	43 (20)	143 (78)	**<0.001**
No	177 (81)	40 (22)	
Age at first paid by someone for sex			
Mean (SD)	17.2 (3.31)	16.3 (3.64)	0.179
Lifetime sexual partners			
Less or equal to 20	121 (55)	56 (32)	**<0.001**
20 plus	101 (46)	120 (68)	
Ever injected drugs			
Yes	109 (49)	130 (71)	**<0.001**
No	113 (51)	53 (29)	
Ever overdosed			
Yes	62 (28)	72 (40)	**0.013**
No	160 (72)	110 (60)	
Ever taken from biological parent			
Yes	144 (65)	130 (71)	0.186
No	78 (35)	53 (29)	
Age at first taken from biological parent			
Mean (SD)	5.1 (4.19)	5.5 (3.95)	0.467
Do any of your parents attended residential school			
Yes	102 (46)	85 (46)	0.986
No	118 (54)	98 (54)	
Ever seriously thought taking own life			
Yes	121 (55)	104 (57)	0.639
No	101 (46)	79 (43)	
Ever attempted suicide			
Yes	76 (34)	85 (46)	**0.014**
No	145 (66)	98 (54)	
Ever Self Harm			
Yes	88 (40)	78 (43)	0.507
No	133 (60)	103 (57)	

Females were also significantly more likely to have been sexually exploited or paid for sex in their lifetime (78% of females as compared to 20% of males, $p = <0.001$). Females

were first sexually exploited at an earlier age when compared to males (16.3 years for females as compared to 17.2 years for males). Males were more significantly more likely to have less lifetime sexual partners than females. Females were significantly more likely than males to have 20 plus sexual partners in their lifetime (p = <0.001). 102 males reported they had a parent attend residential school compared to 85 females. Among youth who reported sleeping on the streets, females were significantly more likely to have attempted suicide in their lifetime (46% of females as compared to 34% of males, p = 0.014).

Drug Use

Among participants who reported sleeping on the streets, a significantly higher percentage of young females than males reported injecting drugs in their lifetime (71% of females as compared to 49% of males, p = <0.001) (see Table 4). Young females were also significantly more likely to have overdosed in their lifetime (40% of females as compared to 28% of males, p = 0.013).

Limitations

A variety of recruitment methods were used to acquire a representative sample including snowball sampling. Selection bias may be an issue, however, since referral chains were long enough to reach members deeply embedded in this hidden population, we are confident that our sample is representative of Aboriginal youth who use drugs in both cities (Pearce et al., 2008). Aboriginal young people who use drugs are a complex and vulnerable sub-population and we must acknowledge that our instruments may not

adequately measure the risk factors for these youth. The question Cedar participants were asked about sexual abuse (Have you ever been forced to have sex against your will an/or been molested) may have resulted in under-reporting the number of youth who were in fact sexually abused in different ways. It would be helpful to use a question that captures the range of abuses that people suffer including unwanted touching and other types of sexual molestation. To measure historical trauma Cedar participants were asked if they had at least one parent who attended residential school. Given the timeline of when residential schools were prominent in Canada it seems likely that this sample of young people may have had a grandparent that attended residential school and not a parent. This question also assumes that intergenerational trauma is transmitted through a parent rather than through the extended family networks in an Aboriginal community. In future survey's it would be helpful to know whether participants had a family member who attended residential school and further follow up questions on the role that this played in their life. All data was self-reported and as a result participants may have under reported experiences of trauma and other experiences that may be too painful to recall or are stigmatizing. Participants were assured of confidentiality and efforts were made to establish rapport between participants and the Aboriginal interviewer (Pearce et al.). Future developments for the Cedar project initiative will integrate further conceptualization and measurement of historical trauma and historical loss. The Cedar project in its next phase will be implementing measures that examine resilience, childhood trauma and historical trauma both qualitatively and quantitatively to provide more insight into young Aboriginal peoples experiences of trauma.

4. Discussion

Scholars agree that homelessness among young people who use drugs is a problem in need of immediate attention and that sleeping on the streets is associated with an array of other social and health related harms (Ennett et al., 1999; Rachlis et al., 2009; Saewyc et al., 2008). Young people account for one third of Canada's homeless population (Rachlis et al.). The present analysis sought to create a profile of Aboriginal young people who use drugs and experience sleeping on the streets. This analysis found that Aboriginal young people who report homelessness were significantly more likely to be located in Vancouver and also be HIV and HCV positive when compared to those who did not report homelessness. Rachlis et al., found that a cohort of at-risk youth in Vancouver engaged in a number of behaviours that elevated their risk for HIV and HCV transmission. These youth were more likely to engage in frequent crack cocaine smoking, public injection drug use and were more likely to be victims of violence (Rachlis et al.). It is not surprising to note that more Vancouver-based youth reported sleeping on the streets given the poor housing conditions available in Vancouver and the high housing costs (Corneil et al., 2006). Further research is needed to investigate the unique experiences of Aboriginal Street involved young people in both Vancouver and Prince George to provide insight into why in the current study Aboriginal young people who were homeless were more likely to be from Vancouver.

Homeless young people face barriers when trying to access health care and social services, placing them at increased risk for health-related harm (Reid et al., 2005). Several studies have reported that the first point of contact for many homeless youth with

the health care system is the emergency room. Homeless youth face multiple barriers including stigma and discrimination and lacking the resources to pay for prescriptions, dental care and transportation to appointments (Reid et al.). When the stigma of being street involved is combined with the discrimination that many Aboriginal people face, Aboriginal homeless youth are even less likely to seek out the services they need. Many youth in the current study reported they were denied shelter because of their drug use. This indicates that basic services such as shelter were not low threshold enough to allow youth to utilize these services when they most needed them. Young people in the current study were more likely to be homeless if they lived in Vancouver, which may indicate that youth face different barriers to finding shelter in Vancouver when compared to Prince George; some such barriers may include higher housing prices, high threshold shelters and services, different employment opportunities and an overall higher cost of living.

Although the majority of homeless youth were straight, 13% were bisexual or gay; this subpopulation may be further marginalized and at increased risk. Some research has shown that gay, lesbian and bisexual (GLB) youth who are also homeless are more likely to have been in foster care, been arrested or suffer from mental health issues. High rates of injection drug use and suicidal ideation have been found in this subpopulation (Noell & Ochs, 2001). A report on Aboriginal street involved and marginalized youth in B.C. conducted by the McCreary Centre Society (MCS) found that Aboriginal GLB youth were more likely to have left home when compared to their heterosexual peers and GLB youth were also more likely to have been kicked out of their home (Saewyc et al.,

2008). Homeless GLB Aboriginal youth face stigma and discrimination demonstrating a further need to provide services that are unique and tailored to this subpopulation.

The majority of homeless Aboriginal young people also reported that they completed high school. These findings are consistent with a study conducted by MCS, which found that two out of three Aboriginal street involved youth were currently attending school and 41% of youth living in precarious living situations such as squats, abandoned buildings, tents or on the street were also attending school. The MCS report also found that Aboriginal youth had positive hopes for their future and 1 in 5 (19%) anticipated they would be attending school five years from now (Saewyc et al., 2008).

Links between Mental Health, Trauma, Violence and Homelessness

Aboriginal young people who slept on the streets were significantly more likely to report being diagnosed with a mental illness. This is not surprising since these youth face significant and multiple challenges in their everyday lives. In the MCS report, Aboriginal youth were asked what services their communities need more of and 20% reported that more mental health services are needed (Saewyc et al., 2008). The high rates of mental health problems among the Aboriginal population is agreed upon by scholars to be largely a result of the impact of colonialism and the history of dislocation and disruption of traditional ways of living (Kirmayer, Brass, & Tait, 2000).

Aboriginal and non-Aboriginal scholars agree that a significant relationship exists between the effects of historical trauma resulting from colonization and residential schools, current trauma and HIV vulnerability (Barlow, 2003; Pearce et al., 2008; Simoni,

Sehgal, & Walters, 2004). An experience of sexual or physical abuse has a devastating impact on an individual. Individuals suffering from sexual trauma are at increased risk of engaging in HIV risk behaviours (Simoni et al., 2004). The present analysis found that young people who reported homelessness were more likely to have been forced to have sex against their will. The young age of reported first sexual abuse is particularly concerning (7.2 years), demonstrating an opportunity to intervene with trauma related services early before youth become street involved and homeless. Simoni et al. posit that sexual abuse is associated with adolescent sexual risk behaviours, including prostitution. Furthermore, sexual abuse has been strongly linked to sexual risk behaviours, sexually transmitted infections and number of sexual partners. The present analysis found that young people who slept on the streets were also more likely to have been sexually exploited. Sexual exploitation also places young people at significant risk for HIV and HCV infection. Homelessness was also related to the number of sexual partners young people reported; homeless youth were more likely to have 20 or more lifetime sexual partners. These findings are consistent with the high percentage of Aboriginal youth who reported previous sexual abuse (39%) and sexual exploitation (Just under 1 in 3 participants) in the MCS report (Saewyc et al., 2008). The MCS report also found that youth who were physically or sexually abused were twice as likely to report being sexually exploited (Saewyc et al.).

Given the high rates of sexual trauma suffered by participants in the current study it is safe to assume that many of these young people may also suffer from post-traumatic stress disorder (PTSD). PTSD describes the symptoms that result from traumatic events like rape, war or prostitution. PTSD includes symptoms such as anxiety, depression,

irritability, flashbacks, emotional numbing and insomnia (Farley, Lynne, & Cotton, 2005). Farley et al. (2005) report a rate as high as 72% for current PTSD among women who are involved in prostitution in Vancouver. The high rates of sexual abuse and sexual exploitation in the present study highlight the immediate need for mental health and trauma related services for this population. Young Aboriginal men and young Aboriginal women differ in their experiences of trauma and therefore gender specific services are required to address these issues. Previous research has shown that those who suffer from PTSD often self medicate with drugs or alcohol, highlighting the need for simultaneous addictions and mental health services (Farley et al.).

Historical Trauma

A large proportion of Cedar participants who reported homelessness also reported that one of their parents attended residential schools (46%). Although the questionnaire did not ask if participants had extended family members or grandparents who attended residential schools it can be assumed that this number would be even higher if this question had been asked. In the current study there was not a significant difference between the youth who reported homelessness and those who did not in terms of having a parent who attended residential school. This can likely be explained by the wording of the question and as previously suggested that participants should be asked about family members who attended residential school. For future research it is necessary to have a more valid measure of cumulative historical trauma. However, based on a review of other research studies it can be implied that historical trauma plays a significant role in the lives of the Aboriginal young people portrayed in the current study. Part of historical trauma is

the current and chronic victimization of Aboriginal young people as seen in the significant sexual abuse, sex trade involvement and the number of youth who were taken from their parents at a young age in this sample. Furthermore, although historical trauma cannot be demonstrated as significant in the data it will still be included as a significant issue in the current discussion.

There is a lack of direct evidence that links HIV/AIDS to residential schools, however it can be argued that the cycle of multi-generational abuse and trauma caused by residential schools has contributed to the risk behaviours that lead to HIV infection (Barlow, 2003). The residential school era was closely followed by a period of aggressive cultural assimilation through the child welfare system in Canada (Fournier & Crey, 1997; Bennett, Blackstock, & De La Ronde, 2005). Aboriginal youth who reported sleeping on the streets were also more likely to have been taken from their biological parent. On average, youth were taken from their parent at the young age of 5 years old. Some studies have noted a link between government care or foster care and subsequent homelessness for Aboriginal youth (Saewyc et al., 2008). In the MCS report, 42% of youth reported they had lived in foster care at some point, 10% were currently in care and 17% had lived in care within the past year (Saewyc et al.). In the present analysis Cedar participants were not asked where they suffered sexual or physical abuse and trauma, whether from a family member or in foster care. It is important to determine the source of the abuse in order to identify protective factors for these youth and to measure the further measure the impact of foster care and intergenerational trauma for Aboriginal youth. It would be helpful to investigate in future studies whether being taken from their biological parent at a young age further contributed to their experiences of trauma.

Suicide

Suicide has been noted as one of the most dramatic indicators of the distress suffered by Aboriginal peoples (Kirmayer et al., 2000). Many Aboriginal communities have high rates of suicide and disturbingly high rates of suicide among youth (Adelson, 2005; Kirmayer et al.). In 1999, the Aboriginal suicide rate was 27.9 deaths per 100,000, which is 2 times the rate of their non-Aboriginal counterparts (Adelson, 2005). These high rates of youth suicide are a result of the combined stressors of poverty, powerlessness, depression, historical trauma and communities in crisis (Adelson, 2005; Saewyc et al., 2008; Kirmayer et al.). The present study found that more than half (56%) of Aboriginal youth who slept on the streets had also seriously thought of taking their own life. Young people who reported homelessness were also significantly more likely to have attempted suicide. Suicidality is likely linked to self-harm behaviours, which were also significantly higher among youth who were homeless.

HIV/AIDS

Little or no literature establishes the specific link between the legacy of residential schools and HIV/AIDS. However, it can be implied that underlying factors such as government policies, loss of culture, cultural assimilation, discrimination, and physical and sexual abuse create a link between this legacy and the overrepresentation of HIV/AIDS among the Aboriginal population (Barlow, 2003). The assimilation policies, which included residential schools, have weakened the foundation of Aboriginal communities and family systems creating a multi-generational legacy. This must be acknowledged as a type of trauma when providing services or care to homeless

Aboriginal youth who use drugs (Barlow, 2003). DeGagne (2007) provides some key recommendations to begin healing from the legacy of residential schooling. Community healing must compliment individual healing; it is necessary to restore connections to community for family support for individuals to begin dealing with childhood trauma (DeGagne, 2007). A successful approach is to provide interventions that use Aboriginal culture based outreach and healing in a climate of cultural safety. Aboriginal communities and individuals are resilient and it is important to use this as a healing resource, those who have made progress in their healing journey can serve as mentors and assume helping roles within the community (DeGagne, 2007). Continuity among services and adequate service infrastructure are necessary to heal the trauma caused by residential schools; however, services that utilize local capacity and incorporate Indigenous knowledge often do not require as many resources (DeGagne, 2007).

Drug Use and HIV Vulnerability

Injection drug use, unsafe drug use practices, unprotected sex and exchanging sex or sexual exploitation are some of the key behaviours that place Aboriginal homeless youth at risk for HIV infection (Ennett et al., 1999). Literature on homelessness suggests that the more deprived the homeless circumstances and the longer youth are homeless the more likely they are to engage in these risky behaviours. Economic and social resources that are available to homeless youth decrease over time leading many youth to turn to alternate routes of meeting their survival needs (Ennett et al.). Furthermore, some literature has shown that homelessness in itself is a predictor of young people initiating injection drug use (Rachlis et al., 2009). The present study provides support for previous

literature and found that youth who were homeless were significantly more likely to have injected drugs in their lifetime and overdosed in their lifetime. One in three homeless youth reported a previous overdose. Some research has shown that urban Aboriginal drug users are at increased risk for HIV infection when compared to Aboriginal drug users on reserve, likely because of sex trade involvement or unsafe sex and drug use practices (Simoni et al., 2004). Further research is needed to investigate the intersectionality of substance use, sexual risk behaviours and trauma and the role these factors play in HIV vulnerability among urban Aboriginal young people who use drugs.

A Gender Context

Few studies on homelessness have investigated the unique experiences of young males and females experiencing sleeping on the streets. Homeless males and females face different types of violence, trauma, stigma and discrimination and different barriers to accessing health and social services (Reid et al., 2005). It is important to pay attention to the contextual factor of gender when investigating the experiences of homeless Aboriginal youth.

A previous study using Cedar project data found that young women were more likely to report frequent drug use for nearly every drug category and among participants who had never injected drugs women had a higher HIV infection rate than men (Mehrabadi et al., 2008). The present analysis found that Aboriginal females who slept on the street were significantly more likely to be HIV positive and HCV positive. Sexual abuse is a significant issue for Aboriginal homeless females as they were significantly more likely to report previous sexual victimization when compared to homeless males.

Homeless Aboriginal females were also significantly more likely to be sexually exploited when compared to males. This is consistent with findings from the report released by the McCreary Centre Society (MCS) which found that Aboriginal street involved females were more likely to be sexually abused; with females more likely to be abused by non-parent relatives, friends and strangers (Saewyc et al., 2008). On the contrary, Saewyc et al. (2008) found that more Aboriginal street involved males reported being sexually exploited compared to females (30% vs. 23% respectively). However, Aboriginal females who were exploited were more likely to be non-status, suggesting that youth who are more connected to their communities may not be as vulnerable to being sexually exploited (Saewyc et al.). Since non-insured health benefits are linked to First Nations status, youth who have status may have access to more health and social services. Further research should investigate the service needs for non-status Aboriginal youth.

In the present study females were also more at vulnerable in terms of their drug use. A significantly higher percentage of Aboriginal females reported injecting drugs in their lifetime and having overdosed in their lifetime compared to young Aboriginal males. Young women who have suffered early sexual abuse or victimization have been shown to have more difficulty refusing unwanted sex, engage in more diverse sexual activities and have a greater risk of contracting HIV (Simoni et al., 2004). Young women who are sexually abused are also more likely to use drugs including injection drug use later in life compared to other women who were not abused (Simoni et al.). It is apparent that the young Aboriginal women who experience homelessness in this sample are at increased risk overall for various adverse health outcomes highlighting the need for gender specific HIV prevention and intervention services.

Simoni et al. (2004) established a model of sexual trauma leading to high-risk sex, which is mediated by injection drug use among American Indian women. This model has important implications for HIV prevention services targeted at Aboriginal young people who use drugs. This model implies that women who were traumatized by sexual abuse may use injection drugs to cope with this abuse which, at some point, leads them to engage in sexual behaviours placing them at risk for HIV (Simoni et al., 2004). This further highlights the need for trauma assessment and treatment in the prevention of HIV infection. Assessment of physical, sexual or historical trauma should be routinely included in HIV prevention and intervention services in order to make appropriate referrals.

Policy Implications and Recommendations

Many organizations and programs are working tirelessly to make a difference in the lives of Aboriginal young people, however it is apparent that the basic needs of Aboriginal youth are not being met and that policy level interventions are needed immediately. Aboriginal young people who use drugs have a cumulative set of risk factors that lead them to be vulnerable to HIV. These risk factors are complex and the only way to address these risk factors is to have a complex set of integrated comprehensive and culturally appropriate services that provide both prevention and intervention programs. HIV prevention must address the direct risks for HIV transmission such as sexual behaviours and IDU practices as well as the underlying risk factors including previous sexual trauma, historical trauma and loss of culture and identity.

Intergenerational trauma is widely discussed in this field however very few services address the relationship between this type of trauma and mental health, suicide, drug use and homelessness. One approach is to increase the education of public health practitioners on the history of Aboriginal peoples in Canada and the effects of intergenerational trauma. Many mainstream health care providers are not aware of the historical trauma that Aboriginal peoples have suffered and therefore cannot provide services that are sensitive to these issues. Mainstream services must be accessible for this population and provide culturally safe services and programs. Furthermore, Aboriginal street involved youth must be meaningfully involved in the design of all programming, in particular, programming that addresses intergenerational trauma, sexual trauma, mental health, drug use and HIV prevention.

This study further acknowledges that Aboriginal youth who use drugs are a complex population with complex health and social service needs. However, their basic needs such as food and shelter must be met before other services will be effective. This provides an opportunity for shelter services that are linked with other social and health services. Homeless shelters must be low threshold and allow youth to use the services whether under the influence of drugs, whether they have a partner or even a pet. It is well-known that Vancouver in particular lacks low-income housing and does not provide enough homeless shelter space. This problem can only be addressed from a policy level.

It is clear that gender differences are important when providing services to Aboriginal youth who use drugs. These gender differences are of particular importance when considering the cycle of foster care for Aboriginal women. Homeless Aboriginal

women who use drugs have their children apprehended if they do not meet the criteria of the Ministry of Children and Families. The apprehension most definitely creates trauma for the mother, father and the child. This cycle is perpetuated further when the child raised in foster care suffers the trauma from being apprehended. Family preservation efforts are required in addition to culturally appropriate foster care. Further research is needed to investigate this cycle of child apprehension and alternative family preservation programs as well as documenting the long-term effects it has on the young Aboriginal children that are being raised in foster care.

Population health and public health often views a population as a mere collection of individuals. However, community healing is necessary for Aboriginal people to begin dealing with the effects of historical trauma. Aboriginal communities whether on reserve, off reserve, urban or rural are a group of individuals that share common experiences and a common history. Population and public health interventions for Aboriginal young people who use drugs can utilize individual and community resilience as an important resource. Aboriginal young people who use drugs and sleep on the streets form their own unique community and possess knowledge, resources and resilience that can be used to help one another. Ultimately mentorship, community based and culturally safe approaches will be the most successful in improving the lives of Aboriginal street involved youth. However without policy level support these approaches will not be successful or sustainable. Until conditions improve to meet Aboriginal homeless young people's basic needs which includes adequate housing, trauma care and culturally safe services, this population will continue to experience poorer health status, which includes HIV.

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