RISK FACTORS FOR DRUG ADDICTION AMONG YOUTH
IN THE VANCOUVER DOWNTOWN EAST SIDE:
A DRUG USERS’ PERSPECTIVE

by
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The purpose of this thesis was to investigate the phenomenon of drug addiction among youth (aged 13-24 years old) in the Vancouver Downtown East Side (DTES). It was aimed at creating a profile of drug using youth in a local context by understanding their characteristics and the issues affecting their lives; and to learn, partially from the youths’ perspective, what were the factors that contributed to the development of addiction in their lives. It also allowed for the expression of the needs of the youths who are affected by drugs and the associated lifestyle, and what they perceive as a potentially effective addiction prevention and intervention program.

Thirty one drug using youth who were involved in the DTES were recruited, and personal interviews took place over a period of two months. Interviews were based on a 72 item questionnaire that consisted of open ended questions (aimed at personal perspectives of the participants) and probing, structured questions (based on previous research in the field). The information that was gathered was analyzed on qualitative and quantitative levels, presenting testimonies from participants’ life experiences and personal perspectives on addiction. The data were further analyzed with descriptive statistics, correlation tests using Pearson’s r, and comparisons between groups of participants using t test for independent means.

The study produced a large amount of material. Among the primary findings were the facts that most of the participants were homeless males, who arrived in Vancouver from other provinces, prostituted to support their addiction, and who were involved in the DTES almost solely because of the availability of drugs in the area. A distinction was
noted between youth who were associated more with the Granville Street area, who used primarily crystal-methamphetamine, and who prostituted in the West End, versus youth who were more associated with the DTES, used crack, cocaine, or heroin, and prostituted in the area as well. Primary findings pertaining to identified risk factors for drug addiction included the finding of removal from home by social services and upbringing by multiple caregivers among most of the participants; experience of physical or sexual abuse; parental substance abuse; and using drugs as a coping strategy. When examining correlations between different risk factors that were identified in the research, association was found between certain indicators of home atmosphere and dynamics within the family; between parental supervision and children's involvement with violence; and between children's popularity in school and their association with violent activities. Some of the results of comparisons between groups using t tests suggested differences in involvement with violent activities among prostituting youth versus drug dealing youth; greater negative characteristics of child-parent relationships, home atmosphere, and family functioning among children of alcoholic parents; and earlier cigarette smoking among children of drug addicted parents and among children that were placed in out of home care.

The study produced a number of conclusions and recommendations for practice and social policy. Among the primary conclusions were the need to provide young children and youth with opportunities to develop and maintain meaningful relationships with their biological family as well as positive relationships with peers; a need to reduce the availability of drugs in the city; and a need to create long term and holistic treatment services for youth.
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CHAPTER 1

INTRODUCTION

UNDERSTANDING THE PHENOMENON OF DRUG ADDICTION IN THE DTES

Published studies on the issue of addiction in the Vancouver DTES are scarce, especially regarding research projects involving drug addiction among the youth in the area. Most of the published studies that have been done focus mainly on the consequences and implications of the addiction phenomenon in the DTES, such as studies on drug related disease (i.e., HIV and Hepatitis C \(^1\)), and criminal behaviours associated with drug addiction\(^2\). However, aspects related to the etiology and to the psycho-social characteristics of the phenomenon are not as evident in the literature, if they exist at all. While studies of addiction in the context of health and crime deal primarily with the results of the phenomenon, the complexity of what causes the actual phenomenon is being neglected, and so is the fact that the latter is what could form a solid knowledge base for prevention and intervention. A foundational belief in this research project is that recognizing the importance of understanding the causes of the phenomenon will promote better methods for both prevention and for addressing it once it occurs.

\(^1\) Related studies were carried by organizations such as the Health Association of BC, The McCreaery Centre Society of BC, Vancouver/Richmond Health Board, Health Canada, and the BC Centre for Excellence in HIV/AIDS, which include the Vancouver Injection Drug Use Study (VIDUS).

\(^2\) Conductors of related studies include the Royal Canadian Mounted Police (RCMP) and the Vancouver Police Department (VPD) under the Ministry of Attorney General.
According to the latest report of the Canadian Community Epidemiological Network on Drug Use (CCENDU) (Single, 2000), there are no precise figures available to reflect the extent of the phenomenon; however, it has been estimated that 4,700 injection drug users (IDU) are living in the DTES (not including drug addicts who use methods other than injecting, such as snorting and smoking drugs). According to the Vancouver Police Department (VPD), this comprises the largest population of IDU of any city in Canada\(^3\). The number of IDU in the Lower Mainland is estimated at 12,000-15,000 (Bohn, 2000). The number of overdose deaths in British Columbia (BC) increased from 29 in 1988 to 361 in 1993, and it has remained above 224 per year since then. The HIV prevalence rate is estimated at 25% among Vancouver IDU, while Hepatitis C prevalence is estimated at approximately 90% (Single, 2000), which has led the Vancouver/Richmond Health Board in 1997 to declare a public health emergency in the DTES (McLean, 2000).

As for drug use among youth in Vancouver (and in Canada in general), the available published data is minimal. The last national survey focusing on alcohol and drugs was conducted in 1994. This survey’s findings refer mainly to cigarette smoking and marijuana use. The survey found that the highest proportion of cigarette smokers were youth: about 37% of 18-19 year olds and 35% of 20-24 year olds reported to be smokers at the time of the survey. Youthfulness was also found to be the strongest predictor of cannabis (marijuana) use: 25% of 15-17 year olds youth; 23% of 18-19 year olds, and 19% of 20-24 year olds (Canada’s Drug and Alcohol Survey, 1994). The survey also found that BC had the second highest rates of alcohol consumption in the country.

\(^3\) Information as available on the web-site of the city of Vancouver: 
http://city.vancouver.bc.ca/police/invesServDiv/sis/drugs/drugs01.html
(75.6% of provincial residents reported to be drinking alcohol); the highest rates of marijuana and hashish use (11.6% of the province’s population), and the highest rates of codeine, Demerol, and morphine use (21.2%).

Currently, the CCENDU is the primary system in Canada that coordinates and facilitates the collection, organization, and dissemination of qualitative and quantitative information on drug use among the Canadian population at the local, provincial, and national levels. Its first national report was published in 1997 and the second in 1999. The second report noted significant increases in alcohol and hallucinogen use among youth (Poulin, Single, & Fralick, 1999). In the year 2000, due to limitations in the collected data, the CCENDU published an overview summary of findings instead of a comprehensive national report. Among the highlights of this report was noted an increase of drug use in general among Canadian adolescents. Regardless of the age of drug users, this report indicated that Canada ranks among the countries with the highest rates of illicit drug use (Single, 2000).

Despite the limited data that is available on the phenomenon of drug use in the DTES, it is clear that it has become a serious and disturbing problem that should concern anyone that cares about the future of youth in our society. It was indicated by Vancouver’s Coalition for Crime Prevention and Drug Treatment that the DTES has already become known internationally for its open drug scene and AIDS epidemic⁴. It is no longer a local problem, but one that has grown rapidly, spreading out to other neighbourhoods. As McLean (2000) had concluded, it is the mobility of this population that had led to the extension of the drug epidemic to satellite municipalities such as

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⁴ Discussion paper of the Vancouver’s coalition for crime prevention and drug treatment from October 1999, available in PDF document online: www.crimepreventiondrugtreatment.com
Burnaby, New Westminster and Surrey, which are situated along the Skytrain route from Downtown Vancouver. Since many drug users, and in particular youth, are homeless and therefore street involved, they are less likely to be attached to one place.

**THE IMPORTANCE OF THE STUDY AND ITS RELEVANCE TO THE FIELD OF SOCIAL WORK**

The importance of this study is evident through its concern with the origin of a devastating local phenomenon that affects individuals’ health and well-being, and more broadly, affects the future of our society. It is aimed at methodically understanding the causes of drug addiction on a local level, with the hope that such an understanding will promote successful prevention program planning that would be tailored to the local youth population.

Since the study deals with the welfare of human beings, it is essentially relevant to the field of social work. The fact that it addresses the DTES area in particular, where the lives of its residents are rarely associated with dignity and well being, also makes the topic relevant to the field of social work.

The belief that guides the work on this project is that it is impossible to prevent something of which the causes are unclear. Therefore, it is essential to conduct comprehensive research to learn the causes of drug addiction in the local context, providing a solid basis for effective intervention.

The idea of tuning-in to the voice and the perspective of the drug user originates in the methods of empowerment theory, which are closely associated with strengths-
based social work practice. This approach arises from the belief that if a marginalized
group is given the opportunity to identify its own issues and needs, there may be a greater
chance that this group will be motivated to deal with the identified issues (i.e., to be given
the opportunity to identify risk factors for drug addiction and to be empowered to educate
others). A powerful community is one that acknowledges the potential of its members for
strengthening it and gives them the opportunity to do so (Pinderhughes, 1983). If future
prevention programs that target youth are based on substantial evidence and authentic
information from peers that have suffered the consequences of addiction, there may be a
stronger possibility for openness and acceptance of these programs by youth.

Finally, by studying the risk factors that are unique to the individuals in our
immediate communities, we are intending to engage in appropriate and adequate planning
of needed resources and community development, and at the same time to act for needed
structural changes, such as changes in relevant policies. The choice in this research to
focus on the DTES derives from the belief that in order to implement successful
intervention in one area, it is important to use information that is specifically relevant to
that area, rather than applying information learned from other places in the world.
Clearly, what may be deemed successful for prevention or treatment in one group may
not be successful with another because of the differences between the two groups. In
addition, as the addiction problem in the DTES is so intense it certainly requires special
attention, which is provided in this project.

Social workers may be able to utilize the findings of the study in their treatment
delivery to individuals, families, groups, or communities that are affected by drug
addiction. The findings may also increase practitioners’ and policymakers’ insights into
the importance of changing policies related to drug abuse; thereby allowing for the allocation of budgets for services, and creating resources to effectively address the identified risk factors.
CHAPTER 2

LITERATURE REVIEW

The following section will begin by defining drug addiction and briefly describing different approaches to drug addiction. It will then outline the core differences between a multidimensional model for studying risk factors associated with drug addiction as opposed to focusing on one particular risk factor or one particular group of factors. The research project in this thesis will utilize a multidimensional model.

The section will further explore limitations in previous studies, and discuss relevant theories and research perspectives that will be utilized in this thesis project. Finally, a review of prior findings will be presented and will include risk factors associated with family, peers, history of abuse, personality and others.

DEFINING ADDICTION

Addiction is defined by Fisher & Harrison (2000) as a compulsion to use substances regardless of the negative consequences. Addiction is characterized by psychological and/or physical dependence, depending on the drug that is used. Wilson & Wilson (1994) described addiction as a primary, progressive and chronic disease that is associated with physical sensitivity to biochemical imbalances, causing unusual and
strong mood alterations, poor judgment, mental obsession, and other mental conditions that support the continuance of the disease. Addiction, according to this definition, is also characterized by spiritual and social isolation. The World Health Organization in 1974 defined addiction as “a state, psychic and sometimes also physical, resulting from the interaction between a living organism and a drug, characterized by behavioural and other responses that always include a compulsion to take the drug on a continuous or periodic basis in order to experience its psychic effects, and sometimes to avoid the discomfort of its absence” (p. 14; In Stevens & Smith, 2001; p. 20.).

The research project in this thesis follows the definition of substance dependence, abuse, intoxication, and withdrawal as presented in the DSM-IV (American Psychiatric Association, 1994), which avoids the usage of the term “addiction”. The combined meaning of the four distinct diagnosis (substance abuse, dependence, intoxication, and withdrawal) was part of the guiding criteria for recruiting participants. The definition of the DSM-IV was adopted in this research because it touches all the elements, circumstances, and implications of the phenomenon, as they occur on a physiological, psychological, and a social level. By breaking the definition into four distinct components, the DSM-IV promotes a better understanding of the phenomenon while providing an in-depth description of each component. Moreover, the DSM-IV associates only certain drugs with certain diagnoses, which makes the definition a more accurate one. It enabled the identification of drug addicted participants based on the type of drugs that they used. For example, this research was not interested in investigating causes for “gateway drugs” (discussed further below) but rather for hard, street drugs, and the DSM-IV’s definition allowed such exclusion and distinction to occur. Marijuana and
hallucinogens were not associated with the diagnosis of Substance Withdrawal in the DSM IV; therefore, potential participants that indicated regular use of those drugs were not interviewed as they did not respond to all four diagnoses, which comprised the definition of addiction for the purpose of this research.

The following are the definitions from the DSM-IV for the four selected disorders, which together form the definition of “addiction” as referred to in this thesis:

1. **Substance Dependence**: occurs when an individual continues to use the substance, despite significant problems related to the substance, and in a pattern of repeated self-administration that usually results in tolerance, withdrawal, and compulsive drug-taking behaviour.

2. **Substance Abuse**: Substance abuse is defined as a maladaptive pattern of substance use manifested by recurrent and significant adverse consequences, such as repeated failure to fulfill major role obligations, repeated use in situations in which it is physically hazardous, multiple legal problems, and recurrent social and interpersonal problems. Substance abuse includes the harmful consequences of repeated use but lack the three core components of substance dependence (tolerance, withdrawal, and a pattern of compulsive use).

3. **Substance Intoxication**: refers to the development of a reversible syndrome (maladaptive behaviour or psychological changes) that is related to and results from the physiological effects of the substance on the central nervous system.

4. **Substance withdrawal**: occurs when there is a cessation of, or a reduction in, heavy and prolonged substance use, manifested in maladaptive behavioural change that is accompanied by physiological and cognitive symptoms. Substance withdrawal causes
significant distress or impairment in important areas of functioning, including social, occupational, and other areas. Individuals undergoing substance withdrawal crave the substance to reduce symptoms of withdrawal (e.g., symptoms that are opposite of those observed in Intoxication and general medical conditions that are not better accounted for by another mental disorder).

In sum, and for the purpose of this thesis, addiction occurs when an individual is dependent on a substance, and abuses it regardless of the adverse consequences associated with such behaviour. It also occurs when an individual experiences intoxication after being exposed to the substance, and withdrawal when in cessation of its regular use.

**MODELS OF ADDICTION**

Models of addiction assist in understanding the phenomenon of addiction and the experiences of individuals affected by it. The following section provides a brief overview of the major etiological theories of addiction, and attempts to explain addiction from the perspective of these different approaches. Further in the literature review, the thesis presents an in-depth exploration of risk factors that were identified in previous studies. The overview of etiological models provides a range of theoretical explanations of the phenomenon, whereas the examination of specific risk factors deals with specific and practical research findings.
It is beyond the scope of this thesis to present all the existing theoretical approaches to addiction. Instead, a selection was made of the four leading approaches: the Moral Model, Psychosocial Model, Medical-Disease Model, and the Biopsychosocial Model. The selection of those four models was based on the fact that they represent the most dominant theories in the field today.

The first model to be applied to addiction and alcoholism was the Moral Model. This model suggested that addiction is the consequences of personal choice made by individuals who were spiritually ill (Fisher et al, 2000; Doweiko, 1999). Intoxication was perceived as sinful and indicated individual weakness. Influenced by religious societal systems, alcohol and indulgence was condemned, and viewed as a degradation that was inexcusable and morally corrupt. It was also assumed that the consumption of alcohol and indulgence could only be controlled by one’s willpower (Stevens & Smith, 2001).

Treatments for addiction were either religious or spiritually-based, and often associated with punishment of the addicted person (Fisher et al, 2000).

The repeal of the American amendment that prohibited the manufacture and sale of intoxicating liquor in the 1930’s preceded a transition in the scientific community from the Moral Model to the Medical Model. The emergence of the Medical Model was also associated with the formation of the self-help organization Alcoholic Anonymous (AA), and the recognition of addiction as a disease by the American Medical Association and by the American College of Physicians.

According to the Medical Model, addiction is a chronic disease that can never be cured. The addicted person is largely powerless over the disease and therefore is not responsible for its existence. Abstinence is an aspired-to goal rather than a complete
recovery from the addiction. Fisher & Harrison (2000) further state that addiction in the Medical Model “exists in and of itself, and is not secondary to some other condition” (p.41). In contrast to the psychosocial model, addiction was not perceived as a symptom or a consequence of a chronic stressor. The shift to the Medical Model, which referred to addicted individuals as not responsible for their disease yet responsible for seeking help to deal with it, removed feelings of guilt and shame that were previously associated with the morally condemned condition. It also opened the door to research in the field of alcoholism and addiction, and to the development of treatment for the victims of these diseases (Stevens et al, 2001).

The Psychosocial Model, in contrast, considers addiction as secondary to psychological problems and social factors. The model recognizes the impact that the environment may have on substance abuse behaviour, as well as internal factors related to the personality and the development of the individual. The model encompasses a wide range of ideas and theories, such as the Social Learning Theory, Behavioural Theory, Situational Factors (e.g., availability, stressors), and the alleviating effect of drugs in the occurrence of emotional pain (Teichman, 1995; Fisher & Harrison, 2000). The model also considers factors such as peer pressure, the power of cultural norms and values contributing to substance use, poverty, and family structure. However, the model ignores physiological factors associated with addiction (Stevens et al, 2001).

The fourth model, which is currently gaining in the number of its adherents, is the Biopsychosocial Model. Instead of positing one factor or set of factors to explain the phenomenon of addiction, it incorporates the other models into one (Kumpfer & Baxley, 1990). This model recognizes that one risk factor that may contribute to drug use
behaviour cannot be seen in isolation from other factors, which may also contribute to the constellation of addiction. It also recognizes that addiction has a multivariate nature. Therefore, it cannot be understood or addressed by utilizing a single narrow approach. A comprehensive perspective of the problem is more adequate, as well as the recognition of the reciprocal effects and the combined influence of the individual, the environment, and the behaviour (Stevens et al, 2001). The biopsychosocial model is an integrated model that brings forward a holistic approach to understanding and dealing with addiction, thereby, allowing for fuller and more realistic understanding of the phenomenon.

This thesis follows the principles of the biopsychosocial model and uses the approach as a basis for the planning and implementation of the research project. It is a foundational belief in this thesis that addiction occurs as a result of a range of factors that interact with one another in a way that increases the vulnerability of the individual to use drugs regularly and become addicted to them. Following the principles of the approach, the questionnaire utilized in this project includes most of the possible risk factors for addiction as they emerge from the community of the individual, his or her family, personality, social networks, experience of abuse, academic life, etc. The open-ended questions were designed partially to address those factors that were not included in the structured questions.

A multidimensional model versus a study of selected risk factors

In accordance with the Biopsychosocial model, this thesis adopts a multidimensional approach to investigate the phenomenon of addiction among youth in the DTES. The literature presents a wide range of research projects that investigate risk
factors associated with substance abuse, and certain trends that can be identified among them. Some studies utilize a multidimensional approach which explore most, if not all, the possible risk factors for drug addiction among youth, such as the work of Hawkins, Catalano, & Miller (1992) and DeWit & Silverman (1995). These factors include associated with parental guidance, family dynamics, education, academic achievement, personality characteristics, experience of abuse and trauma, social interaction and peer influence, etc.

Other studies are focused on a limited selection of risk factors, or a group of factors with a common denominator. The review of relevant literature reveals that most of the available studies of risk factors fit into this approach rather than the multidimensional approach. Such studies may focus on family-related factors (Gerevich & Bacsakai, 1996; Kilpatrick, Acierno, Saunders, Resnick, Schnurr, & Best, 2000; Brook, Whiteman, & Gordon, 1982; Svensson, 2000; Brook, Whiteman, Finch, & Cohen, 2000; McCarthy, William, Anglin, & Douglas, 1990), factors associated with peer group and school (Swaim, Oetting, Edwards, & Beauvais, 1989; Oetting & Beauvais, 1987; Brook et al, 1982; Svensson, 2000; Gerevich et al, 1996), experience of past trauma and abuse (Hawke, Jainchill, & DeLeon, 2000; Kilpatrick et al, 2000), and personality and mental health-related factors (Cicchetti & Rogoshch, 1999; Costello, Erkanli, Federman, & Angold, 1999; Brook et al, 2000; Naimah, Weinberg, Meyer, & Glantz, 1999; Swaim et al, 1989; Brook et al, 1982).

Although it is important to study each risk factor independently and to understand its implications in causing drug addiction, a narrowed approach is effective following comprehensive projects that intend to study all risk factors associated with drug addiction
and to thoroughly understand the etiology of the phenomenon. It can also be argued that both approaches may be suitable for different purposes. When the objective is to learn about the characteristics of a selected group, as in this research project, it is more useful to utilize a multidimensional approach in order to create a complete profile of the subject population. A narrower approach may be utilized when the objective is to focus on certain factors and explore their significance in causing drug addiction. Both approaches may complement one another, and contribute to an in-depth study.

LIMITATIONS IN PREVIOUS RESEARCH ON RISK FACTORS FOR DRUG ADDICTION

Although the literature presents a wide range of research projects that examine risk factors for drug addiction, several limitations may be identified as well as important areas that have not been adequately examined in existing research.

As was identified by Kandel, Treiman, and Faust (1976), investigators have often failed to differentiate between various illicit drugs. Studies often include all mood altering drugs, alcohol, and tobacco at the same study. For example, participants in such studies may use substances ranging from marijuana to heroin, and still be referred to as "drug users". Although marijuana is an illicit drug, the use of it rarely leads to the lifestyle that is often associated with addiction to hard drugs such as heroin and cocaine. Many related studies do not differentiate between "soft drugs" (such as marijuana and hallucinogens) and hard drugs (such as heroin, crack, and crack cocaine). The concept of

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5 "Hard drugs", as opposed to "soft drugs", is a term often used when referring to heroin, cocaine, and crack cocaine. Regular consumption of these drugs usually consists of serious addiction and serious effects.
stages in the development of addiction to drugs, clearly identify the significance of the
type of drug that is used in the determination of the level of addiction. The Stage Theory
(Dupont, 1984; Kandel et al, 1978) refers to soft drugs as “gateway drugs” leading to the
future abuse of hard drugs. In many cases, abusers of hard drugs have a history of abuse
of soft drugs. However, abusers of soft drugs do not necessarily proceed to the abuse of
hard drugs. Accordingly, it is inaccurate to assume that risk factors for drug addiction are
the same among both groups, and at the same time, prevention programming that may be
suitable for one group may not be appropriate for the other.

Other studies investigate the phenomenon of drug addiction together with
alcoholism. Although alcoholism is a serious addiction, its nature and characteristics are
very different from drug addiction, not only physically, but also socially and morally. The
fact that alcohol is a socially accepted substance influences the way that alcohol
consumers are judged by society. Moreover, the fact that possession and use of alcohol is
legal prevents (or delays) alcohol users from becoming involved with crime as opposed
to users or hard drugs who are considered criminals just by the virtue or their use and not
only due to the crimes they often commit to be able to afford the drugs.

In this thesis one of the criteria for selecting participants was addiction to hard
drugs. Poly-drug users were recruited only where one of the drugs they were consuming
regularly was a hard drug.

A second limitation of existing research relates to the age of the studied
population. Most of the research projects that investigate risk factors for drug addiction
include adolescence, the age where abuse of drugs may begin to occur. Although the ages

on the user's lifestyle (e.g., involvement with crime and street life). More information on this will be
provided in the chapter on methodology.
of "youth" varies somewhat from one study to another, most studies focus on school-aged adolescents that are younger than 18 years of age. This age group is the easiest to access, especially for the purpose of large high-school-based surveys, a method that has been implemented in a large number of published studies. Yet, this age group rarely reflects the real picture of youth who are heavily affected by drugs, as most hard drug addicts do not attend school. In addition, older youth are not included in these studies, although heavy drug addiction often develops among older youth.

Similarly, there seems to be a shortage in studies of drug addiction among street involved youth who have dropped-out of school. A large number of research projects have focused on peer- and school-related factors, with a commonly used measuring instrument and method: a survey conducted in several high schools (Kandel, Kessler, & Margulies, 1978; Gerevich et al, 1996; DeWit et al, 1995; Oetting et al, 1987). The Adolescent Health Survey (AHS) II of British Columbia (2000) acknowledged the limitation of such a research focus, and indicated that it may provide information only about youth in school, which represents 88% of BC youth in the study age group (students of grade 7-12). Currently additional studies are being conducted by the AHS to collect comparative data on street youth, youth in the corrections system and other young people who are not enrolled in school. Drug addiction has a higher prevalence in this population as opposed to school-attending youth. Kandel, Kessler, and Margulies (1978) indicated in their research on adolescent initiation into drug use that their sample was biased and therefore may limit the generalization of their findings. Their research involved a random sample of secondary school students in New York, N = 8,206. The researchers admitted that "the use of a high school sample which does not include
absentees and drop-outs probably eliminated young people who are heavily involved in drugs” (Kandel et al, 1978, p. 34).

Research is also limited on specific risk factors such as poverty, residence in crime- and drug-saturated areas, the effects of selected and relevant governmental policies and legal regulations, and ethnic and cultural studies that explore the reasons for protective and predictive factors associated with drug abuse among certain ethnic populations.

Finally, as mentioned, there are limited published studies on youth drug addiction in the DTES. The studies that exist were conducted by local law enforcement and health authorities, and may not always be available for the general public (such as studies conducted by a certain system for the use of the system). Furthermore, none of those studies deal with the etiological aspects of the phenomenon in the local context, nor do they present a profile of the youth in the DTES.

**Other theoretical approaches and models utilized in the thesis**

The work on this research project is guided by several theoretical approaches and the use of relevant models is incorporated throughout the thesis. This thesis borrows concepts from a cluster of theories, as described below, and thereby attends to the complex nature of the researched phenomenon and the purpose of this thesis.

The following theories and models complement one another, and contribute to the understanding of why and how drug addiction occurs.
The Risk Factor Approach

The Risk Factor Approach assists in predicting drug use behaviour. It hypothesizes that the greater the exposure to risk factors, the greater the likelihood of an adolescent engaging in drug use, especially if there are not any protective factors (DeWit et al, 1995; Bloch, Crockett, and Vicary, 1991). Attention is focused on the number of risk factors, with less interest paid toward the meaning attached to the individual predictors. The approach uses an accumulative concept that states, “the greater the number of risk factors in relations to the number of protective factors, the greater the likelihood that problem behaviour will emerge” (DeWit et al, 1995, p. 3).

Unfortunately, the focus of this approach on the accumulative aspect leads to ignoring the importance of the nature and quality of certain factors. It also ignores the possibility of some factors being more powerful than others in their influence on drug abuse behaviour. The most important component of the Risk Factor Approach is the degree of exposure to a number of risk factors, against a number of protective factors, in predicting drug abuse behaviour.

The concept of protective factors is often used in the literature (Hawkins et al, 1992; Gerevich et al, 1996; Brook et al, 1982) as the element that moderates the influence of the risks. Thereby, it reduces the vulnerability while enhancing the resiliency of those at risk for drug abuse (Hawkins et al, 1992). One of the major protective factors that is identified in the literature is attachment, as investigated in the work of Brook et al (1992, 2000), and as reflected in Hirschi’s Control Theory (Hirschi, 1969).

The Risk Factor Approach that will be utilized in this thesis is an examination of the degree to which participants were exposed to risk factors in comparison to exposure
to protective factors. Rather than developing an index of accumulating risk factors, the thesis will focus on examining the nature and the importance of the most frequently reported risk and protective factors.

**Hirschi's Control Theory Model**

Although Hirschi's theory is linked to delinquent behaviour in general number of studies utilize Hirschi's (1969) Control Theory Model to help understand the processes by which adolescents become involved in drug use (Hindelang, 1973; Kandel et al, 1977; Marcos & Bahr, 1988; Gerevich et al, 1996;). Hirschi (1969) suggested that humans are inherently antisocial and capable of committing criminal acts. Rather than asking “Why do people use drugs?” (or what are the risk factors or predictors for drug use), Hirschi asked “Why don’t people use drugs?” (or what are the protective factors?). In other words, the model focuses more on resiliency than on vulnerability to drug use. Hirschi argued that people conform after internalizing societal norms and values, while the bond that develops between individuals and society keeps them from violating the rules. The social bond in Hirschi’s model consists of four elements: attachment, commitment, involvement, and belief. *Attachment* consists of emotional ties to parents, school, and friends. Marcos & Bahr (1988) suggested that attachment influences the next three variables, as those who have high attachment would become more involved in school, have aspirations for higher education, and develop respect for social norms and rules. *Commitment* includes youths’ aspirations for higher education and the attainment of a meaningful occupation. *Involvement* refers to participation in traditional activities (e.g., celebrating holidays, activities within the community), and *belief* consists in a respect for
societal rules and laws. The model predicts that adolescents who score high on those four elements are less prone to deviate from the normative social structure (Marcos & Bahr, 1988), and hence are less likely to use drugs.

Like the Risk Factors model, Hirschi’s model also has an “accumulative aspect.” The impact of factors that are protective (contribute to resiliency) or predictive (contribute to vulnerability) depends on the extent of the exposure to them. Both models disregard the nature of factors and their significance in comparison to other factors. For example, findings in a study conducted by Hindelang (1973) contradicted expected results according to Hirschi’s model. He discovered that a high score on attachment to peer group was in fact associated with delinquent behaviour. If the nature of factors was to be considered in the model, attachment to peer group (or to family ties, society, etc.) should be thought of as either protective or risk factors, depending on the nature of the specific factor. A similar illustration can be viewed in the work of Gerevich & Bacskai (1996), who also utilized Hirschi’s model. In this case, a factor that was thought of as a risk factor was found to be a protective factor. A runaway child easily drifted into peer groups characterized by the use of drugs, and thus was considered at risk for drug use. However, when the child was escaping from pathological parental influences, the same factor, only now seen as a protective, weakens the influence of pathogenic parents. “This group of participants did not avoid addiction, but their distance from the family and reduction of pathogenic influences of the family almost certainly played an important role in the milder course of the addiction” (Gerevich & Bacskai, 1996, p. 37). In reference to the role of protective factors, DeWit et al (1995) suggest that many adolescents exposed to a high number of risk factors during childhood do not exhibit significant problem
behaviours at a later age. This occurs as a result of the existence of protective factors, which provide youth with the resilience to withstand the pressures of living in a high-risk environment. Brook et al (2000) described a paradigm of protective-protective mechanism, according to which certain protective factors work to enhance the influence of other protective factors, which increase the chances of an adolescent being insulated from drug use. Their findings indicated that the effect of protective factors associated with adolescent personality could be enhanced by parental affection, and that protective aspects of low peer drug use were enhanced by protective personality traits such as responsibility and intolerance of deviance.

The thesis will utilize parts of the model by examining the way in which the social bond of participants was broken or guarded, and the way that attachment, commitment, involvement, and belief interacted in their lives. By incorporating the users’ perspective, there will also be an opportunity to examine the quality and the nature of individual factors (risk or protective).

Attachment Theory

The consideration of attachment in Hirschi’s Model opened the door for the recognition of attachment as a highly important component in the etiology of drug use behaviour. The concept of attachment is applied to and linked to many factors, such as how an adolescent maintains reciprocal relationships, including with parents, peers, school, church, community, and other elements in the adolescent’s environment (Ranking & Kern, 1994; Brook et al, 2000; Oetting & Beauvais, 1986; Gerevich et al, 1996). In this sense, attachment plays an important role in the development of many risk and protective
factors in the life of the adolescent. It is the component that describes the quality of the relationship and the connection that the adolescent has with those factors. This theory assists in understanding how and why those factors may impact the adolescent with regard to drug use behaviour.

In the early 1950’s, John Bowlby set the foundations for what we now know as “Attachment Theory.” Bowlby described attachment as a primary motivational system and a basic behaviour, in which one’s need to be close to a parent figure, to seek comfort, love and attention from that person, is as great as the hunger for food (Bowlby, 1973). He focused on the existence of maternal care, or maternal deprivation, as the factor that will affect the healthy or impaired development of an individual, emotionally, intellectually, socially, and physically. Individuals that have suffered long-term separation from a maternal figure during the first few years of life, that were deprived of warm, intimate, and continuous relationship, and particularly those that were raised in institutions, are doomed, according to Bowlby, to neurotic and delinquent behaviour when they grew older, and will possibly suffer from mental illness as adults.

According to Howe (1995), attachment also plays a major role in the development of one’s self-esteem and one’s sense of self within relationships. Disruptions to early forms of attachment is not only experienced as losses that may result in the problems described earlier, but are also a threat to the integrity of one’s self. Nurturing relationships can promote children’s ability to contain and maintain their feelings and not be overwhelmed by them, and their ability to develop a cognitive structure that helps them understand and handle their own experience. Brook et al (2000) also found that a close bond between parents and the children is associated with the development of more
effective self-regulation skills and social skills. On the other hand, children who do not experience good quality relationships do not learn how to cope with anxiety and distress.

The issue of resiliency was explored by Howe (1995) in the light of Attachment Theory. Howe concluded that there are three major protecting mechanisms that promote resiliency in children who suffer disturbed relationships early in life. The first identified mechanism was intelligence and the ability to reflect on one’s self. This was described as the ability to make sense, even of disturbed relationships, thereby protecting the individual from the adverse effects of such relationships. It also includes the ability to reflect on the experiences, feelings, and thoughts of self and other people and make sense of them. The second identified mechanism was psychological support, which referred to the opportunities for alternative psychological support that one may have while living through disturbed relationships. Those opportunities work to enhance a positive concept of self outside of the risk environment, and may include relationships with teachers, counsellors, or other caregivers, as well as opportunities to have meaningful experiences in school, creative classes, etc. The third mechanism is the removal of a child from the adverse and riskful environment. Removal as a mechanism has been supported by research that has, in fact, criticized Bowlby’s theory and that suggested that “it was the remaining in prolonged disturbed relationships that was more likely to lead to impaired development rather than simply losing a relationship” (Howe, 1995; p. 49). The most successful route out of seriously disturbed relationships was identified as adoption where a child is placed in a new nurturing social environment. Arguments against removals of children from their original home environment, advocate for providing the family with
support and assistance to improve the parents capacity to care for their children, thereby avoiding trauma of separation and strengthening the family as a whole.

Research has indicated that a close mutual parent-child attachment protects the adolescent from drug use (Brook et al, 1990). It has been found that such relationships can assist the adolescent in coping with interpersonal problems without rebelling. Eisenberg & Fabes (1992) have found that when parents are supportive, their children can control their emotions and maintain problem solving behaviours. Likewise, when adolescents feel supported by their parents, they accept conventional social values, and are not likely to have deviant attitudes, which in turn protect them from engaging in drug use. According to Rankin and Kern (1994), "positive parent-child attachment results in fewer delinquent behaviours because the child does not want to jeopardize the established relationship. Weak attachment minimizes the child's sensitivity to parental opinions, thereby "freeing" the child to deviate in response to situational demands and peer encouragement" (p. 496).

In this thesis, discussion will often refer to Attachment Theory in an attempt to understand and explain relevant findings. Specifically, Attachment Theory will be utilized in the description of participants' family life as well as street life. The theory will be incorporated in the analysis of the qualitative data, which reveals stories from the personal history of participants; and particular attention will be given to the issue of resiliency, and to findings on apprehension of participants as children from their home and their placement in adoptive or foster-care.
Peer Cluster Theory

Peer Cluster Theory (Oetting & Beauvais, 1986) states that the only dominant variable in adolescent drug use is peer influence. Other psychosocial characteristics only underly the susceptibility to drug use and determine the probability that an adolescent will join a drug-using peer cluster; therefore such factors only influence indirectly. This theory suggests that drug use is nearly always directly linked to peer relationships. Peers are the ones that shape attitudes about drugs, provide drugs, provide the social context for drug use, and share ideas and beliefs that rationalize the drug use behaviour. On the other hand, a different set of beliefs, values, and expectations in a peer cluster may form different norms of behaviour where drug use would be perceived as negative, with abstinence being the typical choice (Dinges & Oetting, 1993).

The definition of “peer cluster” varies from gang or small group, to dyads such as best friends, which are close and highly influential relationships. The drugs in a peer cluster play an important role in defining the group, forming its typical behaviours, and in maintaining the group’s identity and structure. Peers in a cluster are homogeneous and share the same lifestyle. Together peers use the same type of drugs, in the same method, and for the same reasons. Furthermore, “peer pressure” is a concept that is not recognized as an existing mechanism in a peer cluster, as all members in a peer cluster are perceived as actively shaping the norms of behaviour. This is in contrast to the image of a youth who is helpless, innocent, passive, and being pushed into trying drugs by coercive peers.

This thesis will utilize Peer Cluster Theory in an attempt to understand the dynamics of peer influence in causing drug addiction among the participants in the
project. It will also be utilized in an attempt to understand the culture of certain groups of street involved youth in Vancouver.

**Stages Theory**

Stages theory, also known as the “gateway theory”, is a developmental model which describes the course of drug use among adolescents as a process that is initiated with certain drugs and continues gradually to abuse of others. Drug use behaviour was described by Kandel et al (1978) as a behaviour that has a clear onset and a series of predictable stages. In their theory, the investigators did not imply a causal sequence according to which the use of one drug at a prior level may cause the progression to the next level. Furthermore, they did not suggest that once started with the lowest drug, adolescence would necessarily progress through the entire sequence. Rather, the model categorizes type of drugs and behaviours related to their abuse into clear, defined stages, and suggests a developmental framework in which drug use often occurs.

Different versions of this model can be found in the literature. The original version of the model (Kandel, 1975), suggests that a pattern of drug use typically follows the following sequence. In the first stage, adolescents may use beer and wine. In the second stage they may use hard liquor, and proceed to the third stage in which they may use marijuana. Finally, in the fourth stage, they may become involved with other illicit drugs. Oetting et al (1987) describes the sequence of the model with a slight difference: youth are likely to start their substance abuse with consumption of beer and cigarettes, later try marijuana, move on to uppers and later use drugs such as downers, PCP, and heroin. Another general framework for the model was suggested by Brook et al (1982), in
which the first stage involves licit drugs (tobacco and alcohol), moving to marijuana in
the second stage, and finally include the use of other illicit drugs in a third stage.

This model does not provide a unitary explanation of the fact that drug use is a
progressive behaviour and there is no single, integrated pattern that describes the
evolution of the distinct stages. It is, however, suggested in all of the relevant studies that
illegal drug use proceeds from legal drug use, and that marijuana use usually precedes
other forms of illegal drug use (Gergen, Gergen, & Morse, 1972; Huizinga, Menard, &
Eliot, 1989; Kaplan, Marlin, & Robbins, 1984; Sorenson & Brownfield, 1989; Free &
Marvin, 1993).

This model recognizes that different factors are related to the initiation of drug
use at different stages. It suggests that prior involvement in minor delinquent activities is
important for the initiation of hard liquor consumption. On the other hand, beliefs and
values favorable to the use of marijuana and association with marijuana-using peers are
found to be the most important for the initiation of marijuana use. Finally, parental
factors, feelings of depression, and contact with drug-using peers are identified as most
important for other illicit drugs. Using the term, “gateway effects,” Dinges et al (1993)
suggest that “the progression of initiation into illicit drug use increases the chances of
exposure to friends who use other drugs, which increase the probability of deeper
involvement” (p. 5). The investigators assume that the “gateway effect” may therefore be
a peer-based social phenomenon.

The general developmental concept of this theory appropriately describes the
reality of the progressive pattern of drug use among adolescents. However, the model
does appear to be oversimplified, as drug use is a highly dynamic behaviour that changes
over time, varies among different cultures, countries, and communities, and largely depends on the availability of certain drugs in a given location. For example, in certain Middle-East countries, hashish is a much more predominant gateway drug than marijuana. Hallucinogens are now becoming more popular among teenagers following the stage of marijuana use. While marijuana use has become a more common phenomenon in high-schools, hallucinogens are characterized as a “party drug” that are more associated with the “trance” culture. This model needs to be periodically updated according to changing trends in time and adjusted to local cultures, especially when utilized in planning of prevention programs. Finally, the model ignores the method of drug use in the explanation of the progression in drug use behaviour. As a result of tolerance to drugs, drug users not only move on to harder drugs that maintain sensational effects, but also may progress to other forms of consumption in order to achieve higher sensational effects (from smoking and snorting to injecting and other methods of drug use).

This thesis will utilize the Stage Theory in the analysis of the development of drug use behaviour among participants, and in an attempt to conceptualize it based on the general framework of the model. The thesis will further develop the analysis to include other identified factors such as culture, location, method, and age of initiation of each category of drug.
RISK FACTORS FOR DRUG ADDICTION

The following section will present the various risk factors for drug addiction as they are identified in the literature. Instead of outlining each risk factor individually, there will be a review of five primary categories, which are presented in the order they are organized in the questionnaire:

1. Risk factors associated with the family;
2. Factors associated with peers & school;
3. Factors associated with personality;
4. Factors associated with history of abuse; and
5. Other, general factors such as demography, culture, and availability.

It should be noted that the structured part of the questionnaire was designed according to these major categories.

Risk Factors Associated with the Family

The first category includes factors such as family structure and dynamics, family attitudes towards drugs, modelling behaviour within the family, parental substance misuse and involvement in crime, relationships within the family and attachment to parents, spousal abuse, atmosphere in the family, and religious identification and traditions in the family,

A large quantity of published research is related to this group of risk factors. It is also one of the most significant categories of risk factors that influences an adolescent to use or to abstain from drugs.
The family is the primary social framework that individuals form relationships with, learn and apply social skills with, explore emotions with, and that shapes values and beliefs. The family provides the initial experience in which an individual develops physically, cognitively, mentally, socially, spiritually, and emotionally. Oetting et al (1987) indicated that the family is an early and important socialization link that influences many other socialization links. Therefore, its etiological impact on drug use behaviour (as well as any other behaviour) is a crucial one.

One of the important aspects of family structure with regard to the etiology of drug use is the living arrangement, which was defined by Nurco & Lerner (1996) as an “intact home” versus a “non-intact home”. An intact home is when both natural parents reside in the same household. A non-intact home is when one of the natural parents, most often the father, is absent. The investigators found three major groups of living arrangements of non-intact homes among youth drug users. Nearly all reported arrangements consisted of a natural mother living with a male partner. The second large reported arrangement was of a natural mother functioning as a single parent. The third group included other persons functioning as caregivers, such as grandparents, siblings, and other relatives, or the natural father with a female partner. Nurco et al (1996) found that residing in a non-intact household was associated with becoming addicted, particularly in households with a natural mother and surrogate father, followed by single-parents and other non-intact household. Harbach & Jones (1995) reported that adolescents in single-parent-homes are more at-risk for substance abuse than adolescents from “intact families.”
Many studies identify healthy attachment to parents as a highly important protective factor, while poor attachment is found to be a strong risk factor (e.g., Svensson, 2000). Nurco et al (1996) found that addicts were very attached to their mothers or mother figures and less attached to fathers or a father figure. In other words, the investigators found an association between a lack of attachment to fathers or father figures and later addiction. Norem-Hebeisen, Johnson, Anderson, and Johnson (1984) found that drug users saw fathers as more hostile than mothers.

Quality relationships between parent and child, such as warmth and closeness, were found to be important protectors from drug use behaviour in adolescence (Brook et al 1982; Brook et al 1998; Kandel et al 1978). Kandel et al (1978) reported that parent-adolescent closeness was the primary and strongest influence on the use of hard drugs, accompanied by the second strongest influence, that of peer group influence. Related findings suggested by Brook et al (1990) indicated that psychological stability of mothers counterbalance the effects of peer drug use. Observation and identification with a supportive, affectionate, and responsible parent contributed to the formation of a healthy personality, which insulated the adolescent from drug use (also discussed in attachment theory and in Hircshi’s Control Theory).

Nurco et al (1996) indicated that strong attachment to parents may encourage the internalization of positive parental values. Difficulty in parent-child mutual attachment was found to lead to behavioural problems due to interference with the internalization of parental norms, values, and attitudes, and thereby to a higher risk of associating with drug-using peers (Brook et al 1990). When a family is not effectively communicating strong sanctions against drugs, even a caring and intact family loses some of its potency
Related studies show that poor parental discipline, inconsistent discipline, permissiveness or extremely authoritarian parenting were all significant predictors of drug use (Baumrind, 1983; Hawkins et al 1992; Brook et al 1992; Svensson, 2000; Kandel & Andrews, 1987). Studies have suggested that parents’ knowledge and understanding of the psychological development of teenagers may protect youth from engaging in drug use behaviour (Nurco et al 1996; Nowinski, 1990); therefore, parents who resist the development of willpower in their teenage child may either increase rebellion or lead to the surrender of an overcontrolled adolescent (Nowinski, 1990). It was indicated by Svensson (2000) that lack of parental monitoring plays an important role in the prediction of drug use behaviour, as well as lack of parent involvement with the adolescent offspring. Parental monitoring may include knowledge of the child’s whereabouts when the child is out of home, what the child does in his or her spare time, and the friends that the child is hanging-out with (Martens, 1993).

Nurco et al (1996) assert that there is not enough data on home atmosphere as a risk factor. However, it is known that family disruption (e.g., divorce, imprisonment), family dysfunction (e.g., negative communication) and high levels of conflict, aggressiveness and tension in the family are major underlying factors that may lead an adolescent to drug abuse (Baumrind, 1983; Oetting et al 1987; Hawkins, Arthur & Catalano, 1995; Gerevich et al 1996; McCarthy et al, 1990).

According to Oetting et al (1987) the protective effect of religious identification acts indirectly, by enhancing the effect of a strong family (considered as one that includes traditions, values, and beliefs). Such strong families were found by the investigators to lead to good school adjustment. If an adolescent has a strong religious identification it
increases the likelihood that he or she will associate with peers who discourage drug use, and will decrease socialization with friends after school. DeWit et al (1995) found that church attendance and supportive family environment acts as a protective factor from drug use.

Other factors related to the family of the adolescent that may predict drug use include low parental educational aspirations for children (Baumrind, 1983; Kandel et al, 1987); parents’ nondirectiveness (Baumrind, 1983); and parents that are less caring and more rejecting (Norem-Hebeisen et al, 1984). Reilly (1979) reported that families of drug using youth have common characteristics of negative communication patterns, inconsistent and unclear behaviour limits, and unrealistic parental expectations.

Finally, drug use modelling by parents and siblings significantly increase the risk of adolescents’ drug use (Svensson, 2000; DeWit et al, 1995; Brook et al, 1982). Ahmed, Bush, Davidson & Iannotti (1984) suggest that drug salience (i.e., visibility) in the household is the best predictor of children’s expectations to use substances. Parents’ permissiveness towards drug and alcohol use were found to be more important than parental drug use as an influence to adolescent drug use (Brook, Gordon, Whiteman & Cohen, 1986).

Research is scarce on the specific influence of parental incarceration and domestic violence on drug use behaviour.
Risk Factors Associated with Peers and School

Kandel et al (1978) stated that peer relationships were the second strongest influence on the use of hard drugs among youth. However, peer relationships were found by the same investigators to be the primary and strongest influence on the use of marijuana. Oetting & Beauvais (1986) not only have found that the correlation between a youth's drug use and his association with peers who encourage drug use is extremely high, but also that peer relationships often provide the highest correlations with drug use, compared to other risk factors. Other researchers agree that peers are a salient source of influence on drug use behaviour (Dinges et al, 1993; Gerevich et al, 1996; Brook et al, 1982).

Nowinski (1990) defined teen substance abuse as “hedonistic.” He suggested that adolescents use drugs primarily because of curiosity, in order to have fun, and to get high (Holland & Griffin, 1984). Drug use in adolescence is connected with the psychology of the actual stage of development, in which youth are more inclined to take risks, live in the here-and-now, and therefore not consider the consequences of their actions. Nowinski (1990) further stated that when adolescents go through their process of individuation they grow through a successful resolution of the tension between themselves and authorities; through the development of their willpower; through opposition to others, and through their process to achieve independence. However, when an adolescent is being overcontrolled by parents he or she may demonstrate rebellious behaviour and resistance to traditional authorities; thereby increasing the adolescent’s vulnerability to peer pressure (Kandel, 1982; Bachman, Lloyd, & O’Malley, 1982).
Nowinski (1990) described the mechanism of surrendering to peer pressure as an achievement of pseudo-independence by substituting a peer for the overcontrolling parent. Adolescents are sensitive to the norms of their chosen peers and they experience anxiety upon the disapproval of their peers. Changes in youths’ mood can be associated with their constant struggle to win the approval of their peers and keeping it. In this struggle, they are extremely aware of their peers’ norms for appearance, behaviour, and attitudes. Having behaviours such as smoking cigarettes, marijuana, alcohol drinking, and using other drugs as an acceptable behaviour among many peer groups makes it challenging for adolescents to oppose these norms. Norms are often at the heart of many youth subcultures. Once a youth is strongly associated with peer groups whose norms are disapproved of by adults and mainstream society, they drift away from mainstream society and become alienated by adults and other youth who disapprove drug use. As they grow further apart from mainstream society and closer to drug-using peers, it becomes difficult for them to function outside of the group they have identified with, therefore making it more difficult to have a sense of their own selves aside from their peer group. Kandel et al (1978) stressed that drug use leads youth to move away from long-term friendships and seek less intimate relationships with those they share their drug-related behaviour.

According to Herbert & Charles (1999), peers remain the primary source and most frequent co-users of illicit substances. Peer groups, as discussed earlier in regards to Peer Cluster Theory, form the values, norms and settings in which drug use behaviour occurs. Kandel et al (1978) found that attitudes favorable to drug use precede the actual drug using behaviour. Therefore, association with peers who hold attitudes and beliefs
favorable of drug use was suggested as a predictor (Brook et al, 1982; 1990; Kandel and Andrews, 1978; Oetting et al, 1987).

Little research has been done on the use of leisure time among adolescents; however, according to Bell, Wechsler & Johnson (1997), the more time adolescents spend with friends, the greater the risk for marijuana use. Brook et al (1992) identified a high level of deviance from societal norms among friends and more time spent with peers as significant risk factors for alcohol and marijuana use.

Schools provide an opportunity to interact with different peer groups, as well as the academic experience, which may also be related to the development of drug using behaviour. Failure in school has been identified as a risk factor for adolescent drug abuse (Jessor, 1976, Oetting et al, 1987). According to Holmberg (1985), truancy, placement in special classes, and early drop-out from school were found to predict drug use. “The available evidence suggests that social adjustment is more important than academic performance in the early elementary grades in predicting later drug abuse. Early antisocial behaviour in school may predict academic failure in later grades” (Feldhusen, Thurston & Benning, 1973). Academic failure in late elementary grades may exacerbate the effects of early antisocial behaviour or contribute independently to drug abuse” (Hawkins, et al, 1992, P. 84).

Finally, a low degree of commitment to school and educational aspirations appear to be related to youth substance abuse. It was found by Bachman et al (1985) that drug use was significantly lower among high-school seniors who planned to continue their education and attend college as compared to high-school seniors who did not. Friedman
(1983) found a relationship between adolescents’ drug use and time spent on homework and their perception of course work.

Further research is required in the area of leisure time of adolescents and its relationship with drug use behaviour, and the quality of activities that may protect or increase the risk of drug use. Other studies need to examine the danger of labelling certain student populations by school systems, and the effectiveness of placing students in special classes or programs, with respect to risk for drug use in such students.

Risk Factors Associated with Personality

This section discusses the way that developmental deficits may lead to drug abuse among adolescents, including disruptions to normal development, mental and emotional abnormalities, and delays in cognitive development.

Costello et al (1999) found that most psychiatric disorders showed their first symptoms well before the onset of substance use. It is important to recognize that a linkage may exist between risk factors associated with personality and risk factors associated with history of trauma and abuse. Being a victim of trauma and abuse may cause developmental deficit or mental conditions. Therefore, if past abuse and trauma preceded the onset of personality deficits and mental disorders, it is necessary to evaluate them as the primary or the original cause for addiction rather than identifying the resultant personality condition as the primary risk factor. In such cases, it could be that the mental condition would never occur if the individual was not a victim of abuse and trauma. In their investigation of the impact of Post Traumatic Stress Disorder (PTSD) on drug use behaviour, Kilpatrick et al (2000) refer to the clinical reaction to negative life
events. They found that PTSD increased risk for marijuana and hard drug use. Other than PTSD, Rohde, Lewinsohn & Seeley (1996) found that having any psychiatric disorder predicted an earlier onset of alcohol abuse or dependence. Their study did not examine abuse of substances other than alcohol. Albert (1998) claimed that the great majority of addicts had one or more severe personality disorders, such as: paranoia, antisocial personality disorder, borderline personality, obsessive-compulsive disorder, and schizoid personality disorder. Even if addicts were not diagnosed with a specific personality disorder, Albert (1998) found that they were more inclined to exhibit anxiety, panic, depression and rage.

Brook et al (1998) suggested that childhood personality traits influence the parent-child relationship, which in return affected the quality of relationships and the development of the child. Specifically, the investigators found that a child's antisocial behaviour and childhood aggression may result in the parent rejecting the child, which in turn will impact the quality of attachment between the parent and the child. Hawkins et al (1992) explain that aggressiveness may also result in exclusion of children from groups of conventional peers, but would get acceptance by other aggressive peers who may foster drug use and delinquency. The lack of bonding with society and alienation were found to be strongly associated with drug use by a number of other researchers (Jessor et al, 1976; Kandel et al, 1982).

Brook et al (1982; 1998) documented that ongoing unconventional behaviours may predict drug use. Unconventionality, nontraditionality, and non-conformity in the personality of an adolescent is associated with rebelliousness, lack of responsibility, and tolerance towards deviant behaviour. The investigators did not base their findings on the
occurrence of an isolated event or a transient state of unconventionality, but rather a stable phenomenon that occurs over years of development. Brook et al (1998) also indicated that an unconventional personality may have a temperamental feature which is manifested in aggression. Conduct disorder, which involves manifestation of such behaviours of unconventionality and rebelliousness, was found to have a strong and consistent association with substance abuse disorder at a later age (Weinberg et al, 1999; Costello et al, 1999). This association was found by Bukstein, Glancy, & Kaminer (1992) to be the most common antecedent for substance abuse among boys. Oppositional Defiant Disorder, a frequent antecedent to conduct disorder, was found by Costello et al, (1999) to be associated to substance abuse and Antisocial Personality Disorder. Antisocial Personality Disorder was a frequent (but not certain) outcome of Conduct Disorder and was also found to be associated with substance abuse (Weinberg et al, 1999).

Contrary to studies that were done in clinical settings (Bukstein, Brent, & Kaminer, 1989; Milberger, Biederman, Faraone, Wilens, & Chu, 1997) that reported an association between Anxiety Disorders or Attention Deficit Hyperactivity Disorder (ADHD) and substance abuse, a longitudinal study of Costello et al (1999) did not find such an association. Anxiety disorders and ADHD were considered to be disorders with an onset that is earlier than other personality disorders, and had relatively little effect on later substance abuse. Furthermore, Costello et al concluded that even if the association between those two disorders and substance abuse was found, it tended to be weaker than the association of substance abuse and other psychiatric disorders. It was suggested that if an association between ADHD and substance abuse was found, it was generally mediated
by Conduct Disorder, which strengthens the assumption that ADHD does not increase, by itself, one’s vulnerability to drug use. Another aspect that was raised in the literature in regard to ADHD and substance abuse was the practice of prescribing stimulant medication and other forms of treatment for the disorder (Weinberg et al, 1999). This issue remains controversial, although it was indicated by Klein (1998) that drug users with past or current history of ADHD do not demonstrate a specific preference for use of stimulants.

Research has suggested a strong connection between substance abuse and depression (Costello et al, 1999; Bukstein et al, 1992). According to Bukstein et al (1992), depression was a common predictor for substance abuse among girls. However, according to Costello et al (1999) and Cicchetti et al (1999), it is possible that depression may contribute to substance abuse disorder, while it is also possible that substance abuse contributes to the development of depression, whether it is by virtue of the effects of the drugs on the central nervous system or by the reinforcement of stress and other difficulties that drug use imposes on the lives of users. This issue was raised vis-a-vis the dynamics of “self-medication,” which suggests that the original state of depression is the cause for the consumption of drugs, with the purpose of alleviating the emotional distress. It is possible that the consumption of drugs may deepen the depression and reinforce it (Costello et al 1999).

Different types of temperament were found to be associated with vulnerability to drug use, such as a strong need for independence (Hawkins et al, 1992), disinhibition, novelty seeking behaviour, and “difficult temperament” (Weinberg et al, 1999, p. 293), which may be manifested in high level of activity, rigidity, and distractibility. A
combination of shy and aggressive features at an early age was also found to be associated with vulnerability to drug use, although individuals with only inhibited or shy characteristics not only were not at risk for drug use, but were also found to be protected from it, at least during adolescence (Windle & Windle, 1993).

The literature presents other areas of research related to factors associated with personality. For example, early difficulty with speech and language may indirectly increase vulnerability to drug use, as it may underlie other identified risk factors such as poor social skills and academic failure. The same mechanism of indirect influence on vulnerability to drug use may occur with learning disabilities (Weinberg et al, 1999).

Further research is needed on the relationship between ADHD and substance abuse, considering the fact that so many children presently are being diagnosed with this condition. It is important to study and differentiate between risk factors for drug use that originate in personality and those that originate in a history of trauma and abuse. It was indicated earlier that many personality deficits may be triggered by life circumstances and their prediction of drug use. Finally, “labelling” children and youth with any personality deficits can have a tremendous impact on their development and relationship to society. However, this critical dynamic has not been investigated with connection to drug addiction.

Risk Factors Associated with Past Abuse and Trauma

The next section will discuss how past abuse and trauma may increase the risk for substance abuse among youth. Some related ideas were presented earlier in the review of risk factors associated with family dynamics and with personality (such as family
disruptions that often have stressful or traumatic impact on children in the family, the effect of PTSD on drug use behaviour, and the relationship between depression and drug use). Research is scarce on history of abuse and trauma and the way it influences the development of drug use and addiction; therefore, the mechanisms that translate experiences of childhood abuse into later drug use are still unclear (Hawke et al, 2000). This category of risk factors is commonly considered as one of the main causes of drug addiction in youth, and it is assumed that many (if not most) of drug addicts have experienced some level of trauma and abuse in their past. The literature does not present evidence or a theory that questions to what extent an adverse history in a child’s life may predict drug addiction in the future. One of the difficulties that was identified in the literature was the fact that it is a complex task to isolate the risk of substance use associated with victimization. Both substance use and victimization may be risk factors for one another (Kilpatrick et al, 2000). History of victimization may be a risk factor for substance abuse, but could increase the risk of an individual to be victimized over and over again. According to Hawke et al (2000), clients who enter drug treatment with a history of abuse in childhood typically exhibit severe drug abuse problems and greater psychopathology than non-victims. The timing of various life events was noted as a significant predictor of drug use, when in general, events reported to occur early in life were positively associated with drug use (DeWit et al, 1995).

Drug use has often been viewed as playing an important role in coping with past abuse and related emotional distress. It helps avoid pain by the virtue of the drugs’ mood-altering effects (Nowinski, 1990). Drug use may be the “first layer of defense” in dealing with the trauma of abuse (Cavailo & Schiff, 1989) when used as self medication. It
assists the victim to avoid the trauma associated with the abuse (Hawke et al, 2000) and the emotions associated with the trauma. Kilpatrick et al (2000) suggested an hypothesis, according to which individuals are driven to engage in behaviours that reduce negative emotions and distress by situational avoidance and drug use. The investigators claim that the use of substances following physical assault (trauma) may be an effective strategy to diminish the negative affect; however, the strategy is maladaptive as it does not resolve the emotional impact of the trauma on the victim. Finally, it was stated that “increased negative affect following exposure to stressors... increases the likelihood and intensity of use” (p. 19).

Victims of child physical assault are more likely to use marijuana, prescription drugs and hard drugs (Duncan, Saunders, Kilpatrick, Hanson & Resnick 1996). Kilpatrick et al (2000) found that individuals who experienced either physical or sexual abuse or assault were at increased risk of past-year substance abuse and dependence. The investigators found strong evidence that, “witnessing violence was among the most powerful risk factors for substance use disorders, multiplying the risk of abuse/dependence for all substances even after effects of demographics, familial substance use, and victimization were controlled... Observing interpersonal aggression, such as domestic violence, might be particularly frightening to children, leading to extremely high levels of negative affect. The fact that domestic violence is typically ongoing and that an adolescent’s ability to escape from households in which domestic violence is occurring is limited, may serve to further exacerbate negative affect” (p.26).

Surprisingly, there are very limited studies on the relationship between past abuse and drug use. Although the relationship between the two seems to be obvious, and given
that past abuse is often held as a simplified explanation for youth drug addiction, there 
remains very limited evidence in the literature to support such an explanation. If drug use 
is identified as a coping mechanism among individuals that experienced childhood abuse, 
then this process needs to be clarified, so it may be possible to address it by planning the 
appropriate intervention. If there is a relationship between drug use and experiences of 
abuse early in life (DeWit et al, 1995), it could be said that the drug use of a victim is a 
replacement or a reinforcement of another maladaptive coping strategy in individuals 
who have avoided dealing with the experience of abuse in a healthy way. The hypothesis 
presented considers avoidance, not the actual trauma, as the factor that leads to addiction, 
as drug use provides a strong avoidance opportunity. If the relationship between drug 
addiction and past abuse is derived from the reinforcement of maladaptive coping 
strategies, preventative intervention among identified population should include a 
component of enhancing constructive coping mechanisms early in life.

Other Risk Factors for Drug Addiction

Other risk factors have been identified in the literature as contributing to drug 
addiction. This section will provide an overview of some of them.

Differences in gender were found to have strong relationship to the level of 
vulnerability to drug addiction. Males were significantly more likely than females to use 
illicit drugs on a frequent basis (DeWit et al, 1995), and were found to be at a higher risk 

McCarthy et al (1990), asserted that family size, correlated with maternal distress 
and with negative parental interaction with children, contributed to vulnerability to drug
use. Large family size significantly increased vulnerability to drug use (McCarthy et al, 1990), where children born to large families often received less attention from their parents and less individualized tutoring and teaching. This pattern was referred to as “diminished parenting effectiveness” (p. 2).

In other studies, demographic and socioeconomic factors were found to be insignificant predictors for adolescents’ drug use (DeWit et al 1995; Zastowny, Adams, Black, Lawton, & Wilder, 1993). The demographic and socioeconomic variables that were examined by DeWit et al (1995) included number of siblings, place of birth, parental education, dwelling status and employment status of parents. Furthermore, Hawkins et al (1992) indicated that although a negative relationship between socioeconomic status and delinquency had been found, a similar relationship has not been found for drug use. Yet, when poverty was extreme and occurred in conjunction with childhood behavioural problems, an increased risk for later alcoholism and drug problems was evident.

Studies that explained the broad concept of culture, as it interacts with vulnerability for drug addiction, indicate that shifts in cultural norms, in the legal definitions of certain behaviour, and in economic factors, have been shown to be associated with changes in drug-using behaviour and in prevalence of drug abuse (e.g., Hawkins et al 1992). Hawkins et al (1992) suggested that laws affect the reality of supply and demand, where legal restrictions influence the availability and prices of substances. Laws regarding drug use vary from culture to culture and therefore shape different social norms among diverse cultural groups. For example, laws and norms that express greater tolerance for the use of alcohol were associated with a greater prevalence of alcohol
abuse (Hawkins et al, 1992). This same equation was suggested by Johnson (1991) with reference to laws and norms involving illicit drugs. On the other hand, there are suggestions in the literature (e.g., Mitchell, 1990) that prohibition of drugs and drugs’ law enforcement have failed in reducing the problem; moreover, prohibition have actually caused damage by creating an extensive black market that feeds organized crime; it increased violence; clogged prisons and courts; and even compromised democracy by granting drug control monopolies to police and physicians.

Another relevant theme that should be examined as a risk or a protective factor is Harm Reduction as an approach to find resolution to the damage caused by drug addiction. Presently we are witnessing a progressive movement towards Harm Reduction as a philosophy that inspires innovative drug policies in number of countries around the world, and also in Canadian communities. Kendall (1999) defines harm reduction as an approach that suggests alternative measures of progress in dealing with the disease of addiction; measures that promote reduced harm to self, family, community and society. “These are usually preceded by the steps of less harmful use, less use, and ultimately… no use of addictive substances” (p. 425). It was argued by MacCoun (1998) that harm reduction might send the wrong message in two ways: first, through directly delivering a rhetorical message which could be interpreted as encouraging drug use, as the absence of strong disapproval of drug use might be perceived by youth as an endorsement of drug use and as downplaying its adverse influence on the life of its users; and, second, in making drug use less risky (and more “user friendly”) the harm reduction approach may remove the barrier that once made non-users afraid of drugs and their consequences. When the fear around the consequences of drug use is removed, “taking chances”
becomes less risky. It is too early to conclude whether the harm reduction approach does in fact create a risk factor for drug addiction, and there is no study to support or dismiss such a hypothesis. However, it was argued by Coleman (1999) that in Switzerland, which is among the leading countries in creating and implementing policies based on a harm reduction philosophy, adolescents use more drugs per capita than adolescents in any other country in Western Europe. Coleman stated that the spirit of the Swiss drug policy may be the cause of, and not the response to, these statistics.

The availability of drugs and their affordability can be considered another risk factor. Cook & Tauchen (1982) found that increases in taxes on alcohol, for example, sharply decreases liquor consumption and related mortality. Still on the availability of alcohol, Gorsuch & Butler (1976) argued that when alcohol is more available, the prevalence of drinking, the amount of alcohol consumed, and the heavy use of alcohol all increase. According to Teichman (1995) the transition from the wish to use drugs and the actual use depends on the availability of the drugs. Availability is not only the accessibility to drugs and the drugs’ actual existence in one’s environment, but also the knowledge about drugs and about sources of purchase, their affordability, and the existence of the right social context in which they are going to be used. Teichman further asserts that although the social influence and social process related to drug use are important factors (see Factors Associated with Peers), such a process would not occur if drugs were not readily available for youth. Nowinski (1990) stated that 90% of high school seniors reported that marijuana would be “very easy” or “fairly easy” for them to obtain, and 48% reported the same with regard to cocaine. He further stated that, “Substance use among adolescents has become the rule and not the exception” (p.13).
Finally, the approach that holds drug availability as one of the most important causes for drug use suggests that the best strategy for combating drug use is by reducing the availability of drugs (Teichman, 1995). If less drugs are available then fewer drugs will be used, not only because of the limited supply but also because of their higher prices.

Many studies have been conducted on physiological factors associated with alcoholism, and many have indicated relationships between certain biochemical conditions and the risk for developing a dependency on alcohol (Li, 1977; Schuckit, 1987). However, little research has been conducted on genetic predisposition and the abuse of drugs other than alcohol (Hawkins et al, 1992). In their longitudinal research, Shedler & Block (1990) have found that poor impulse control in childhood predicts frequent marijuana use at the age of eighteen. From another study conducted with animals, there was evidence of heritable predisposition to barbiturate and morphine abuse (Marley, Miner, Wehner & Collins, 1986). However, there is no corresponding evidence from studies conducted with humans.

An interesting and innovative perspective on the antecedents of drug addiction (or addiction in general) was suggested by Alexander (2001), in his article, the roots of addiction in free market society. Alexander asserts that the basic human need to achieve "psychosocial integration" is not being met in modern societies, which exist within the principles and norms of free markets. Psychosocial integration refers to the drive to establish and maintain close relationships, such as with friends, within ethnic or religious groups, or with one's extended family. When individuals are unable to form such relationships they are not fully participating in society and they achieve insufficient

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psychosocial integration. Alexander calls this condition “dislocation,” which is also known as alienation or anomie. It is this condition that serves as a link between modern economy and addiction. According to Alexander, free markets are the spheres of modern societies, in which all of their members must participate and necessarily be affected by, to a greater or lesser degree. Free markets require that participants be unburdened by family and friendship obligations, be free of community responsibilities, ethnic and religious values, and of charitable feelings. In a struggle to find or restore psychosocial integration, dislocated people construct lifestyles that substitute for it, and that includes compromised relationships which are insufficiently close, stable, or culturally acceptable. Being an eccentric artist or a street drug addict are two of the examples of substitute lifestyles provided by Alexander. Both lifestyles provide a sense of identity that compensates for the dislocation. According to Alexander’s theory, dislocation is the only underlying cause for addiction, which occurs in the life of persons who have found no better way to cope with it. In the light of this explanation for addiction, Alexander also describes how dislocation acts as the precursor for addiction among Native Canadians, when considering the history that alienated them from their own heritage.

**SUMMARY**

The literature review presented a number of definitions and etiological explanations for the phenomenon of drug addiction. It especially focused on the DSM IV’s definition of four distinct disorders, which together formed a definition of addiction that was utilized in this research project. Following an overview of limitations in previous
research related to risk factors for drug addiction, the thesis presented the primary theoretical approaches that guided the work in this project.

A major part of the literature review included an extensive overview of research findings explaining risk factors for drug addiction. The findings were organized and presented in five categories, as follow: risk factors associated with the family; with peers and school; with personality; with history of trauma and abuse; and a fifth category that included other areas, such as demography, availability of drugs, and physiological related factors.

The next chapter discusses the methodology utilized in this research project. It explains procedures related to participants' selection and recruitment and describes the primary tools that were used for data collection (the questionnaire and the personal interviews). It also describes the process of data analysis as it was conducted in this project.
The purpose of a descriptive design is to gain a better understanding of a phenomenon as it exists in a specific context, and to clarify the nature of some aspects of the phenomenon (Anastas, 1999). According to Anastas, a descriptive design consists of five elements: a phenomenon, a population affected by the phenomenon, a context in which the phenomenon occurs, aspects of the phenomenon, and a perspective from which the research is conducted. Accordingly, the goal of this research project was to have a better understanding of certain characteristics of individuals affected by drug addiction (The Population and The Phenomenon) as occurs in the Vancouver DTES (The Context). The Aspect of the phenomenon that was chosen to be focused on was the etiology of the phenomenon. The Perspective from which the data was collected was, in part, the perspective of the participants in this study and in part the perspective of the investigator, based on previous published studies. The adherence to the perspective and to the voice of participants as a way of understanding and conceptualizing the data they provide applies to the reasoning process called “induction”. This process compliments the other method used in this project, in which the investigator explores particular elements of the phenomenon based on findings, recommendations and conclusions made in prior studies. This reasoning process, which is grounded in and grows from theory, is called “deduction”. According to Anastas (1999), deductive and inductive processes occur in all
studies "as the investigator moves back and forth between theory and data in framing questions, observations, and conclusions" (p. 35).

RECRUITMENT PROCEDURES & SAMPLING

In December of 2000, a process was begun to recruit participants. Social agencies and organizations in the DTES were approached and their help was sought to identify and access potential participants. The use of their facilities for the interviews was also arranged. Potential agencies were selected based on the population they served, in accordance with the selection criteria for the project (outlined further below). Many "cold-calls" were made to various potential agencies, during which information was provided on the purpose and needs of this research project. Most of the contacted agencies refused participation in the project at that point. This was unfortunate as some of the organizations could have made a valuable contribution to the project, such as a youth drop-in centre in the heart of the DTES drug scene. Others agreed to review more detailed information on the project before they made their decision. Finally, four agencies agreed to participate:

1. The Adolescent Service Unit, which offers protection services, mental health and addiction counselling, shelter and other services to street youth;

2. The Urban Native Youth Association, which specializes in providing services to aboriginal youth in the DTES;

3. The Broadway Youth Resource Centre, a drop-in for youth, which provides services such as, drug and alcohol counselling, peer support, and health services; and
4. **The Gathering Place**, a community centre for the disadvantaged, which provides programs for street youth, persons with HIV, and residents of Single Room Occupancy (SRO**) dwellings, and also provides laundry, showers, and recreational activities.

Most of the participants that met the selection criteria specified for this project were regular clients of at least one of the above agencies.

Since the targeted population was anticipated to be homeless and street-involved youth*, which could not have been easily reached, it was known that systematic and random selection was not possible. Rather, a combination of purposive sample and snowball sample methods were utilized. Anastas (1999) noted that purposive sample is one that is nonrandom, and that its “respondents are atypical in some way that specially equips them to be useful as study information” (p. 288). Anastas noted two main issues with purposive sampling. First, exclusion criteria must be carefully defined as minor variations can change markedly the scope of phenomena under study. Secondly, gaining access to people who meet these criteria can be challenging. The snow-ball technique, on the other hand, was used along with the purposive sampling to assist in networking and accessing faster a large number of participants. “Snow-ball technique is used when there is initial access only to a very limited number of identifiable sample members. These few people who meet the sampling criteria are recruited, and they in turn are requested to

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** SRO, Single Room Occupancy, available in cheap hotels and rooming houses that saturate the DTES. These are often poorly managed hotels with shared bathrooms, and which most likely are the only housing in the Lower Mainland that can be afforded by recipients of Income Assistance.

* The expression *street-involved youth* refers to youth who are homeless, often children that either ran away from their homes or were kicked-out by their caregivers, and who are more likely engaged in activities such as, drug use, pan-handling, and prostitution.
identify other people like themselves who would be eligible to participate in the study” (Anastas, 1999; p. 289).

Recruitment occurred by advertising the project and the participation requirements in all of the above agencies. The poster (Appendix 2), which also served as a flyer, was posted on bulletin boards of participating agencies, and outlined the purpose of the study as well as the criteria for participation. In addition, a meeting was held with representatives from each of the participating agencies where more information was provided on the project and where agencies were encouraged to distribute flyers to potential participants among their clientele. Finally, at the end of each interview, participants were asked to pass on flyers to other youth they might know. This snowballing method proved to be the most efficient one, and often participants stated they had heard about the project from a friend rather than reading the poster.

When potential participants contacted the investigator, a brief process of screening took place over the phone, insuring that potential participants did meet all criteria. Interviews were held in the facilities of participating agencies, in quite and private places on the streets, parks, and even in the DTES' alleys. At the end of each interview, an honorarium of ten dollars was issued to each participant.

The sample that was recruited was comprised of thirty one (31) youths. The rationale for the focus on youth as an age group stemmed from the intention to gather the most relevant, up-to-date, and accurate information. It was assumed that the more recent the addiction was, the more accurate and reliable would be the recall of the demonstrated risk factors. The residue of experiences (such as dropout of school, peer pressure for
experimental use, caring for parental addiction needs, etc.) may have been "fresher" among younger drug addicts than older ones. In addition, some risk factors could have been the results of recent policies (such as child welfare policies), with youth more likely to have been affected by them. Older addicts may have demonstrated risk factors related to policies that were obsolete (such as the effects of residential schools with First Nations participants).

Some of the criteria for selecting participants were based on the DSM-IV definitions for Substance Dependence, Abuse, Withdrawal, and Intoxication, which together were adopted in this thesis as a definition for drug addiction. The criteria that were outlined on the posters included the following (in addition to the criterion referring to age group, as described earlier):

1. **Being a current or former regular drug user:** Instead of defining "regular use," the DSM IV refers to the repeated pattern of self-administration occurring regardless of consequences of use, which results in tolerance, withdrawal, and compulsive drug taking behaviour. The frequency of use by participants varied according to the type of drug that was used, although there was always at least one type of drug that was used daily by all participants.

   In determining whether the use of drugs was regular or not, Parikh & Krishna (1992) suggest considering the frequency of drug use, which leads to physical dependency, and which without its regular consumption the body will suffer withdrawal symptoms. The second factor that is related to the frequency of use is tolerance, which explains the physical adaptation to the amount and type of drug
consumed, and the inevitable need to increase consumption, frequency, or switch to a more powerful drug (See Stage Theory in the Literature Review).

2. The second criterion was **drug of choice being one or more of the following:** heroin, cocaine, crack cocaine, speed, speed-balls (a combination of heroin and cocaine), and poly-drug user with one of the above drugs being used. Excluding alcohol and prescription drugs, which are not the focus of this thesis, the DSM-IV indicated that all of the above four disorders may occur with the regular use of any of the following street drugs: amphetamines (speed, crystal-methamphetamines), cocaine, and opiates. For example, the DSM-IV indicated that Substance Withdrawal Disorder did not apply to cannabis or hallucinogens (although to both Substance Dependence Disorder may apply), and therefore the regular use of these drugs was not considered for the purpose of this thesis as “drug addiction”. In other words, and for the purpose of this study, drug addiction occurs at a later stage of the drug use, when the youth moves-on not only from occasional misuse to a regular use, but also from soft drugs to hard, illicit drugs.

3. **Individuals are involved in the DTES** in some way, such as residency, purchasing or selling drugs, accessing local services, etc. The purpose of this study is to focus on the phenomenon as it exists in the context of the DTES. The rationale for this is that with a problem as serious as the open drug scene in the DTES, and its related (or consequent) morbidity, crime, and poverty, it is problematic to apply and use findings from other global research projects when trying to understand the local phenomenon. It is so immediate and urgent that it requires full attention to thoroughly study the problem, in order to know how to address it effectively. It is the belief of the
investigator that although some global findings may be applicable to the subject research (e.g., risk factors such as drug availability, crime saturated area, and poverty) most of the risk factors are unknown, as they are unique to the DTES community, and to the individuals that seek involvement in it.

The method of drug administration was insignificant to include in this study, and could vary from injecting, snorting, smoking, and ingesting. In addition, this study sought a diversity of participants from both genders and a range of cultural backgrounds.

Data Collection

As mentioned earlier, the design of this research project was aimed at collecting both quantitative and qualitative data from the perspective of the participants as well as the investigator. In order to achieve those purposes, the instrument used (Appendix 1) was a 72 item questionnaire that included structured questions with fixed response categories (either Likert Scale or yes/no answers) and open-ended questions directed at the personal perspective of the participants.

There were three parts to the questionnaire, with a number of subsections for each part. The first part, which was aimed at collecting background information, contained three subsections: first subsection for general, demographic data; a second one for information pertaining to the involvement of participants in the DTES; and a third subsection inquiring about drug use patterns and history.

The second part of the questionnaire dealt with participants' perspectives on risk factors for drug addiction. Accordingly, it contained only open-ended questions, which
enabled participants to elaborate on their own thoughts, beliefs, and experiences prior to entering the final part of the questionnaire, which guided their thoughts and framed them into fixed answers.

The third and last part of the questionnaire included primarily fixed response questions inquiring about risk factors for drug addiction. The third part contained six subsections divided according to six categories of risk factors associated with:

1. Environment and drug availability;
2. Family (including drug use and delinquency among family members; family attitude to drugs; family economic status; family relations and dynamics);
3. Personality and misconduct;
4. School;
5. Peers; and
6. Risk factors associated with history of trauma and abuse.

Most of the questions in part one and three of the questionnaire were drafted based on findings of previous studies in the field of addiction as discussed in the previous chapter. Sometimes questions were specifically articulated based on general risk factors and abstract themes found in the literature. For example, the literature indicated a link between broken attachment and vulnerability for substance abuse (e.g., Brook et al, 1990). In the questionnaire there were a number of questions that explored attachment issues in the lives of participants, including apprehensions by social services, multiple caregivers, age of disruptions in relationships with primary caregivers, etc. Such specification in the questions was made in order to enhance clearer results upon which particular conclusions and recommendations could be made.
The questionnaire was completed during personal interviews. The interviewer took notes as participants were speaking and there was no use of type recorder. The use of personal interviews as opposed to asking participants to complete the questionnaire individually, derived from recognizing the emotional impact that some of the questions could have on the interviewees. The questionnaire raised deep, personal, and sensitive parts of the participants' life histories, and many of them experienced the process as very emotional. Therefore, the interviews were conducted by an experienced counsellor who ensured the safety and well being of all participants, by establishing an atmosphere of safety and trust, and by addressing the questions in a highly sensitive manner. At the end of the interview, the interviewer allowed time for debriefing as needed. Total interview time varied from 30 minutes to 2 hours. The second reason for conducting personal interviews rather than allowing participants to fill out the questionnaire independently was to enhance accurate and comprehensive data collection, by rephrasing unclear questions, asking for interpretation of slang and common jargon used among street-kids, completing open ended questions, etc.

Personal interviews took place over a period of two months (June-July 2001), with the goal being to conduct 30 interviews in total. After having completed 28 interviews and just before making the decision to end the stage of data collection, an opportunity came to interview 3 more female users in the DTES who were not associated with any of the participating agencies. Thus, the total number of personal interviews conducted was 31.
DATA ANALYSIS

This research project produced a high volume of narrative and quantitative data, not only due to the length of the questionnaire, but also because of the number of interviews and the nature of the questions that were asked (most of the questions induced voluntary provision of explanations and examples from the life histories of the participants), which added to the qualitative data.

Data collection and data analysis occurred simultaneously in this project. Throughout the period of gathering the data, there was also an ongoing, parallel process of coding and organizing the data and inputting it into the computer. Quantitative and narrative data were handled separately, with a coding system developed for each type of data. The numbers of the questionnaires were kept throughout the process on both systems, to ensure the possibility of cross-referencing the right narrative with its matching quantitative data. This was made in order to maintain the identity of each participant (their entity and uniqueness rather than by name) and to allow the observation and the drawing of trends and ideas on personal levels (trends in the course of addiction of each participant) in addition to the general-group level (characters and ideas that contributed to identify processes among the whole sample of participants).

Coding and analyzing quantitative data:

As noted earlier, data was inputted into the computer immediately after each interview. This was found to be the most effective strategy to manage the data and to prevent disorder in a large number of questionnaires awaiting to be transcribed. It also
ensured that all information would be recorded accurately as often the investigator used abbreviations and shortening in notes taking during the interviews. Such abbreviations and short hand had to be interpreted and elaborated immediately after the interviews, so their meaning would not be forgotten and so they would be understood clearly. The responses to each fixed question was coded into numbers and was entered into the computer software, ‘Microsoft Excel’. In certain questions separated columns were created for each response (e.g., q. 27 had nine responses, one for each potential caregiver). The easiest way to handle such multiple responses was to create a column for each caregiver. A total number of 145 variables on separated columns were created on ‘Excel’. After the information from all 31 questionnaires was inserted, the data on ‘Excel’ was transformed onto the computer software, ‘Statistical Program for Social Sciences’ (SPSS), from which the descriptive and inferential statistics were produced.

Both the descriptive and the inferential statistics contributed to create the profile of youth drug users in the DTES and to understand how various factors contributed to their drug addiction. For the inferential statistics, this thesis utilized two type of tests. First, Pearson’s “r” was used to examine correlations and associations between different variables. Secondly, a t test for independent samples was used to explore differences between different groups of participants.

This study was primarily exploratory in nature and, as was discussed in the beginning of the chapter, was largely inductive and drawn findings from the perspectives of the participants. The intention of this study was to learn the characteristics of the investigated population and to understand how those characteristics were developed. It was also intended to draw a profile of youth in the DTES as learned through the study
sample. The deductive part of the study (reflected through part three of the questionnaire) complemented the inductive process by asking questions that intended to explore factors that were not raised voluntarily by participants. It was an attempt to examine whether risk factors that were found in previous research also exist in the population investigated in this study, assuming that generally, the construction of addiction among youth in the DTES would be similar to the construction of addiction among other populations. Nevertheless, it was hoped that by exploring a wide range of factors it would be possible to observe which factors were more dominant than others and to examine the existence of factors that are unique to the investigated population.

**Coding and analyzing qualitative data:**

Throughout the process of writing, the display of empirical data was entwined with narrative data, which provides illustrations from the participants' life histories as well as explanations and extensions of some of the ideas as given from the perspective of the users. Therefore, the presentation of the descriptive statistics was incorporated within the presentation of the qualitative data, including participants' perspectives, explanations, and stories. This method of analysis enables the reader to expand the experience of understanding the course of addiction among participants and presents the reality of the users in the DTES in a way that goes beyond statistics and numbers. The lifestyle of the participants, their life history, the street jargon, and their emotional world serve as a stage for the presentation of the qualitative data.

The Grounded Theory Method (Glaser and Strauss, 1967) was utilized in the process of analyzing the qualitative data in this thesis. According to the Grounded Theory
a constant comparison of themes' indicators occur in the initial process of coding narrative data. This process of coding, which is active and progressive, involves fracture, elaboration, and interpretation of the data, and leads to the "inevitable payoff of grounded conceptualization" (Strauss, 1987, p. 29). The next stage following the process of constant comparison in the Grounded Theory is presented in the axial coding. This stage involves focusing on each category of themes separately and on the link between the established categories. Finally, the analysis of data throughout the process of constant comparison and the axial coding leads to the generation of theory from the qualitative data.

In this study, the investigator created written transcripts of the data after each interview. The information recorded in the transcript was laid-out according to the sequence of questions as they appear in the questionnaire. This allowed a faster reference to ideas by associating the data with its location in the questionnaire (e.g., data recorded in part one was known to the investigator to be associated with background information; data recorded under questions number 68-72 was known to be associated with history of abuse and trauma, etc.). This manner of handling the narrative data also allowed a maximal structure in the verbatim as opposed to recording one flow of statements and stories shared by participants. The verbatim of each participant was saved as a separated document under the number of the questionnaire it was transformed from.

A major role that the personal statements played in this research was in grounding concepts and results in the words of the research participants themselves by presenting carefully chosen excerpts from the data verbatim (Anastas, 1999). In addition to the use of participants' verbatim as a way of elaborating, supporting, and explaining empirical
data, verbatim was also transformed into statistical data, especially in questions number 14-16, of part two of the questionnaire (open-ended questions). The process of coding was not so complex in this study, as the questions were specific and concrete, yet, not limiting the participants’ freedom of expression. Such questions promoted clear responses that could easily be classified into themes and labeled according to the meaning they represented. The unit of analysis in the coding process was always the theme or the main idea in the statement. The themes were established and labeled separately and specifically for each one of the open-ended questions.

In question number 14 and 16 (personal perspectives on causes for addiction in the lives of the participants; risk factors for drug addiction affecting other youth in the DTES) themes were defined according to the area of risk factor they represented, such as curiosity, experience of trauma and abuse, parental drug use, etc. Fifteen different categories were created for themes that were identified as capturing the main ideas in responses to question number 14. Fourteen categories were established for themes that were raised in responses to question number 16. There was no risk factor/theme that was identified by participants and that was left unclassified. Some themes were ‘sub-themes’ to a larger group. For example, the investigator was interested in counting the number of family associated causes for addiction as was identified by participants. However, a group of themes identified as “family associated factors” was too broad, therefore, in addition to this global category a “sub-category” was created for parental addiction.

In Question number 15 (participants were asked to identify preventative factors that could have steered them away from using drugs or reducing their drug consumption), themes were defined according to the area of need that was identified, such as a need for
more affordable sports and recreational opportunities for youth in the community, increased awareness for the consequences of drug use, and a need for social ties and belonging. Eleven categories of themes were established for this question.

In the process of coding, labels for the themes were created and written beside their appearance on the verbatim of each participant. Each question was processed separately. At the end of this process a table was created with a column for each category of theme/area of risk factor. The number of the questionnaire in which themes were identified were recorded in the appropriate category/column. For example, all the numbers of the questionnaires that presented the theme “peer pressure” under question number 14, was recorded in the column labeled as “peer pressure” in the table for question number 14. Eventually, the numbers in each column was counted and converted into descriptive statistics.

LIMITATIONS & STRENGTHS

A number of limitations exists in this study. First, since the design of this project does not including a comparison group, it does not enable the making of causal arguments, a factor that could make this research more valuable. There was no opportunity in this research to rule out the existence of certain risk factors, therefore the factors that were found to be associated with addiction in this study cannot be seen as actually causing addiction. This limitation means that the results in this study do not provide a direct answer to the question: “what are the causes for drug addiction among youth in the DTES”. Rather, it shows an association or lack of association between
certain factors and the phenomenon, and reflects the prevalence of certain factors, with limited reliability, as noted below.

Secondly, there are issues concerning the representativeness of the selected sample. Because of the nature of the investigated population (street involved, homeless, and difficult to reach) a random sampling method was impossible to implement. Although the sample was large, it was not large enough to make it representative of the whole investigated population. Therefore, this limitation results in a selection bias, that is due to the non-random sampling method. Participants in this study were selected primarily from the clientele of the four participating agencies, or through clienteles of those agencies, by using the snowballing method.

The instrument used in this study was a valid one, as it did examine what was meant to be examined, and in most cases, questions were presented in a way that responses to them could be evaluated. For example, when attempting to examine family dynamics, a fairly abstract factor, the questionnaire presented a sequence of operational questions examining specific indicators of family dynamics, such as communication patterns, time spent together with members of the family, etc. A related limitation may be related to the fact that the indicators that were selected by the investigator to examine more global or abstract factors are not necessarily the ultimate indicators or the only indicators to provide an understanding of the factor under examination. Finally, the investigator was conducting the interview and therefore was able to clarify to the interviewee the meaning of each question.

Before utilizing the instrument, it was reviewed and modified according to the input of a number of readers, including a former drug user and a person that was working
with drug addicted youth in the DTES. The instrument and the method (personal interviews) were consistent and reliable, although certain limitations applied. If the same instrument would be used in the future with the same participants, their perspectives on causes to drug addiction or on prevention measures could be different, as people’s views transform over the years. However, other items on the questionnaire produced outcomes that would be the same even if examined years from now (e.g., facts related to experience of abuse, diagnosis with mental health issues, parental addiction, etc.).

Since the research was retrospectively exploratory, information provided by participants could be, at times, inaccurate due to limitations related to memory. Although the design attempted to reduce the likelihood of forgotten material by limiting participants’ age group to 13-24, many of the questions referred to childhood experiences that could have been vague in their memory. Other potential errors are related to deliberate lies. Some of the questions were extremely intrusive and personal, and one meeting with a stranger during a personal interview was certainly not enough to gain participants’ trust. This error was especially felt by the investigator to occur on questions such as involvement in the sex trade and criminal activity. Rearranging the sequence of questions in a way that such intrusive questions would appear after a certain level of comfort was achieved (close to the end of the interview rather than in the beginning of it), could have reduced the occurrence of such an error.

The method of using personal interviews may be a strength in this study as it minimized errors related to misunderstanding of questions. Other strengths rest with the fact that this study provided a clear understanding of one of the most important aspects of drug addiction in a local context, partially through drug users’ perspective and enabled
the generation of a profile of the investigated population. According to Anastas (1999), “it is this result of a study that allows one to develop theoretical models explaining (at least structurally) how and even why, a phenomenon might function as it does” (p. 138).
Chapter four will present the results of this study. It will first display descriptive statistics and narrative data (participants’ testimonies and perspectives on the explored themes). The descriptive statistics are laid-out according to the sequence of the questions as they appear on the questionnaire. Results will be presented in three parts according to the three parts of the questionnaire. Following the presentation of the descriptive statistics and narrative data, the thesis will explore correlations between various variables using Pearson’s r, and comparisons between groups of participants, using a t test for independent means. A discussion of the major findings and conclusions drawn from them will be linked to the previous literature review and will be summarized in the final chapter of this thesis.
PART ONE

DEMOGRAPHIC DATA

Section one, part one of the questionnaire addressed general demographic data.

Age of participants:

The ages of the 31 participants varied from 18 to 24 years, with the average age being 21. It should be noted that interviews were scheduled with younger adolescents (aged 13, 14, 15, 16), however, these subjects did not appear at their interviews.

Sex of participants:

Twenty five of the participants (80.6%) were males and six were females (N=31). Although appointments were set up with more females than six, only six showed up.

Some participants tried to explain why female youth who were drug users were hard to reach for the purpose of this project:

A female participant: “Girls on the streets are ‘followers’. If they are with someone on the street, and this person offers (them) to smoke a ball or to pay them cash, they’ll go with this person... they are less responsible in their drug use, they don’t set limits for themselves. That could interfere with anything they plan ahead of time... They may be controlled by their pimp, and not being free to do whatever they want. They are first committed to their pimp... girls usually don’t come to places that provide recreational or social services. If you would tell me that there’s a girl playing pool at the Gathering Place, that would sound really weird to me.”

A male participant: “Girls get dates. A date is not only money. It is someone that cares about them and would give them love, make them feel loved. They prefer that.”

A male participant: “Girls don’t show up for their interviews ‘cause they don’t want to share their drug use with others. They tend to be pretty quiet about it.”
Racial background:

The following table presents the distribution of the participants’ racial background:

Table 1: Racial Background

<table>
<thead>
<tr>
<th>Race</th>
<th>N (31)</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caucasian</td>
<td>17</td>
<td>54.8%</td>
</tr>
<tr>
<td>First Nation</td>
<td>7</td>
<td>22.6%</td>
</tr>
<tr>
<td>Other/Mixed</td>
<td>7</td>
<td>22.6%</td>
</tr>
</tbody>
</table>

Ancestries of the participants in the “other” category included four participants that were half Caucasian and half Native; one that was half Swedish and half Congolese; and two that were not sure about their cultural background as they were adopted at a young age and never knew their biological parents. However, both of them believed themselves to be Caucasian. If those two participants were added to the Caucasian group, the number of Caucasian participants would be increased to N=19 (61%).

Residency:

Excluding the ones that rented apartments or SRO, and the one participant who lived with his parents, 23 (74.1%) participants were basically, homeless. The participant that lived with his parents stated that when he was using drugs he “bounced around friends’ places”, and it was only after he quit drugs that his parents allowed him back home.
### Table 2: Residency

<table>
<thead>
<tr>
<th>Residency</th>
<th>N (31)</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Renting an apartment</td>
<td>1</td>
<td>3.2%</td>
</tr>
<tr>
<td>shelter</td>
<td>5</td>
<td>16.1%</td>
</tr>
<tr>
<td>Single Room Occupancy (SRO)</td>
<td>6</td>
<td>19.4%</td>
</tr>
<tr>
<td>Staying with parents</td>
<td>1</td>
<td>3.2%</td>
</tr>
<tr>
<td>Staying with friends</td>
<td>6</td>
<td>19.4%</td>
</tr>
<tr>
<td>Live on the streets</td>
<td>12</td>
<td>38.7%</td>
</tr>
</tbody>
</table>

One girl said that her husband and she hitchhiked from Calgary, so the trip didn’t cost them any money. As for residency, she said:

"my husband and I never had a place of our own. We used to sleep in Main Park (Main & Terminal). Sometimes we stayed with people that we met and that had a room in a DTES hotel. We paid the guest fee, which is $10, and stayed with this person... those hotels are all about drugs."

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**Participants' involvement in the DTES**

As part of studying the profile of the youth drug users in the DTES, eight questions explored the history and the nature of their involvement in the DTES (Q. 6-13). It was found that only seven (22.6%) of the participants were born in the Vancouver area, and that almost 80% (N=24) came from elsewhere. Forty eight percent (N=12) of those that were not born and raised in Vancouver, had been in Vancouver less than two years, while the rest (N=13; 52%) have been in Vancouver for longer (from 2-9 years). The following two tables present the place of origin of the participants:
Table 3: Place of origin: Participants raised in Vancouver area

<table>
<thead>
<tr>
<th>Place of origin</th>
<th>N (N=7)</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vancouver East Side</td>
<td>4</td>
<td>57.1%</td>
</tr>
<tr>
<td>DTES</td>
<td>2</td>
<td>28.6%</td>
</tr>
<tr>
<td>North Vancouver</td>
<td>1</td>
<td>14.3%</td>
</tr>
</tbody>
</table>

Table 4: Place of origin: Participants arriving in Vancouver from elsewhere

<table>
<thead>
<tr>
<th>Place of origin</th>
<th>N (N=24)</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elsewhere in BC</td>
<td>4</td>
<td>12.9%</td>
</tr>
<tr>
<td>Another province</td>
<td>19</td>
<td>79.2%</td>
</tr>
<tr>
<td>Another country</td>
<td>1</td>
<td>4.2%</td>
</tr>
</tbody>
</table>

The one participant out of the 31 sampled who claimed to spend less than several hours a week in the DTES was actually residing in a shelter in the DTES, but had no other business there beside that. In addition, he had just arrived in Vancouver from another province at the time of the interview and claimed to be drug free. Eighteen participants (58%) claimed to be spending time in the DTES every day, while the rest (38.8%; N=12) stated they go there almost every day.

Feelings about the DTES were mixed among participants, although most of them spoke negatively about it. The following are statements made by participants describing their feelings about the area:

"This is where the greyhound bus drops you... it's your first stop in Vancouver: the DTES, right into a cheap hotel... The attraction to drugs came only later."

"I prefer not to be here."
“Everything that I’m trying to change about my life is right there: drugs, poverty… Everywhere in Canada people know what East Hastings means. I didn’t want to go there, I was afraid of this place”.

“I go there only during the day. No one would dare go there at night… I’ll be dead.”

“I was attracted to the street life in the DTES… Even though I hate it, I’m addicted to this place.”

“I’m addicted to Hastings.”

“People that live in the DTES cannot avoid using drugs!”

“Everyone is in the DTES for the same reason.”

“Drugs are the only reason I go there.”

“I go there just to get my down.”

“I go there to get my drugs, do drugs, and leave.”

“Nothing in the world will get me out of here… I don’t want to get out of here… just want my drugs, I’m happy with my drugs… I want to die in the DTES.”

“It’s really sad. Vancouver is such a small town. I don’t consider it a city, and I’ve been to many. And yet, the drug problem here is so huge, it is nothing like a drug problem anywhere in the world. The police knows what’s going on there, they do nothing. The city of Vancouver, everybody knows… but people ignore it and just let it grow. For some people, Vancouver may be the beautiful, scenic, peaceful city, with the mountains and the ocean, but for others around the world and in other provinces in Canada, it is simply the city where you could get drugs easy and cheap. No one would stop you here from becoming a junkie… until I got to Vancouver, I never realized there were so many drug users.”

“I don’t want to go near there anymore… I’m clean now.”

Participants were attracted to the DTES for different reasons. However, as the table below indicates, it was mostly drugs that attracted youth to the DTES. Participants could score for more than one category.
Table 5: Attraction to the DTES

<table>
<thead>
<tr>
<th>Attraction to the DTES</th>
<th>N</th>
<th>percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Availability of drugs</td>
<td>24</td>
<td>77.4%</td>
</tr>
<tr>
<td>Low cost accommodation</td>
<td>18</td>
<td>58.1%</td>
</tr>
<tr>
<td>Local friends and family</td>
<td>10</td>
<td>32.3%</td>
</tr>
<tr>
<td>Access to social services</td>
<td>5</td>
<td>16.1%</td>
</tr>
<tr>
<td>Did not choose to be here</td>
<td>2</td>
<td>6.5%</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>9.7%</td>
</tr>
</tbody>
</table>

Those that stated that the availability of drugs did not attract them to the DTES had different explanations to offer. Some indicated that the quality of drugs in the DTES was not good, and that it was better and safer to purchase them in the West End.

"In the DTES, you never know what you’re getting... you can tell that the quality of drugs is low, and that they mix it with stuff such as baby laxative... you get the runs or you break-out in zits."

Others stated that they get their drugs in gay bars, where cocaine is very accessible and available at all times ("Everybody uses it there...").

Some youth have stated that their drug use took place in the growing community of street-kids in the Granville Street area of Vancouver. In most cases, the drug of choice there is crystal-meth, which is more available there than in the DTES. Participants have referred to the difference between the cultures of the DTES and the Granville area, describing drug users in the DTES as being "Junkies" and "Coke and heroin-heads on Hastings." However, the stage of being an active drug user in the Granville area was also identified as a step in becoming "a junkie in the DTES". One participants described her own experience of
"gradually moving from Granville street to the DTES... being a street-kid on Granville was the beginning of the drug scene in my life."

With regard to low cost accommodation, it was indicated that most of the low cost shelters in Vancouver are located in the DTES. If one wants to rent an affordable SRO, one can only do that in the DTES. For some participants, living in the area and being constantly exposed to the drug scene, preceded their interest in using drugs.

At the time of the interview, a transit strike was in effect in Vancouver. It was indicated by at least one participant that the strike increased his involvement in the DTES, as he was not able to go anywhere else by transit. Others that felt their involvement in the area was not voluntary, and identified friends as responsible for bringing them down there.

Those that were attracted to the DTES for other reasons stated that:

"It was the subculture of graffiti art and abnormal society... I liked the fact that the streets were not regular, no offices and regular stores, no nicely dressed people, unusual..."

"What attracted me to the DTES was the reality, the fact that people were truthful about what they are, don’t try to hide it. People are real and therefore life is more solid there."

"The street life attracted me."

The questionnaire was interested in capturing the nature of the youths’ involvement in the area. The emphasis in the next table is not on the initial attraction to the DTES, but rather on the continuing and on-going involvement of participants in the life there:
Table 6: The nature of participants’ involvement in the DTES

<table>
<thead>
<tr>
<th>Nature of involvement</th>
<th>N</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do drugs</td>
<td>29</td>
<td>93.5%</td>
</tr>
<tr>
<td>Residency</td>
<td>15</td>
<td>48.4%</td>
</tr>
<tr>
<td>Social activities</td>
<td>10</td>
<td>32.3%</td>
</tr>
<tr>
<td>Dealing drugs</td>
<td>9</td>
<td>29%</td>
</tr>
<tr>
<td>Prostitution</td>
<td>8</td>
<td>25%</td>
</tr>
</tbody>
</table>

As shown in the above table, doing drugs was the main activity that youth engaged in while in this area. One of the two participants who claimed not to be doing drugs while in the DTES was the same one that claimed to be spending less than a few hours a week there, had quit using drugs, and had arrived from another province just three weeks prior to the interview. The other participant who claimed not to be doing drugs in the DTES, stated that he got his drugs from gay bars, where he often worked as a prostitute.

One participant described his social experience in the DTES as follows:

“You hang-out with so-called-friends... everyone is trying to make money on each other... you got to fight to keep your own drugs, so easy to get robbed... they take you to the alley, saying they just want to look at your drugs, and then they beat you and take it from you. You got to know how to be careful. Everyone wants others to fall. That’s how they make their money.”

Participants elaborated on their activities in the DTES. For example, one dealer stated that he bought doctors’ prescriptions from people, got the drugs from pharmacies, and later sold the drugs at a higher price. A few of the participants indicated that all temporary employment agencies, such as Labour Ready, are in the DTES. One person stated in particular that he often went there to check for temporary job opportunities.
Another participant stated that he liked to hang-out with friends there, and often used the gym at Carnegie Centre.

It should be noted that the figures for prostitution and dealing drugs reflected from Table six refer only to the participants' engagement in such activities in the DTES. These figures, as will be shown in Table eight, are different when they reflect youth prostitution and drug dealing as a means of financial support, not only in the DTES area.

When participants first arrived to the DTES, local social services were not identified as an attractive factor in the area. In fact, only five participants indicated that access to services was an attractive factor (See Table five).

Table seven, on the other hand, shows the utilization of services in the DTES by participants during the period when the interviews occurred. Responses to this question indicated that services were central and useful for many participants:

Table 7: Access and use of services in the DTES

<table>
<thead>
<tr>
<th>Use of local services</th>
<th>N</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Free food</td>
<td>19</td>
<td>61.3%</td>
</tr>
<tr>
<td>Recreational &amp; Social drop-ins</td>
<td>17</td>
<td>54.8%</td>
</tr>
<tr>
<td>Detox</td>
<td>16</td>
<td>51.6%</td>
</tr>
<tr>
<td>Emergency shelter</td>
<td>15</td>
<td>48.4%</td>
</tr>
<tr>
<td>Needle-exchange</td>
<td>14</td>
<td>45.2%</td>
</tr>
<tr>
<td>Free telephone &amp; computer</td>
<td>14</td>
<td>45.2%</td>
</tr>
<tr>
<td>Income Assistance</td>
<td>13</td>
<td>41.9%</td>
</tr>
<tr>
<td>Medical services</td>
<td>8</td>
<td>25.8%</td>
</tr>
<tr>
<td>Employment services</td>
<td>5</td>
<td>16.1%</td>
</tr>
<tr>
<td>Counselling services</td>
<td>3</td>
<td>9.7%</td>
</tr>
</tbody>
</table>
It is clearly evident that the provision of services responding to basic human needs such as food, shelter, and social belonging were the leading priority among the youth that utilized them. The use of detox services was also high. However, participants indicated that detox programs are limited and that the wait lists for these programs make it difficult for youths to access the service when they truly need it. One youth stated that once you put an addict on a wait list for detox, you miss the opportunity to help him, because the momentum of the motivation to quit drugs is very hard to hold on to. This is especially true if addicts remain in the same environment they associate with drug use (such as remaining in the DTES) because they are more vulnerable to be triggered to their old habit.

Youth disclosed various ways in which they had supported themselves. The leading method of financial support was prostitution, followed by income assistance, drug dealing and committing other types of crimes such as described in the personal statements below.

Table 8: Methods of financial support

<table>
<thead>
<tr>
<th>Method of support</th>
<th>N</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prostitution</td>
<td>16</td>
<td>51.6%</td>
</tr>
<tr>
<td>Drug dealing</td>
<td>13</td>
<td>41.9%</td>
</tr>
<tr>
<td>Income assistance</td>
<td>13</td>
<td>41.9%</td>
</tr>
<tr>
<td>Other crimes</td>
<td>10</td>
<td>32.3%</td>
</tr>
<tr>
<td>Work</td>
<td>9</td>
<td>29%</td>
</tr>
<tr>
<td>Pan handling &amp; squeegee</td>
<td>4</td>
<td>12.9%</td>
</tr>
<tr>
<td>Employment Insurance</td>
<td>1</td>
<td>3%</td>
</tr>
</tbody>
</table>
As shown in Table eight, prostitution was the leading method of financial support found among drug using youth in the DTES.

Out of the six female youth who participated in the project, four were prostituting. The other two that were not involved in prostitution had boyfriends who supported their drug use by drug dealing and committing other crimes. One of these girls was five months pregnant, and stated:

“I used to work as a babysitter for a woman that used to be a prostitute. She used to pay me with crack. Today, it’s mostly my boyfriend that gets the money for drugs - $100 per day for both of us.”

The other girl that did not engage in the sex trade said that:

“We have connections with people who are big dealers in the DTES. My husband used to work for them, so we didn’t have to pay them. They just gave us drugs. When we did drugs, we didn’t need to have money cause we didn’t sleep much and we didn’t eat much. We also tried to sell drugs, but we used more than we sold or we got ripped-off, so we stopped doing that.”

This young woman’s husband, who also participated in the project, appeared to be very protective and anxious about what his wife might say during her interview, and therefore repeatedly interrupted her interview, asking when it was going to be over. In regards to financial support, he stated the following:

“I worked for the drug dealers for six years, since I was 13 years old. I used to wrap all their drugs and spits (little bottles of cocaine). They gave me as much drugs as I wanted, I didn’t need to have money to get drugs or anything. They took care of me. I saw a lot of drugs... never left the house, ’cause all I needed was inside the house...”

Approximately one out of two participants were involved in prostitution to finance their addiction. One participant admitted to pimping his girlfriend out in order to
support their drug use. Prostitution was also referred to as “having a date”, “selling myself”, “selling my ass”, and “working the streets”.

Twelve male participants supported themselves through prostitution. They reported that they worked primarily in “Boys’ Town”, a gay prostitution area located on Homer Street. Prostitution also took place in gay bars. This type of work was referred to as “sitting in bars”.

The following are personal statements of what youth prostitutes experienced:

“I hang out all over in bars. In Surrey, Vancouver, Burnaby…”

“All my friends and myself prostitute, we’re all in the sex trade. The reason why I look good and clean is because I have to, that’s how I get my drugs... I sit in bars, and that’s what I do all night every night.”

“It was considered to be cool to be a prostitute for guys… Women shouldn’t be doing that. It is not a place for them, (prostitution) is a tough world… Today, my problem is that I can’t get a date anymore. It seems as if I passed the age limit.”

“After I ran away from the foster home, the first thing that I did to support myself was to strip. I learned that from the son of the foster parents. Shortly after that came the prostitution. I had to do that to get money for food... I traveled all over the world, it was part of my job as a prostitute since the age of 15. I started prostituting since the age of 15. I was stripping in Montreal and posed nude for magazines... I was always with filthy disgusting rich old men, who took care of me. I had a long relationship with a doctor who used to spend so much money on me. He didn’t want me with him for sex, we had sex maybe twice in the years that we were together. He wanted me as a companion. When he went for conferences he used to either take me with him or leave me with lots of cash and credit cards. When he came back home he was just asking ‘so, how did you entertain yourself today?’, and I used to tell him that I spent the day shopping and in restaurants, while really I was on the streets shooting crack... I was always a pretty boy, had no problems getting dates. Now I’m kind of thin, too thin because of my drugs. I totally lost my appetite. With heroin, on the other hand, I do gain back my appetite. But with speed, maybe it is the fatigue that doesn't allow you to feel your hunger... I never had to limp on the streets as so many other boys, I always had men that wanted me and just told me, here is the key to my BMW, here is a credit card, go have fun.”

“Working in bars is a lot better than working on the streets. Now I don’t bother standing in corners anymore... Prostitution goes in stages: before you get to the
age that you’re allowed into bars and after you reach the age. When you’re underage, you have no choice but to work on the streets. You stand around in the cold and rain, getting into cars with drunk old men. When you’re in a bar, there is always someone that buys you drinks, give you drugs... it’s a lot better...”

One participant who was not gay and worked as a male prostitute said that he often threw-up after “having a date”, and that the only way he could deal with the pain and humiliation of having to do that was by doing more and more drugs. This is often the cycle that is found in prostitution and addiction.

Participants that worked in jobs other than in the sex trade, often secured work through temporary employment agencies such as Labour Ready, which are haphazardly located around the DTES.

Panhandling and squeegee were also common methods for making money, amongst 13% of participants in this project. Squeegee was reported to take place mostly at the intersection of Main Street & Terminal Avenue. It was reported that the money made through squeegee could range between 20-30 dollars per day.

In addition to Income Assistance (IA), prostitution, drug dealing, panhandling and squeegee, participants reported that they committed various crimes as a method of supporting themselves. Some examples are:

“Trafficking drugs”

“Pawning”

“I stole, robbed cars, people, stores, and houses. I never did anything legal to make the money that I spent.”

“Forging cheques, mooching-off my parents, snatching purses.”

“Do whatever it takes... mostly, selling drugs. That’s how I’ve been supporting myself since I was 16. Sometimes I’d casual work at Labour Ready, do shoplifting...”
Those that tried to stay away from committing crimes reported:

“I don’t believe in doing crimes. I was once in jail, and that was enough for me. I also try not to sell drugs, ‘cause it’s dangerous. Most of the murders that happen on the streets are related to that. You can’t make profit on drugs that you buy for your own use, it’s just not acceptable.”

“I borrowed money from friends, worked to get drugs, and used meal tickets for food.”

“My parents often wired me money from Calgary. I fed them bullshit until they got tired of me.”

“It is uncommon thing for me to do crimes such as shoplifting, I prefer to do other things such as working in the sex trade or sometimes sell the drugs that I buy cheap. It is dangerous though, ‘cause there are those that control that. If they find you selling drugs on their block or selling drugs that you bought from them they will force you out of the block.”

**DRUG USE PATTERNS**

All 31 participants (100%) were cigarette smokers at the time of the interview.

The average age of initiation of cigarette smoking was 12.3 years of age, with the youngest age of initiation being six years old and the oldest being 21. The average number of cigarettes smoked by participants per day was 19.

All 31 participants (100%) reported they had experimented with marijuana. Twenty eight of the 31 participants (90.3%) reported that at the time of the interview they still used the drug. The average age of first experimentation with marijuana was 12.5 years old, with the youngest reported age being eight and the oldest being 18. One participant said that if he did marijuana regularly, he “would be way out of troubles.” Another had indicated that he used a lot of pot and alcohol as a replacement when he quit hard drugs.
Experimentation with hallucinogens, or "acid" (such as LSD), among participants was found to be less common than experimentation with marijuana, with 89.7% (N=26) of the participants reporting to have used acid. The average age of first experimenting with acid was 14.8 years old, with the youngest reported age being 10 years of age, and the oldest being 19 years old. It was stated that acid was hard to find in the DTES and that "you can get ripped-off when you buy it. Sometimes all you get is pieces of paper". Other participants reported:

"I love it! When you’re on an acid trip, nothing is real. You can’t function very well though…"

"I wish I could use acid everyday. I haven’t used it for a long time, it is not something you can access easily here. It is also impossible to do it everyday. There are some hallucinogens that keep you awake all night. It can make you insane if you take it too often, 'cause it makes you believe you can do stuff that you can’t really do, like flying. Acid is not addictive. It only works in your mind”.

One participant described how he became numb for three months, without being able to talk, after doing too much acid.

The abuse of prescription drugs was found to occur only among 32.3% (N=10) of the participants, with age of first experimentation varying from eight years to 22. The type of prescription drugs included Tylenol 3 (T.3), methadone, morphine, Benzodiazepines, Ritalin, and others. One participant indicated that he used prescription drugs only when he was detoxing. Others that had experimented or used prescription drugs made the following statements:

"First experiment was with my mom’s sleeping pills. She always had them by her bed. I used to sleep in her bed ‘cause my dad worked nights in the factory. I had insomnia as a child, probably because of all the stress at home. I couldn’t fall asleep. My mom’s pills knocked me out for two days… Years later, I had two friends that their parents had a drug store, a pharmacy. Those two friends are dead now. They’ve used everything in that store."
"My friends introduced me to morphine, which is twice as addictive than heroin, and twice stronger. The first time I used it scared the shit out of me. I was sure I was gonna die. I thought I did too much, but it was just how this drug was."

The following tables show the drug use pattern pertaining to common street, hard drugs, including heroin, cocaine, speed (crystal-methamphetamines), and crack cocaine. Most of the participants had experimented with all of these drugs, and some became poly-drug users and addicted to more than one drug.

Table 9: Scale of participants’ drug of choice

<table>
<thead>
<tr>
<th>Drug of choice</th>
<th>N (N=31)</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cocaine</td>
<td>12</td>
<td>38.7%</td>
</tr>
<tr>
<td>Heroin</td>
<td>8</td>
<td>25.8%</td>
</tr>
<tr>
<td>Speed</td>
<td>5</td>
<td>16.1%</td>
</tr>
<tr>
<td>Crack-cocaine</td>
<td>4</td>
<td>12.9%</td>
</tr>
<tr>
<td>Prescription drugs</td>
<td>1</td>
<td>3.2%</td>
</tr>
<tr>
<td>Speed-balls</td>
<td>1</td>
<td>3.2%</td>
</tr>
</tbody>
</table>

Many of the participants considered cocaine and crack-cocaine to be the same type of drug. Others viewed each of these drugs as very different than the other. Those that did consider crack to be different than cocaine usually perceived crack as a much harder drug than cocaine with much a stronger impact on the body and the mind:

"I first started with Coke, the powder. I didn’t touch crack until much later."

"Real crack can be found only in the States. In Vancouver they mix it with ammonia or baking soda, which can fuck your systems. In the States they mix it with ether. The effect is much better."

"I tried crack once, and I immediately threw-up."
Another trend that was identified in drug use patterns was that in order to get off one drug, participants had to alter their addiction to another:

“I use speed now as a substitute for crack. It basically got me off crack”.

“I quit heroin by using Coke.”

“Coke was my biggest problem. I exchanged this addiction with addiction to speed”.

Sixteen participants (51.6%) were IV drug users, and 15 (48.4%) smoked or snorted drugs. IV drug users, however, used their drugs in additional other methods, except for one participant who indicated that he only injected his drugs. This participant stated that he had started his drug use straight by injecting and therefore never bothered trying other methods. Other participants stated the following:

“Once I shot drugs, I couldn’t do it other way anymore. If you don’t shoot it, it’s a waste of drugs. With crystal, only if I don’t have enough I smoke it. With Coke, you need less for shooting than for snorting.”

“It is cheaper to smoke speed cause it lasts longer and you don’t use as much. I don’t think I could be able to shoot speed cause I’m new to this drug.”

“It is cheaper to do speed than to do lines (of Coke) or than smoking crack. With crystal, you spend 60-100 dollars a day (the cost for one gram of crystal-meth is 100 dollars). Crack and cocaine can cost 300 dollars a day. The high of crystal-meth also last for a longer time.”

“With crystal and crack it is stupid to get yourself caught on long runs. It is a waste of drug and you totally abuse your body. You don’t get off the high if you don’t rest and eat. If you don’t get rest from the run the drug don’t work to its full potential. I only use it once a day and then I enjoy it. People chase the high and never achieve it really. They destroy their body and their nerve system.”

“Eating speed would give you one of the better highs.”

Other methods of drug use that were identified by participants included eating (digesting) and “hooping”, in which the drug is administered through the rectum. One
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participant explained that hooping drugs was a method that was discovered by inmates who tried to smuggle drugs into prisons by hiding the drug in their rectum. During this process the drug was sometimes accidentally released out of its package into the smuggler's body and caused a strong and immediate sensational high.

The following tables present findings pertaining to the four major street drugs used by participants: Cocaine, Heroin, Crystal, and Crack-Cocaine.

Table 10: The use of Cocaine

<table>
<thead>
<tr>
<th>Use of cocaine</th>
<th>N</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current use of cocaine*</td>
<td>17</td>
<td>54.8%</td>
</tr>
<tr>
<td>Past use of cocaine</td>
<td>13</td>
<td>41.9%</td>
</tr>
<tr>
<td>Never used cocaine</td>
<td>1</td>
<td>3.2%</td>
</tr>
</tbody>
</table>

As indicated in the above table, a remarkably high number of participants have used cocaine (96.7%). The drug of choice of the one participant who never used cocaine was, in fact, crack-cocaine, which he used to prepare by himself.

The average age of first experimentation with cocaine was 16.2 years of age, with the youngest age reportedly being nine and the oldest being 21 years old. One participant had even said that since he was born to a mother who used cocaine through her pregnancy, he considered himself to be involved with the drug since he was born. Seventeen participants (54.8%) reported using the drug daily.

The perception of this drug and the experience of using it varied among participants. The following statements reveal the individual experience with the drug:

"Coke is the hardest drug. I'm lucky to stay away from it now" (quit Cocaine).

* The number of participants reflected under "current use" of a specified drug does not include the number of participants who only used the drug in the past.
“I hate the Coke. I wish I could just be like some friends of mine: drink, smoke... not having to be stressed about getting my Coke.”

“Cocaine starts to be a problem quicker than other drugs.”

“Cocaine and crystal meth are deceiving drugs. At first, they give you energy to do so much stuff, but when you get addicted to them, they take everything away from you: you can’t sleep unless you have them, you can’t eat unless you have them, you can’t live unless you have them.”

“Cocaine makes your heart race. It makes you awake and alert. You are stoned for maybe five minutes, and you’re always concerned with wanting more and how to get more. Once you try Coke – that’s it. You’re hooked, cause it is so good. You have to have it again. Everyone that starts doing it loves it. It makes you feel really good. It is for people who want to party”.

“Cocaine is very expensive. As I’m getting older I can’t afford it... It is easier to hide cocaine addiction. It is mostly mental addiction, you could quit without suffering any physical pain”.

“I did a lot of cocaine. I lost weight, lost jobs, dropped out of school because of it, can’t go back to my family... cocaine put me on intense high. Everytime it blew my mind how intense it was. I smoked myself stupid until it fried my brain. My memory is screwed up because of the drugs... I can’t remember anything from my 18th birthday”.

Table 11: The use of Heroin

<table>
<thead>
<tr>
<th>Use of heroin</th>
<th>N</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current use of heroin</td>
<td>10</td>
<td>32.3%</td>
</tr>
<tr>
<td>Past use of heroin</td>
<td>10</td>
<td>32.3%</td>
</tr>
<tr>
<td>Never used heroin</td>
<td>11</td>
<td>35.5%</td>
</tr>
</tbody>
</table>

The total percentage of participants who experimented with heroin (versus used regularly) was 64.6%. The average age of the first use of the drug was 17.9 years old, with the youngest being 13 and the oldest being 23. Thirteen participants (41.9%) reported using the drug daily, with one participant stating that she had to use it at least every six hours. Heroin (also called ‘Down’) was used by most of the speed users as a
way to come off the effects of the speed. Some cocaine users reported using down for the same purpose.

The common experiences with heroin amongst the participants are presented in the following statements:

"My first experiment with heroin was in Amsterdam, where no one told me that I can snort it or smoke it. They shoved a needle in my arm right away."

"When I did heroin, I did it every day all day. I did it as if there was no tomorrow."

"At first I didn’t like how it made me sleepy all the time. Now as I’m getting older I like my sleep. Getting tired of staying awake for three days in a row."

"Heroin knocks you out. It makes you drowsy, and it lasts a lot longer than Coke. You are stoned for a good eight hours. After a long run of Coke I need to get down, so I take heroin to get some sleep."

**Table 12: The use of Speed (Crystal-Methamphetamines)**

<table>
<thead>
<tr>
<th>Use of speed</th>
<th>N</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current use of speed</td>
<td>16</td>
<td>51.6%</td>
</tr>
<tr>
<td>Past use of speed</td>
<td>10</td>
<td>32.3%</td>
</tr>
<tr>
<td>Never used speed</td>
<td>5</td>
<td>16.1%</td>
</tr>
</tbody>
</table>

The total number of participants who experimented with speed (also called ‘jib’, ‘creeper’) was 83.9%. The average age of first experimentation with the drug was 18.3, with the youngest being 13 years of age and the oldest being 24 years old. Thirteen participants (41.9%) reported using the drug daily.

Crystal-meth was often referred to by participants as the “new crack on the street”. It was easy to identify those that used it heavily, as they often fell asleep during the interview. They would wake up suddenly after a few minutes and were completely clear and alert, until they fell asleep again. At the time of the interview, those participants
stated they had been on a speed-trip for days and that it had been a very long time since
they were able to have a restful sleep.

“Crystal-meth is my favourite drug. Once it kept me awake for 16 days straight,
with maybe 15 minutes sleep a day. But sleep in the day never gets you the sleep
that you need. After those 16 days, I slept for two days in a row.”

“Crystal-meth is called the ‘creeper’ cause it creeps-down on you. You won’t
notice it until it’s too late.”

“I don’t like speed. It make me feel like I’m having a heart attack.”

“Speed for me is like chocolate, it heightens the sexual drive in a big way. It
keeps me energetic and awake.”

“The speed in the East (Eastern Canada) is totally different than the speed in
Vancouver. Back East, we call it ‘Bath-Tub’ Speed’. It is brown, and looks like a
really-really good heroin. Back East people either drink speed or shoot it, no one
heard of snorting or smoking it, as they do here… I personally shoot it. There are
many here that do too. When I tried once to snort it, it burned my nose… With
speed you’re always in alert. It keeps me awake for two days at least, until I get
tired and then I take a shot of down (heroin) to get me off it and fall asleep. The
good thing about speed is that you are not as obsessed as with crack. But the bad
thing is that it kind of builds-up, and you need to take more and more every time.”

“When you use speed you have to eat and sleep, otherwise it won’t have the same
effect on your body. Some good friends that I have on the street won’t let me
touch the drug if they see that I’m too tired and getting all weird… Street kids like
the speed ‘cause it replaces sleeping and eating, two luxuries that they don’t
have… I believe that crystal-meth is a physically addictive drug. There are some
people that don’t agree. But when you sit near a person that uses it, his face gets
greasy, the drug comes out of his body through the skin, and it has this burned
rubber smell. You could also taste it on the skin of that person. When you smell it,
you definitely crave it… this drug is nuts, all the other drugs are pretty straight
forward.”

<table>
<thead>
<tr>
<th>Use of crack-cocaine</th>
<th>N</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current use of crack</td>
<td>13</td>
<td>41.9%</td>
</tr>
<tr>
<td>Past use of crack</td>
<td>14</td>
<td>45.2%</td>
</tr>
<tr>
<td>Never used crack</td>
<td>4</td>
<td>12.9%</td>
</tr>
</tbody>
</table>
The total percentage of participants who experimented with crack-cocaine was 87.1%. The average age of the first experiment with the drug was 18.5 years old, with the youngest being 13 years of age and the oldest being 21 years old. Twelve participants (38.7%) reported using this drug daily.

"Crack is an anti-social drug. It puts you into psychosis. You see those people that are always moving and looking for rocks (of crack) on the ground, like they’ll find it there? Those are the crack-heads."

"Crack is not a very social drug. People are constantly preoccupied with fixing their pipes and cooking-up some more. People on crack are so self absorbed, you can’t talk to them. They want to be left alone. Also, it makes people paranoid."

"Crack is a boom of adrenaline. When you smoke crack you get what is called a ‘ringer’. You suddenly hear a strong ring in your ear, like a police siren is going off inside your ear. Your immediate response is to cover your ears with your hands as strong as you can, and run. I knew someone that smoked crack when he was on the roof of a building, ran and died. Crack makes people paranoid. It’s frightening... I’m so happy I got off it."

Participants reported using other types of drugs than the aforementioned, but these are not as common. For example, the use of speed-balls, which is a mixture of heroin and cocaine, was found among only 19.4% of the participants (N=6), who reported using it regularly. Three other participants indicated that they had experimented with the drug in the past. PCP, also known as ‘Angel’s Dust’, was used by seven participants (22.6%), but the use of it was largely dependent on the availability of the drug. It was indicated by a number of participants that PCP was easy to access in Montreal; however, in Vancouver it was a fairly rare drug.

Here are some of the statements made by participants with reference to other types of drugs:

"‘Goof-ball’ is crystal and heroin mixed in one. Fast rush, energizer... depends on how much crystal in it."
“Speed-ball is such a weird drug. I tried it once. It is heroin and cocaine rolled in a paper, you swallow it while drinking it with a pop or any kind of ferment. Then there’s a poof, the balls opens in your stomach and the drug gets out.”
“Speed-balls are an instant way to die.”

“After trying speed-ball once, I was scared to do it again. Your heart doesn't know what to do. You feel rush like in crack, your heart goes wild, and then you’re down, and then high again... it is a waste of drug: you don’t get high and you don’t get down.”

“I didn’t like speed balls. Didn’t like going both ways at the same time.”

“I tried speed balls once. It almost killed me. It didn’t give me the buzz, made me paranoid and jumpy.”

“I tried inhalants. It’s either nail polish or shoe polish put in a bag.”

“When I was 14 years old I sniffed glue and fell asleep in the snow, wearing only a T-shirt.”

“I used horse tranquilizers. It is a very powerful drug, very strong, I couldn’t remember half of the day.”

“I used a lot of horse tranquilizers at parties. Used all kinds of ecstasy: MDA, DMT, and MDMA. Also used GHP, which is called ‘date rape drug’. It is a depressant liquid that just a drop of it can knock down a girl. You could die from the withdrawal symptoms of this drug.”

Summary:
Part one of the questionnaire primarily focused on establishing the profile of drug using youth in the DTES. It provided background information on the investigated population and explained the way this population is involved in the DTES. The data pertaining to the population’s drug use patterns explained in detail the type of drugs that are commonly used by youth in the DTES and also provided a general illustration of the drug scene in the area. Statistical data were incorporated with personal statements and provided enriched description of the investigated phenomenon.
The next section (reflecting part two of the questionnaire) presents participants' perspectives on drug addiction, its causes, and issues related to prevention of addiction. It also provide their perspectives on factors affecting other youth who use drugs.

PART TWO

RISK & PROTECTIVE FACTORS FOR DRUG ADDICTION

DRUG USERS' PERSPECTIVE

The findings presented in the next part of the thesis are participants' answers to open-ended questions pertaining to risk and protective factors for drug addiction and to prevention strategies. These responses elaborate and strengthen findings that were collected later in the interview through fixed-response questions (part three). The purpose of part two was to obtain youths' view on what they consider to be the most significant and dominant factors in causing addiction. Not all participants were as verbal and as comfortable with these types of questions; therefore, data collected in this section is partial and not reflective of the perspective of all participants. Since not all participants answered all the open-ended questions, frequencies of responses may appear lower than in other parts of the thesis.

The participants' perspective was explored to gather information on three major themes:
1. Risk factors for drug addiction on a personal level (according to users’ opinion, what caused their own addiction or reduce their drug use).

2. Protective factors that may have steered them away from using drugs (what could have prevented them from using drugs).

3. Risk factors for drug addiction among youth in general (from their experience and knowledge of how addiction occurred in the lives of their friends, what are the major factors that contribute to drug addiction among youth).

Participants’ Perspectives on Causes for Addiction in Their Own Lives

Factors associated with participants’ family life:

It was reported by 64.5% (N=20) of participants that factors in their family life had contributed to their drug use. Reported factors varied from dynamics in the family, parental attitudes to drugs, communication patterns within the family, and significant family events such as divorce and deaths of significant family members. The following are some of the statements made by participants describing their views on how factors in their family life contributed to their addiction:

“I had a tough life. Took care of everyone in my family, physically and emotionally. My parents were the children and I had to take care of them... I have a brother who was locked-up in his room for four years. He is a difficult guy, my parents couldn’t handle him. I was the only one that cared for him, brought him food to his room, left school to check on him... my life wasn’t easy...”

“I had a shitty family life and a strange family...”

“My dad was very negative. He always told us what we did wrong, but never said anything about what we did right... My parents were too strict with us. They
made us do things at home, put us down. Me and my other three brothers are drug addicts. One is screwed up totally, he is a mental case on top of his addiction."

“My parents never seemed to care.”

“I was adopted and kicked out from home by my adoptive parents.”

“I was deserted by my family. I have nothing to do with them anymore, and don’t want to see them ever. I was born in Toronto, moved here with my parents when I was 9 years old. Then we left again and moved to the valley. I started to get into trouble, and my parents didn’t want me anymore. I was a criminal, didn’t want to listen, didn’t want to go to school. They kicked me out, sent me to a foster home. Instead of talking with me about my problems and helping me, they kicked me out. You’d think you would get grounded, instead you lose your child. I had to take care of myself since I was very young... When I had nobody else to turn to – I turn to those that accepted me. A friend of mine injected me with heroin at the age of 13. At that moment, I stopped feeling pain.”

“My mother is a cocaine user. I was raised by my grandfather and his wife. She had a look that could melt steel. She had laser eyes, always knew what I was doing. My grandfather was scared of her. He was an anti-social, passive. She talked to him about adopting me, he didn’t want to raise me. He always tried to avoid me.”

“My parents were very cold. They were there for me financially, but never emotionally. My father never showed affection. I was always seen but not heard. I used to tell my parents, ‘you know, we’re not in the dark age, there is electricity, turn the light on and see the children in this house’. I don’t know if it is the emotional deprivation that I suffered as a child, but I desperately needed to feel loved and belonged. I can’t allow myself to be attached to anyone. When I become close to someone, I quickly detach myself. I don’t want to know other people too well. I can’t even read books ‘cause I don’t want to get involved in other people’s life. I would start a book and never finish it.”

Past trauma & abuse

Seven participants (22.5%) associated the roots of their addiction with past experience of abuse and trauma. These experiences included sexual, emotional and physical abuse; experience of chronic neglect in childhood; witnessing domestic violence and deaths. The following are some of the statements made by participants describing their recollection of past trauma and abuse:
“My dad had a bad temper. It didn’t take much of a reason for him to freak out. He always had a reason to hit us, even for stupid reasons. He knocked me out few times, and when I was on the ground he would still kick the shit out of me. And then he would tell me that I could have avoided it…”

“When I lived with my family in a hotel in the DTES, I remember looking out the window and seeing someone on the alley doing the chicken and dying”.

“This man, who used to be my father, used to kick the shit out of me. He even killed my dog in front of my eyes… He kicked him so bad”.

**Drug use as a chosen coping mechanism with emotional difficulties and life events**

As many as 21 (67.7%) participants reported using drugs as a method of coping with emotional distress and adverse life events. In most cases, the perception of drugs as a pain-reliever was accompanied by positive attitude towards drugs. Depression, in particular, was repeatedly mentioned by participants as one of the factors that drove them to use drugs.

“I use drugs to escape life. Even before the hard drugs, when I did the soft drugs, I did it so heavily that it was obvious that it was a problem. I used to do like eight weeds a day.”

“I’m depressed without them, I have no interest in anything, I just want to die when I don’t have them.”

“Without it I can get very depressed. Feelings can get very overwhelming sometimes, and drugs stop it.”

“Drugs numb you for a while, they shut down your pain. But only for a short while. After that, it kind of opens your eyes and makes you face reality... I’ve heard that speeds especially are the type of drugs that increase your ability to observe your feelings, analyze your thoughts. That’s why people become very creative when using it. This insight that you gain can actually be pretty painful and sad. Yet, most of the time it’s the numbing effect that I seek. When I tried detox and counselling, I cried for hours. Without my dope, my defenses were really down.”
“My drugs of choice are pain killers. That says something… forget life. But it is so hard to quit it, cause your body don’t have any natural opiate anymore, so there is pain and no energy.”

“Drugs make me feel good for a time being, not depressed, not down. I like it… I’m ashamed of this habit… I come from a very dysfunctional background, had rough childhood. When I’m on drugs, I’m not thinking about it.”

“When I started doing heroin I had many crises going on in my life that I never dealt with properly: my best friend got shot in the head, my girl-friend broke up with me, my parents split-up, and another girl told me that she is pregnant with my child. Drugs shut the reality on you, it numbs you, shuts the world out. Nothing is real anymore - All the things that I didn’t want to deal with. I could pretend that I don’t live my life anymore.”

“Drugs take away memories. There are lots of problems in my head and drugs calm me down. Otherwise, I would hurt people… I love drugs. they make the day go faster.”

“I was depressed, still am… wanted to get more and more high, forget about life. I was living by myself on Hastings Street since the age of 16.”

“Drugs totally numb you. Even if you feel insecure and depressed – it’s all gone once you take a hit. You don’t care about what people may think of you, you don’t give a shit about others.”

“I used drugs to get away from reality. Drugs make me feel special, or not to care about how I really feel about myself… drugs make me feel like an adult, feel sexy. It gives me energy.”

“You use drugs to get yourself high, and then you don’t worry about suffering. Get away by using drugs.”

“Drugs help me relieve life stress and pain. Nothing is bad or real after using drugs. At least not in the first 20 minutes…”

Parents’ substance abuse:

Seventeen (54.8%) participants found their parents’ substance abuse to be an important factor in influencing their own drug use behaviour:

“My mom introduced me to coke and offered it to me when I was 18. With alcohol, it was my grandpa who got me into it. I was an alcoholic at the age of 12.
My grandparents were divorced, and I was raised by my grandma. When I visited my grandpa, he used to pour vodka into me.”

“When I was eight years old, my father was smoking pot, and he had me rolling joints with him. I never considered it a drug. It was part of our life… My father told me that if I really want to try drugs I should always try it twice, to get the full effect of it.”

“My father gave me pot. It was during a BBQ party we had in our backyard. My friends were there, and then my dad came, sat with us, everybody drank and there was my dad passing me a joint… I was shocked. It was so scary… I told him that I don’t smoke it, and he said, ‘come-on, I know you do’. He wanted me to feel comfortable about it with him. My parents didn’t care what I was doing as long as I did it at home… My first experiment with Coke was with my older brother, in his place. I wanted to kind of fit in with him.”

“My mom died this year from AIDS… She shared needles and finished her life at the Dr. Peter’s Centre. My dad OD’ed on heroin when I was 13.”

“My step-mother always drank. She used to scream, ‘don’t touch my orange juice!’… the bottle killed my dad, and my grandma killed herself. Everybody in my family drank.”

“Mom and dad using and drinking at home. I was often the one that got them their drugs so they would be more relaxed.”

“My dad used to drink all night and smoke weed, he said that he preferred it than cigarettes. He used to do that in front of us. We lived with him, he grew it in the basement. We tried it and liked it, used to take it from him… my mom used drugs too, but she wasn’t involved with my life. I was with her until I was three years old, and after that I saw her once when I was 11.”

“My father was a drug addict. Drugs were always around. It was really bad at home when dad had friends over, and I was spending time at his place… I did drugs together with my dad.”

Curiosity & experimentation

Ten participants (32%) believed that their curiosity was one of the factors that drove them to experiment with drugs, and that partially had caused their addiction.

“I always wanted to try stuff that was dangerous.”
“It was the curiosity that killed the cat... a bunch of curious children getting together, they want to find out what this drug is all about, so they try it... It started as a social thing, occasionally used it here and there, and then it turned to be part of my life.”

**Peer pressure**

Peer pressure was found to be a dominant risk factor and was perceived by 64.5% of the participants as contributing to their drug addiction:

“Started to use to fit in, to be part of the group.”

“If you weren't stoned, you weren't cool.”

“Drugs make you feel more sociable.”

“Using drugs was the norm among my group of friends. It was the scene, even more than alcohol.”

“It all started from experimenting with others just to have fun, and suddenly, I’m a junkie. I can’t go one day without my drugs.”

“They used to tell me not to try heroin ‘cause I’ll get hooked, and I said that I had to prove to them that I can use it without getting hooked.”

“Peer pressure is the first factor. My friends were doing it, then I did it. Didn’t take much arm twisting. To be cool, I started smoking, and look where I am now... now it is just part of my life.”

“I was forced to it when I was 11, in foster care.”

**Involvement with street life**

Street life was often referred to as the only answer participants had for their need of belonging, and as the only relief from their loneliness. Eleven participants (35.4%) viewed their involvement with street life as one of the most profound reasons for their first experimentation with drugs:

“I’ve been living on the streets for four years now, and it kind of sucks. It is only now that I try to get myself off. When you’re on the street, doing drugs gives you
something to do. It was the street life that turned me to drugs… it is so much easier to get involved with drugs when you’re not living at home. You have the combination of no supervision, the availability of drugs and the culture of street life… drugs make you happy, make you depressed, make you cranky, make you think about your life, cause you’re awake for so long. You have lots of time to think, especially at night, when it is so quiet on the streets… It’s been three days that I didn’t get any sleep. When my boyfriend was in jail, I stayed in a safe house, I slept most of the time. They have nice beds there… now, I can’t go, ‘cause they won’t let my boyfriend in and I can’t leave him on the streets… Everyone wants to kill themselves ‘cause they have no place to go, and nowhere to live… they are not willing to help themselves ‘cause they are so addicted to drugs… when you’re on the streets, you turn into a back-stabber. When you wake up in the morning, all your stuff is gone. They steal everything from you. They stole the only picture that I had of my mom. They take everything you own… they steal your life… people on the streets are so selfish. It is what you need to become in order to survive. They don’t understand the value of the simplest stuff, I want to get away from all those people.”

“The streets are the only life I know. I would prefer not to be there.”

“I had no home… my family were on the streets of DTES… both parents died from drug and alcohol… I was shuffled around 50 foster homes.”

“Drugs help me getting a sense of belonging. I belong to other junkies like me. every junkie is ‘one of us’, we all at the same situation.”

“Using drugs is fun when you’re on the streets of Toronto. I spent three years on the streets of Toronto… I started using drugs since I started living on the streets. Started with pot, moved to crystal, and so forth. Drugs keep you up all night, so instead of sleeping on the streets, you walk all night.”

“I had good reputation among street youth. I was the one that always had a big bag full of dope, and I used to give it to friends. People liked me… Now I know that they only liked my dope. They are the people that you would think they care, ‘cause they all share the same experience, but really they are the last to care about others. They are so selfish, they take and take from you until you have nothing to give. And if you have nothing to give – you’re worthless on the street. I knew that if I want to change my life, it would only be through a recovery house, through the use of treatment facilities and professional help. Those people really care about you, they have real interest in helping you, they don’t want anything back from you, they really care. Street kids? All they care about is whether you have a bag of dope or not.”
Availability of drugs

Fifteen participants (48.3%) believed that the availability of drugs promoted their engagement with drug using behaviour, and in many of the cases, the availability of drugs was found to be most significant in the DTES rather than in the participants’ places of origin. For many, it was only after they became familiar with the Vancouver DTES that they learned how easy and accessible drugs can be.

“Availability… I never used drugs until I got to Vancouver. It’s so easy to get it here. I wouldn’t get it if I knew there will be cops there, or if it would be more expensive.”

“I grew up in a neighbourhood in Calgary that is equivalent to the DTES. It’s called Forestlawn & Boness. Lots of bikers and drugs.”

“I grew up in a small town north of Calgary, where it was inevitable to use drugs. It was just meant to be.”

“With crack, a guy took me down to Hastings and got me on it.”

“It was always there, even at home. My first experiment with weed was on my dad’s joint.”

“In the school that I went to there used to be lots of drugs.”

“This city got me into drugs.”

“Drugs are everywhere in your face, it’s so easy to get it.”

“Being in this area of town (DTES) is the biggest factor. When I lived in Victoria, everyone tried to stop me from taking drugs, so I ran away from there. Drugs are so expensive there too… you pay $50 for one shot of heroin, where here you can get it for $10, sometimes less. Crack is really cheap here, $5 a rock. In Victoria you can’t find crack anywhere, I had to prepare it myself.”

“DTES. All the people that I met there did it and offered it to me, so I took it. It didn’t seem bad at the time. Now I feel lost most of the time…”

“Drugs are always around when you are a hustler, especially in bars. There’s lots of it, especially among gays.”
“While I was visiting my parents in the valley, I didn’t touch any drug. Nothing, not even cigarettes. As soon as I got off the Greyhound on Hastings, first thing I did was to go and get a hit and a pack of cigarettes.”

Low self-esteem:

Although low self-esteem clearly underlines many of the other factors that were mentioned by participants (with relations to sexual identity, peer-pressure, loneliness, etc.), there were only a few (N=4) that identified it specifically as one of the reasons they turned to drugs.

“My step-grandma always communicated to me that I was ugly. She was jealous of me, she was fat, had big teeth. She called me a slut before I had sex, so I started sleeping around… now it’s all different. I feel like a loser. I hate myself, I’m weird. Drugs are a self-destructive thing. I feel like I don’t deserve to be happy and that is why I can’t stop it.”

“I came from a world of hate… I don’t want to live in the real world, which never accepted me… drugs freed my pain, I prefer to stay in my own madness… it is not so crazy.”

“Why I started doing drugs is a mystery to me… maybe lack of self worth, I used to get down on myself.”

Other factors:

Four participants found a connection between their current drug use and the process in which they have established their sexual identity.

“At the age of 11-12, I started to be confused about my sexuality. I started to realize that I was different. People accept lesbian girls, they think it’s pretty, but when it comes to boys – they think it’s weird.”

“My adoptive parents were ministers. They kicked me out from home because I was gay.”

“I have three older brothers who used to go with my dad on weekends to do their stuff. They were big, machos… I was always going with my mom to the hair salon or shopping. My mom and I were very close, we even slept together in the same bed every night while my dad was working. He always blamed her for
‘babying me too much…’. He was so loud, and my brothers were feral. When I knew about myself, I couldn’t talk to anyone… My dad and brothers always called me ‘a faggot’, even before they knew that I was gay. They never accepted me, so did friends at school and in the neighbourhood. Every time that I had an argument or a fight with my dad, he used to begin by saying, ‘listen, it is not the gay thing…’, when it was so obvious that it did underline every problem he had with me…”

Aside from the attraction to the pain-relieving effect of drugs, many participants had a generally positive attitude towards drugs, which increased their likelihood to experiment with drugs:

“For $10, drugs are better recreation than going to the movies. It is stimulating.”

“Because it was fun… Drug are awesome…”

“Started in order to get high. Now, I’m at a point of not getting high anymore, but I keep doing it ‘cause I’m addicted.”

“Drugs get you thinking constantly. Your body may be tired, but your mind goes click-click-click... you get crazy from thinking about the whole world... I wish I could get rid of this habit, but it’s addiction. You don’t think about using, but you do that. It’s your body that walks you to the dealer without even wanting to”.

“People told me that drugs expand you mind, make you creative… this is all bullshit.”

“I was afraid to grow up. I wanted to be 18 forever. Drugs kind of kept me at that age, I never had to take responsibility over my life.”

One participant believed that “dropping out of school” got him “into the tough crowd”. Three others started using drugs because they wanted to rebel against their parents. A few others mentioned the significant impact that the media and music had on the way teenagers form their attitude towards drugs. Two mentioned the movie “Trainspotting” as a major influencing factor that drove them to experiment with drugs:

“I loved this movie, although it was twisted. You have a handsome actor, who makes drug use so glamorized. Even if it was tough on him sometimes, eventually
in the movie, everything turns out to be good. He quit drugs, yes... it wasn’t easy to quit, but in the movie it lasted 30 seconds.”

Four participants (12.9%) indicated that boredom contributed to sensation-seeking behaviour and to experimentation with drugs. Four others (12.9%) mentioned lack of sense of belonging and loneliness as a factor that made it easier for them to be influenced by peer pressure as well as to join groups of youth on the streets.

Finally, one participant believed that his speech impairment and the emotions he experienced around being different contributed to his vulnerability to use drugs:

“I had a speech impairment since I was a child. So I was different even then, before even realizing that I was gay. And children were very mean to me, vicious. I’ve carried this baggage with me”.

Summary:

The first open-ended question dealt with participants’ perspectives on causes for addiction in their own lives. Many factors were identified, however, the followings table summarizes the most reported factors that were noted by participants as causes for their drug addiction:

**Summarizing Table A: Identified causes for addiction in the lives of participants**

<table>
<thead>
<tr>
<th>Identified causes for addiction</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug use as a coping strategy with pain and emotional difficulties</td>
<td>67.7%</td>
</tr>
<tr>
<td>Peer pressure</td>
<td>64.5%</td>
</tr>
<tr>
<td>Factors related to family dynamics and relationships</td>
<td>64.5%</td>
</tr>
<tr>
<td>Parental addiction</td>
<td>54.8%</td>
</tr>
<tr>
<td>Availability of drugs</td>
<td>48.3%</td>
</tr>
<tr>
<td>Exposure and involvement in street life</td>
<td>35.4%</td>
</tr>
<tr>
<td>Curiosity</td>
<td>32%</td>
</tr>
<tr>
<td>History of trauma and abuse</td>
<td>22.5%</td>
</tr>
</tbody>
</table>
The next section presents participants' perspectives on causes for addiction in the lives of youth in general.

**Participants' Perspectives on Risk Factors for Drug Addiction Affecting Other Youth Who Use Drugs in the DTES**

When considering factors that had led other youth to use drugs, the highest number of participants (N=15; 48%) reported street life as a primary cause of addiction. Kids were kicked out of home, ran away, and had no other place to go to except for the streets.

“When you’re on the street you form a gang. It becomes your family, it is sort of a family, and it is inevitable to use drugs in such a group. If you don’t, you risk being alone.”

“Most of them went through the stereotypical pathway of becoming drug users. They ran away from home, they had no dreams, no hopes, no desires, no initiations... they are pissed off with the world. They all have an attitude, they think that everybody is here to help them out, but they are not going to help themselves.”

“Other youth are using drugs ‘cause they have no place to go, and when you’re on the streets, of course you’re going to use drugs, ‘cause it’s there, and it’s the norm.”

“They are one of many, they are lost... No one cares about individuals, people talk about ‘a problem’, the streets kids are ‘a problem’... but each of them have their own baggage... Their minds are too lost, no direction in life, they just crash here on the street, having nothing else to do, nowhere else to go...”

“Most of the kids on the streets have parents who gave up on them, who couldn’t handle them and kicked them out. The child only wanted to get his parents’ attention, ‘cause he had a life that sucked, and what he got instead is humiliation and loneliness. There’s feeling that really, nobody gives a damn about you.”

“Many children here were kicked out of home for smoking dope... Kids that ran away from homes in which they used to smoke dope with their parents.”
The next most reported risk factor for addiction among other youth as identified by participants was the pain-relief and comfort that drugs brought (N=10; 32.2%). Emotional difficulties, stress and depression were repeatedly mentioned to be resolved by drug-taking behaviour. So were feelings of despair and shame, and a sense of having no meaning to life.

"Kids are lonely and insecure. Many have experienced losses and drugs are the only thing that will take their sadness away. When you're stoned you don't care about seeking comfort and love, and you can manage without support. Drugs become your best friend, and you begin to trust yourself, and only yourself."

Seven participants believed that other youth were using drugs because they suffered from a difficult family life. Another five participants believed that it was the experience of abuse in particular that drove youth to use drugs.

"Many were coming from single parent homes, people that never even knew their real parents... There are a lot of injured personalities here... Until I got to Vancouver, I never met so many children that were sexually abused."

"Other youth grew up in homes where they used with their parents, suffered abuse... drugs shut out the reality."

"All my friends were outcasts, abused, were going to go down, and did."

Five participants identified loneliness and longing for close relationships as an important factor. For many, groups of youth that use drugs provided a sense of belonging and acceptance:

"All of us... (youth on the street) need to be accepted, to have a sense of belonging, to be loved and cared for. When you're a junkie you get that from one another, and you get that from some services that don't judge you."
Nine participants (29%) said that peer pressure was the cause for addiction among many youth. It was stated that “youth were asked to try it”; that they started using “to fit in and to be cool”; and that “drugs are the norm in schools today, everyone is doing it”.

“Everyone is caught-up with the good feeling of drugs at the beginning, but no one realize the bad effects that happen later on. At the beginning, no one knows what it really does to you.”

“Everyone that I knew felt peer pressure.”

Low self-esteem and self-hatred was identified by five participants as a risk factor, and two other participants identified rebelliousness as the cause for drug use among youth.

“Not liking themselves.”

“Self-hatred, lots of kids talk about that… I’m going to be bad if you think I’m bad.”

“Kids that feel they are worth nothing would start using drugs.”

Boredom and having no meaning and no direction in life was mentioned by six participants as a possible risk factor for drug use among youth in general. Four others explained that often curiosity leads to experimentation and that this is the beginning of drug use and addiction.

“They do it for fun, to experiment, and they end-up being junkies.”

Availability of drugs was specified as a risk factor (N=3), and so was the lack of knowledge about the consequences of drugs (N=2). One participant stated that he didn’t believe “youth realized what they’re getting into”. A factor that was related to the lack of knowledge about the adverse consequences of drugs was youths’ positive attitude to
drugs (identified by three participants). Such a positive attitude was believed by three other participants to be significantly influenced and even created by the media:

"TV is a big one. All that kids are watching is full of drugs, all the people that I respect are talking about drugs and doing drugs, all the bands, the music industry, music that kids are listening to, the hip-hop, Dr. Dre', Eminem... too much of drugs all around. It's the culture of drugs. Drugs are socially accepted now..."

"Media is a big advertisement machine for drugs. Youth start smoking cigarettes like some actors on movies and TV. It is terrible to make movies like Traffic and Trainspotting. Along the presentation of the down side of drug use there is always the glorification of it. Movie makers should know the consequences of their art".

"Kids get the legitimacy to use drugs through TV, magazines, pop music, movies, everything that they are exposed to involves drug use. Rap artists sing about how they murder and kill people, they're all tattooed and stoned, and they are the heroes of kids today. Anything that is good, like Gretzky the hockey player, is not cool anymore. Only bad, aggressive is good".

Summary

Less participants answered this open-ended question, and stated that they did not know what may have happened in the lives of other people. Among those that did respond, different factors were identified as potential causes for addiction in the lives of other youth. The most frequently reported factors are summarized in the following table:

**Summarizing Table B: Identified causes for addiction in the lives of other youth**

<table>
<thead>
<tr>
<th>Identified causes</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exposure and involvement in street life</td>
<td>48%</td>
</tr>
<tr>
<td>Drug use as a coping strategy with pain and emotional difficulties</td>
<td>32.2%</td>
</tr>
<tr>
<td>Peer pressure</td>
<td>29%</td>
</tr>
<tr>
<td>Family related factors</td>
<td>22.5%</td>
</tr>
<tr>
<td>Boredom</td>
<td>19.3%</td>
</tr>
<tr>
<td>Loneliness</td>
<td>16%</td>
</tr>
<tr>
<td>Low self esteem</td>
<td>16%</td>
</tr>
</tbody>
</table>
Responses to the above question provided interesting insights to issues affecting youth nowadays, particularly to how the media is influencing youths’ beliefs and behaviours.

The next section presents findings from the last open-ended question, which asked for participants’ perspectives on preventative measures.

PARTICIPANTS’ PERSPECTIVES ON PREVENTATIVE MEASURES THAT MAY HAVE STEERED YOUTH AWAY FROM DRUGS, OR THAT MAY HAVE HELPED REDUCE THEIR DRUG USE

The third question that involved participants’ perspectives explored protective factors and preferred preventative measures as perceived by youth. The four leading categories of protective factors that were identified by youth were, in their order of frequency,

1. Having a sense of belonging and positive and meaningful relationships with others;
2. Having lived a different family life;
3. Being off the streets and away from the DTES; and
4. Having a deeper awareness of the adverse effects of drugs.

A total of 14 participants (45%) identified a sense of belonging and meaningful relationships as main protective factors that could have both prevented them from turning to drugs, or enhanced their likelihood of using less or quitting drugs. Some hoped for love and wished to create a family of their own, and some hoped for real friendships with people that were honest and caring. Youth identified negative peer pressure as the consequence of dishonest and destructive relationships.
"If I had love from friends and family... I am used to always being alone... If I had kids, that would be important to me."

"If I would be able to go back home, to my band."

"Need a lot of positive influence in my life. Someone that would teach me to look at things in a different perspective."

"Maybe if I was close to my family I wouldn’t be using. I don’t want them to know that I’m using, don’t want them to think of me as an addict."

"I have nephews and nieces, I don’t want them to know me as an addict... don’t want them to follow my steps."

"If I could go back home to Halifax... If I would have a kid, I couldn’t do drugs in front of my kid."

"Love... falling in love with someone that doesn't use drugs."

"Peer support, people who care... someone that would tell me ‘don’t do it!’.

"Kids need good inspiration, to see beautiful things again, pay attention to them. They need to think more and have hopes... They need people to look up to and believe that they can do anything."

"If I had a good relationship with someone, a healthy relationship, someone that would really love me."

"I quit drugs for my wife... got married when was 19, my wife was with me through everything. If it was for me, I would never stop using."

"Community that was honest... the sense of home, growing up in a home..."

"To know someone who cares... I don’t use telephones ‘cause I don’t know anyone with a phone."

"Love, someone that I can trust... to feel like I had someone or something in my life. I am so used to being let down."

Fourteen participants (45%) believed that if they had a different family life they would not have turned to drugs.
“Family life means so much. I had an angry dad, and I did everything I could to get away from home.”

“If I would have had some parental guidance... I never had it.”

“More of a stable home life... I didn’t have real foundations. I could be out until 2 a.m. and my parents wouldn’t care.”

“More family support.”

“If I was growing up with adoptive parents... If I would be encouraged to be myself... if I would be nurtured and allowed to do things my way. I was always judged for my actions.”

“If I had more acceptance from my family to the fact of being gay-transsexual... If I could communicate with my mom. She won’t talk to me.”

“If I had a different family... My mom doesn’t want to see me. She’s now clean, thinks I’m a scum, doesn’t care about me, doesn’t want to come and see me here. I’m not allowed in my reserve anymore, so I can’t go and visit my family. I caused too much troubles there, too much crimes... I was the biggest drug dealer in the whole area, I smuggled drugs... I miss my sisters.”

“If I had different life circumstance... A mom who cared...”

“Having a family life, travelling with parents... when you have a family, you don’t want to leave it. Family is what matters...”

Not having to live on the streets, and not being kicked-out or running away from home was also identified as an important preventative factor. A total of 9 participants (29%) believed that getting off the streets would help in resolving their drug use. Four participants stated that moving away from the streets of the DTES would particularly help.

“Get away from the DTES. Drugs are everywhere in your face, it is so easy to get it... would help to find a safe place to go to.”

“Anything to get youth out of the streets... If you have a place to go to, it’s a step in the right direction.”
“Give more support to street-kids. The Street Nurse program is excellent and so is the Downtown Ambassadors who often offer their help, give information on where to find free food and shelters.”

Two participants reflected on their experience in foster care, and emphasized that reducing trauma related to placements and multiple-placements in care can assist in preventing drug use.

“Not so much moving around from group homes to foster homes... All I remember is thinking, “oh, they’re moving me again...”. Social Services screwed me up. Until you get used to one place, you are moved to another... Social services also need to screen better foster homes. Not all of them are safe for children.”

“If they would let me stay in the foster home where my sister was. They kicked me out because of my anger. All the time I beat caregivers, and because of that I kept being shuffled around 50 foster homes.”

For one participant, who used to panhandle on streets such as Robson Street in Downtown Vancouver, being able to see the “other side of the streets” was a turning point and a motivation to quit drugs:

“I decided to become self-sufficient. I earned my money and stopped relying on society... I despise the street life now, the attitude among street youth... It is too easy to live on the streets, that is why it is so hard to get off it. There are many opportunities and lots of help and support for street youth, but they choose to be freebees. You get everything for free – food, showers, money from panhandling, why stop? When you’re on the streets you have no worries, you take no responsibility over your life, and plus – you take drugs, which makes everything even easier, cause whatever you might feel – it shuts it out. By the time you want to get off the streets – you are so heavy on drugs, that it really then becomes a challenge. I no longer want to associate myself with this group of people. I got to a point where I really wanted to have a taste of the other side of life: I told myself that I want to be like those kids walking on Robson Street, I want to wear the type of clothes they are wearing, I want to be like them. When you’re on drugs – you can’t be like them.”
In contrast to the above statement, three others believed that more services need to be created and delivered to street youth. It was believed that addressing adolescents’ boredom would steer youth away from using drugs by engaging youth in sports activities, arts and recreational programs.

“Get more things for youth to do on the streets and to get them off the streets. Music, art, sports, gymnasium, swimming pool... Nobody gives a shit anymore.”

The need for more detox programs and safe houses was identified by five participants. Further suggestions were given to make accessibility to detox easier.

“Kids need more detox. It takes too much time to get into detox. You need to phone so many times and wait... It is discouraging even if I want to do it.”

“If it was easier to get into detox, that would help a lot. They expect you to sit by the phone for a week till you get bored of the idea.”

“Safe houses, shelters like the Covenant House, houses that are safe for prostituting men.”

Two participants believed that reducing the availability and increasing prices of drugs would reduce the use of drugs or prevent it.

“The availability is ridiculous and it has to be cut off... It is so safe to go there (to Main & Hastings), there’s no cops, no one to stop you...”

Eleven participants (35.4%) spoke to the need for knowledge about the consequences of drug use. Increased awareness directed particularly at youth with vivid descriptions of the adverse consequences of drugs was suggested by five participants. Five others stated that they wished the negative consequences had appeared earlier, at a point where it could be easier to quit using drugs. For one participant, an early experience of overdose on hard drugs led him to quit using. For another, being in jail “saved” him, as he did not have access to drugs there. Participants also talked about the potential
effectiveness of peer-counselling, especially done by peers who suffered drug life and survived it.

"It would help if the bad effects would hit you faster. It kind of crept-down on me, and I didn’t have warning. I didn’t realize what’s happening."

"Drug education is needed, but they need to find another way of doing that. They present the danger of drug use in a way that you cannot relate to, so it doesn't really get into your head. They need to show youth what could happen to them if they would use drugs."

"In high-school, they show you videos of junkies, movies about the DTES, which you can’t relate to. I used to laugh at those videos and didn’t believe I would become like that. They need to show those movies, but to make them in a way that youth can relate to."

"what happened to me when I quit two weeks ago was that I woke up and realized what drugs did to me, to my life, and I didn’t like it at all. It destroys your life quickly. I knew that I should get my shit together before it was too late... My brother ODed on heroin, that scared me."

"If there was a real understanding of addiction. No one knows what it is like to take drugs when they educate you on that. No one ever told us at school that if you have emotional baggage you will become a drug addict. No one warned us, or gave us the opportunity to deal with it."

"The last time I went to Main & Hastings I had a spiritual experience that made me stop using drugs. As I was getting close to the corner, seeing all the junkies there, I got scared. I felt a strong fear of becoming like them. As I saw the dealer, I turned back."

"More information on drugs, hands-on information. What could help is talking to someone that was on drugs and couldn’t get off it. Build a better prevention that reflect the reality of drugs in Vancouver and the life of street kids. Not glorifying drug use, as done in some movies, music and TV shows today."

"Show kids movies on the fucking DTES! Show them how desperate users can get and what they are willing to do to get their drugs... show them how they shoot in their neck cause they can’t wait to get high, and cause the drug doesn't work on them anymore... show them how people are beating and killing each other for a fucking $5 rock... it is a bunch of zombies walking there, and you think that when they experimented drugs they thought they could get to be like that? Hell no... kids should know that you gain nothing by using drugs. It doesn't make you cooler, smarter or more popular. Eventually, when you are an addict you're alone. Drugs turn you into what you are not, and it happens so fast."
Summary

The final open-ended question asked for participants' perspectives on what is needed in order to prevent and reduce drug addiction among youth. Responses addressed the need for more support services for street involved youth, for recreational and sports facilities to reduce boredom, and even the need to handle child apprehension and placement in care in a manner that would be less traumatizing for children. However, the most frequently reported suggestions provided by participants for what they view as effective prevention planning are summarized in the following table:

Summarizing Table C: Identified needs & preventative measures for drug addiction

<table>
<thead>
<tr>
<th>Needs and preventative measures</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Having a sense of belonging and meaningful relationships</td>
<td>45%</td>
</tr>
<tr>
<td>Having lived a different family life</td>
<td>45%</td>
</tr>
<tr>
<td>Having a deeper awareness of the adverse effects of drugs</td>
<td>35.4%</td>
</tr>
<tr>
<td>Getting off the streets</td>
<td>35.4%</td>
</tr>
<tr>
<td>A need for detox services that are more easily accessible</td>
<td>16%</td>
</tr>
</tbody>
</table>

The next section presents findings from part three of the questionnaire, which includes probing questions for various risk factors. The first presented group of findings is related to risk factors associated with the environment and drug availability (Part three, section D in the questionnaire).
PART THREE

RISK FACTORS ASSOCIATED WITH THE ENVIRONMENT
AND DRUG AVAILABILITY

Participants were asked to evaluate the safety in the community they grew up in, namely to examine whether drugs were readily available in their neighbourhood, and whether there were activities such as prostitution, violence, gangs, and drug scenes. Most of the participants (64.5%; N=20) considered the neighbourhood they grew up in as a safe community. Nevertheless, as Table 14 indicates, 54.8% of the participants reported obtaining their drugs from their neighbourhood. Among the 35.5% (N=11) that consider it unsafe, there were two that grew up in the DTES. One participant that was raised on Broadway & Fraser Streets, stated that:

"There's lots of hos, pimps, drug dealers, Johns... All the way of Kingsway to Victoria Dr. is a track. It becomes a smaller version of Hastings street... In this neighbourhood you can find mostly crack".

It was found that when participants started using drugs they obtained them from various sources, as follows:

Table 14: Sources of drugs

<table>
<thead>
<tr>
<th>Source of drugs</th>
<th>N</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>In my neighbourhood</td>
<td>17</td>
<td>54.8%</td>
</tr>
<tr>
<td>In my school</td>
<td>15</td>
<td>48.3%</td>
</tr>
<tr>
<td>In my home</td>
<td>12</td>
<td>38.7%</td>
</tr>
<tr>
<td>Other sources</td>
<td>4</td>
<td>12.9%</td>
</tr>
</tbody>
</table>

In other words, at least 87% of the participants obtained their drugs nearby.
The next section presents findings that were gathered through section E of part three of the questionnaire, which deals with family related risk factors.

**Risk Factors Associated with the Family**

Parental substance abuse and delinquency among family members

When participants were asked about parental alcoholism, 74% (N=23) reported that one or both of their parents were alcoholic. Noticeable findings were also indicated with parental drug addiction; 61.3% (N=19) reported that one or both of their parents were addicted to drugs. The following tables provide details of these findings:

Table 15: Parental alcoholism

<table>
<thead>
<tr>
<th>Parental alcoholism</th>
<th>N (N=31)</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Both parents alcoholic</td>
<td>7</td>
<td>22.6%</td>
</tr>
<tr>
<td>Father alcoholic</td>
<td>7</td>
<td>22.6%</td>
</tr>
<tr>
<td>Mother alcoholic</td>
<td>9</td>
<td>29%</td>
</tr>
<tr>
<td>Neither parent alcoholic</td>
<td>8</td>
<td>25.8%</td>
</tr>
</tbody>
</table>

One participant (included in ‘no parental alcoholism’) stated that his parents were not alcoholic “but they sure drank a lot”.
Table 16:  Parental drug addiction

<table>
<thead>
<tr>
<th>Parental addiction</th>
<th>N (N=31)</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Both parents addicted</td>
<td>8</td>
<td>25.8%</td>
</tr>
<tr>
<td>Fathers' addiction</td>
<td>4</td>
<td>12.9%</td>
</tr>
<tr>
<td>Mothers' addiction</td>
<td>7</td>
<td>22.6%</td>
</tr>
<tr>
<td>Neither parent addicted</td>
<td>12</td>
<td>38.7%</td>
</tr>
</tbody>
</table>

Table 17:  Substances used by parents of participants

<table>
<thead>
<tr>
<th>Substance used by parents</th>
<th>N</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marijuana</td>
<td>19</td>
<td>61.3%</td>
</tr>
<tr>
<td>Hard drugs</td>
<td>10</td>
<td>32.3%</td>
</tr>
<tr>
<td>Other soft drugs</td>
<td>8</td>
<td>25.8%</td>
</tr>
</tbody>
</table>

Twelve participants (38.7%) admitted that at least one of their family members had been incarcerated at the time they started using drugs. Although the questionnaire did not ask about participants' involvement with the law (but only the involvement of their family prior to participants' initiation of drug use), eight participants voluntarily disclosed that they had been in jail.

"I was arrested only once, when I committed a robbery. I was smart enough to get rid of the knife before the cops arrived. I say, if you do a crime, do it right. I did so many crimes, but was never in jail. I caused many people pain and suffering..."

"I was in jail too many times. Every six months I got back in for trafficking".

Family attitudes toward drug use

When asked if parents set clear rules against the use of drugs, 61.3% answered negatively; When asked if parents openly discussed drug use and potential consequences with them, 74.2% answered negatively.
The following are some of the statements made by participants regarding family attitudes towards drugs:

"My parents used to grow pot on their farm. They used to tell me that if I'm doing drugs, I should do it at home so they would know that it's safe. My mom used to say, if you have drugs bring them home, smoke it with me."

"My mother kicked me out of home because she found out that I was using drugs. I couldn’t talk about it with her. My father was open-minded, and a user himself, he rather I talk to him than do drugs on the streets."

"My parents never set clear rules against the use of drugs ‘cause they didn’t know that it exists."

"With my dad I wasn’t allowed to use drugs at home. But with my mom it was ok to smoke pot at home. She didn’t want me to do it on the streets, she was open-minded, great mom…"

"They didn’t care even if I fixed in front of them."

**Table 18: "Parents discussed openly drug use and its consequences"

<table>
<thead>
<tr>
<th>Always</th>
<th>Sometimes</th>
<th>Rarely</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage</td>
<td>12.9</td>
<td>12.9</td>
<td>22.6</td>
</tr>
<tr>
<td>N</td>
<td>4</td>
<td>4</td>
<td>7</td>
</tr>
</tbody>
</table>

"Although my parents knew about my drug use and about the drug use of my 4 brothers, they never confronted me about it."

"My grandparents were ignorant about drugs. When I was 14 they even asked me about it for their own general knowledge."

"Because my parents never discussed drug use with me I was very curious about it when I left home at the age of 17."

"They gave me information and let me make my own decision."

"When I started using dope my mom used to ask me if I liked it, and if I did, she said I should get her some too."

"My parents are extremely liberal. They are great. We’ve had lots of discussion on things. They used to say that if I want to use drugs I need to come to talk to
them. They believed that the more you hold a kid from not doing something, the better the chances they will do it.”

“They just threatened me, and said ‘don’t!’ They didn’t talk about it with me.”

**Family economic status**

Nineteen participants (61.3%) reported that their family’s economic status was average. Eight (25.8%) stated that it was below average, and four (12.9%) said that it was above average. Nevertheless, when asked whether parents were in receipt of income assistance for a period of longer than one year, 38.7% (N=12) answered positively.

**Caregivers & upbringing**

Eight participants reported being raised by both of their parents, out of which three were apprehended as children by social services, and one participant had his grandparents as his primary caregivers. In other words, only four participants (12.9%) were in fact raised by both of their biological parents.

Twenty four participants (77.4%) were raised by multiple and different caregivers. Four out of the seven participants that were raised by the same caregiver throughout their childhood and adolescence were raised by both of their biological parents, one by adopting parents, one by grandparents, and another one by his biological mother.

Six participants (19.4%) were raised partially or solely by adoptive parents. The average age of participants at the time of their adoption was 24 months old. Only two of the adopted participants stayed in the care of their adopting parents throughout their childhood and adolescence.
At least at one point in their lives, fifteen participants (48.3%) were raised by a single parent. Eleven (35.5%) were raised by their biological mother and four (12.9%) by their biological father. Furthermore, seven participants (22.6%) experienced being raised by one of their biological parents and a step-parent. Seven participants (22.6%) were raised by their grandparents, and five participants (16%) grew-up with other relatives, such as uncles, aunts, and older siblings.

Sixteen participants (51.6%) had the experience of being placed in a foster home, and 14 others (45%) were also in group homes and institutions such as Youth Detention Centre and The Maples. In total, 77.4% of the participants (24%) were removed from the care of their first primary caregivers at some point in their lives. The average age of removal was 7.2 years old, ranging from a few days old to 15 years of age. Another notable finding was the fact that 20 out of those 24 participants (83.3%) had experienced multiple transitions and placements.

The following statements describe some of the upbringing and care experiences of participants:

“Mom gave me to my grandma at the age of nine months, I stayed there until I was 16, and then with my mom till I ran away at the age of 18. My mom had many boyfriends.”

“My step-father was a piece of shit, I’d rather see him dead... I was found on the streets by the police, and social services put me in a group home. I couldn’t handle it, so I ran away...”

“Both my parents lived at home, but my dad was always out of town, worked a lot, the family fell apart. When he was gone, the house was stress free. My mom had no expectations of us when he was gone.”

“Being in care was confusing, emotionally and spiritually. I often got depressed, had too much of it. Four of the places that I lived in used to beat me. I ran to defend myself. I never preferred to be in foster care... Even though life was tough with my mom, I preferred being with her than in care.”
“When my mom gave birth, she wasn’t ready emotionally to take care of me. So it was my grandmother who raised me until I was three years old, when she killed herself.”

“I was adopted at the age of eight months... My father put me in care repeatedly...being in care sucked.”

“I was adopted at the age of 3. When I was kicked out from home I only had my name and my teddy bear, I had no one in the world. I’ve been told that I have a brother that my parents couldn’t adopt at the time. I don’t even want to try and find my family. I am so angry with my family for deserting me. If you take on yourself a responsibility of establishing a family, you need to serve this responsibility.”

“I never knew my real dad and haven’t seen my mom since I was adopted by my aunt at the age of three. She just disappeared. I tried to find her... My aunt never took good care of me and my brother... I learned how to look for myself and care for my brother very quickly, ‘cause she was never there.”

“My mother was, like me, an addict who lived on the streets. She couldn’t take care of me and always used to hand me out to other people, always moving me around, until my grandparents adopted me... my mom used to live with us often, but she was like an adopted sister to me. Only at the age of 13 I knew she was my real mother.”

“Mom raised me till the age of nine. She started being hospitalized in mental hospital since I was seven years old. After that I was in three different foster homes, moving back and forth with my mom, until finally moved in with my dad and step-mom... I wasn’t happy in care, was never part of the families. My mom didn’t come to pick me up...”

“Parents took turns in parenting me... I had lots of new starts... my uncle took care of me for two years ‘cause my mom couldn’t take care of me, I was out of hand and my dad was in jail... Once I was removed and put in foster home for a week ‘cause my mom and her boyfriend got arrested. I was with other kids, was scared, didn’t know what was going-on, wondered where was mom...”

“After my father left home, my mom couldn’t handle me, I was too difficult. My experience in care was very lonely, it was far away from home, I didn’t see my mother, only stayed with my dad occasionally.”

“My mom got pregnant with me when she was 15, and my dad was 16. She made him get married, and after a while they got divorced. My dad married another woman, had another girl with her... My mom was adopted herself, so until I was 5 I grew up with my mom and her adopting family. At the age of 5 I moved to my
dad's mother, 'cause my mom didn't want to take care of me, 'cause she got hooked with a new guy... I saw my father twice in my life, last time on my son's funeral... I wish I was apprehended before the age of 11. By the time they apprehended me I was already pretty much fucked up mentally. Nothing could have saved me at that point."

Eight participants that had been in care talked about injustices that had happened to them in foster homes; about adverse experiences and abuse caused by foster parents. Those experiences varied from emotional abuse and making foster kids feel they were not part of the family, to physical and sexual abuse perpetrated by foster parents. The following are some of the statements made by participants, describing their experience in state care:

“I was never abused in care, but it was obvious that the caregivers did that just for their pay cheque. As long as you did your chores, you were quiet, stayed in your room and didn’t bother anyone, you were fine.”

“Being in care was nice, cool... first place was hell though. An old lady that bitched at kids over nothing.”

“The home was in a community of farmers, outside of Toronto. I remember that when I got there my first response was, “what the hell is this place?!”. It was so lame... Years after that I met a girl that was there with me, and she told me that the father in this house was sexually abusing her. She was a slow girl, and this man was taking advantage of her... The son of the foster parents was the one that introduced me to pot. He was a male stripper who got me into the idea of doing that.“

“Some of the places were cool, other foster parents needed to learn how to do their job, they weren't appropriate caregivers. They beat me, they threatened me.”

“Foster parents physically abused me. Group homes, foster homes, it is all bullshit. The ministry is bullshit. All they do is bounce you from one house to another, until you get tired and you just run away.”
Family Dynamics

Twenty five participants (80.6%) reported that their parents divorced or split-up when they were children. The average age of participants when divorce occurred between their parents was 4.7 years old. In 21 of the cases (67.6%), divorce occurred before the child turned 12 years old.

Fourteen participants (45.2%) reported they never knew their real father, and 29% (N=9) reported they never knew their real mother. Thirteen (41.9%) stated they knew they had other siblings which they had never met. One participant even disclosed he knew he had a five month old baby who was “probably in the care of social services”.

“I grew up with my step-father and we were always on each others’ throat for 10 years. When I finally met my real father at the age of 16 he said that he doesn't want to have anything to do with me... When I was born, my dad didn’t believe that I was his son, so he just took-off. I always asked about him and my mom said that he was dead. When I was 13 I found out about him, and she arranged for this meeting between us. I was already on the streets by then. At the age of 16 he said that he doesn't want to have anything to do with me, and I was very disappointed. I just wanted him as a friend.”

“I never knew my real father... My mom knows who he is, but she doesn't want to tell me. She just said that he is Italian. I have another brother, he has a different father, but doesn't know who he is either. My mom wouldn’t tell us.”

“My mom had a son from a previous marriage, which none of us knew and that my mom was never in touch with. We just know that he is also on the streets.”

Nineteen participants (61.3%) reported they were kicked out from home by their parents or caregivers, or that they chose to run away from home and never returned to live there.

“I ran away from home many times, starting at the age of 15. My parents never looked for me.”

“I was kicked out from home because I was gay.”
“My mom never really kicked me out, she just sent me to my father or my uncle when she couldn’t handle me. I started running away from home when I was 15.”

“I ran away from home because of my stepfather. He was the one that also kicked me out often.”

“My parents kicked me out ‘cause I dropped out of school, got heavy on drugs, partied a lot, and often got involved in petty crimes.”

“I was kicked out by my band permanently.”

“Dad kicked me out when he found that I smoked.”

“Being kicked out and running away from home was a yo-yo.”

Question number 37 asked whether participants considered their family life while growing up to be normal. Sixteen participants (51.6%) responded negatively while 15 (48.4%) considered their family life to be normal.

“Hell no! My family life is far from being normal.”

“Family life was not normal. We rarely had my parents’ attention. Only when I did something for their needs I got their attention, they saw me then... At the age of eight I already got them their drugs and alcohol.”

“I don’t know if there is anything like a normal family anymore...”

Living at home was reported to be a fearful experience for 48.4% (N=15). Twenty five participants (80.7%) stated that living at home was a stressful experience for them and for other members of their family.

“It wasn’t fearful. It was bitter and strange...”

“I had troubles with my father. He used to throw the Holy Bible at me and say that I need to pray really hard.”

Twelve participants (40%) reported that there was violence between their parents. Fifteen (48.4%) reported that parents were violent towards their children as well.
"My mom had many boyfriends, they were often violent towards her. Once, when one of her boyfriends found that she was a Coke head, he threw chairs on her and stuff... it was bad..."

"My parents never got divorced. They would fight, and beat, and bitch and I prayed that they divorce, but they didn’t. My dad died when I was 18. They used to fight and swear, and then she cried, he showed remorse, and afterward they were sweethearts again. It was pathetic..."

"Violent fights and swearing was common in my home. My mom used to be a lady wrestler. It was usual to call her ‘fucking bitch’.

Most of the participants reported that their parents were caring and loving (74.2%; N=23). However, only 58% (N=18) felt that their parents were there for them when they needed them. For 77.4% (N=24) talking about feelings was not something that was encouraged in their family, with 41.9% stating that talking about feelings was never encouraged in their home. One of the participants indicated that she could not talk to her caregivers (grandparents), and disclosed that they used to lock her up and never allowed her out, except for school. Another participant said that the experience was different when he lived with his mother than the experience of living with his father:

"Living with my dad was a fearful and a stressful experience. He was never caring and loving and was never there for us when we needed him. He never spent quality time with us, but always wanted to know where I was going and when I would return. Mother was bartender, she was away from home most of the time. Dad never encouraged us to talk about feelings, mom was big on angels, was very peaceful."

Forty-five percent of the participants stated that when they went out, their parents were not interested in knowing where they were going and when they would return.

"My mom never worried if I didn’t come home at night. She knew I could take care of myself. She treated me like an adult."

"My parents always had their own agenda. They treated me like shit. They treated me like a grown-up at a very early age, saying that I got to learn it myself; that if
I’m doing something wrong, I got to find that out the hard way. I needed guidance, someone to lay down orders sometimes.”

“Everybody in my family held it in.”

“If I would talk about feelings in my family, they would use it against me.”

Eighty seven percent of the participants (N=27) reported that their family would celebrate holidays together; however, only 45.1% indicated that their family maintained traditional family activities, such as having dinner as a family, spending Sundays together as a family, etc.

“I appreciate the fact that my parents taught me good manners. It is nice to know how to used a knife and fork, and how to sit at the table. Perhaps that is why rich men were comfortable with me... I am an intelligent person, even if I didn’t graduate from school, I always thrived for knowledge, I love ballet and classical music...”

“We never had traditions in my family. My brother and I prepared dinner and had it together. My father never cared about us having dinner or not”.

“I hated holidays. On Christmas my dad used to invite people and shame me in front of everyone. He was evil...”

“My mom used to celebrate holidays with her family, or her boyfriends, but I was never allowed at the table. We had to stay in the bedroom. They didn’t want me around when they celebrated. They didn’t want me around at all... Even if I was sitting in the living room and watching TV she used to shout at me that I was a mistake, and send me to my room. After they had their dinner, they used to bring us some food to our rooms. I don’t have even one single good memory of my family.”

Eighteen participants (58.1%) indicated that their parents were not involved in activities related to their schooling and academic achievements.

“My parents never even met my teachers”.

“For two years I was out of school, and my parents didn’t know”. 
Fifteen participants (48.4%) stated that their parents were not involved in their social life and friendships:

“They didn’t care about my friends. They never wanted them around…”

“I didn’t have any friends when I grew up. I never went to friends’ homes or had friends over. She (grandmother) never allowed me, and never encouraged me, to have friends”.

“My mom never cared about my school or social life”.

The following table refers to item number 52 on the questionnaire, which inquired about the expectations participants’ parents had from them:

<table>
<thead>
<tr>
<th>Response</th>
<th>N</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parents had realistic expectations</td>
<td>9</td>
<td>29%</td>
</tr>
<tr>
<td>Parents had unrealistic expectations</td>
<td>6</td>
<td>19.4%</td>
</tr>
<tr>
<td>I never knew what my parents expected of me</td>
<td>16</td>
<td>51.6%</td>
</tr>
</tbody>
</table>

“Mom used to say that I’ll never amount to anything, never gonna get to anything.”

“They thought I was a genius. They wanted me to have 95% at any subject. They never let me fail… It was always disapproval by my grandmother.”

“I had wonderful parents (adopting parents). I was their only child and I used to get what I wanted. They were very understanding… They believed that anything was possible to achieve. They pushed me and believed in me, and I think that this is why I never gave up or lost hope.”

“I was expected to take care of everybody in my family, including my parents.”

“They surely didn’t expect that I’ll become a heroin user in the DTES…”

Participants were asked to evaluate the level of protection provided to them by their caregivers. Other caregivers that participants referred to in this question included
caregivers that looked after them for significant periods of time, and were identified as grandparents, step-parents, members of the extended family, and foster parents. Table 21 summarizes these findings:

Table 20: Caregivers' protectiveness over their children

<table>
<thead>
<tr>
<th>The Caregiver</th>
<th>Overprotective</th>
<th>Protective enough</th>
<th>Under-protective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father</td>
<td>24.1%</td>
<td>41.4%</td>
<td>34.4%</td>
</tr>
<tr>
<td>Mother</td>
<td>25.8%</td>
<td>38.7%</td>
<td>35.5%</td>
</tr>
<tr>
<td>Other caregivers</td>
<td>21.4%</td>
<td>35.7%</td>
<td>42.9%</td>
</tr>
</tbody>
</table>

"My dad was very strict, always worried... My uncle was very blunt and forward, never held anything back. First thing that he got me when I came to live with him at the age of 12 was a pack of condoms and a pack of cigarettes."

"My real mother was my caregiver since I ran away from my grandparents at the age of 13, but she never really cared for me. There is no emotion between us."

Summary

The above section covered questions 19-52 in the questionnaire, which dealt with risk and protective factors associated with the family. Findings in this section indicated high prevalence of parental alcoholism and drug addiction. Inconsistency and multitude of caregivers was notable, as well as the number of participants that were removed from the care of their parents and placed in out of home care. Results indicated that the many of the participants were raised in single parent families, and that many experienced losing one of their parents during their childhood (through divorce or parental separation). Family dynamics in the lives of participants were found to be mixed. For most of the participants, life at home was stressful, and for almost half of them life at home was even
fearful; yet, the majority reported experiencing their parents as caring and loving and almost half of the participants considered their family life to be normal.

When examining family attitudes towards drug use, it was found that most of the participants were not able to discuss drug use openly in their families and that for many, parents did not set clear rules against the use of drugs.

The above section presented various of other findings related to family dynamics, communication, structure, and relationships.

The next section will present results from questions 53-57 of part three in the questionnaire, which deals with risk factors associated with mental health and behavioural issues.

**RISK FACTORS ASSOCIATED WITH MENTAL HEALTH AND BEHAVIOURAL ISSUES**

Sixteen participants (51.6%) reported having used intimidation and aggressiveness to get what they wanted. The same number of participants reported having vandalized public or personal property, and to have been involved in violent fights at school and in the neighbourhood.

"I always vandalized public property. I used to have no respect for others. I broke windows, did graffiti, I rode my bike into stuff, it was bad when I drank... that’s why I am so afraid of picking up the bottle today."

When asked about diagnosis of mental conditions, 51.6% reported that they were diagnosed positively by mental health professionals. Two of the participants were diagnosed with more than one mental health issue. Participants that believed themselves to be suffering from mental health condition but were never formally diagnosed, are not
included in the findings presented in the following table. One participant that was also 
excluded in the following table indicated that he was diagnosed with a speech impairment 
in his early childhood, and to still be suffering from this impairment. The mental health 
conditions that participants have identified as “other diagnosed mental health issues” 
were FAS, FAE, depression, bipolar disorder, anxiety, and learning disabilities.

Table 21: Mental health diagnosis

<table>
<thead>
<tr>
<th>Mental health</th>
<th>N</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADD/ADHD</td>
<td>11</td>
<td>35.5%</td>
</tr>
<tr>
<td>Other mental health diagnosis</td>
<td>7</td>
<td>22.6%</td>
</tr>
</tbody>
</table>

Summary

Almost half of the participants reported to have been involved in aggressive 
behaviour and to be formally diagnosed with a mental health condition. The most 
frequently reported mental health conditions that participants were diagnosed with were 
ADD and ADHD.

The next sections will present findings from section G of part three in the 
questionnaire, which inquired about risk factors associated with school and participants’ 
academic life.
For 48.4% of the participants (N=15), attending school was one way to escape from home, with 61.3% (N=19) stating that they enjoyed school. Table 23 outlines the scale of responses to item 58 on the questionnaire.

Table 22: “I enjoyed school”

<table>
<thead>
<tr>
<th></th>
<th>Always</th>
<th>Sometimes</th>
<th>Rarely</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>2</td>
<td>17</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>Percentage</td>
<td>6.5</td>
<td>54.8</td>
<td>6.5</td>
<td>32.3</td>
</tr>
</tbody>
</table>

"School was boring for me. I found it to be unstimulating. Besides, I was afraid to go to school 'cause I was always carrying the baggage of being different, and kids were very cruel to me. They teased me for my speech impairment and also called me 'faggot'. I can’t understand how social services could not see that, and just blamed my parents for not supervising my attendance at school."

"School was a way to escape home mostly when I lived with my dad."

"I always wanted to escape school so I could go home to my sisters. I had sisters who were five, three, and two years old, at home with my addicted-alcoholic parents. I wanted to be home and take care of them. If I wouldn’t be there to feed them, they wouldn’t get anything to eat."

Nine participants stated that their performance at school was poor or below average (29%); 48.4% stated that it was average; and 22.6% stated it was above average. Sixteen participants (51.6%) reported that they used to do their homework and prepare for exams. Finally, 80.6% of the participants (N=25) reported they graduated from high-school (one graduated through a returned student program; one graduated with honours; and two participants reported to be high and already involved with drugs at the time of their graduation). Five participants never advanced to high school at all.
Summary:

Questions 58-62 inquired about participants experience at school and about their academic achievements. For almost half of the participants attending school was one way of escaping from home. Yet, it was found that the majority enjoyed school and completed their grade twelve education.

The next section will present findings from section H of part three of the questionnaire, which deals with risk factors associated with peers.

**Risk factors associated with peers**

Table 24 presents the difference in popularity of participants in elementary school versus high school.

<table>
<thead>
<tr>
<th></th>
<th>Always popular</th>
<th>Sometimes</th>
<th>Rarely popular</th>
<th>Never popular</th>
</tr>
</thead>
<tbody>
<tr>
<td>In elementary</td>
<td>41.9%</td>
<td>19.4%</td>
<td>16.1%</td>
<td>22.6%</td>
</tr>
<tr>
<td>In high school</td>
<td>50%</td>
<td>30.7%</td>
<td>11.5%</td>
<td>7.6%</td>
</tr>
</tbody>
</table>

"In elementary school I was always beaten-up. In high school I was accepted 'cause I was selling drugs and they wanted that."

"In elementary, I was popular 'cause nobody wanted to bug me... I was never in high school."

"I was always accepted by my peers, was always the new kid in school that everybody wanted to be around. It was difficult for me... usually, for new kids at school it's a challenge, it's not easy to make new friends. But for me, I guess I wanted to have ALL the attention all the time, and I got it..."
Table 25 presents the type of substances used by peers that participants socialized with in high school.

Table 24: Substances used by peers of participants in high school

<table>
<thead>
<tr>
<th>Type of substance used by peers</th>
<th>N (N=26)</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cigarettes</td>
<td>26</td>
<td>100%</td>
</tr>
<tr>
<td>Alcohol</td>
<td>26</td>
<td>100%</td>
</tr>
<tr>
<td>Marijuana</td>
<td>24</td>
<td>92.3%</td>
</tr>
<tr>
<td>Hallucinogens</td>
<td>12</td>
<td>46.1%</td>
</tr>
<tr>
<td>Hard drugs</td>
<td>7</td>
<td>26.9%</td>
</tr>
</tbody>
</table>

None of the participants reported to have had their first experimentation with hard drugs with peers at school. The most reported setting for the first experiment with hard drugs was with peers in the neighbourhood (N=14; 45.2%). Five participants (16.1%) reported they first experimented with hard drugs with a family member, one participant stated that she experimented with hard drugs by herself (although it was a friend on the street that gave her the drug), and 11 participants (35.5%) described other settings (seven out of those eleven participants referred to the street as the setting in which they first experimented with hard drugs).

"On the streets with my street father… he was a biker."

"On the streets, two weeks after running away."

"First experimented with hard drugs in Vancouver."

"On the streets of Toronto, when I started prostituting. It was probably the third date that I had, a man pumped me with blow (cocaine), and I just couldn’t stop babbling for hours after that… Using drugs was never something that I’ve done by myself. It was always a social thing. Now look where I am… I only do it by myself. There is no fun in it anymore."
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"On the streets of the DTES."

"With friends in a bar."

"From the lady that I worked for."

"With older people in my neighbourhood. They gave me drugs, and sexually abused me in return. I couldn’t stop it... I was drunk as a skunk."

"In Vancouver... I was picked up by a guy, a date... got high on Coke with him."

"First hit of Coke was in a party with friends in North Vancouver. There is lots of Coke in parties there..."

"DTES."

Sixteen participants (51.6%) reported they felt pressured by their peers to use drugs. However, as mentioned earlier in part two of the open-ended questions, 64.5% identified peer pressure as a cause to their addiction.

"In school we always talked about drugs. Whomever refused to use it, we simply ignored them."

"Friends would never let you get out with the weed. You never stop smoking until it’s all gone."

"If you don’t use, it’s common to hear stuff like, ‘chicken’, ‘chicken shit’, and ‘punk’. My friends coerced me to use."

Summary

The majority of participants reported they were popular in both elementary and in high school. Reports of being more popular in high school than in elementary school were notable.

Interesting results were found with respect to the type of substance used by peers in high-school, with the most frequently reported used substances being tobacco, alcohol, and soft drugs, particularly marijuana. The first experimentation with hard drugs, on the
other hand, was most frequently reported by participants to be with peers in the
neighbourhood. Finally, more than half of the participants reported feeling peer pressured
to use drugs.

The next section will present findings from the final section of the questionnaire,
which inquires about historic experience of trauma and abuse.

**RISK FACTORS ASSOCIATED WITH HISTORY OF TRAUMA & ABUSE**

Table 26 outlines findings related to the history of abuse in the lives of the participants:

<table>
<thead>
<tr>
<th>Type of abuse experienced by participants</th>
<th>N</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional abuse</td>
<td>21</td>
<td>67.7%</td>
</tr>
<tr>
<td>Physical abuse</td>
<td>17</td>
<td>54.8%</td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>11</td>
<td>35.5%</td>
</tr>
<tr>
<td>Experience of other traumas</td>
<td>14</td>
<td>45.2%</td>
</tr>
</tbody>
</table>

The following are some of the stories shared by participants with regards to their
experience of abuse:

"When I was 14 I went into a bath house, although I wasn’t allowed in, and this
man raped me. I’ll never forget that… I keep seeing this scene. I can’t have sex
now unless I use drugs before… and sex is the only way I get my drugs."

"At the age of eight, a guy gave me a ride. He took me to a place, held a knife to
my throat and told me to get naked. He molested me for eight hours, then threw
me on the way back, and gave me $10."
"I was kicked out from home at the age of nine. A year before that my baby brother died in his crib when he was two months old. I was alone at home with him, the one that found him dead and called the ambulance. I was blamed for that by my parents."

“When I was a child my mom overdosed on pills. I remember seeing blood coming out of her ears. She stayed at the hospital for one year, had a lot of emotional issues and depression.”

“I witnessed my mom trying to kill herself with a knife.”

“I think the fact that as a baby I was constantly switched between people was pretty traumatic. I never had someone to hang on to, someone to hold on to, was always passed on to people.”

“My mom used to put me down and abuse me ‘cause I looked like my dad. She threw me out the window once ‘cause I forgot to feed the dog. I was 7 at that time. She skinned me alive. I have scars all over my body because of her.”

“My dad beat me for every little thing, that I didn’t know how to avoid it... He abused me emotionally, but I was used to it, thought that that’s the way it’s suppose to be...”

“My dad was a military man, twisted me mentally and emotionally. He tortured me. Used to beat me and say ‘yeah, cry, cry... you probably want your mom to come and wipe you butt...’ he was big and I wasn’t. I never wanted to be like him, so I never developed my body. I hated him so much that when he died I spit at his grave and laughed. Why? Why did he hit me?... But I loved him too, deep inside. I wanted him, I wanted to marry him, to sleep with him. He was also adopted as a child, I identified with him... I was sexually active since I was six years old. A friend of mine had a 56 year old uncle that we visited often. I am so angry with society that decides for people what is right and wrong... so what if he was 56 and I was six years old? I wanted him too...”

“I saw my friend die of overdose at the age of 16. When we were doing drugs, together with other friends, she suddenly started doing the chicken, I thought that she is just getting high. When I got over my high, I went to her and she was lying there dead, with the needle still in her arm.”

“My best friend got shot in the head and died. They were in a party, one of the people had a gun that he stole from a B&E, there were drugs too, and he shot him.”

“I saw someone got shot in the head over drug money.”
"The things that a kid has to go through when working in the sex trade are all sexual abuse really, but it is with your consent… even if you hate it, you got to do it. For me, I can’t see myself doing crimes, and I certainly don’t want to be in jail, so I have to work as a prostitute. I hate doing it, but I have to, I prefer not to suck on dicks and not to sell my ass, but that’s my only choice. It is even harder when you are not gay, ‘cause you most likely be serving old men... There are some sick twisted people out there. A man offered me $100 if I would agree to shit in his mouth. Of course I didn’t do it… I rather sell a blow-job for $40. Then I would go and throw up and get my hit quickly to forget about what I just did.”

“As a girl on the street, sexual abuse used to happen a lot. Everyone wanted to fuck me and I wasn’t strong enough to say no. I still live on the streets and hardly get a decent night’s sleep. Sometimes I get to crash on friends’ couches for the night. They would offer to take me over for the night, but then all they really want is to fuck me. After a long day of working on the streets that’s the last thing I want to do. So either I let them have it and then go to sleep, or I would just pick up my stuff and go back to the streets.”

“Living in the DTES is a never-ending trauma.”

Only 14 participants (45.2%) reported receiving adequate help and support to address the experience of abuse and trauma.

“I never got real help and support cause I was always blamed for everything. I was ‘a troubled teen’.”

“I was never in counselling. I went to detox and that’s it. For my trauma, I consoled myself by drugs.”

Summary

The most reported type of abuse mentioned by participants was emotional abuse, followed by physical and sexual abuse. It was found that only two of the participants did not experience any type of abuse; in other words, 90.3% of the participants experienced emotional, physical, or sexual abuse. Less than half of the participants reported receiving adequate help to address their experience of abuse or trauma.
The next chapter will present an analysis of inferential statistics and will include presentation of results from correlation tests using Pearson’s r and results from t test for independent means examining differences between selected groups.

**Inferential Statistics**

As discussed earlier in the methodology chapter, this thesis is exploratory and therefore, preliminary hypotheses were not articulated. Instead of examining specific research questions, the study aimed at generally exploring the data to provide a better understanding of addiction among youth in the DTES.

**Examining correlation between variables using Pearson’s “r”**

Results of using Pearson’s “r” reveal a number of interesting findings. These findings contribute to the understanding of how different risk factors may interact in the lives of participants and the way they may increase youth vulnerability to drug use. Findings mainly relate to family dynamics, atmosphere in the home and the family identity, as well as to peer pressure, personality, and school life.

A fearful experience of living at home correlated highly with parents not being caring and loving \((r=-680, p=.000)\), and with not having parents “being there for their children” \((r=-478, p=.007)\). The correlation between the latter variable (parents being available for their children) and having parents setting clear rules against the use of drugs
was interesting ($r = .372$, $p = .039$), as it may indicate that youth do appreciate clear rules set by their parents. Further on the atmosphere at the home of the participants, it was found that parents who were prone to discuss openly with their children drug use and potential consequences correlated highly with youths' perceiving their home atmosphere as being stress-free ($r = -.534$, $p = .002$). This supports the belief that open communication between youth and their parents enables youth to talk freely with their parents about any concerns they may have and thereby enhance their trust in their parents.

Parents who used to spend quality time with their children correlated highly with youth perceiving their parents as caring and loving ($r = .706$, $p = .000$) and correlated negatively with experiencing the atmosphere at home as fearful ($r = -.515$, $p = .003$), and stressful ($r = -.558$, $p = .001$).

Parental supervision as reflected through question number 44 (“when I went out my parents wanted to know where I was going and when I would return”) associated with parents setting clear rules against the use of drugs ($r = .431$, $p = .016$). It also correlated with the family’s economic status ($r = -.356$, $p = .050$). Parental supervision can also be viewed through question number 50 (involvement in school life) and 51 (involvement in social life). Youth that had parents' involvement in their social life correlated negatively youth involvement in violent fights ($r = -.483$, $p = .006$). This may indicate that parental supervision over their children’s social life may result in children’s association with non-violent peers. Parental involvement in their children’s social life was also linked to indicators of the quality, or nature, of the relationships between youth and their parents (e.g., parents being caring and loving: $r = .549$, $p = .001$; parents being available for their children: $r = .559$, $p = .001$; and parents encouraging their children to talk about feelings:
Similar associations were found between the above factors and parental involvement in their children's school life.

Having parents that were caring and loving had a negative correlation with youth using aggressiveness and intimidation to get what they wanted ($r = -0.379$, $p = 0.037$) and youth being involved in violent fights ($r = -0.363$, $p = 0.045$). This may indicate potentially higher self-esteem among those children who benefited from loving parents, having better communication skills and being able to trust others.

Other interesting findings relate to the fact that variables associated with family structure and identity correlated with other protective factors. For example, families that had and maintained their own traditions (such as spending regular time together, having daily dinner together as a family, etc. as reflected in question number 45 in the questionnaire) correlated with parents setting clear rules against the use of drugs ($r = 0.431$, $p = 0.016$); effective supervision of parents over their children ($r = 0.463$, $p = 0.009$); parents having realistic expectations from their children ($r = 0.424$, $p = 0.018$); children not getting involved in violent fights at school and in the neighbourhood ($r = -0.371$, $p = 0.040$); with performance at school ($r = -0.407$, $p = 0.023$), and even with youth not being popular in high-school ($r = -0.464$, $p = 0.008$). The variable 'popularity in high school' among participants in this project correlated highly with lack of parental supervision ($r = -0.360$, $p = 0.046$); having vandalized public and private properties ($r = 0.382$, $p = 0.034$); and with being involved in violent fights in school and in the neighbourhood ($r = 0.470$, $p = 0.008$). Both popularity in elementary school and in high school correlated with lack of parental supervision ($r = -0.435$, $p = 0.014$; $r = -0.360$, $p = 0.046$). Such a finding may suggest that children who do not have a curfew time, and who can engage in any activity they want at any time of the day, may
gain peers’ admiration. At the same time, peers may lose their popularity if they always leave in the middle of social activities because they need to be home on time (This is one explanation for the identified correlation and may depend on the type of peer group).

Youth that did not feel peer-pressured to use drugs correlated with having a stressful family life ($r=-.426, p=.017$). On the other hand, youth that did feel peer pressure, correlated with having parents that spent quality time with their children ($r=.367, p=.042$) and with youth meeting school expectations by doing homework and preparing for exams ($r=.413, p=.021$).

Having life at home considered to be stressful was found to be associated with considering attendance at school as an escape from home ($r=.410, p=.022$). Realistic expectations set by parents were found to be associated with higher academic performance ($r=-.397, p=.027$).

**Exploring differences between groups using t test for independent means**

The 31 participants sampled represented a number of independent groups based on various themes, such as prostitutes and non-prostitutes; children of drug addicted parents and children of parents who were non-addicted; and youth that were removed from the care of their parents versus children that were not removed. These groups were utilized as comparison groups while testing differences in selected variables.

Assuming that the amount of variability in each comparison group is equal (unless stated differently), the following results were found.
The amount of time that homeless youth (N=23) spent in the DTES was compared to the amount of time spent there by youth who were not homeless (N=8). No difference was found between the groups: $t_{(29)} = -.93$, $p=.36$. The same variable was examined among youth who were raised in Vancouver (N=7) versus youth who arrived in Vancouver from other places in BC, Canada and outside of Canada (N=24). No difference was found between these two groups as well: $t_{(29)} = -1.18$, $p=.244$.

Youth were grouped independently according to the source of their financial support, and comparison groups were formed based on the following criteria: youth who were dealing drugs (N=13) versus those who did not (N=18); and youth who prostitute as a source of income (N=16) versus youth who did not prostitute (N=15).

Drug dealers spent more time in the DTES than non-dealers. Yet, although the probability of this finding being true due to involvement in drug dealing activity was fairly high ($p=.062$), type one error is still greater than .05. The results for this test were: $t_{(29)} = -1.94$, $p=.062$.

Drug dealers scored significantly higher on “using aggressive behaviour and intimidation” than non-dealers: $t_{(29)} = -2.8$, $p < .01$. They also scored higher on being involved in violent fights at school and in their neighbourhood: $t_{(29)} = -3.07$, $p < .01$. This may suggest that different personality traits and behavioural characteristics may be predictors for youth involvement in drug dealing.

There was no difference between the amount of time that youth prostitutes spent in the DTES versus non-prostituting youth: $t_{(29)} = .23$, $p=.81$. Prostitutes did score lower on their involvement in all three variables related to aggressive behaviour:
1. Using aggressiveness and intimidation: $t_{(29)} = 2.05$, $p < .05$.

2. Having vandalized public and private property: $t_{(29)} = 2.67$, $p < .05$.

3. Being involved in violent fights at school and in the neighbourhood:
   
   $t_{(29)} = 2.60$, $p < .05$.

A comparison was made between youth who had alcoholic parent/s (N=23) and youth who had non-alcoholic parents (N=8), using different variables, in order to examine the impact of having an alcoholic parent on some aspects of the youths’ lives.

No difference was detected between the two groups on the age they began smoking cigarettes or marijuana ($t_{(29)} =-.60$, $p=.54$ for cigarettes; and $t_{(29)} =.51$, $p=.61$ for marijuana). Yet a significant difference was found in the following areas:

1. Lower economic status in families with alcoholic parent/s: $t_{(29)} = -2.08$, $p < .05$

2. Participants experiencing their home atmosphere as more fearful:
   
   $t_{(29)} = -3.20$, $p < .01$; and stressful: $t_{(29)} = -2.09$, $p < .05$.

3. Participants perceiving their parents as being less caring and loving:
   
   $t_{(29)} = 2.96$, $p < .01$.

4. Having less traditional activities in the family (question number 45):
   
   $t_{(29)} = 2.57$, $p < .05$

5. Parents were less involved in their children’s social life: $t_{(29)} = 2.6$, $p < .05$.

Similar comparisons were made between children of drug addicted parents (N=19) and children of non-addicted parents (N=12). Children of drug addicted parents were found to begin their cigarette smoking earlier than children of non-addicted parents. Average age of commencement of cigarette smoking among this group of children was
11.3 years of old. The average age for beginning cigarettes smoking among children of non-addicted parents was 14 years old. The results of the t test were:

\[ t_{(29)} = -2.33, p = .027. \]

No difference was found in the age of commencing marijuana use.

As with children of alcoholic parents, economic status of families with drug addicted parents was lower than in families of non addicted parents: \[ t_{(29)} = -2.66, p = .012. \]

In contrast to the test among children of alcoholic parents, children of drug addicted parents did not find their home atmosphere to be more stressful or fearful than children of non-addicted parents. However, similar to families with alcoholic parents, there was a difference in the level of traditions maintained by families of addicted parents versus families of non addicted parents, indicating that in homes with addicted parents there were nearly no traditions in the life of the family: \[ t_{(29)} = 2.61, p = .014. \]

When examining the levels of school performance between the above two groups, it was found that the performance of children of addicted parents was lower than the performance of children of non-addicted parents: \[ t_{(29)} = -2.76, p = .010. \] Such a significant difference was not found when comparing children of alcoholic and non-alcoholic parents. Furthermore, children of drug addicted parents were less inclined to prepare their homework and prepare for exams than children of non addicted parents:

\[ t_{(29)} = 2.66, p = .012. \] Finally, drug addicted parents were found to put less clear rules against the use of drugs than non-addicted parents: \[ t_{(29)} = 2.07, p < .05. \]

Differences were examined between the group of participants who were removed from the care of their parents (N=24) and participants who were not removed (N=7). It was found that participants who were removed as children began smoking cigarettes
earlier than participants who were not removed. The average age of commencing cigarette smoking behaviour was 11.5 years old versus 15.2 years of age among non-apprehended children ($t_{(29)} = -2.99, p < .01$). As indicated earlier in the descriptive statistics, the average age of removal of the 24 participants was 7.2 years of age.

Similar findings were found when examining differences in the age participants started smoking marijuana. Participants who were removed as children began smoking marijuana at the average age of 12.1 years. Participants that were not removed from the care of their parents begun smoking marijuana at an average age of 14.1 years ($t_{(29)} = -2.44, p < .05$).

Participants who disclosed domestic violence were found to be more involved in violent fights at school and in the neighbourhood than participants who reported no domestic violence: $t_{(28)} = -2.21, p < .05$. No difference was found in the level of involvement in violent fights when comparing participants who were themselves victims of physical abuse in their homes and participants who were not: $t_{(29)} = -.43, p = .66$.

Victims of physical abuse (N=17) evidently found their home environment to be more fearful: $t(29) = -3.54, P = .001$. They were less inclined to consider their parents as caring and loving ($t(29) = 2.43, P = .021$) and reported, more than non-victims, considering attendance at school as an escape from home: $t(29) = -2.07, p < .05$. An interesting finding related to victims of physical abuse was the significant difference in their drug of choice as opposed to non victims: $t(29) = -3.70, p = .001$. It was found that participants who were physically abused by their parents were more inclined to use
heroin, while non-victims clearly preferred the use of cocaine and crack-cocaine. Such a finding was not evident among victims of emotional abuse. However, a similar difference in drug of choice was found between victims and non-victims of sexual abuse: $t(29) = -2.14, p = .040$.

A fearful atmosphere at home was experienced significantly higher by victims of sexual abuse: $t(29) = -4.21, p = .00$. Talking about feelings in families of victims of sexual abuse was less encouraged than in families of non-victims: $t(29) = 2.48, p = .019$. No difference was found in the latter variable among victims and non-victims of physical and emotional abuse.

Two independent groups were created for the purpose of conducting a test based on participants’ experience with peer pressure. A number of variables were examined while comparing between participants who did feel peer pressured to use drugs ($N=16$) and participants who did not feel peer pressure ($N=15$).

The results revealed that there was no difference in indicators of home atmosphere of participants from the two groups (home atmosphere being fearful or stressful). There was also no difference in parental inclination to discuss drug use openly with their children or in the degree to which parents set clear rules against the use of drugs. However, significant difference were found in the following four areas:

1. Participants who felt peer pressured to use drugs enjoyed school more than those who did not feel peer pressure: $t_{(29)} = -2.88, p = .007$, and had a higher school performance: $t_{(29)} = 2.15, p = .039$. They were also more inclined to do their homework and prepare for exams: $t_{(29)} = -2.66, p = .012$. One way of interpreting
these findings is that they may point out certain traits in profile of youth that are more vulnerable to peer pressure.

2. Participants who felt peer pressure began smoking cigarettes at a later age than those who did not feel peer pressure. The average age for commencing cigarette smoking among the first group was 13.8 years old, and for the second group the average age was 10.8 years old ($t_{(29)} = 2.78, p = .010$).

No difference was found in the popularity of participants from either group.

Summary

The inferential statistics concluded the presentation of findings from this research project. The next chapter will draw some inferences from the above findings and will present a discussion involving selected findings presented earlier in the chapter. Results from this study will be linked to findings from previous research as presented earlier in the literature review.
A combination of a multidimensional approach and a risk factor approach (see literature review) was utilized in this research, assuming that in order to understand addiction effectively there is a need to capture as many influencing factors as possible. The risk factor approach contributes the accumulative aspect, according to which the greater the exposure to risk factors, the greater is the likelihood of engaging in drug use behaviour. Both approaches stem from the fundamental assumption of the biopsychosocial model of addiction, which this study was built upon, and according to which addiction is caused by a range of factors from various areas of life. This study has shown that causes for addiction can be unlimited and moreover, factors that contribute to the development of addiction are linked to one another, influenced by and influencing other factors. For example, the media as a risk factor for drug use, may form a positive approach to drugs, which may be strengthened by parental addiction (or initiated by it), or may be enabled by parental lack of supervision; further can be triggered by boredom and curiosity, and facilitated by peers, to whom one may surrender due to low self esteem or due to a need for social acceptance, and again can be enabled by the availability of drugs in one’s environment; and that finally, can be followed-through with when there is a lack of adequate knowledge about the adverse consequences of addiction. This is only one way of conceptualizing the interactivity of risk factors’ influential mechanism. This thesis
concludes that such a mechanism has most likely occurred in the life of every one of the participants, changing according to the unique circumstances of every one of them. The notion of ‘protective factors’ basically reflects the opposite of ‘risk factors’. If in this interactive-influential mechanism of risk factors one experiences protective factors (e.g., adequate parental supervision and involvement in their child’s life) this mechanism can be interrupted and may not lead to addiction. In the same way that certain factors may be more dominant than others in potentially increasing one’s vulnerability to use drugs, certain protective factors may be more significant and powerful than others in hindering addiction (e.g., a positive and meaningful bond with someone or with something).

Little is known from the literature about drug using youth in Canada, and even less is known about drug using youth in the Vancouver DTES. However, it was indicated that the problem of drug abuse among Canadian youth is an area of concern that has grown significantly in the past few years (Poulin et. al. 1999; Single, 2000). It is also known that the DTES’s drug scene in general is a devastating societal and health problem that affects the lives of thousands of people (see introduction to this thesis).

A significantly higher number of participants in this study were males (80.6%). The literature review suggest that males are at a higher risk for substance abuse in later adolescence than females (Johnson et. al. 1991; DeWit et. al. 1995). On the other hand, it is possible, as some participants suggested, that females are simply less inclined to participate in research (i.e., committed to their pimp and being less open about their addiction).
More than half of the participants were Caucasian (61%) and almost a quarter were First Nation. The rest (16.4%) were mixed Native-Caucasian, except for one participant who had another racial background. Considering the fact that 30% of the total estimated population in the DTES is native (McClean, 2000), the proportion of native participants in the study is fairly reflective of the composition of the population in the DTES.

Almost 80% of the youth came to Vancouver from elsewhere (primarily from another province in Canada) and almost half of them have been in the city for less than two years. Some participants stated that they knew about the DTES and the drug availability before they came to Vancouver. Although many of the youth started their drug use before coming to Vancouver, many of them reported that their addiction became worse ever since they came to the city, and spoke about the difficulty of quitting drugs when living in, or close to a drug saturated community. As was discussed in the literature review, availability of drugs is more than just the actual existence of the drug in one’s environment. It is also the affordability and the existence of the right social context in which people use their drugs (Teichman, 1995). If availability of drugs is a significant risk factor for drug addiction (as reported by almost half of the participants that answered the open-ended questions, which means that the number of respondents could have been even higher if a question on availability was specifically articulated in the structured part of the questionnaire) surely the factor is extremely profound in the DTES, and as one participant stated, “the availability there is ridiculous!”: the indiscreet drug related activities including the “open drug market”, the dealers, the users, the injections in the alleys and parks, the remains and reminders of used needles and wraps of drugs that are
thrown on sidewalks and grounds, the "stoned people", the drug-sick people, and more than all, the common knowledge that drugs are so easy to obtain and that there are no obstacles to stop anyone from getting their drugs in the DTES.

Involvement of youth in the DTES was mostly limited to drug related activities. According to this research, they were first attracted to the area because of the drug availability and they continued to maintain their involvement in the area for the same reason. The second most frequently reported factor identified as attracting youth to the DTES was the affordable residency. However, the use of affordable rent as a reason for continuing involvement in the DTES was much less recurrent than involvement linked to drug activity. Fifty eight percent (58%) identified “low rent” as the initial attractive factor to the area as opposed to 77.4% identifying drug availability as an attractive factor, and 48.4% reported to continue being involved in the DTES because of the affordable rent as opposed to 93.5% continuing their involvement in the area because of the drug availability.

When t tests were conducted to examine differences in the amount of time spent in the DTES between groups of homeless versus non-homeless youth, and between youth born in Vancouver versus youth born outside of Vancouver, no difference was found. These findings may strengthen the assumption that the predominant factor for youths’ involvement in the DTES is the availability of drugs and that drugs may be the only factor that determines how much time youth spend in the area.

One of the most worrying findings in this study was the fact that almost three quarters of the participants (74%) were homeless. This finding is particularly alarming when considering the fact that unstable housing and residency in SRO were found to be
risk factors for HIV transmission (Strathdee, Patrick, Currie, Cornelisse, Rekart, Montaner, Schechter, and O'Shaughnessy, 1997). The habit of living on the streets for a long time was hard to break for many of the participants. Some even noted that they were “addicted” to the streets and to the DTES. Shelters for drug using youth in the city are limited and the rent allowance from Income Assistance can only pay for a rent of an SRO in the DTES, which was not a very attractive alternative for youth. Moreover, youth reported that they formed a community on the streets; they reported to be connected to other youth that they could relate to and identify with; and to develop a sense of belonging to this “community”. For street involved youth, the streets are their home, a familiar environment that they have learned how to live in. As long as they stay on the streets, they become more “addicted” to it, or more used to being there. Moving from life on the streets to an independent and normative way of living can be quite challenging for street kids. Such a transition entails commitment to having a place of their own, paying rent, bills, and even entails getting used to the loneliness in a room or in an apartment after being used to be together with other youth in the community formed on the streets. The meaning of stabilization can be very scary, especially for youth who are not used to stability. Even if street kids have their own apartment, they spend most of their time in their familiar community of friends and activities on the streets. They often continue to spend nights on the streets, especially if they continue using drugs and the drug keeps them awake for a number of days. Eventually, the importance of keeping an apartment diminishes or they get evicted from their apartments for not paying the rent, for doing drugs in the apartment, or for other reasons. Although “getting off the streets” was identified by 35% of the youth as a factor that can help them with reducing or quitting
their drug use, there are no integrated and holistic programs that can help youth successfully get off the streets and move into an independent life; programs that are long term enough to ensure that youth do not fail in the process of adjusting to a lifestyle that is so different than street life (see conclusions). Despite the cold and the hunger that homeless youth may experience, there may be other factors that make it somewhat comfortable for them to remain on the streets, particularly the lack of pressing rules and expectations if one is a street kid (they don’t have to go to school, to meet school expectations, they can continue using drugs and be supported for such a behavior by their peers, have no curfew time, and as one participant stated, they can get “freebies”). Such a dynamic can be better understood when considering the fact that almost three quarters of the participants escaped from home, or from the care of foster parents, institutions, and alternative caregivers, who may have been more strict about rules and expectations than what the youth was used to at home. Other youth were kicked out of home by parents who disapproved of their child’s choices and lifestyle. Once on the streets, the youth was no longer facing criticism, disapproval, or lack of understanding. Rather, their choices were supported and strengthened by other youth who had made exactly the same choices as them and that had gone through similar life experiences as them. Subjects indicated that the sleepless nights on the streets and the drugs made them think a lot about their life. They talked to their peers on the streets who could identify with them and understand them since they went through similar difficulties and abuse. In this light, the initial bond that youth form with peers on the street can clearly be understood, and so is the difficulty of one to say “No” to drugs when it is offered by such friends.
On the other hand, there were some participants that spoke differently about street kids, saying that if one does not have what street kids want (drugs) then such a child is worthless; that relationships on the street are dishonest and interest-driven. Nevertheless, even those participants who doubted the kindness and honesty of street youth indicated that in the beginning, their experience was different, and that they were accepted by their peers on the street. It may be that the positive perspective and feelings about being on the street are an initial stage. Once addiction becomes a problem, getting the drug is a priority that masters the desire to have sincere relationships or a place to call home (both were identified as strong factors that can assist in reducing or quitting drug use). Once addiction becomes an issue in the lives of street youth, they enter a cycle in which on one hand, they are trapped in the street-life because of matters related to convenience, habit, and sense of belonging; and on the other hand, they have to continue their addiction in order to “cope” with the never-ending-trauma of living on the streets and with whatever drug addicts have to do in order to afford their addiction.

An interesting distinction became evident among two groups of youth in this study. Although all of them were involved in the DTES in some way, apparently distinct groups were observed based on the area where they mostly hang-out. The first group was more associated with the Granville Street milieu. Their drug of choice was primarily crystal-meth (although in most cases they used other types of drugs as well), and nearly all of them were male participants who worked as prostitutes in a gay prostitutes area called Boys’ Town located in the West End. The other group was more associated with using, living, and being in the DTES every day, all day. Their drugs of choice were crack-cocaine, cocaine, and heroin (often all drugs used daily). Female participants (four
out of the six that participated in the project) were among youth from this group, and were prostituting on the streets of the DTES. The latter group identified the involvement in the Granville Street as the initial phase in the process of becoming a ‘hard core drug user’. The West End may be more associated with being cool and funky; there is more of a ‘social drug use’ and an illusion of less of ‘addiction problem’; and more gay bars and clientele for gay prostitutes. Youth from this area of town, clearly viewed youth from the DTES as ‘junkies’, ‘crack-heads’, or ‘messed up’.

Such a distinction as described above may be occurring based on a number of contributing factors. First, it should be kept in mind that the availability of drugs and the consumers of the drug are reciprocally linked: one cannot exist without the other. The fact that on the Granville Street milieu crystal-meth is the primarily available drug, ensures that its consumers remain in the area. However, once the addiction involves other drugs that are primarily available in the DTES (cocaine, crack-cocaine, and heroin) youth drift to the DTES milieu, where it is more profitable for dealers of such drugs to be active. In addition, the services that are available in each milieu are somewhat different and accommodate the needs of each group. In the Granville Street area there are mainly services with a mandate to serve street kids, regardless of their addiction (e.g., dinner for street kids, drop in for street kids, shelters for youth, etc.). In the DTES area there are services that are more associated with addiction and adult-oriented services, such as the needle exchange program, DEYAS, and NEXUS. When youth become IV drug users (as found among 51.6% of the participants) it is more convenient for them to be close to the needle exchange and to the dealer who can sell them the drug that they inject (which is less likely to be crystal-meth, as reported by participants). Finally, as youth become more
entrenched in their addiction, they may also drift away from their peer group in the West End, feeling that they do not belong there anymore, and knowing how the Granville Street youth view 'hard core drug users'. It is possible that for such drug addicts, being in the DTES is not only convenient but also more socially comfortable.

The literature review presented the Stage Theory (or the Gateway Theory), which describes the development of drug use among youth. Instead of implying a causal sequence the model defines a framework in which the progressive nature of substance use among youth may be understood. Youth often begin using licit drugs (e.g., tobacco and alcohol), move on to illicit soft drugs (e.g., marijuana and hallucinogens) and conclude with abuse of hard drugs (e.g., cocaine, heroin, etc.). As indicated in the literature review, this model appears to be oversimplified and ignores the different aspects that involve drug use behaviour. Nevertheless, findings in this study imply that stages in drug use among youth in the DTES can also be clearly identified.

The following illustration refers to this study and conceptualizes the progression in drug use among youth in the DTES:

<table>
<thead>
<tr>
<th>Cigarettes (at average age of 12.3)</th>
<th>marijuana (12.5)</th>
<th>hallucinogens (14.8)</th>
<th>Hard drugs (cocaine at 16.2; heroin at 17.9; speed at 18.3; and crack-cocaine at 18.5)</th>
</tr>
</thead>
</table>

The stages of drug use may be linked to drug availability in certain settings. For example, it was found in the study that none of the participants had their first experiment with hard drugs at school, but rather in the neighbourhood and on the streets where dealers of hard drugs are more common. It may be that this is one of the reasons why school aged youth are less commonly using hard drugs, if they are still attending school.
On the other hand, marijuana use is wide-spread in high schools. Findings in this study suggested that 92.3% of the participants’ peers in high school used marijuana and 100% of participants’ peers used alcohol and cigarettes (Data pertaining to the frequency of use of these substances is unavailable). A few years ago, school aged youth used to hide and smoke cigarettes together during recess or after school. Today, students are quite open about their cigarette smoking, and it is common to see them smoking during recess on school grounds, not even trying to hide it from their teachers. Students nowadays are hiding when they smoke marijuana. However, smoking marijuana is becoming such a growing phenomenon that is accepted by youth as well as many adults, that there could come a time in the near future when students would not feel that they have to hide their marijuana smoking either. Similar to the dynamic on the Granville Street setting versus the DTES, school aged youth that used hard drugs and still attended school (27% of the participants), most likely had separate hiding places that were different than the ‘marijuana smoking places’. As was noted in Chapter two, the type of drug that is used by certain ‘peer clusters’ (Oetting et. al., 1986) plays an important role in defining the group, forming its typical behaviours, and maintaining the group identity and structure. Peers in a cluster use the same type of drug and share the same lifestyle (this also pertains to the distinction between youth on Granville Street versus the youth in DTES).

Peer pressure to use drugs (experienced by as many as 64.5% of the youth) was not recognized as a mechanism that exists in peer clusters by Oetting et. al. (1986) as they believed that all members in a peer cluster are perceived as actively shaping the norms of behaviour. In this research participants reported actually risking losing their “social status” and acceptance by their peers if they did not use drugs. Even if some did not feel
coerced to use drugs the social price that youth could have paid if they did not use, or continued to use drugs, would have been too high to bear. Street kids especially indicated that by not using drugs, one would risk being lonely. Only in the beginning phase was doing drugs experienced by youth as a social activity. However, once a youth became an addict, doing drugs was not only depressing and stressing, but also a lonely and expensive activity that one cannot afford sharing with others.

Loneliness and lack of sense of belonging were not explored in this research in the form of structured questions, however longing for honest, meaningful, and caring relationships was noted by many participants in the open-ended questions. Most of the participants that discussed the issue of relationships on the streets referred to their friends as ‘so called friends’ and spoke about the interest-driven connections youth form with other street kids. Kandel et. al. (1978) noted that youth move away from long-term relationships and seek less intimacy with their drug using peers, but at the same time, as youth become more involved with their addiction they drift away from mainstream society and become alienated by those who disapprove drug use (Nowinski, 1990). In other words, they lose having a sense of belonging and connection altogether, both with members of mainstream society and with their peers on the streets. Yet, the human need for intimacy, belonging, and connection always remains strong. Being socially detached and displaced, in addition to experiencing historic adverse life circumstances, can naturally lead to the sadness and to the depression that was reported by so many participants and that was described as being suppressed by drugs. It was Alexander (2001) that spoke about addiction as the response people may find to their feeling of dislocation and their failure to fully participate in their society. Lack of identity and sense
of belonging (or what Alexander refers to as ‘psychological integration’) lead people to choose a substitute lifestyle, even one that is as harmful as drug addiction and street life.

Attachment, as was described in the literature review, is an emotional tie and a linking factor not only to caregivers and significant others, but also to the community, to one’s aspirations, peers, etc. (see Hirschi’s Model, p. 22). The condition of ‘dislocation’ or lack of ‘psychological integration’ (Alexander, 2001) is better understood when considering people’s experiences of ‘broken social bonds’ (Hirschi, 1969) and damaged ability to form attachment with others, with their community, and with their spiritual world (e.g., aspirations, beliefs). In the lives of nearly 80% of the youth, factors related to apprehension from primary caregivers, separation from or abandonment by biological caregivers, and multiple transitions between various caregivers have most likely contributed to the results of a disturbed attachment. It was stressed by Brook et. al. (2000) that disturbed attachment with parents affects the development of the ability to contain and maintain feelings and allow one to be overwhelmed by them. In other words, disturbed attachment affects the mechanism of self-regulation. The findings in this study and Attachment Theory provide insight into the finding that the most frequently reported cause for addiction suggested by participants was “using drugs to deal with emotional pain” or to “escape from reality” (67.7% in an open-ended question, which again, could have been much higher if articulated in a structured question). Participants not only experienced damaged attachment with their parents that affected their self-regulation, but also (and most likely related to the broken attachment) suffered from lack of guidance and support from parents that could have assisted them in turning away from drugs (61% reported parents did not set clear rules against the use of drugs; 74% noted that their
parents did not discuss openly drug use and related consequences with them; 77.4% said their parents did not encourage talking about feelings). Moreover, for most of the youth, substance abuse as a coping mechanism was modeled from their parents (74% had alcoholic parents; 61.3% had drug addicted parents); and finally, learning alternative and effective coping skills was, paradoxically, a strong need among youth in the study, considering the facts that more than 90% of them were victims of abuse and that for more than 80%, living at home was a stressful experience.

Knowledge and awareness pertaining to the real adverse consequences of drug use was one of the primary needs identified by youth for prevention. Youth wished they had someone in their lives who cared enough to tell them “don’t do it!”. In Chapter Five, a correlation was found between parents setting clear rules against the use of drugs and parents being available for their children. Such a correlation may imply that youth do appreciate clear rules set to guide them as to what is an appropriate behaviour. In addition, the correlation between parents discussing drug use openly with their children and youth experiencing their home atmosphere to be stress free, may support the perception of open communication as an important factor in the relationship between youth and their parents. Participants that indicated that their parents were permissive and allowed them to smoke pot or do drug at home, were not necessarily appreciative of such a parental approach, as was evident in some of the participants’ testimonies. Permissiveness was not found only in families where parents were using drugs or drinking alcohol, but also in families with parents that were considered by their children to be effective parents. In fact, parents’ permissiveness towards drug and alcohol was found in the literature to be more important than parental drug use as influencing
adolescent’s drug use behaviour (Brook et. al. 1986). The study’s findings reflect the helplessness that may be experienced by parents nowadays in their attempt to do the “right thing” in preventing their children from becoming drug users. Parents may be confused as to what may be the best approach to educate their children about drugs and how to react when discovering that their child is experimenting with drugs. Being too permissive or too strict are two extremes of parental approaches, but in between them may lie the potentially effective, and at the same time challenging parenting approach, which comprises of various parental qualities: being patient, well-aware and educated on the matter, yet, open to be educated by the child, being non-judgmental, supportive, understanding, assertive, logical, and perhaps more than all, be available and willing to invest unlimited time and emotions in the youth who need the supportive guidance of their parents. Many of the youth reported being wounded by the fact that not only did their parents not guide them with respect to drug use, they have even given up on them, kicked them out of the home, or never made efforts to bring them back home when they ran away.

It was suggested in the literature that when parents have knowledge and understanding of the psychological development of teenagers it may protect the youth from engaging in drug use behaviour (Nurco et. al. 1996). It was further noted that when parents fail to communicate strong sanctions against the use of drugs, even a caring and intact family loses some of its potency (Oetting et. al. 1987). The harmful effects of lack of monitoring and lack of involvement in the lives of the youth was also stressed by other researchers (Svensson, 2000; Martens, 1993). In this study, parental supervision was lacking among only 45% of the participants. Nearly half of the participants stated that
their parents were not involved in their social life, and 58% reported that their parents were not involved in their school life either. Association was found between parental supervision and parents setting clear rules against the use of drugs. It also correlated with youth involvement in violent fights. This may indicate that parental supervision and involvement in children’s social life may influence youth to socialize with peers that are approved by their parents and that are less likely to be associated with violence. These findings may be linked to the difference found between youth drug dealers (42% of the participants) and youth prostitutes (51.6%) in their level of involvement in violence. Participants who not only used drugs but also sold drugs were significantly more involved in violent fights at school and in the neighbourhood than prostituting youth; in vandalism; and in using aggressiveness and intimidation to get what they wanted. It may be that there are different personality characteristics that make youth choose drug dealing versus prostitution as a method of financial support. This research did not explore the link between parental supervision and engagement in either drug dealing or prostitution as a method of financial support. The extent of involvement in criminal activities and the seriousness of the criminal offenses and their relationship with parental supervision was also not addressed in this research. Drug dealers may be at a higher risk of being incarcerated, not only due to the selling of drugs, but also due to the violence associated with drug dealing. Participants noted that most of murders on the streets are related to drug dealing activities.

Lack of parental supervision was also found in this study to be associated with popularity in high school, which in turn correlated with involvement in vandalism and violence. Such findings may suggest that children who do not have a curfew time, and
who can engage in any activity they want at any time of the day without being stopped by adequate parental supervision, may gain their peers’ admiration. At the same time, peers may lose their popularity if they always leave in the middle of social activities because they need to be home on time. The literature review presented a hypothesis made by Rankin et. al. (1994) according to which, a weak attachment to parents makes it easier for youth to give in to peer pressure. Damaged attachment was also linked in the literature to low self esteem (Howe, 1995), which was reported as a cause of addiction by participants in this study, and which can explain the surrendering to peer pressure in order to gain social acceptance.

It was interesting to find an increase in reported popularity of youth in high school versus popularity in elementary school (80.7% versus 61.3%). One way of interpreting this finding relates to the correlation found earlier between popularity and violence. Perhaps youth that presented as strong, fearless, and controlling were more admired by their peers. Findings from participants’ perspective speak about the trend in the culture of youth today to admire anything that is mean and bad, and that this trend is even promoted by the media through music, movies, and commercials. It was reported that any thing that is good in nature is not cool anymore. It may be that this troubling trend is noticeable even among social groups that youth are presumably trying to connect with and find a response to their need for meaningful and honest relationships. Even becoming ‘a bully’ can be viewed as being a victim of the media, the trend described above in today’s youth culture, and of other influencing factors in our society today, however it is beyond the scope of this thesis to analyze this topic. Other related explanations could be linked to an expression made by one of the participants: “I was popular ‘cause nobody wanted to bug
me...". It may be that considering youth that presented as ‘tough and strong’ popular or feared, and allowing them to feel admirable, was one way to deal with fearing them and avoiding getting ‘bullied’ and hurt by them. Two participants indicated that they were popular because they always had drugs. They either had what other youth wanted or, as indicated on the violence among drug dealer, they may have also presented as strong and tough, admirable qualities in youth cultures today. Finally, increased popularity in high school versus elementary school may be related to the fact that as kids get older they become more preoccupied with having or not having what their peers may consider as ‘cool’. Sometimes the things that make youth become more ‘cool’ than others are things that the child has no control over such as, material goods, the look of a child, clothing, etc. When offered drugs, all that youth need to do in order to be welcomed by a peer group, is to say ‘yes’ to the drug. It is possible to assume that children that were not popular in elementary school finally found social acceptance just by conforming to norms of peers that were experimenting and using drugs in high school. They are given an opportunity to have control over what can make them become ‘cool’.

This study presented other significant findings that may be supported by previous findings in the literature. For example, Nurco et. al. (1996) indicated a strong link between ‘non-intact homes’ (see literature review page 32) and vulnerability for drug use. In this research, 87% of the youth were raised in non-intact homes, with nearly half of the participants reporting they never knew their real father. Considering Attachment Theory again, it may be that vulnerability for drug use could be increased when children are not only lacking consistency in their relationship with their primary caregiver, as was found to be so profound in this study, but also when children are completely deprived from a
relationship with their biological caregiver (either one or both of them). These findings may be linked back to Alexander's theory on dislocation (dated 2001) and the risk that lies with not having a holistic identity.

The study produced other significant findings that were not discussed in this chapter, however, were presented in Chapter four. The above discussion focused on selected, primary findings that were linked to the literature and to participants perspectives when appropriate.

Conclusions & Recommendations for Social Work Practice and Social Policy

Various needs were identified by youth or emerged from general findings in this study. Upon the identification of those needs the following conclusions were made. They include recommendations for practice and social policies that may affect youths' lives in a way that may protect them from using drugs.

1. Creating social support for youth:
Youth identified a strong need for belonging and meaningful relationships, which was clearly stressed in the literature as a profound source of protection from drug use. Special attention will be given further below to such a need in the context of parent-child relationship and family ties. The following recommendation addresses the need for meaningful relationships in the context of peer relations. Every youth may benefit from connection to "a big brother or sister", "a buddy", or to a "peer counsellor" at school.
Such programs should be widely spread and developed appropriately in every school, in every grade, offering an opportunity to every child. Such programs empower the 'volunteering child', support the 'benefited child', increase integration among peers, promote value-based relationships (e.g., helping relationship), and prepare children to be contributing members in the community (and in return, benefit from a strong community and from a sense of empowerment). Similar programs (peer counselling and peer outreach) can be effective among street youth and drug using youth, using the same productive method of being empowered to assist others and being open to receive assistance from someone who shares similar experiences and with whom a street youth can identify.

2. Prevention planning and enhancing awareness of the consequences of drug use:

Youth identified a need for deeper awareness of the adverse effects of drugs, and asked to be shown videos on the DTES. However, prevention programs must ensure a realistic link between the consequences of addiction and initial stages of experimentation with drugs. Youth indicated that they could not relate to prevention programming as they were detached from their immediate reality. Utilizing peers input, peer presentations, peer counselling, and peer outreach can be highly effective in prevention planning as well. It cannot be focused only on giving information on the adverse consequences of drugs, which is a valuable element as itself. In addition to giving youth information on drugs, they should be trusted to comprehend the causes of addiction and allowed to participate in a process of identifying needs and responses that can prevent drug use. Such a dynamic may promote youths' insight into their own personal experience and to understand what
their friends may go through; no youth wants to end up being a ‘junkie’, but no one wants to admit being frightened, weak, needing acceptance, and even needing help. This is the complete contradiction of the image of a ‘cool’ teenager that was described earlier. Programs that utilize empowering techniques; that build trust among youth and encourage openness to discuss drug use issues faced by youth; and that enhance awareness to processes of peer dynamics promoting drug use behaviour, along with awareness to the consequences of drug use may protect youth from using drugs. Youth may grow from such programs, not only by gaining knowledge pertaining to consequences of drugs and insight to peer dynamics, but also from learning how to be assertive and say ‘no’ to drugs, individually and collectively.

3. Creating a message that discourages drug use:

Also related to prevention planning is the message that we, as a society, pass on to youth about drugs, which is often confusing or permissive. The message that youth receive may be transferred not only through the tolerance that adults may express, directly or indirectly, towards substance use, but also through philosophy of services in their community and the media. The belief of the writer is that passing on a strong message against drugs use is a responsible approach of a caring society. As was indicated in the literature review, tolerance of marijuana use and of alcohol drinking have only led to an increase in their consumption. Addiction bears only destructive outcomes in the lives of people affected by it, not only due to the lifestyle that is forced upon them due to the association of drug use with criminal activities. Addiction affects the potential of human beings to be free and not to depend on chemicals to live; the drug interferes with a
person's ability to function physically, socially, emotionally, and intellectually, thereby reducing the chances of such a person to be an equal member of the society. Attempts to prevent addiction by educating children should be supported by actions and aligned with policies that do not enable addiction. The writer does recognize the urgency of reducing harm associated with addiction among those that are already affected by it, but at the same time is concerned that certain actions that may be taken to reduce harm among long term regular drug users may contradict the message and the actions taken to prevent those that are 'at risk' from becoming regular users themselves. Participants indicated they regret not having someone in their lives that warned them about the consequences of drugs; they expressed their concern about the message delivered by the media with respect to drug use, and concern about the availability of drugs in the city. This study did not explore youth's perspectives on specific harm reduction issues. Therefore, recommendations suggested in this section are not directly driven from findings of this study, but rather from the personal perspective of the writer. Bearing in mind the limited findings in this study that may or may not support any type of discussion on harm reduction, this thesis concludes that:

a. Education on the adverse consequences of drugs as they affect the user, the community and the public at large is highly important, as well as an interactive and empowering prevention planning as described earlier;

b. Policies and services adopting a harm reduction approach should be anchored in a public health model, recognizing addiction as an adverse condition (physically, mentally, and socially); the addict as one that may require help in maintaining his personal health (e.g., preventing transmitted diseases), and the community as needing
to be protected from the harmful effects of drug use (e.g., not having syringes thrown on the sidewalks and not having children being solicited by dealers on the streets). This approach may reduce the likelihood of such services being perceived as enabling or promoting drug use.

4. Supporting parents and caregivers

Parents and caregivers should be educated about how to approach and to deal with the subject of drug use with their adolescent children. The family plays a major role in forming youths’ attitude towards drugs. Parental guidance, along with monitoring and supervision, is a crucial preventative strategy. Therefore, parents should have a source of support and consultation that is non judgmental and accessible. Parents especially should be supported and guided on how to avoid ‘giving up’ on their children, who are at the tender and complex stage of forming their identity, and who may be quite frustrating to handle. During the interviews of youth for this research, subjects used to cry always at the same point in the interview: the question about parents kicking them out of homes, and the following sequence of questions about family relationships and dynamic. Youth need their parents’ help, care, and guidance, and parents need support while dealing with their child’s drug experimentation of drug use.

5. Recommendations pertaining to child welfare policies and practice:

‘Having lived a different family life’ had the same importance as a preventative measure in the eyes of the youth as ‘longing for meaningful relationships and having a sense of belonging’. However, these two may be associated with one another, as well as
with other needs as noted further below. If children and youth have a positive and meaningful relational experience within their family unit, such relationships remain meaningful for life, no matter how intense the contact is as the youth turns into an adult; youth may always have the confidence that ‘they can go back to where they came from’, that ‘they can go back home’ (a privilege that most of the participants in this study did not have). Educating and supporting parents as noted earlier may promote a better connection between youth and their parents, which in return can better the experience of the youth while growing up with their families. If the negative experience of youth with their families relates to neglect or abuse, an early disclosure and termination of child abuse and neglect is needed. Nevertheless, the high number of subjects that were removed as children from their families may suggest that there is a strong need to keep the integrity of the family as much as possible, by reducing apprehension of children and placement in out of home care. Child apprehension not only damages the child’s emotional world and attachment; it damages the family integrity, affects the relationships within the family, and depending on the age of the child and the extent of time that the child spends in care, apprehension has the potential of alienating family members from one another thereby destroying the family unit. Apprehended children, who cannot always make sense of the apprehension, may experience resentment towards their parents for causing a reason for the apprehension; for letting the institution (social workers, court) interfere with their family life and break it, and may lose trust in both their parents and the institution. The emotions experienced by children in care are not necessarily resolved once the child returns to the care of his or her family. Children who are not happy in the care of the state may escape to street life straight from foster homes and may
not be successful in reunifying with birth family for different reasons (e.g., the family may already be broken or damaged because of the experience of losing a child and guilt feelings, fear of social services interfering with the family life again, if the child returns home, etc.). Because their placement in care may have been unsuccessful they cannot consider the foster home “a home”. Child apprehension may therefore, contribute to the experience of loneliness and despair, particularly in the lives of children who have broken family ties, no home to go back to, and who have unresolved emotions towards their parents and the institution. The experience of the parents are similarly difficult. Even if they do not want to give up on their children, they are often powerless when dealing with the institution. For some parents, the point of losing their children, even to a temporary placement in care, is a destructive experience, from which they may regress (e.g., blaming family members and separating from partners, getting into depression, etc). Often with drug addicted parents social workers may witness either dramatic changes in the lifestyle of the parent or an intensification of the drug problem, which in return ensures that the children would not go back to the care of their parents.

Social policies should be directed at increasing support services to the biological family in order to enhance parental skills, alleviate stress that may be experienced by the family (including financial strains), and monitor the well being of the child without removing the child from the care of the parents. In most cases, putting as much support into the biological family would make it easier for parents to care for their children and would better the welfare and happiness of children who remain where they belong: with their own parents. In today’s society, the family, which has always been the traditional protective and nurturing system, is at risk for weakening due to major disruptions to its
structure and functioning. Elements related to interference of social welfare authorities (e.g., child apprehension), separation of family members, separation of parents, transience and relocations, financial strains, yet, being surrounded by a materialized lifestyle, and other stressors that are beyond the scope of this thesis to capture, lead to an absurd situation where young people cannot even draw a basic family tree and admit to maintain relationships with members identified in it. Whereever applicable, child welfare agencies should support the families and assist them to maintain their integrity. At present, the policies of the Ministry for Children and Family Development (MCFD) are moving towards this goal, and the practice of child apprehension is less encouraged. Even in cases of parental drug addiction, harm reduction-based guidelines for practice have been developed*. These new Ministry guidelines stress that substance use in itself does not constitute a child protection concern and that in order to determine likelihood of harm to the child parental substance use and addiction issues should be assessed in a contexts of their impact on the child. At the same time, the guidelines recognize that substance use has a potentially significant impact on parents capacity to provide safe and effective parenting and that it may directly harm the child or place his safety at risk. In practice, the guidelines suggest that a Harm Reduction Agreement would be reached between the parent and the Ministry, in which measures are specified to reduce identified risks for the child’s safety and well-being while setting realistic expectations from the parents (e.g., acknowledging and planning for a possibility of relapse in a recovery process). The goal of the harm reduction approach adopted by MCFD is for the parent to achieve recovery while cooperating with a service delivery plan (e.g., drug and alcohol counselling).

random drug test, respite care for the children, etc.). The harm reduction agreement is not suitable when parents demonstrate substance use that is uncontrolled and that results in a behaviour that put the child’s safety at risk.

This thesis strongly supports the approach adopted by MCFD in dealing with drug using parents. As was stressed earlier, maintaining the integrity of the family while providing the parents with support, as needed, is the recommended approach of dealing with child welfare concerns. In addition, the use of residential treatment programs that are offered to parents with their children (e.g., Peardonville and Kakawis) are highly recommended for families that struggle with parental substance abuse. In such programs, parents not only deal with their substance abuse issues but also learn effective parenting skills while being able to practice them with their children in a supportive environment. Children, on the other hand, benefit from a continuity of care with their parents, an opportunity to interact with other children in a stimulating and family oriented environment, and most of all, be there with their parents when they go through their recovery.

In cases where removal of children from the care of their parents is inevitable (such as in cases of a serious abuse, a life threatening neglect, and when parents deal with a serious addiction that puts risk for the safety of the child and where the parents are unwilling to deal with their addiction) there is a need to ensure a least traumatic experience for the child, and most importantly, to minimize transitions and placements with multiple caregivers that can damage the child in a way that may compromise the effectiveness of the apprehension as a ‘protective measure’. While the child is in care it is in the child’s best interest to maintain regular contact with his or her parents to reduce the
harmful effects of separation between the them and the risk of destroying the family identity. MCFD's current child protection policies are all directed at ensuring a selection of a least disruptive measure to protect the child. This may include, for example, bringing child into care by the agreement of the parent when applicable as opposed to a forced removal. A voluntary care agreement basically allows the parents to maintain custody over their children and be part of, and in control of decisions made with respect to their children (e.g., health, education, recreation, etc.). MCFD also protects and encourages contact between the child in care and the parents, unless such contact can put the child in danger and is deemed not to be in the best interest of the child.

Related to child abuse and the trauma of separation from the biological family is the highly important need to teach children and adolescents effective coping strategies to prevent them from turning to drugs as a method of 'numbing the pain' (the most frequently identified by subjects as the reason for their drug use). Early identification of distress in the lives of children and early intervention may increase the effectiveness of programs aimed at teaching children traits and skills that ideally would be incorporated into their repertoire. The nature of such programs should be supportive and practical, bearing in mind the age of the children and their developmental capacity. It is believed that removal of children from their homes often provide only a temporary illusion of protection from harm, which in the long term may induce the use of repression and denial as a coping mechanism. For children at certain age and stage of development, who have been used to live and cope with life circumstances that may have compromised their well-being (e.g., living with an alcoholic or drug addicted parent or living in a neglectful environment) removal can be experienced as a 'quick (and not completely
comprehended) fix of a problem’. Such children are only technically being detached from the adverse reality they lived in, while emotionally and mentally they may still live the problems they left back home; removal, in this sense, just artificially makes the problems disappear from the life of such children in the same way that at a later stage in their life running away from home and using drugs to ‘escape from reality’ would make problems disappear. Therefore, and in continuum to prior relevant recommendations, this thesis suggests to increase awareness of children to the effects of their particular life circumstances on their emotional state and mental condition; provide them with support and therapy; and teach them constructive and adaptive coping skills. Such a process is believed to contribute to the development of resilient children.

6. **Help youth get off the streets and access rehabilitation services**

Other needs that were suggested by participants included getting off the streets and away from the DTES, as well as a need for more detox services that are easy to access. These needs are associated with alleviation of the affects of street life and addiction rather than with prevention. Remaining on the streets perpetuates the cycle of addiction, as addiction is not only perpetuated by street life and the availability of drugs on the streets, but also because addiction is the only way to cope with the trauma of living on the streets. There are not enough shelters for youth, particularly shelters that are long term and that have other programs attached to them, such as, lifeskills programs, professional and peer counselling, employment and educational related services, and programs that provide other links to the community. As discussed earlier, the transition from the streets to independent living is difficult, and normative societal expectations can
be quite scary. Therefore, a 'bridge' should be built to ease the process of transiting from the streets to an independent life. Subsidized housing for youth that has a 'co-op-like' component to it may empower youth and give them a sense that they are capable and skilled in helping themselves and others. Additional components to such a long term residential program should all be directed at instilling hope for change, trust in others, and belief in oneself to achieve anything he or she wants. With only rent and living allowance from IA, youth can never make it from the streets to an independent and satisfying life. Similarly, detox programs in isolation from other programs, are viewed in this study as quite useless, unless they are immediately linked to a long term residential program that not only allows youth to resolve causes for their addiction but also to change habits, learn new lifestyles, and practice them for a substantial period of time so they can be internalized and be part of the youths' way of living.

7. Recommendations for further research

Further research is needed on the effectiveness, or the risk of the harm reduction approach in the field of addiction. Users' and non users' perspectives should be explored on the message that the approach convey. Potential effectiveness of specific changes to policy and service delivery that are advocated for by the approach should also be explored.

It is suggested that special attention will be given to studies of child welfare policies (e.g., the effect of in home support services on reducing child abuse and neglect as opposed to apprehension) and their relationship with addiction. A particularly interesting research project may be a retrospective one that asks current drug users about
their perspective on effective protective measures that can be taken by social services to reduce child abuse and enhance child welfare.

The dynamics of peer pressure was discussed in this study, however not in depth. The study mentioned some general innovative ideas related to the unique characteristics that may be associated with children who may be more vulnerable with respect to peer pressure to use drugs. These ideas should be further developed, and the relevant findings presented in Chapter Four should be further explored.

Other factors that need to be investigated in linkage to addiction are 'labelling' children by the school system and social services (special classes, special schools, 'special needs') and by mental health professionals; and finally, further study needs to be conducted on the potential protectiveness of youth involvement in the community and in leisure time activities.

This study brings a contribution of new knowledge to the field of addiction by promoting the recognition and understanding of the unique characteristics of a young population, which is affected by a devastating psychosocial and health problem occurring in one of North America’s most infamous location for drug use and related morbidity. Furthermore, the research uncovered issues that could only be revealed by adhering to the perspective of the drug users as was partially done in this study. Finally, the research produced pragmatic recommendations for practice, social policies, and further research.


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RISK FACTORS FOR DRUG ADDICTION AMONG YOUTH IN THE
DOWNTOWN EAST SIDE: A DRUG USERS’ PERSPECTIVE

Part 1

A. GENERAL INFORMATION

1. Year of birth: __________________________

2. Sex          χ Male          χ Female

3. Residency (Please check any that apply)
   χ Apartment rent  χ SRO/Hotel  χ Staying with friends
   χ Shelter        χ Living with parents  χ Street
   χ Other

4. What is your ethnic-cultural background?
   __________________________

5. Would you consider yourself a regular user (use on a daily basis)?
   χ Yes          χ No

B. INVOLVEMENT IN THE DOWNTOWN EAST SIDE (DTES)

6. Were you raised in the Vancouver area?  χ Yes          χ No
   * If yes, please specify:
   χ Vancouver East side  χ Vancouver West side  χ DTES
   χ Richmond             χ Newest Minster      χ North Vancouver
   χ West Vancouver       χ Surrey              χ Other

7. If not, where did you arrive from?
   χ Elsewhere in BC  __________________________
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8. If not, when did you arrive in Vancouver?

9. Approximately how much time do/did you spend in the DTES?
   - Every day, all day
   - Every day, most of the day
   - Almost every day
   - Several hours a week
   - Less than that

10. What attracted you to the DTES? (select any that applies)
    - Low cost accommodation
    - Access to social services
    - Availability of drugs
    - Not my choice to come here
    - Local friends or family
    - Other

11. What activities do you engage in the DTES (social, drug use, residency, etc.)?

12. What are the local services that you most frequently access? (Select any that applies)
    - Needle exchange
    - Recreation and social drop-ins
    - Free food
    - Detox
    - Counselling
    - Employment related
    - Income Assistance
    - Users’ groups
    - Medical
    - Emergency shelter
    - Free telephone & computer
    - Other

13. How do you support yourself?
## C. Drug Use Patterns and Drug of Choice

<table>
<thead>
<tr>
<th>Type of Drug</th>
<th>Never used</th>
<th>Used in the past</th>
<th>Age when started use</th>
<th>Current use</th>
<th>Frequency of use</th>
<th>Method of use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cigarettes</td>
<td></td>
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<tr>
<td>Marijuana</td>
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</tr>
<tr>
<td>Inhalants</td>
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<tr>
<td>LSD (Acid)</td>
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<tr>
<td>Speed</td>
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<tr>
<td>Prescription drugs</td>
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<tr>
<td>Heroin</td>
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<tr>
<td>Cocaine</td>
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<tr>
<td>Crack cocaine</td>
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<td></td>
</tr>
<tr>
<td>PCP (Crystal)</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Speed-balls</td>
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</tr>
</tbody>
</table>

### Part 2

**Risk & Protective Factors for Drug Addiction**

14. From your perspective, what were the main factors that contributed to your drug use (hard drugs)? (List factors)
15. From your perspective, what would have been the main factors that would have steered you away from drugs (hard drugs) or that have helped reduce your use of hard drugs? (List factors)
From your perspective, what are the main factors that contribute to drug use in the lives of other youth in the DTES?
Part 3

(Probing questions to be asked when certain areas of risk factors are identified)

D. RISK FACTORS ASSOCIATED WITH ENVIRONMENT & DRUG AVAILABILITY

16. Would you consider the neighbourhood you grew-up in a safe community?
   \( X \) Yes \( X \) No

17. When you started using drugs, where did you obtain them?
   \( X \) In my neighbourhood \( X \) In my school \( X \) In my home
   \( X \) In all three options \( X \) Other _______________________

E. FAMILY RELATED RISK FACTORS

Drug use and delinquency among family members

18. Were your parents alcoholic?
   \( X \) My father \( X \) My mother \( X \) Both \( X \) No

19. Were your parents addicted to drugs?
   \( X \) My father \( X \) My mother \( X \) Both \( X \) No

20. If known, please indicate the drugs that were used by your parent/s
   \( X \) Heroin \( X \) Cocaine \( X \) Crack cocaine \( X \) Speed
   \( X \) Speed-balls \( X \) LSD (Acid) \( X \) Marijuana \( X \) Inhalants
   \( X \) Prescription drugs \( X \) PCP (Crystal) \( X \) Cigarettes \( X \) Other _______________________

21. At the time that you started using drugs, had any of your family members ever incarcerated?
   \( X \) Yes, my father \( X \) My mother \( X \) Sibling/s \( X \) Other _______________________
   \( X \) No member of my family was ever incarcerated

Family attitudes toward drug use
22. My parents set clear rules against the use of drugs
χ Always  χ Sometimes  χ Rarely  χ Never

23. My parents openly discussed with me drug use and potential consequences
χ Always  χ Sometimes  χ Rarely  χ Never

**Family economic status**

24. Which of the following best describes your family's economic status?
χ Poor  χ Below average  χ Average  χ Above average

25. Before you started using drugs, were your parents income assistance recipients for a period longer than one year?  
χ Yes  χ No

**Risk factors associated with family relations and dynamics** (Prior to participant's drug use)

26. Who was your primary care giver during your childhood/early adolescence? (if applicable, check more than one)
χ Both my parents  χ One of my biological parents & a step parent
χ My biological father  χ My biological mother
χ Adopting parents  χ Foster parents
χ Group-home/institutional setting  χ Grandparents
χ Other relative __________________________

27. If removed from the care of biological parents, at what age did that occur?  
χ Was not removed  χ __________________________

28. When placed in out-of-home care, did you experience multiple-transitions between foster care, adoption, or alternative care (such as group-home)?
χ No  χ Yes __________________________ (Number of transitions)

29. How would you describe your experience of being in care?

________________________________________________________________________

________________________________________________________________________
30. My parents divorced/split-up when I was a child  
   \( \chi \text{ Yes} \quad \chi \text{ No} \)

31. I never knew my real father  
   \( \chi \text{ Yes} \quad \chi \text{ No} \)

32. I never knew my real mother  
   \( \chi \text{ Yes} \quad \chi \text{ No} \)

33. I know I have other siblings that I have never met  
   \( \chi \text{ Yes} \quad \chi \text{ No} \)

34. I was kicked out from home by my parents/guardians  
   \( \chi \text{ Yes} \quad \chi \text{ No} \)

35. I ran away from home and never returned to live there  
   \( \chi \text{ Yes} \quad \chi \text{ No} \)

36. Would you consider your family life while growing up to be normal?

37. Living at home was a fearful experience for me and for other members of my family  
   \( \chi \text{ Always} \quad \chi \text{ Sometimes} \quad \chi \text{ Rarely} \quad \chi \text{ Never} \)

38. Living at home was a stressful experience for me and for other members of my family  
   \( \chi \text{ Always} \quad \chi \text{ Sometimes} \quad \chi \text{ Rarely} \quad \chi \text{ Never} \)

39. My parents were physically violent towards each other  
   \( \chi \text{ Only my father} \quad \chi \text{ Only my mother} \quad \chi \text{ Both} \quad \chi \text{ Never} \)

40. My parents were physically violent towards their children  
   \( \chi \text{ Only my father} \quad \chi \text{ Only my mother} \quad \chi \text{ Both} \quad \chi \text{ Never} \)

41. My parents were caring and loving  
   \( \chi \text{ Always} \quad \chi \text{ Sometimes} \quad \chi \text{ Rarely} \quad \chi \text{ Never} \)

42. My parents were there for me when I needed them  
   \( \chi \text{ Always} \quad \chi \text{ Sometimes} \quad \chi \text{ Rarely} \quad \chi \text{ Never} \)

43. When I went out, my parents wanted to know where I was going and when I would return  
   \( \chi \text{ Always} \quad \chi \text{ Sometimes} \quad \chi \text{ Rarely} \quad \chi \text{ Never} \)

44. We would maintain traditional family events on weekends (e.g. family dinner)  
   \( \chi \text{ Always} \quad \chi \text{ Sometimes} \quad \chi \text{ Rarely} \quad \chi \text{ Never} \)
45. We would celebrate holidays as a family
   \(\checkmark\) Always \(\checkmark\) Sometimes \(\checkmark\) Rarely \(\checkmark\) Never

46. My parents spent quality time with me (e.g., activity time such as traveling, movies, reading)
   \(\checkmark\) Always \(\checkmark\) Sometimes \(\checkmark\) Rarely \(\checkmark\) Never

47. Talking about feelings was encouraged in my family
   \(\checkmark\) Always \(\checkmark\) Sometimes \(\checkmark\) Rarely \(\checkmark\) Never

48. Which of the following describe best your

   Mother: \(\checkmark\) Over-protective \(\checkmark\) Protective enough \(\checkmark\) Under protective

   Father: \(\checkmark\) Over-protective \(\checkmark\) Protective enough \(\checkmark\) Under protective

   Other primary caregiver \(\checkmark\) Over-protective \(\checkmark\) Protective enough \(\checkmark\) Under protective

49. My parents were involved in activities related to my schooling and academic achievements
   \(\checkmark\) Always \(\checkmark\) Sometimes \(\checkmark\) Rarely \(\checkmark\) Never

50. My parents were interested in my social life and my friendships
   \(\checkmark\) Always \(\checkmark\) Sometimes \(\checkmark\) Rarely \(\checkmark\) Never

51. My parents had realistic expectations of my ability to achieve
   \(\checkmark\) Yes \(\checkmark\) No \(\checkmark\) I never knew what my parents expected of me

F. **RISK FACTORS ASSOCIATED WITH MENTAL HEALTH AND BEHAVIOURAL ISSUES**

52. I have used intimidation and aggressiveness to get what I wanted
   \(\checkmark\) Always \(\checkmark\) Sometimes \(\checkmark\) Rarely \(\checkmark\) Never

53. I have vandalized public or personal property
   \(\checkmark\) Always \(\checkmark\) Sometimes \(\checkmark\) Rarely \(\checkmark\) Never

54. I have been involved in violent fights at school and in the neighbourhood
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55. I have been diagnosed with Hyperactivity or with Attention Deficit Disorder
   $\chi$ None $\chi$ Hyperactivity $\chi$ ADD $\chi$ Both (ADHD)

56. Where you ever diagnosed with any other conditions related to mental health?
   $\chi$ Yes $\chi$ No

---

G. RISK FACTORS ASSOCIATED WITH SCHOOL

57. I enjoyed school
   $\chi$ Always $\chi$ Sometimes $\chi$ Rarely $\chi$ Never

58. For me, attending school was one way to escape from home
   $\chi$ Always $\chi$ Sometimes $\chi$ Rarely $\chi$ Never

59. As a student, my performance in class was
   $\chi$ Poor $\chi$ Below average $\chi$ Average $\chi$ Above average

60. As a student, I used to do my homework and prepare for exams
   $\chi$ Always $\chi$ Sometimes $\chi$ Rarely $\chi$ Never

61. Did you graduate from high-school?
   $\chi$ No $\chi$ Yes

---

H. RISK FACTORS ASSOCIATED WITH PEERS

62. In elementary school, I was accepted by peers
   $\chi$ Always $\chi$ Sometimes $\chi$ Rarely $\chi$ Never
63. In high-school, I was accepted by peers
   - Always
   - Sometimes
   - Rarely
   - Never

64. Please check any of the substances used by peers you socialized with at high school
   - Cigarettes
   - Alcohol
   - Marijuana
   - Hallucinogens
   - Hard drugs (cocaine, heroin)
   - None

65. My first experiment with hard drugs was
   - With peers at school
   - With peers in the neighbourhood
   - By myself
   - With a family member
   - Other

66. Would you say you felt pressured by your peers to use drugs?
   - Always
   - Sometimes
   - Rarely
   - Never

**J. RISK FACTORS ASSOCIATED WITH ABUSE (Before drug use started)**

67. Did you ever experience emotional abuse by a family member? (such as deliberate humiliation, putting you down, and disregarding your feelings)

68. Did you ever experience physical abuse by a family member? (physical violence, deliberately depriving you from basic physical needs)

69. Did you ever experience sexual abuse?

70. Were you ever exposed to other trauma (such as witnessing death, being a victim of war or natural disaster, witnessing one of you parents being battered, etc.)?
71. If you were ever exposed to any kind of abuse, did you get adequate help and support?