Tracking Our Youth

A Comprehensive Review of the Literature on Research Conducted with Homeless Youth in Edmonton

June 2005





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Edmonton Joint Planning Committee on Housing

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Executive Summary

Background and Objectives:

The Edmonton count of homeless people, completed on October 23, 2002, found 1915 homeless people. Youth, aged 15 to 18 years, made up 7% (*n* = 133) of the total homeless count. Of the four youth serving shelters polled in the homeless count, Safe House, Protective Safe House, Inner City Youth Housing and the Youth Emergency Shelter, a total of 68 spaces were available for youth. On the day of the count, the four shelters had an occupancy rate of 74%.

The purpose of this study is to draw together and synthesize all available research information, data collected, and analysis on homeless youth in Edmonton, for the following purposes:

- to inform future program planning,
- to illuminate whether there is a need for future research, and
- to advise on the specific research questions for future research.

Method:

A comprehensive review of three studies conducted among street youth in Edmonton was completed. The studies included:

- *Enhanced STD Surveillance of Canadian Street Youth Phase II (n* = 288*) & III (n* = 389*;* Edmonton site) coordinated by Health Canada,
- *Perception of Strengths and Gaps in Youth Homelessness Services in Edmonton* (*n* = 25), conducted by Native Counselling Services of Alberta, and
- *Support Intervention for Homeless Youth (n* = 19*)* conducted by the Social Support Research program at the University of Alberta.

All studies used a convenience sample and recruited youth from community agencies providing service to street youth.

These studies were analyzed to answer the following objectives of this review:

1. What research has been done to date on homeless youth in Edmonton?
2. What are the common or consistent findings in these research projects?
3. What findings can be used right now for program and service planning?
4. What else do we need to know to be effective planners?

Results:

- **Demographics:** Youth ranged in age from 15-27 years with an almost equal representation of males and females. The majority of the youth were born in Canada and all three studies' samples included almost 40% Aboriginal representation.
- **Education:** The majority of youth were not registered for school at the time of interview. The top 2 reasons for not being in school included dropping out and being kicked out.

- **Income**: Youth reported that a major obstacle to employment was the lack of identification and a permanent address for employers to contact them. Youth rely on family, work (including regular work and odd jobs) and welfare for their income.
- **Leaving Home**: The majority of youth reported that they had left home due to family problems, in particular, arguing about rules.
- **Parents**: The majority of youths' parents were separated or divorced. Phase III youth reported parental behaviours including verbal and physical abuse between one another, throwing things and being in jail.
- **Abuse:** Over 10% of youth reported abuse as the reason they left home. Abuse included emotional, physical and sexual abuse. The average age at which youth were sexually abused was about 8 years old, with only 7.4% of perpetrators unknown to the youth.
- **Housing:** Nearly 70% of youth have had a social worker while over 40% of youth have spent time in a foster or group home. Just over half of Phase II youth reported having a permanent home and most of these were housed with family. Phase II youth report the greatest barrier to permanent housing is money. Almost half of Phase III youth reported that they would be spending that night in a shelter.
- **Street Activity:** The average age of first turning to the streets was 15 years. Over one quarter of Phase III youth reported spending greater than 50 hours a week on the street.
- **Criminal Activity:** Nearly half of the youth reported spending a night in prison and nearly half of the youth reported having a probation officer.
- **Substance Use:** The majority of youth are using tobacco, alcohol and other illegal substances. Over 90% of youth reported using non-injection drugs sometime in their life. Nearly 80% of youth reported marijuana as the drug most commonly used in the last 3 months. Fortunately rates of injection drug use are much lower, with just over 10% of youth reporting use in their lifetime. The mean age of first injection was 15 years.
- **Sexual Activity:** The majority of youth were sexually active, beginning their sexual activity at an average age of 14 years. Just over 10% of youth reported exchanging sex, beginning at an average age of 15 years. Money was the item most often exchanged for sex. Through outreach testing, 45 cases of chlamydia and 9 cases of gonorrhea were detected.
- **Mental Health:** 20% of youth reported feeling down, depressed or hopeless, with over one third of Phase III youth reporting they had attempted to commit suicide in the past.

Program Planning Recommendations:

Prevention.

- Health determinants like social and physical environments, economics, education, and employment, as illustrated in this review, play an important role in the successful development of children. Therefore, the prevention of homelessness

begins with the healthy development of children, which requires an investment in children and their families.

- This review found that the majority of youth are not in school and have not finished grade school. Keeping youth in the education system is imperative if they are to develop the knowledge and skills to enter the work force and gain resources for life. Therefore, our recommendation is the continued development and support of alternative educational programs.
- Youth reported a need for a variety of housing options. Suggestions for youth housing include a combination of emergency shelters and transitional housing with programming that includes longer interventions and supported living.
    - *The Youth Emergency Shelter Society is an example of a shelter system that has reorganized their service to include emergency shelter service, a skills program, and longer term living programs.*
- Youth reported safety as a major concern. A priority should be given to ensuring the provision of a safe environment for youth, wherever they may be.

Comprehensive Service Provision.

Youth identified a multiplicity of needs; therefore there is a need for comprehensive service delivery**.**

- Housing choices need to be coupled with support programs like life skills and employment counselling, health and education services, and better access to income assistance and child welfare.
    - *The Old Strathcona Youth Coop is an example of a drop-in centre on the south side of Edmonton that hosts a wide variety of service providers.*
- Youth in this review and other studies support the extension of service to youth past the age of 18.
- Youth identified the desire to be respected by service providers.

Health Services.

Youth are participating in many behaviours that place their health at risk.

- One outstanding health concern is the level of substance use reported among the youth, and the resulting barriers to accessing services that result from addictions.
- Other service delivery strategies need to be explored, such as incorporating harm reduction principles in program planning.
    - *The Victorian Order of Nurses' People in Crisis Program provides an example of outreach nursing service provided in a youth shelter.*

Future Research:

- The literature suggests that child poverty is a mitigating factor in youth homelessness. Policies and programs that aim to end child poverty recommend a commitment to raising family incomes. What are the socioeconomic backgrounds of Edmonton street youth and their families?
- What is the cost-benefit analysis on preventing a youth from becoming homeless?
- What is a meaningful intervention to youth in Edmonton? Would a case study evaluation of current programming in Edmonton provide us with keys to

successful interventions that could be replicated and built upon for new interventions? How can we work to support current housing options and do we need to create new options?

- What is the role of peers/ natural helpers in brokering knowledge to youth who are not accessing community services?
- Do service providers have the skills and resources to work with youth who may have a multitude of care needs, including mental health, addictions and criminal involvement?
- Through a longitudinal study of youth moving through children's services, what are the factors associated with a successful exit?
- Youth and service providers agree that youth services sho uld be extended past the age of 18. Is there any benefit to increasing the exit ages of programs and youth success?
- Is there a role for harm reduction in these programs that would decrease the barriers to youth accessing service?
- What are the barriers to accessing healthcare in Edmonton and what motivates clients to access care?

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I. Background

Homelessness among youth is a major social and health issue in Canada. The exact number of youth living on the streets of urban centres across Canada is unknown, although estimates range from 45,000 to 150,000 youth (Roy et al., 2000). The pathway to youth homelessness is multifaceted and may include factors like family violence, poverty, gaps in child welfare service and gaps in social services for mental health and addiction issues (Canadian Mortgage and Housing Corporation, 2001). Characteristics of this heterogeneous group include homelessness, unemployment, truancy, criminal activity, substance use, survival sex, and involvement with many governmental systems such as children's services, social services and justice programs (Health Canada, 1998).

Definition of Homelessness

Multiple definitions of homelessness exist. However, the Edmonton Community Plan on Homelessness (2000) provides a definition for the purposes of this review:

> An individual or family is defined as homeless if:
>
> - the individual or family has no residence at all and is living on the street; or
> - The individual or family is living in any premises which is not intended or suitable as a permanent residence; or
> - The individual or family is at risk of becoming homeless
>   - Through losing their residence, or
>   - Through being discharged from an institution/facility and has nowhere to go, or
>   - Through loss of income support (p. 6).

Edmonton's Homeless

The Edmonton Homelessness Count Committee undertakes the annual count of homeless people in Edmonton. The most recent count, completed on October 23, 2002, found a population of 1915 homeless people. The Edmonton Homelessness Count Committee (2002) further distinguishes homelessness into two types, absolute and sheltered. Many (63%; n = 1213) of the homeless were absolutely homeless with no housing alternatives, while the remaining 37% (n = 702) of the homeless were sheltered individuals and families (i.e. the invisible homeless) who have been living in emergency shelters or condemned housing but who remained on the street at the end of their stay. The predominant age group in the homeless count (71%; n = 1342) was among adults aged 19 to 54 years, while 7% (n = 133) of the population was youth aged 15 to 18 years. Of the four youth serving shelters polled in the homeless count, Safe House, Protective Safe House, Inner City Youth Housing and the Youth Emergency Shelter, a total of 68 spaces were available for youth. On the day of the count, the four shelters had an occupancy rate of 74%.

In order to support homeless youth in Edmonton, we need to learn more about our street youth population. Gaining an understanding of the determinants that contribute to homelessness among street youth may aid in the development of new initiatives that prevent future youth from entering the pathway to homelessness and may assist current

street youth in modifying behaviours that place them at risk. Therefore, the purpose of this study was:

- to inform future program planning,
- to illuminate whether there is a need for future research, and
- to advise on the specific research questions for future research.

Three studies were used in this review. The Edmonton sample from the *Enhanced STD Surveillance of Canadian Street Youth* provides an environmental scan describing the extent of certain behaviours and issues among street youth. The *Perception of Strengths and Gaps in Youth Homelessness Services in Edmonton* and the *Support Intervention for Homeless Youth* provide needs assessment research from youth and service providers' perspectives.

These studies were analyzed to answer the following objectives of this review:

1. What research has been done to date on homeless youth in Edmonton?
2. What are the common or consistent findings in these research projects?
3. What findings can be used right now for program and service planning?
4. What else do we need to know to be effective planners?

II. What research has been done to date on homeless youth in Edmonton?

Methods

Enhanced STD Surveillance of Canadian Street Youth. In 1998, Health Canada began the *Enhanced STD Surveillance of Canadian Street Youth* and launched a national, multi-centre, cross-sectional surveillance system to provide information that would be useful in prevention and control efforts for sexually transmitted infections (STI) among Canadian street youth. Information gathered during Phase II (February to October, 1999) and Phase III (February to October, 2001) are presented in this report.

Data collection in Edmonton followed the research protocol developed for the national study. Snowball sampling was used for recruitment and participants were enrolled through weekly visits by interviewers to three drop-in centres and two shelters.
Inclusion criteria for participants included:

- 15 to 24 years of age,
- able to understand spoken French or English, and
- in the last six months, youth must have not lived at home for three days or more.

Research nurses experienced in working with street-involved youth received informed consent through verbal explanation of the study. Youth were asked to complete a questionnaire and lab portion of the study with the interviewer in private rooms in the drop-in centres. Youth received $10 in food vouchers for compensation of their time. Returning participants were provided with chlamydia, gonorrhoea and Hepatitis B results. Treatment was given to all participants with laboratory-confirmed positive results. Ethical approval for the study was received by The Health Research Ethics Board of Capital Health.

A total of 699 youth participated in both Phase II and Phase III of the *Enhanced STD Surveillance of Canadian Street Youth*. A total of 11 Phase II participants and 11 Phase III participants were deleted from the database as they were identified as duplicate respondents in the same phase. In order to maximize the number of biological samples available from duplicate participants, questionnaires with specimens were kept and the earliest participation was used when possible. Thus, the resulting sample sizes were 288 for Phase II and 389 for Phase III.

Perception of Strengths and Gaps in Youth Homelessness Services in Edmonton. In 2003, Native Counselling Services of Alberta researchers interviewed youth, service providers and community members for their perceptions of strengths and gaps in youth homelessness services in Edmonton. Phase I of the study involved the development and pilot testing of interview questions on the three participant groups. Qualitative interviews collected information on demographics, family of origin, housing, and substance use among homeless youth. Phase II of the study involved recruitment of members from each participant group. Youth participants were recruited from locations where youth frequently "hung out". Inclusion criteria for participants were youth who were:

- up to 29 years of age, and
- who were relatively homeless (e.g. in shelters), or
- absolutely homeless (e.g. living in squats).

A total of 25 youth, aged 15 to 27 years, were recruited. Interviews by phone were also conducted with ten agency members. Finally, ten community members were interviewed and recruited from a variety of locations including businesses from downtown and Whyte Avenue, as well as from the general public, who were recruited from the street.

Support Intervention for Homeless Youth. The Social Support Research Program of the University of Alberta (2004) undertook a two phase study to:

- determine the support needs and wants for a support program for homeless youth (Phase I) and
- create a support program based on the findings from Phase I (Phase II).

Information from Phase I (April to July, 2002) will be presented in this report.

Phase I of the study used qualitative interviews with youth and service providers to determine what coping strategies are used by youth, youths' support resources and support needs, strengths and weaknesses of current programs, remaining gaps and youths' preferences for support interventions. A community advisory committee was created in the fall of 2001, who advised the research team with interview questions and agency identification.

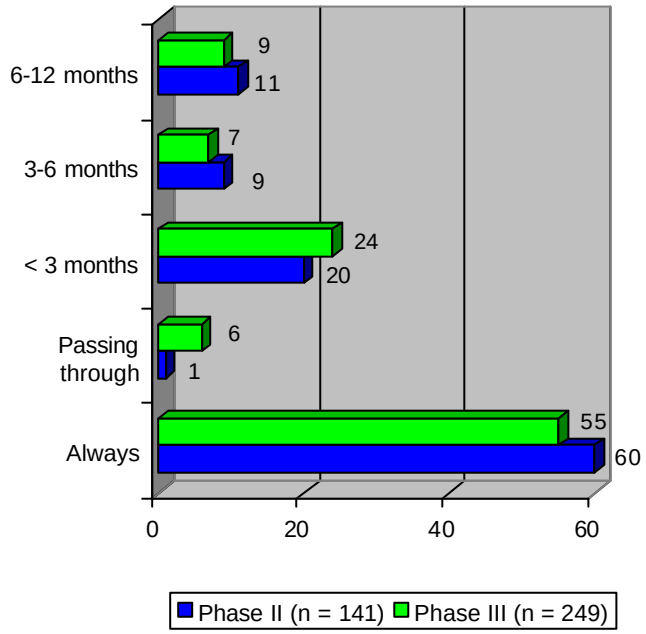
Similar to other studies, youth were recruited from drop-in centres, alternative high schools and emergency shelters. Researchers recruited 19 homeless youth, aged 16-25 years, and researchers also individually interviewed 18 service providers of street youth serving agencies representing emergency shelters, drop-in centres and community agencies. The majority (n = 15) of service providers had gained their experience through education and work, while a small number of service providers (n = 3) shared their personal experience. All together, the service providers had an average of 6 years working in the field.

III. What are consistent findings in these research projects?

Demographics

Enhanced STD Surveillance of Canadian Street Youth. Participants ranged in age from 15 to 24 years with a mean age of 18 years. The study sample had almost equal representation of males and females among both phases. The majority of youth in both phases were born in Canada, and approximately 40% of youth identified themselves as Aboriginal (includes First Nations, Métis, Inuit, and Cree; see Table 1 for demographics). Most of the youth in both phases stated they had always lived in Edmonton, while another 20% reported being in Edmonton less than three months (see Figure 1).

Figure 1. Length of Time in Edmonton (%)



Perception of Strengths and Gaps in Youth Homelessness Services in Edmonton. Participants ranged in age from 15 to 27 years with a mean age of 20 years. The majority of participants were male, with only 4 females participating in the study. The study sample had almost equal representation between Aboriginal youth (including First Nations, Métis, and Non-status) and Non-aboriginal youth (see Table 1). Only 4 (18%) of the youth stated they were born in Edmonton, while the remaining participants arrived in Edmonton, at an average age of 16 years (range of 2 to 27 years). These participants had been in Edmonton between 2.5 weeks to 21 years with an average of 4 years.

Support Intervention for Homeless Youth. Participants ranged in age from 16 to 25 years with a mean age of 18 years. The sample had almost equal representation between male and female participants. Similar to the above studies, 37% of youth identified

themselves as Aboriginal (including Metis and Native), with the remaining youth reporting their ethnicity as Caucasian (see Table 1).

Table 1: Demographics

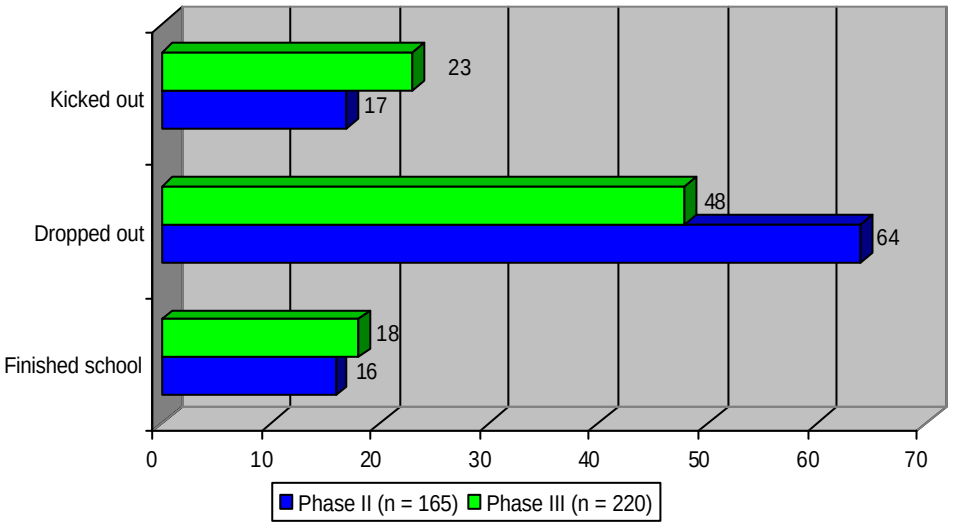
	Phase II (*n* = 288)	Phase III (*n* = 389)	PSG* (*n* = 23)	SIHY** (*n* = 19)
Mean Age	18.2 (*SD* = 2.7)	18 (*SD* = 2.4)	20	18
Gender				
Male	156 (54.4)	206 (53)	20 (87)	10 (53)
Female	131 (45.6)	183 (47)	3 (13)	9 (47)
Born in Canada	275 (95.5)	371 (95.4)	N/A	N/A
Aboriginal[1]	119 (41.8)	157 (40.4)	12 (52)	7 (37)

Note. * Perception of Strengths and Gaps in Youth Homelessness Services in Edmonton, ** Support Intervention for Homeless Youth.

Education

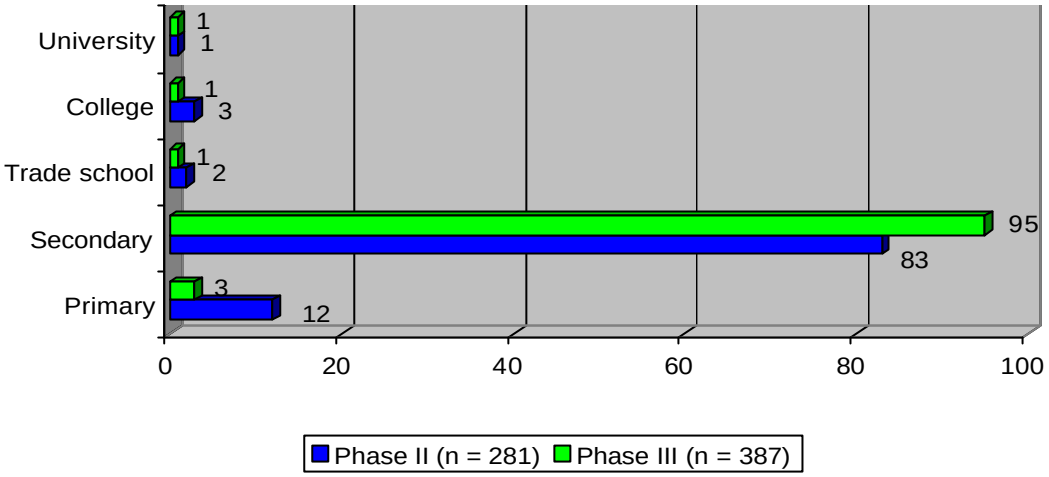
Enhanced STD Surveillance of Canadian Street Youth. At the time of interview, over half of Phase II (57.5%; *n* = 165) and Phase III (56.7%; *n* = 220) youth were not registered for school. Figure 2 provides the top 3 reasons for youth not being registered in school. The greatest reason reported for not being in school was dropping out, followed by being kicked out of school. Less than 20% of youth reported being out of school because they had finished their schooling. The majority of Phase II and Phase III youth were at a secondary school level (see Figure 3).

Figure 2. Absences from School (%)



[1] Includes First Nations, Metis, Inuit, and Cree

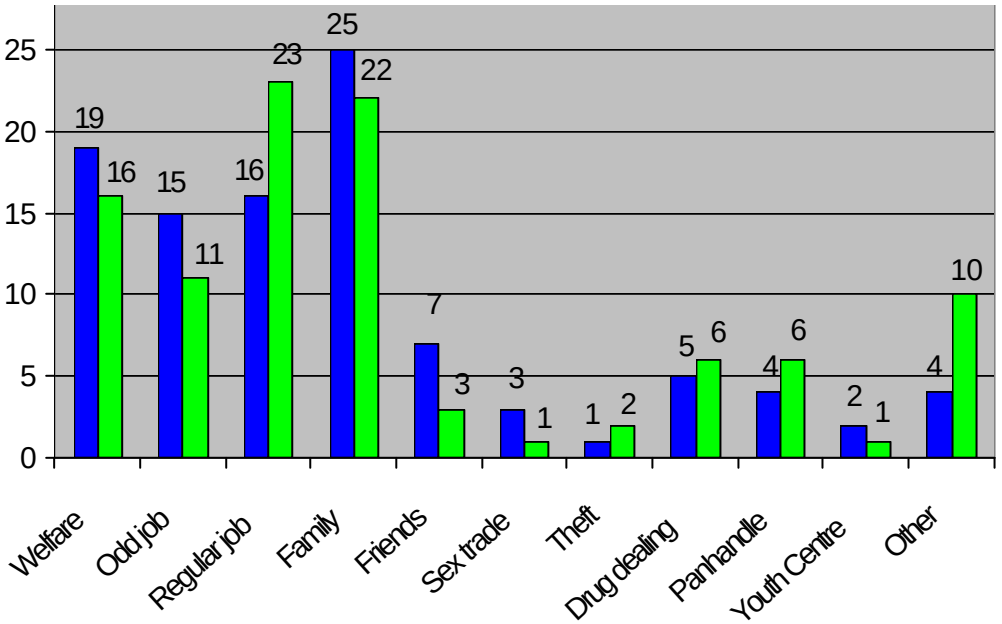
Figure 3. Current Level of School (%)



Income

Enhanced STD Surveillance of Canadian Street Youth. The two main sources of income was family, reported by Phase II participants, and regular work (including both part-time or full-time), as reported by Phase III participants. See Figure 4 for other sources of income.

Figure 4. Main Source of Income (%)

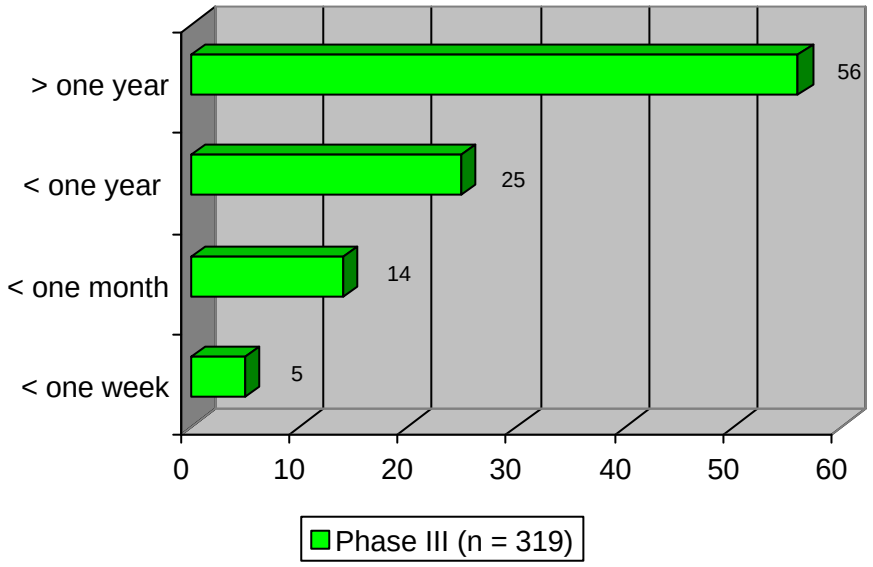


Perception of Strengths and Gaps in Youth Homelessness Services in Edmonton. Youth reported that a major obstacle to employment was the lack of identification and a permanent address for employers to contact youth. A number of youth (48%; *n* = 12) reported utilizing job services to help locate employment, while another 13% (*n* = 3) of youth utilized the services of the welfare system for income support.

Environment

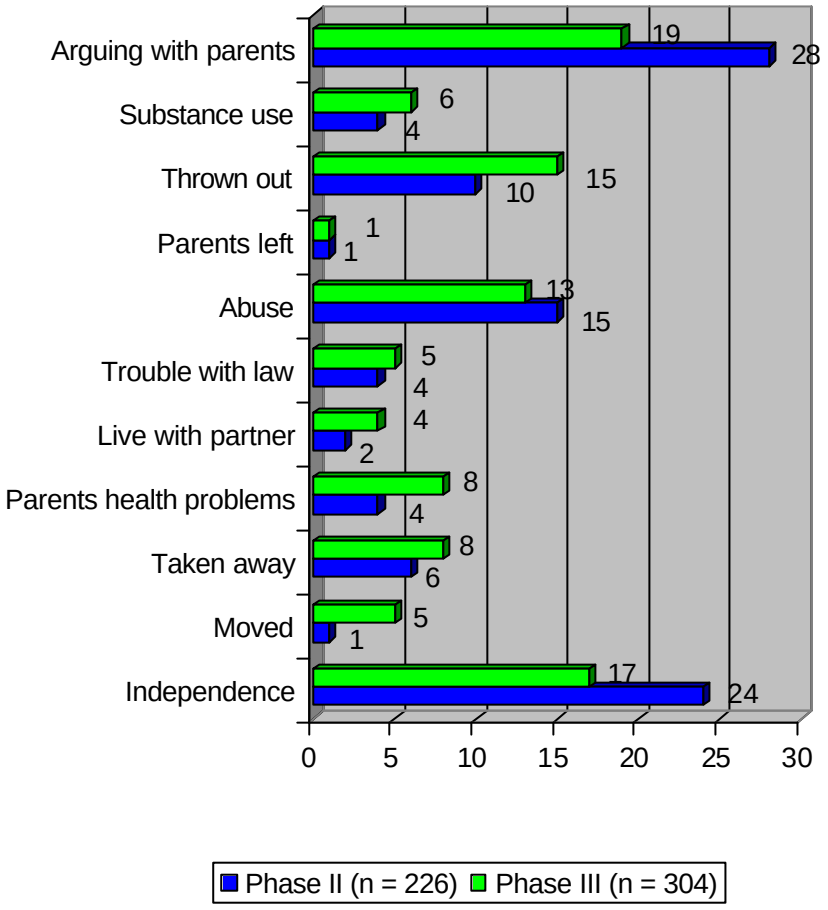
Enhanced STD Surveillance of Canadian Street Youth. At the time of interview, the majority (82%) of youth in both phases were not living with their parents. The majority of Phase III youth had not lived with their parents for greater than one year (see Figure 5).

Figure 5. Length of Time not living with Parents (%)



The main reason cited for leaving home among both Phase II and Phase III youth was arguing with parents (see Figure 6 for other reasons for leaving home). The majority of Phase III youth (*n* = 46; 28%) reported the main theme of their arguments with parents was arguing about rules being set and then broken.

Figure 6. Main Reason for Leaving Home



Perception of Strengths and Gaps in Youth Homelessness Services in Edmonton Similarly, the main reason for youth (*n* = 22) in this study to turn to the streets was family problems. This included reports of abuse, abandonment and substance use problems. As well, youth reported disliking rules set out by parents. A third theme, reported by youth (28%) was a dislike for school resulting in dropping out of school and turning to the streets. Similar to youth respondents, agency and community members also cited family problems, abuse, substance use and mental health problems as some of the reasons that youth are homeless.

Abuse

Enhanced STD Surveillance of Canadian Street Youth. Over 10% of Phase II and III youth cited abuse as the reason that they left home (see Figure 7). Of the 74 Phase III youth who reported physical abuse, the majority (*n* = 66; 89.2%) defined the physical abuse as physical fighting between them and their parents. A total of 84 Phase III youth

reported emotional abuse with 50% of youth defining the emotional abuse as mean things being said to them (see Figure 8 for other descriptions of emotional abuse).

Figure 7. Number of Youth Reporting Abuse

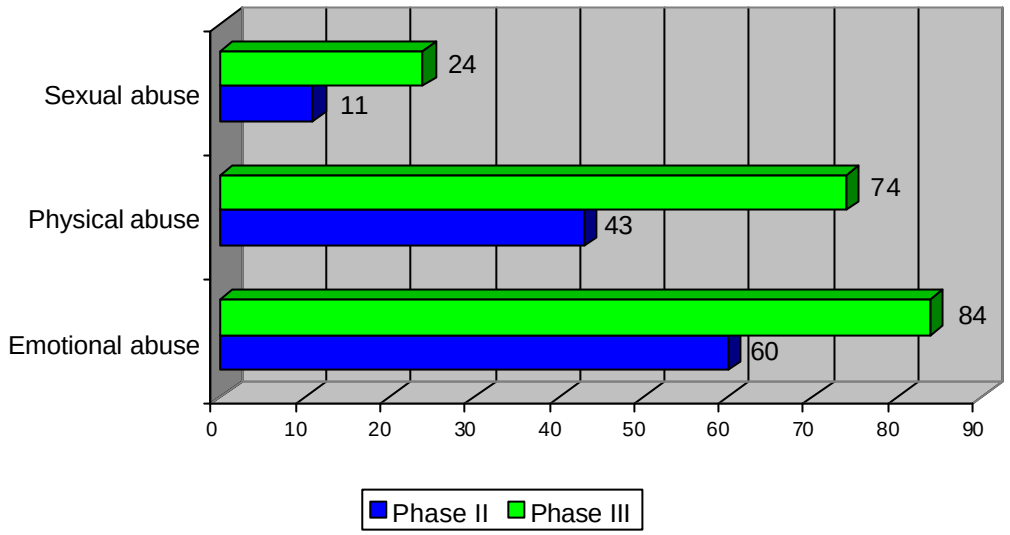
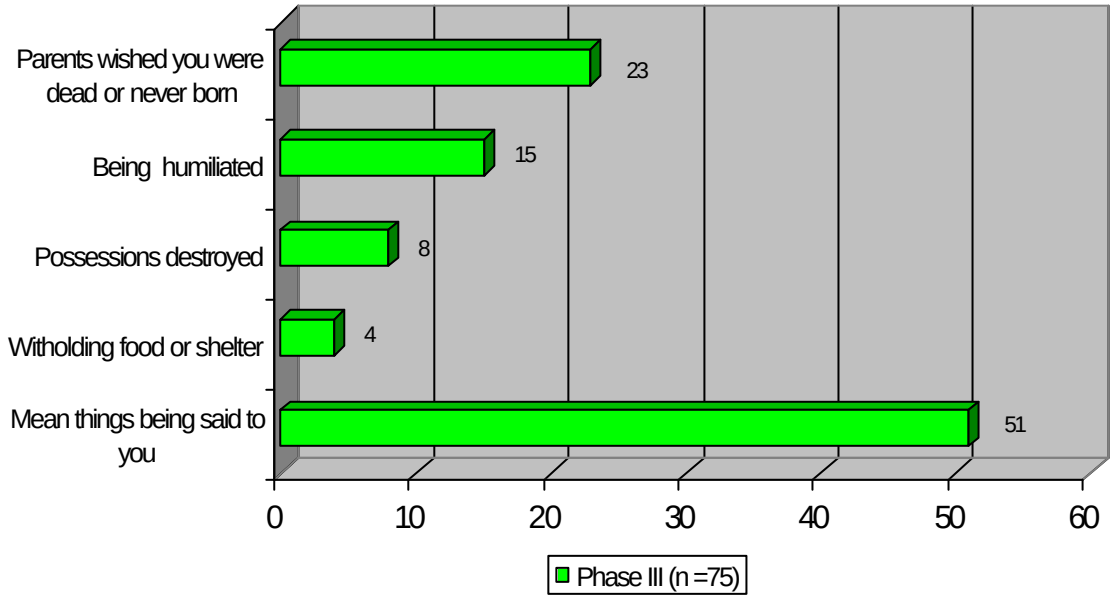


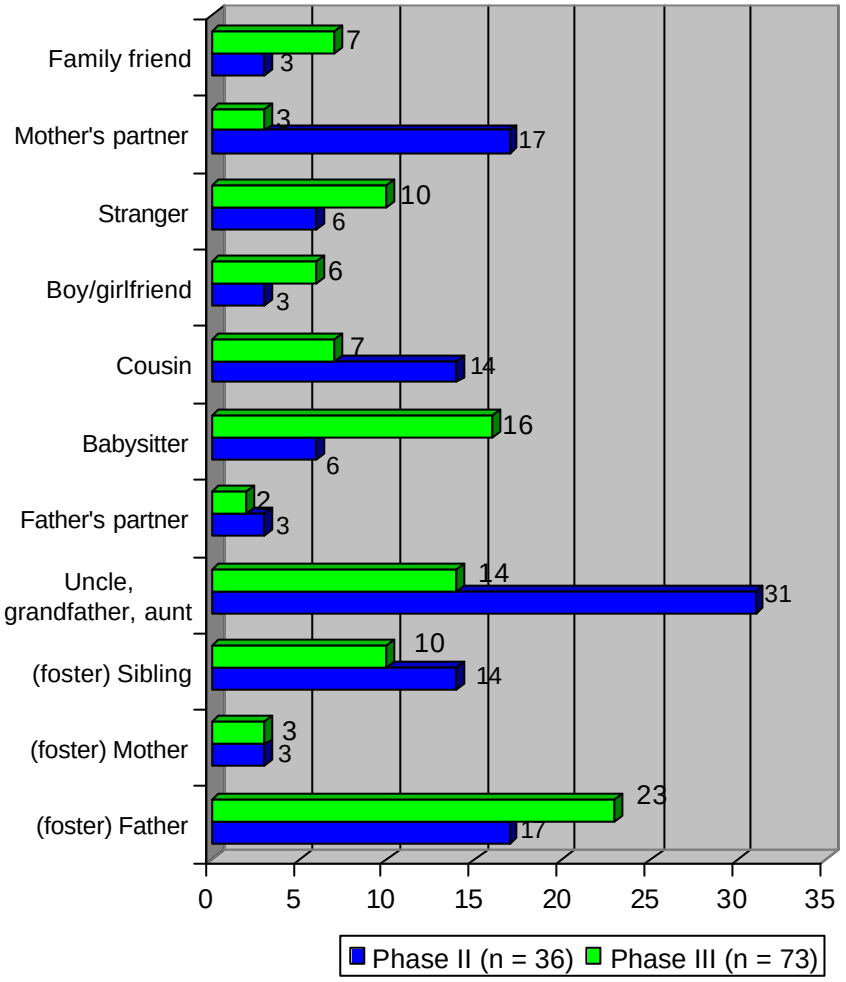
Figure 8. Descriptions of Emotional Abuse (%)



A total of 99 youth from both Phases reported unwanted sex. The age range for unwanted sex was 2 to 21 years, with Phase II youth reporting a younger age (μ = 7.3 years) as compared to Phase III youth (μ = 9.1 years). Only 7.4% of perpetrators were unknown

by the respondents, with foster fathers and uncles, grandfathers, and aunts being named most often as the perpetrator (see Figure 9).

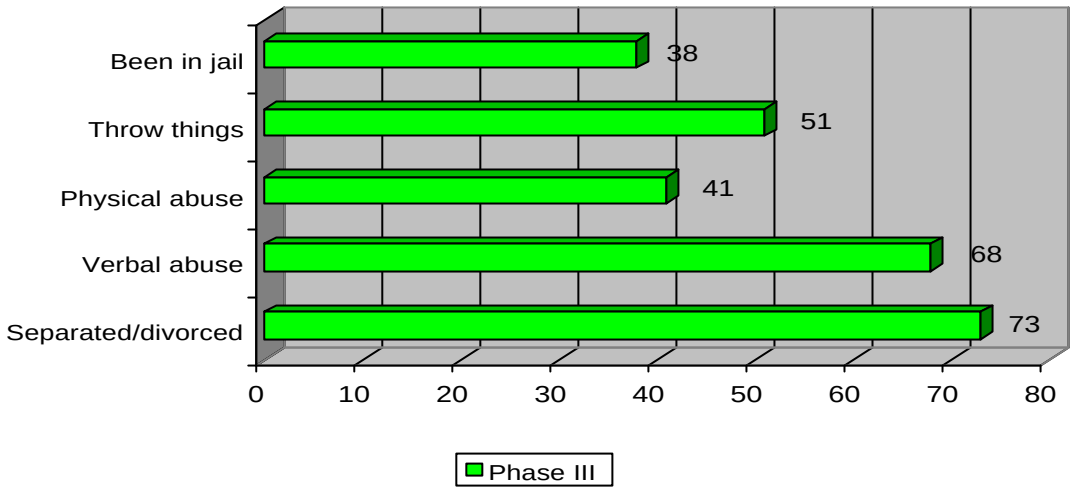
Figure 9. Perpetrators of Sexual Abuse (%)



Parents

Enhanced STD Surveillance of Canadian Street Youth. Although the majority of youth were not living with their parents, most youth remained in contact with their parents. More youth remained in contact with their mother (86.3%) as compared to their father (61.1%). Among Phase III participants, 12.6% (*n* = 49) reported that their families had been homeless. Almost three-quarters of Phase III youth reported that their parents had been separated or divorced. The majority of Phase III youth reported that their parents/caregivers had verbally abused one another and had thrown or broke things in anger. Less frequently, youth reported that their parents/caregivers had hit one another and that their parents/caregivers had been in prison (see Figure 10).

Figure 10. Parental Behaviour (%)



Housing

Enhanced STD Surveillance of Canadian Street Youth. About 40% of youth have been placed in foster or group homes at some point in their lives (see Figure 11) with nearly 70% of youth having had a social worker. Just over half (53.3%; *n* = 154) of Phase II youth reported having a permanent home. The majority of youth who reported having a permanent home were living with family (see Figure 12 for other living situations). Of those youth without a permanent home, the main reason cited for stopping them from getting a home was lack of money (see Figure 13 for other barriers to housing).

Figure 11. Social Services use (%)

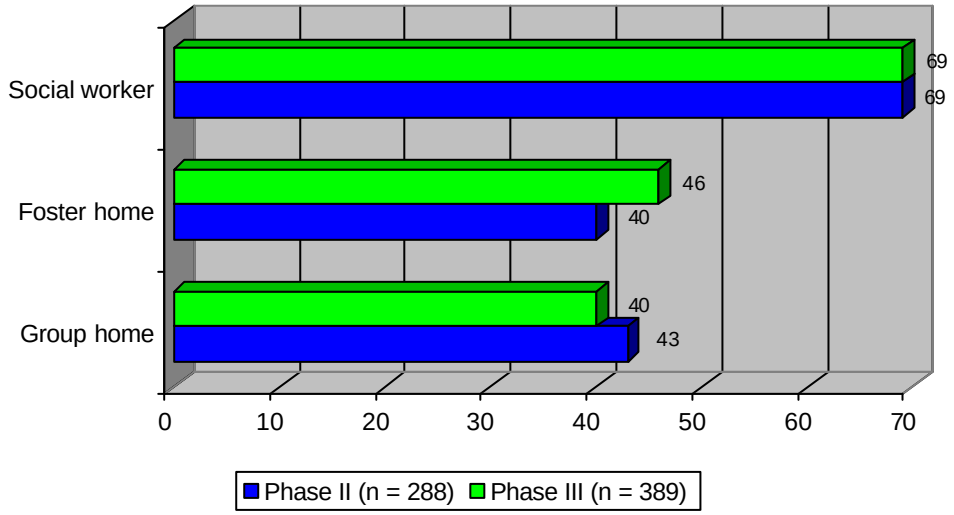


Figure 12. Permanent Homes (%)

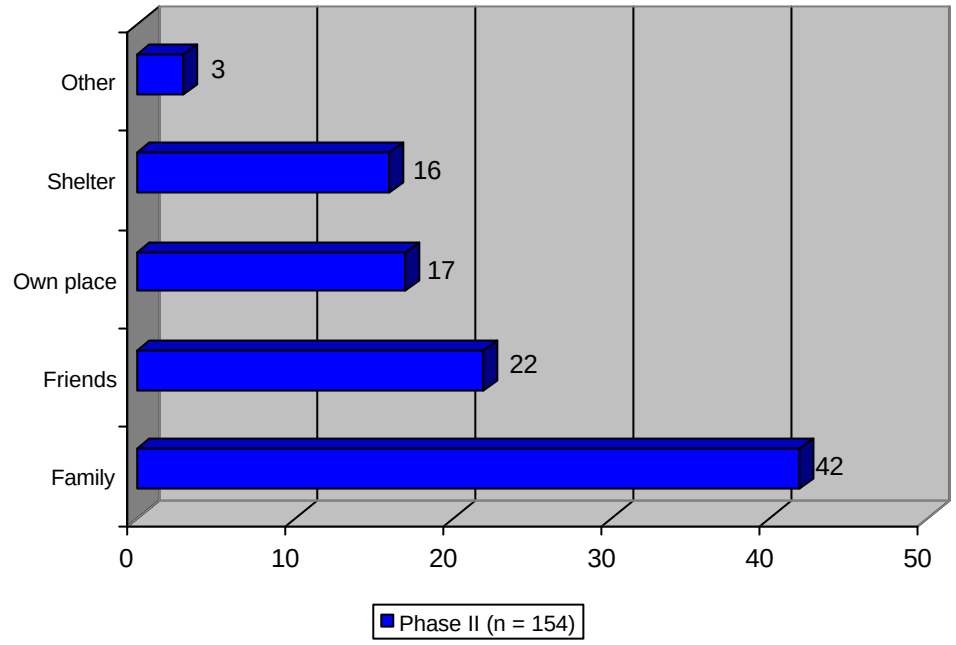
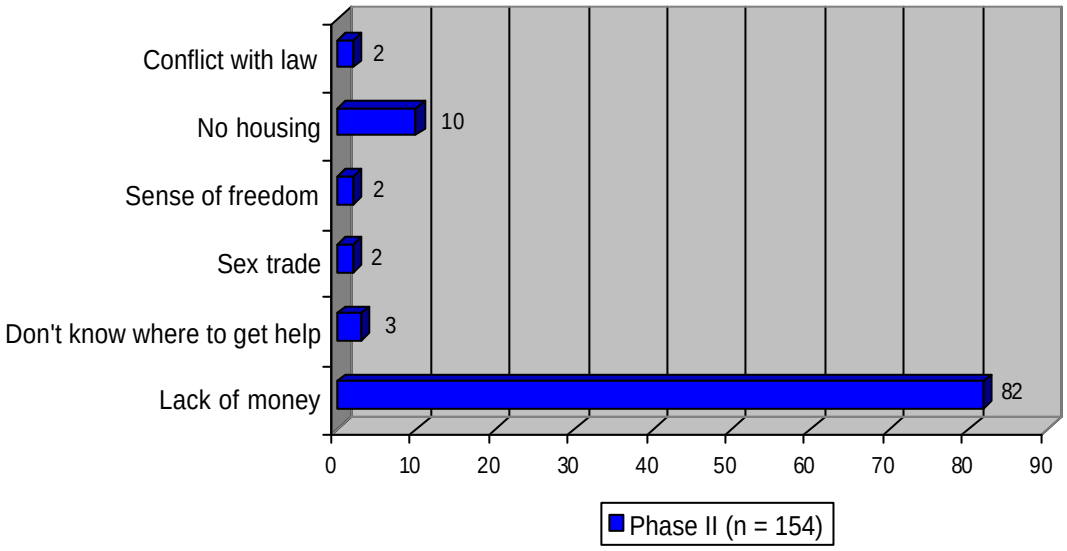
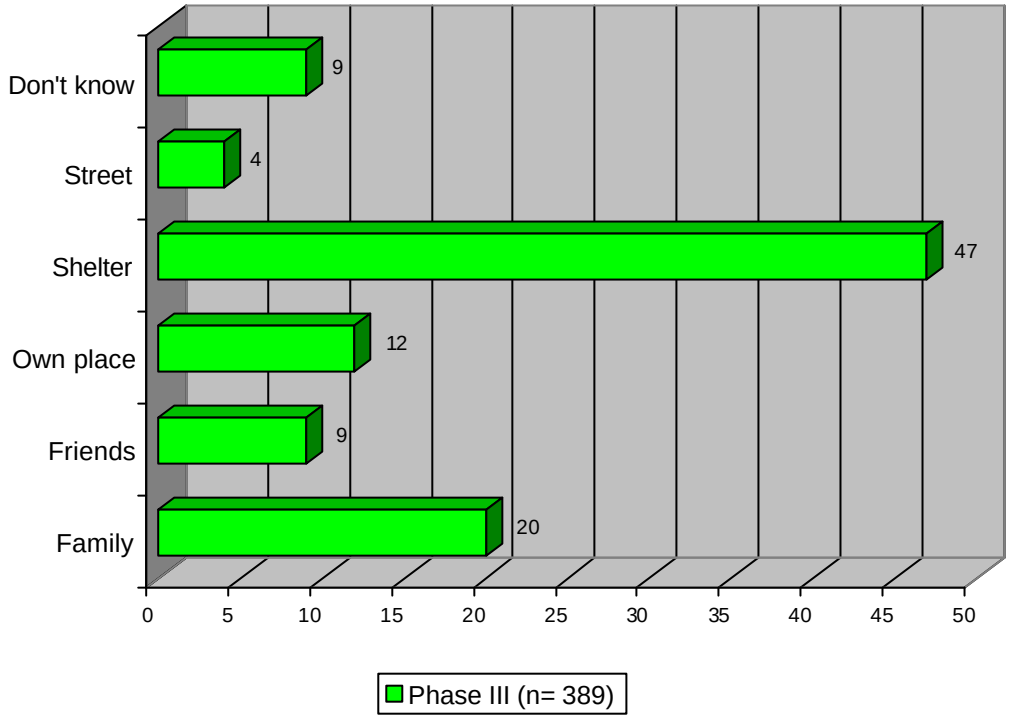


Figure 13. Barriers to Housing (%)



Nearly half of Phase III youth (49%) reported having lived on the streets at some point in their lives. As well, nearly half of Phase III youth reported that they would be spending that night in a shelter/hotel/hostel (see Figure 14 for other sleeping options).

Figure 14. "Where will you Sleep Tonight"? (%)



Perception of Strengths and Gaps in Youth Homelessness Services in Edmonton
The majority of youth (68%; *n* = 17) were relatively homeless with over one third (*n* = 9) of youth living in transitional housing, while another 25% (*n* = 6) of youth accessed emergency shelters, hostels, and motels. The remaining 32% (*n* = 8) were absolutely homeless with five youth living in a squat house. The majority of youth (68%) were currently accessing, or had accessed in the past, transitional shelters, with another 56% accessing emergency shelters.

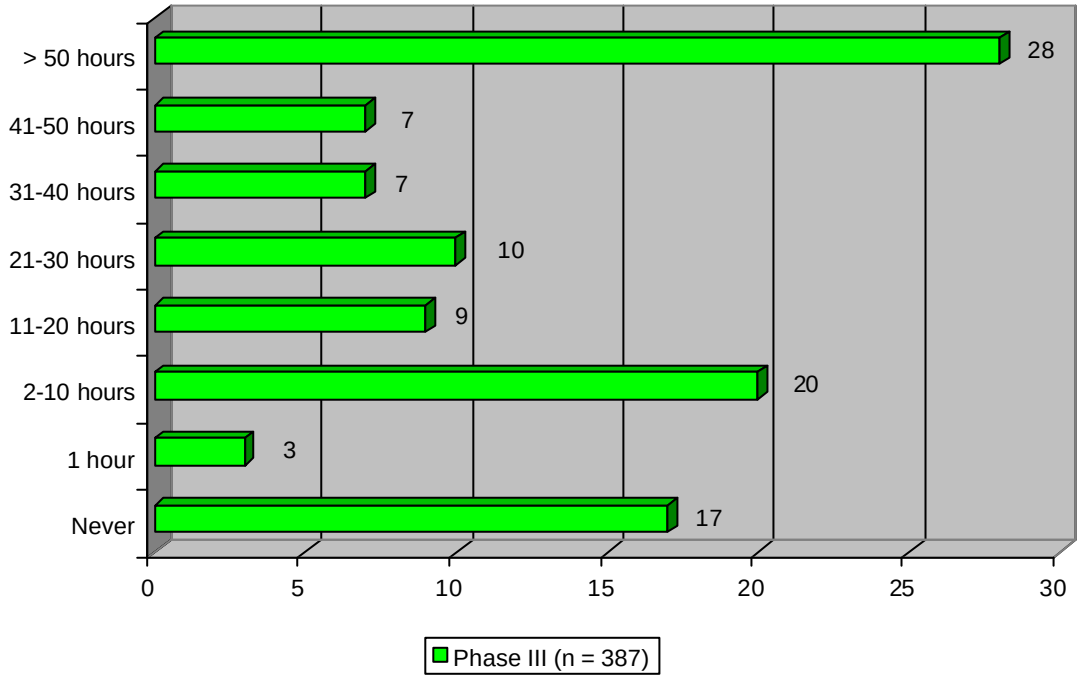
Agency members from downtown and Old Strathcona estimate that 15 to 75 youth would be on the street at any given time. Community members had varying estimates dependent upon their residence, with Old Strathcona residents estimating 25 to 50 street youth and downtown residents estimating 50 to 1000 street youth. Half of the agency members were aware of the Edmonton Homeless Count and believed the estimate to be accurate, the remaining half stated that this count does not reflect seasonal variations and does not capture hidden pockets of homeless people who survive without accessing services. None of the community members were aware of the Edmonton Community Plan on Homelessness.

Support Intervention for Homeless Youth. The majority of youth (32%; *n* = 6) were living with friends or family. Another six youth were staying at emergency shelters for youth (*n* = 2) or for adults (*n* = 4). Three other youth were living in supportive environments promoting life skills (*n* = 2) and recovery (*n* = 1). Three youth remained absolutely homeless and were sleeping outside or in abandoned buildings. Suggestions for improvements to shelters were increasing the number of beds, creating a more home-like environment with fewer rules, different age restrictions, and a caring staff.

Street Activity

Enhanced STD Surveillance of Canadian Street Youth. Over one quarter of Phase III youth reported spending greater than 50 hours a week hanging out on the street (see Figure 15). Over half (56.2%; *n* = 181) of Phase III youth reported that the amount they hang out on the street does not change due to the weather.

Figure 15. Hours Spent on the Street in One Week (%)

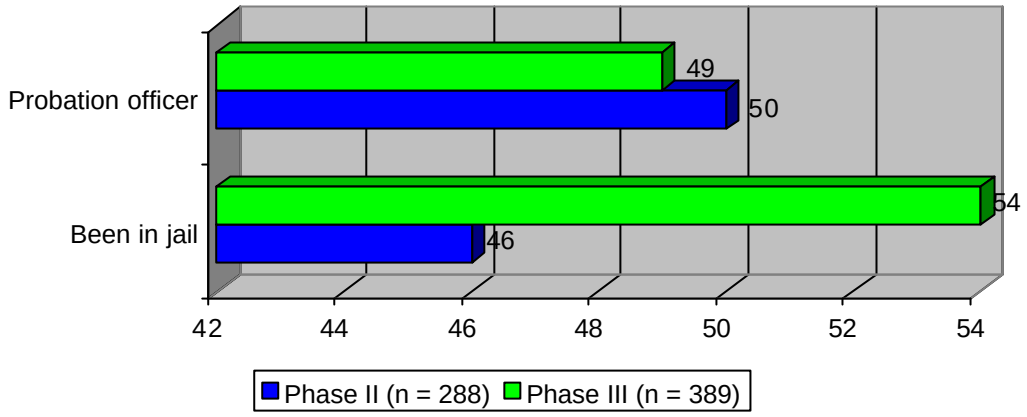


Perception of Strengths and Gaps in Youth Homelessness Services in Edmonton. The average age when youth reported first going to the streets ranged from 12 to 21 years with an average age of 15 years. Many of the youth (64%; *n* = 15) reported having used the services of a drop-in centre for support.

Criminal System Involvement

Enhanced STD Surveillance of Canadian Street Youth. Almost half of youth reported they had been to a youth detention centre or jail overnight or longer and almost half of youth reported they had had a probation officer (see Figure 16).

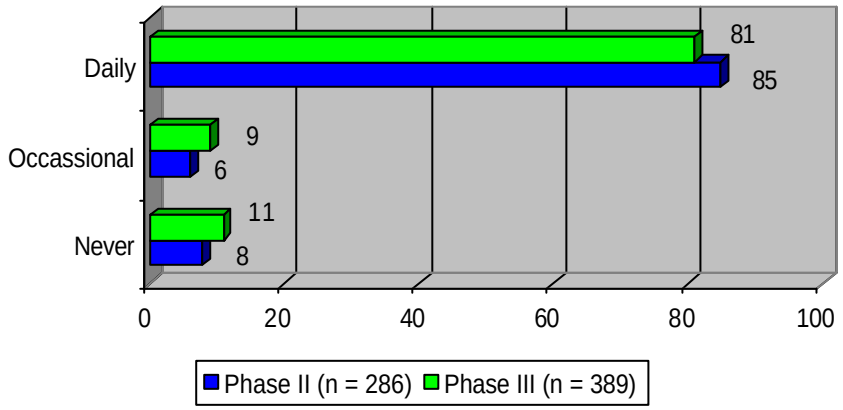
Figure 16. Criminal System Involvement (%)



Tobacco use

Enhanced STD Surveillance of Canadian Street Youth. Over 80% of youth smoked daily (see Figure 17), with Phase II youth smoking a higher average of 17 cigarettes a day as compared to Phase III youth smoking 14 cigarettes a day.

Figure 17. Current Tobacco Use (%)

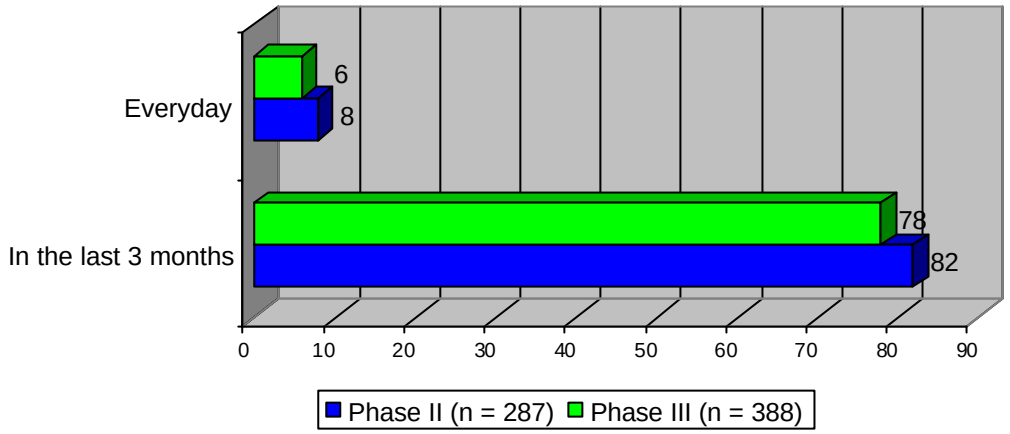


Perception of Strengths and Gaps in Youth Homelessness Services in Edmonton. In this study, only 56% of youth (n = 14) reported using cigarettes, although eleven of the youth reported being addicted to tobacco.

Alcohol Use

Enhanced STD Surveillance of Canadian Street Youth. Over three-quarters of youth had used alcohol in the last 3 months with a minority of youth reporting daily alcohol use (see Figure 18).

Figure 18. Alcohol Use (%)



Non-injection Drug Use

Enhanced STD Surveillance of Canadian Street Youth. Over 90% of Phase II (94%; *n* = 272) and Phase III (97%; *n* = 376) youth reported using non-injection drugs sometime during their life with up to 25% of youth reporting that they had quit in the last three months (see Figure 19). Of those youth who had used non-injection drugs in the last three months, the majority of youth reported marijuana as the drug they had used most (see Figure 20). Phase III youth reported using non-injection drugs on average 6 times a week, more often when compared to Phase II youth using 3 times a week.

Figure 19. Non-injection Drug Use in the Last 3 Months (%)

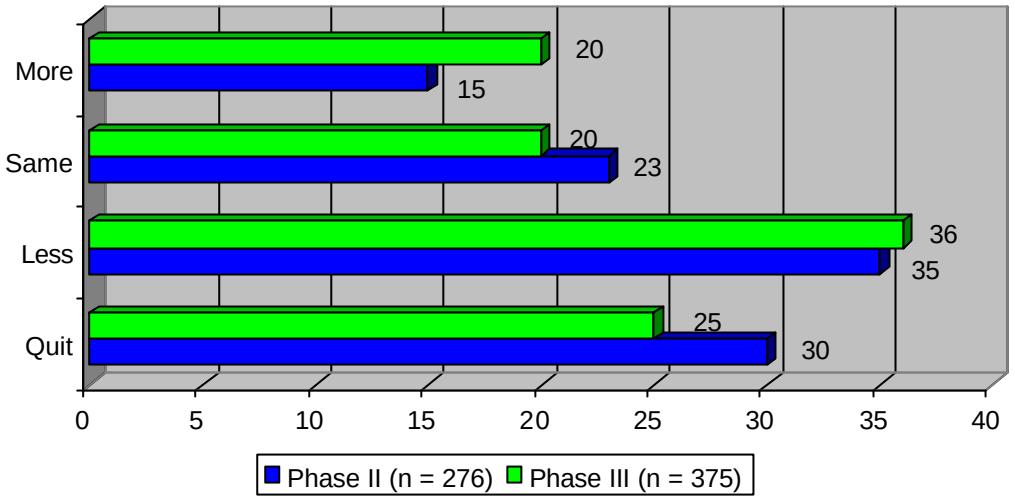
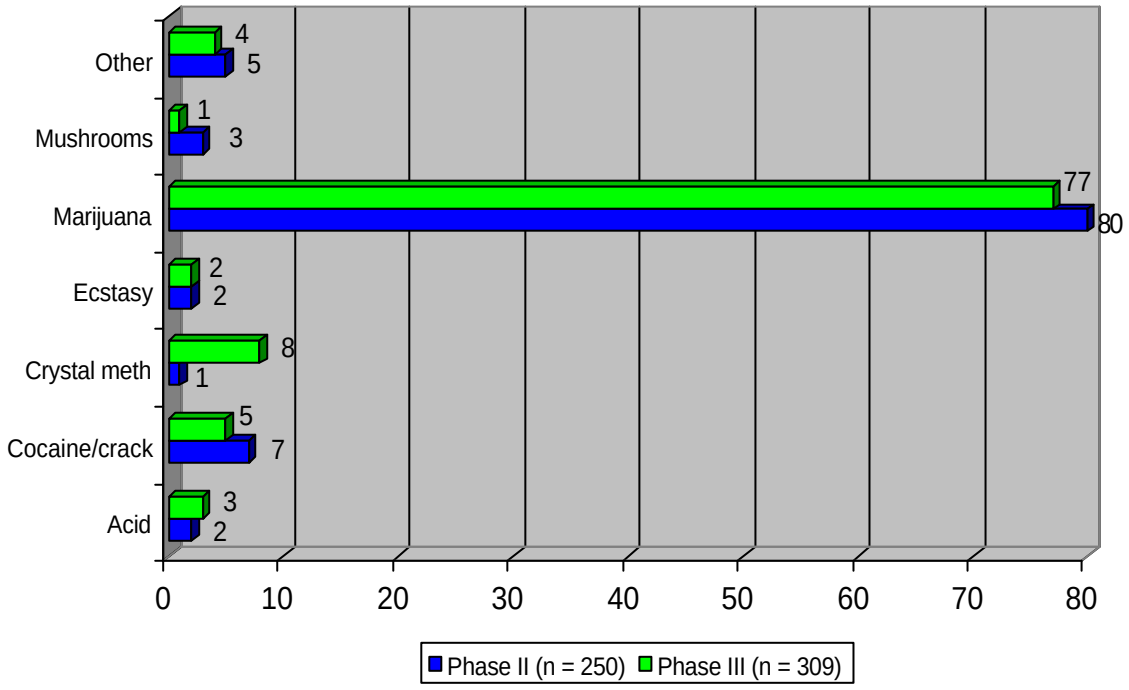


Figure 20. Most Common Non-injection Drug Used in the Last 3 Months (%)



Perception of Strengths and Gaps in Youth Homelessness Services in Edmonton. Service providers cited youths use of substances as a barrier to youth accessing services. The substance youth self-identified most as a problem was tobacco (*n* =10). The next substances of concern for youth were marijuana (*n* = 8), cocaine/crack (*n* = 6), followed by alcohol (*n* = 6) and chemical drugs (including speed, crystal methamphetamine and ecstasy; *n* = 4). Two of the youth reported having used addictions counselling at some point in their life.

Injection Drug Use

Enhanced STD Surveillance of Canadian Street Youth. Just over 10% of youth reported using injection drugs sometime in their life, with an average age of first injection of 15 years, ranging from 9 to 24 years. Almost one quarter of youths' parents had injected drugs (see Figure 21). Over three-quarters of respondents using injection drugs reported always using clean injection equipment (see Figure 22). As well, over three-quarters of respondents who had reported ever using injection drugs stated they had quit in the last three months (see Figure 23) with only 17.6% of Phase II youth (n = 6) and 36.8% of Phase III youth (n = 14) having used a treatment centre to quit. Of those youth still injecting drugs, Phase II youth reported injecting an average of 48 times per week while Phase III reported an average of 13 times per week.

Figure 21. Injection Drug Use (%)

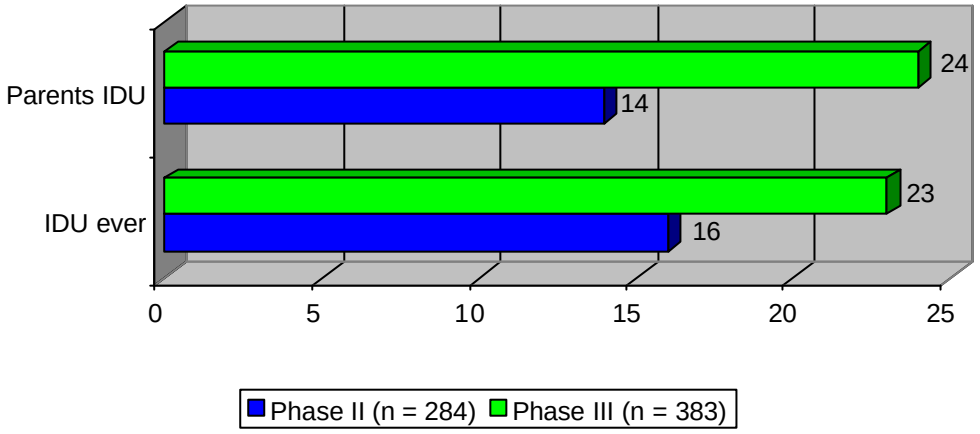


Figure 22. Use of Clean Injection Equipment (%)

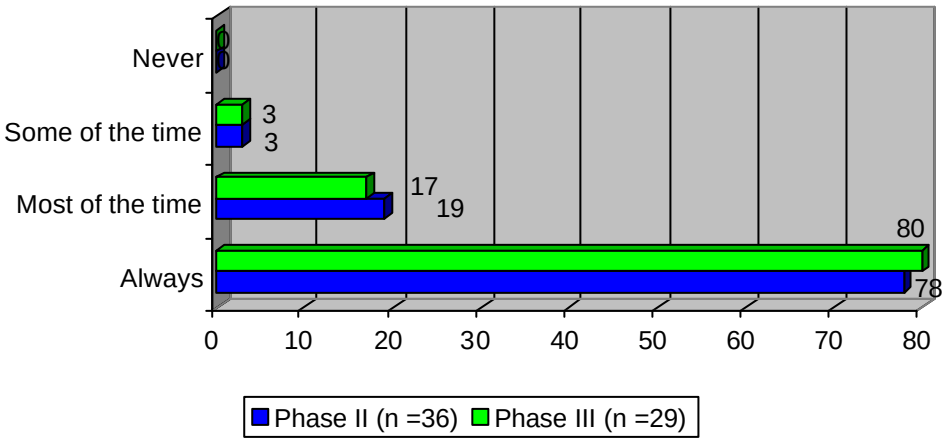
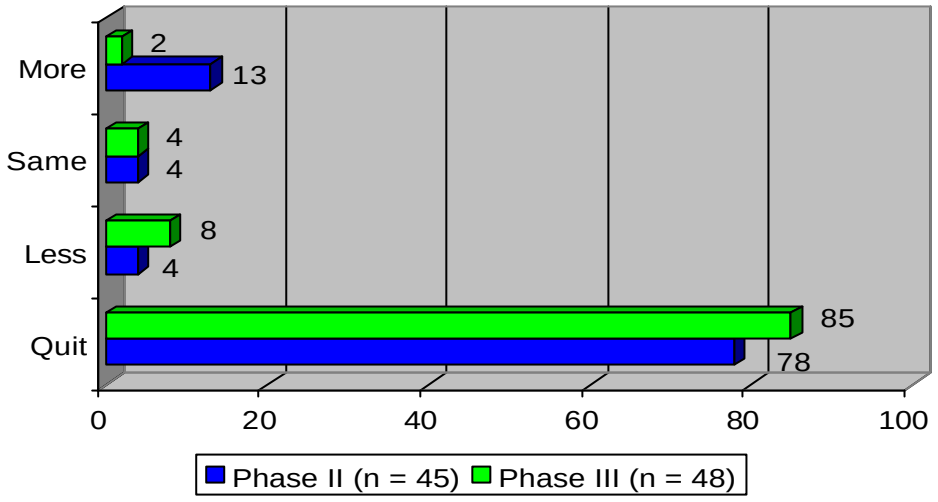


Figure 23. Injection Drug Use in the Last 3 Months (%)



Sexual Health

Enhanced STD Surveillance of Canadian Street Youth. Most youth (95.8% of Phase II youth and 91.8% of Phase III youth) were sexually experienced, defined as vaginal, oral or anal sexual activities with a male or female partner. The mean age of sexual debut for willing sexual activity was 14 years with youth becoming sexually active between the ages of 7 to 22 years. The majority of youth in both phases reported their sexual preference as heterosexual (see Figure 24), with the majority of youth engaging in vaginal intercourse (see Figure 25). Over half (61.9%; *n* = 219) of Phase III youth reported using a condom with their last partner. The mean number of sexual partners that youth reported in the last three months was just under 3, ranging from 0 to 104 partners. As well, nearly half of female respondents in Phase II (49%; *n* = 65) and Phase III (44%; *n* = 44) reported being pregnant at some time.

Figure 24. Sexual Preference (%)

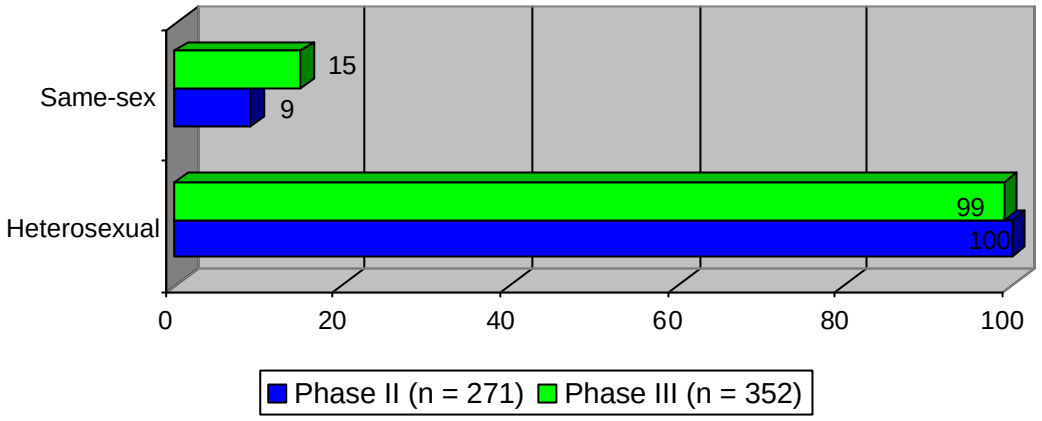
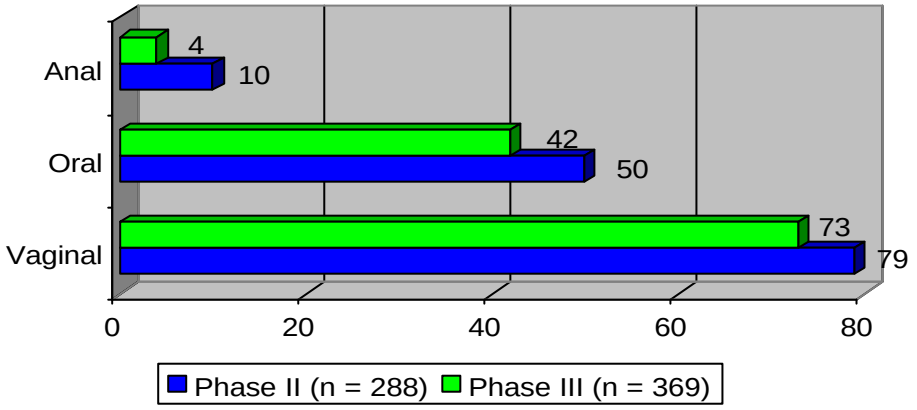


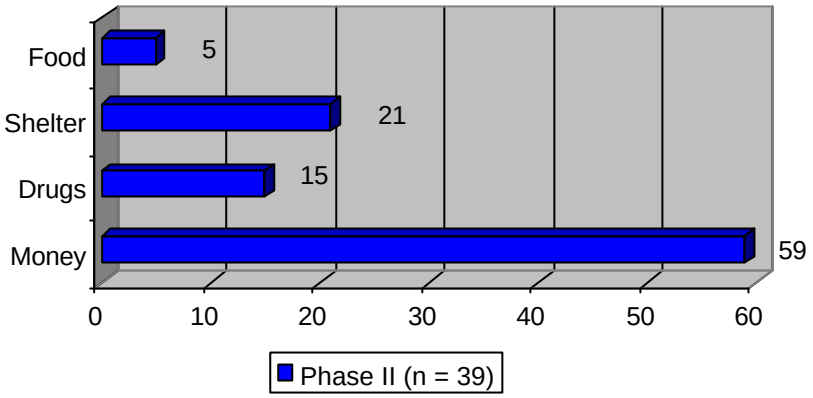
Figure 25. Type of Sexual Activity (%)



Sex Trade

Enhanced STD Surveillance of Canadian Street Youth. Just over ten percent of Phase II (12%) and Phase III (16%) youth reported trading sex for money, gifts, drugs or shelter at some time in their livesd. The average age when youth first exchanged sex was 15 years, ranging from 7 to 23 years. The average number of partners that youth have exchanged sex with was just over 50 with a range from 1 to 1000 people. Phase II youth who exchanged sex reported the most common item received was money (see Figure 26). Only 47% (*n* = 43) of Phase II youth reported using condoms with their last sex trade partner, while Phase III youth reported 78% (*n* = 41) condom use.

Figure 26. Items Most Often Received for Sex Trade (%)



STI/Blood Borne Pathogen testing

Enhanced STD Surveillance of Canadian Street Youth. Despite various behaviours that place youth at risk for STI acquisition, almost half of youth rated their risk of acquiring a STI as low (see Figure 27). Greater than half of youth reported being previously tested and 18% of youth in both phases had previously been told they had an STI. During data collection, STI/BBP testing in outreach settings became increasingly acceptable as the number of participants who provided urine and blood samples increased in Phase III (see Figure 28).

Figure 27. Risk of Acquiring a STI (%)

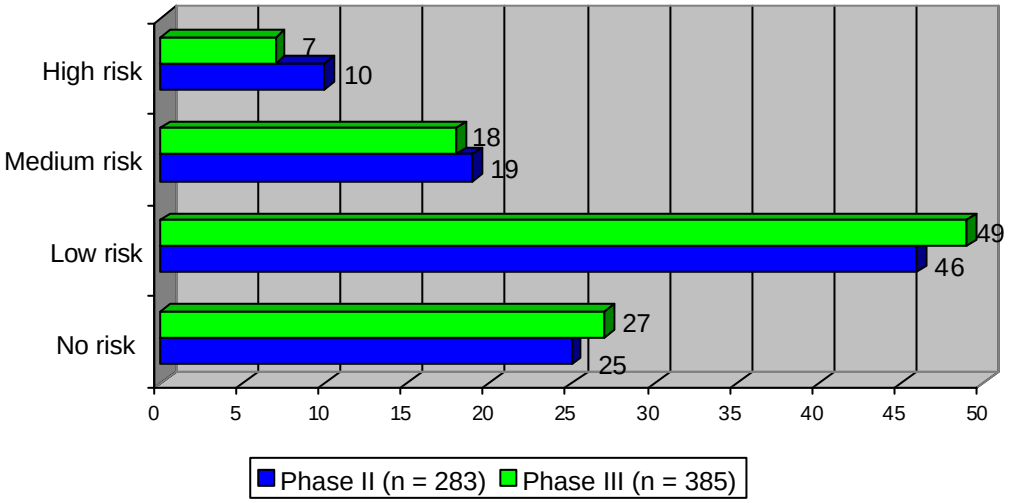
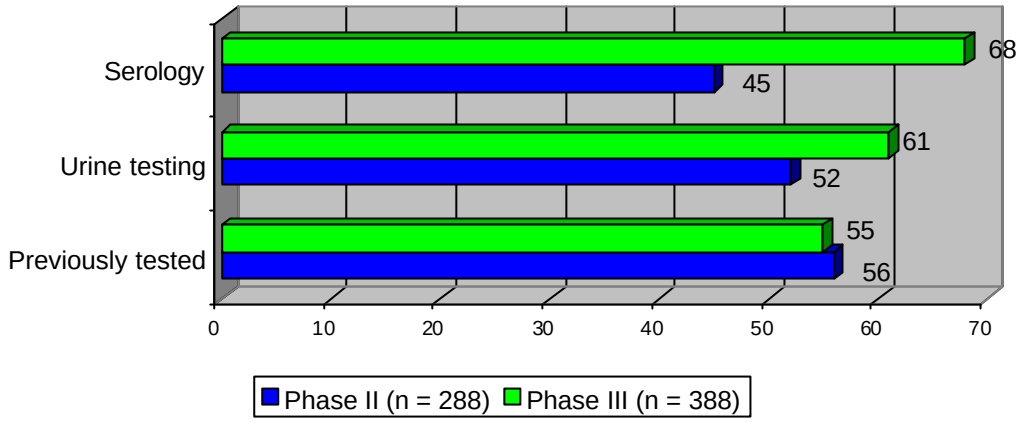


Figure 28. STI Testing (%)



The chlamydia results from the urine PCR testing found a decrease prevalence rate between Phase II and Phase III. In comparison, gonorrhea prevalence rates increased slightly between Phase II and Phase III (see Figure 29). Syphilis testing was added to Phase III serology and no youth were found to have reactive serology. Serology results for exposure to Hepatitis B virus (antiHBc) found a slight increase between Phase II and Phase III. The serology marker for immunity to HBV (antiHBs) found a significant increase between Phase II and Phase III which may be related to the introduction of a universal Hepatitis B immunization program. Hepatitis C results also rose slightly between Phase II and Phase III (see Figure 30).

Figure 29. STI Results (%)

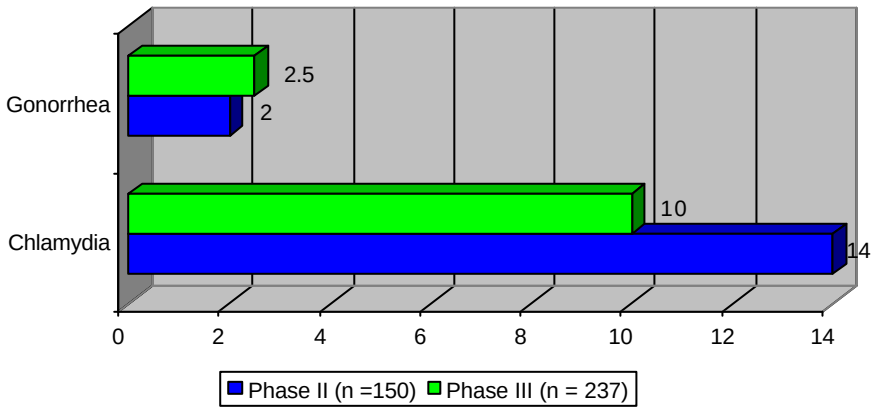
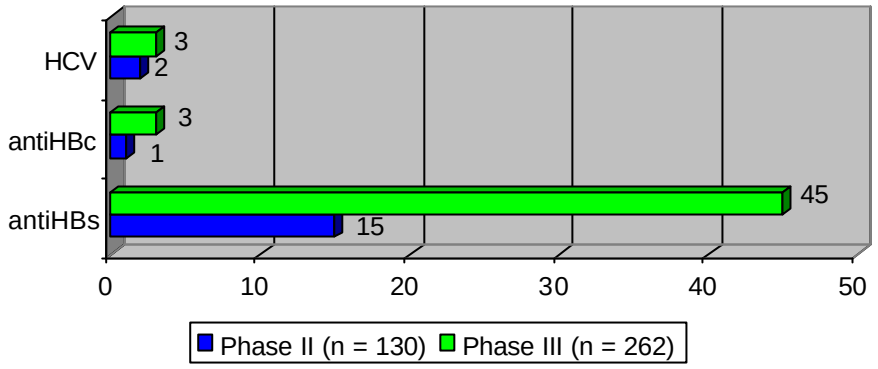


Figure 30. Serology Results (%)



Mental Health

Enhanced STD Surveillance of Canadian Street Youth. Youth were asked to respond to an 11 item self-esteem/mental health scale. The following two questions were selected to illustrate mental health concerns. Twenty per cent of youth in both phases agreed or strongly agreed that they were feeling down, depressed or hopeless (see Figure 31). Over one third of Phase III youth reported that they had attempted to commit suicide in the past (see Figure 32).

Figure 31. "I am feeling down, depressed or hopeless." (%)

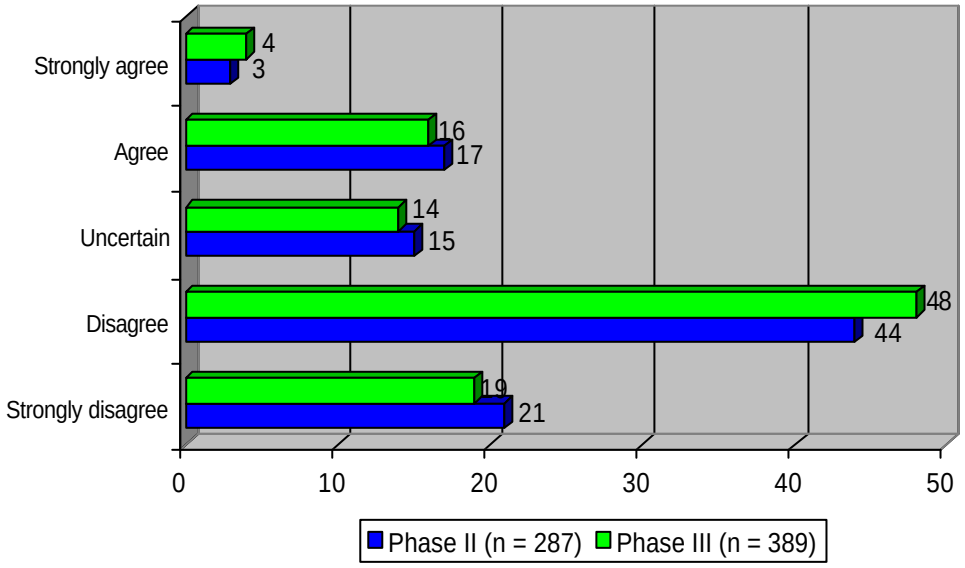
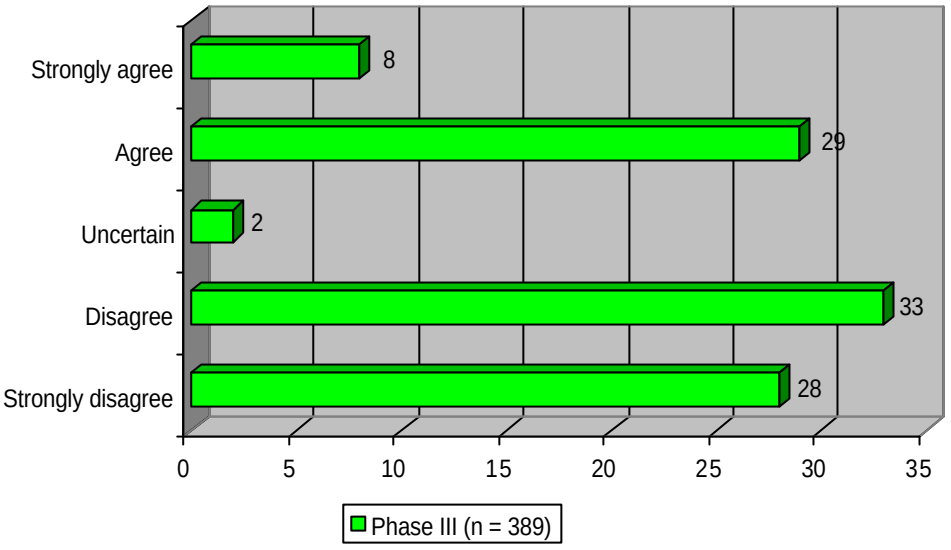


Figure 32. "In the past I have attempted to commit suicide." (%)



Perception of Strengths and Gaps in Youth Homelessness Services in Edmonton
Some of the youth reported mental health concerns including Attention Deficit Disorder (*n* = 4), Fetal Alcohol Effect/Syndrome (*n* =1), learning disabilities (*n* = 6), and speech disabilities (*n* = 1).

Support Intervention for Homeless Youth. The majority of youth (79%; *n* = 15) and service providers (100%) reported the need for emotional support. This support included the sense that agency staff really cared for youth and would listen to youths' concerns, invoking a sense of trust in their relationships. Unconditional support by non-judgmental people would affirm youths' self-worth as individuals.

Other Health Issues

Perception of Strengths and Gaps in Youth Homelessness Services in Edmonton
Youth reported few health problems. Of those mentioned, chronic illnesses were reported by 4 of the youth; conditions included chronic back pain, asthma, and hepatitis C. More acute illnesses included broken bones and a cold.

Services

Perception of Strengths and Gaps in Youth Homelessness Services in Edmonton
General awareness of available resources among youth was good, although youth recommended the creation of a list of youth services for service providers. Service

providers also reported a lack of knowledge regarding services outside of their own agency.

Youth and agency members perceived transportation as a barrier to services; therefore the solution suggested was centralizing services. The recommendation included the availability of services for employment, addictions, family counseling and medical services at the shelters and drop-ins that youth are accessing. Agency members reported that more staffing is required to work with youth on various levels, including professional services. Community members were also supportive of youths' needs for a wide variety of counselling services.

Many youth found turning 18 and the jump to adult services difficult, as youth were not prepared for activities associated with adult homeless populations. Therefore, youth recommended a review of the age criterion for youth services, expanding this criterion past the age of 18 to include youth up to the age of 24. Many youth also expressed safety concerns about accessing services downtown and reported that they would prefer a south-side location; this preference was also supported by service providers.

Youth identified strengths among current services as receiving personal respect from staff, and services being accessible. Youth felt it was important to be among their peers as this often provided additional support. Youth also valued access to basic resources such as food and clothing.

Support Intervention for Homeless Youth. An overall theme reported by youth was a desire to be cared for, to be treated as a person and respected. Youth reported that agency staff who were honest and respectful and who had personal experience with homelessness would be a benefit. Youth reported that strengths of an agency are flexibility in structure and holistic programming including food, housing, recreation, financial support, and healthcare. Similarly, service providers reported the same strengths and added the provision of a safe environment with long-term programming.

Youth reported that weaknesses among current programming are rigid and unrealistic structures with difficult or invasive procedures for accessing resources. Youth reported that environments were unsafe, lacked privacy and were depressing or dirty. Youth felt there was a shortage of service providers and those that were there were uncaring and did not understand youths' issues. Youth recognized that the service providers are the most critical aspect to their participation in a support program. Recommended qualities for a service provider included being non-judgmental, understanding, caring, relating to youth and sharing experiential knowledge. Youth reported that they want service providers who are a similar age or slightly older and who are committed to a project and the youth. The majority of youth preferred one-on –one support in a face to face style, with accessible hours, including evenings and a choice of service provider.

The most critical gap reported by service providers was the gap between over-capacity and under-funding. Service providers identified areas of improvement for agencies. The first improvement would be reduced staff to client ratio which would allow for more one-

on-one support, as desired by the youth. A second improvement for service would be a long-term commitment to youth with transitional supports for youth, moving them towards self-sufficiency. A final improvement would be the development of youth specific services for mental health issues, addictions, food and health care.

IV. What findings can be used for program planning?

> It is obvious that the main barrier to good health among the homeless is their lack of the adequate, safe, accessible and affordable housing that is linked to employability, community support, personal health care and access to health services (Begin, Casavant, Chenier & Dupuis, 1999).

Many of the findings from the review of these studies can be used for program planning. Not only are findings consistent between the studies completed in Edmonton, but many other national papers on homelessness support the issues raised by youth and service providers in Edmonton (Canada Mortgage and Housing Corporation, 2001; Serge et al., n.d.). Homelessness goes beyond the lack of shelter and includes lack of employment, education, and social support (Serge et al., n.d.). Due to the complexity of homelessness, strategies cannot be exclusive of one another, and should be examined in combination. The foundation of all potential strategies is based on the development of healthy public policy, which creates the climate for tackling homelessness (Frankish, Hwang, & Quantz, 2002).

Prevention

The prevention of homelessness begins with the healthy development of children, which requires investing in children. *The Healthy Development of Children and Youth* (Division of Childhood and Adolescence, 1999) highlights the importance of all health determinants and the role each plays in the successful development of children. These determinants include social and physical environments, economics, education, and employment, as well as individual characteristics.

Family income is critical in preventing children from growing up in poverty. Children living in poverty are more likely to have trouble with the law, have lower educational achievements and are at greater risk for health problems including disability and death (Division of Childhood and Adolescence, 1999). Policies and programs aimed at ending child poverty should begin with a commitment to raising family incomes.

Education is key to improving economic security and socioeconomic status. Similar to the youth in our studies, other youth in Canada reported having difficulties in traditional education systems (Serge et al., n.d.). The development and support of alternative educational programs, with the goal of keeping youth in the education system, is key to providing youth with the skills to enter employment and gain resources for life.

Poor physical environments, like substandard housing, are also detrimental to healthy development. Families need assistance in finding permanent housing. Suggestions for youth housing include a combination of emergency shelters, transitional housing and longer interventions with supported housing (Canada Mortgage and Housing Corporation, 2001). An example of responding to youths' changing needs is the reorganization of services at the Youth Emergency Shelter Society (YESS). Recently YESS has undertaken a revamping of service and have included four different phases of

programming for youth. Phase One is comprised of a 16 bed shelter program for youth in active crisis who need assistance with their immediate needs of shelter, food and clothing. Phase Two is a 12 bed long term life skills program that supports youth who want to gain independence and stability. Phase Three housing has ten individual bedrooms and provides a more home-like environment for youth who are involved in productive activities like school or work. Phase Four is the community enhancement program which assists youth in making the transition back into the community (YESS, Spring 2004).

A child's social environment provides him/her with social support. Parental health behaviours are a large influence on youth, and supporting families is key in preventing youth homelessness. Family structures are changing and therefore the social support provided by parents is also changing. As identified in the *Enhanced STD Surveillance of Canadian Street Youth*, many street youth have suffered abuse at the hands of their families and have left home for this reason. Children who witness family violence are missing the provision of a safe and secure environment, and are missing models for healthy relationships. The child welfare system has been set up to provide children with a safe environment. However, youth have reported mistreatment by these care providers, as well. A priority should be given to ensuring the provision of a safe environment for youth wherever they may be.

Comprehensive Service Provision

Youth and service providers interviewed in Edmonton reported a need for a comprehensive service model. Several other national studies support this finding as well (Canada Mortgage and Housing Corporation, 2001; Novac, Serge, Eberle & Brown, 2002). Due to the complex needs identified by the youth interviewed in Edmonton, any housing choices need to be coupled with support programs like life skills, employment counselling, health and education services (Novac, Serge, Eberle & Brown, 2002). Youth in our review reported difficulties in accessing governmental departments; other studies also support the need for improvement to income assistance and child welfare access (Canada Mortgage and Housing Corporation, 2001).

Any potential program for youth needs to be available on a long term basis with transitional support (Novac, Serge, Eberle & Brown, 2002). Authors of a study on homeless youth with prior child welfare service experience have found that homelessness may be related to reaching the arbitrary age restriction for programs, but not being developmentally ready to exit programs (Serge et al., nd.). Our youth and service providers, as well as other authors, recommend an extension on youth age restrictions.

Youth in both needs assessment studies identified the desire to be respected by service providers. Findings from other sites across Canada agree that creating a supportive relationship with an individual (family member, foster family, or social worker) is crucial to success (Serge et al., nd.). An evaluation of current staffing for agencies in Edmonton may provide insight into the support required for agency staff. Do they have adequate education, debriefing and staffing levels?

The Old Strathcona Youth Coop (OSYC) is answering the request from youth and service providers to provide a comprehensive service center on the south side of Edmonton. Opening its doors in 1998, the OSYC is a drop-in centre for youth. Community agencies, including health, police, children's services, and housing, have joined together to provide a variety of services for youth on-site (*Old Strathcona Youth Coop*, n.d.). Evaluation of this program could provide important insights on successful program features as well as gaps that still exist.

As well, youth and service providers' request for a list of services has been met in Edmonton. Three resources are available to the public. These include *The Tough Times Handbook*, the *Directory of Youth Services: Street Version*, and the *Youth Help Card.* Each resource comes in a different format and lists contact information for various programs in Edmonton. This request may be better answered with an evaluation of the best means for distributing resources that are already in place.

Health

In our review of the three local studies, many behaviours were revealed that place youths' health at risk. The majority of youth reported non-injection drug use with a minority of youth reporting injection drug use. These behaviours predispose youth to addiction issues and in the case of injection drug use, life threatening infections like HIV. Other behaviours include sexual risk taking behaviours like multiple sexual partners, involvement in sex trade and STI acquisition; which place youth at risk for acute infections, infertility, and chronic health conditions. All of these behaviours have been documented in other Canadian cities (Dematteo et al., 1999; Poulin et al., 2001; Roy et al., 2000).

Despite the provision of universal healthcare in Canada, youth and service providers report the need for better healthcare delivery to homeless youth. Begin et al. (1999) clearly identify issues to accessing healthcare.

> The homeless are unable to: obtain medical treatment without a health card (and applying for a health card requires an address); pay for items not covered by provincial medical or drug insurance plans; receive adequate treatment in cases where their personal appearance alarms health providers; make a health appointment, because they lack an address and a telephone; and receive coordinated care when comprehensive medical records are not kept in one location with one provider. Problems continue following treatment or hospitalization, because the homeless have no place to recuperate and no consistent caregiver.

One solution to providing health care services to homeless youth is taking the service to them. Success with outreach services have been demonstrated in many studies across Canada and the United States (Rietmeijer et al., 1997; Gunn et al., 1998; Jones, Knaup, Hayes, & Stoner, 2000). Key to success is the integration of holistic health services, where general health needs can be met in one convenient visit. With the overwhelming

substance use among this population, programs need to be examined for their use of harm reduction principles. Youth reported a major barrier to accessing many services is a program requirement for youth to be sober before accessing care. Perhaps, care needs to support youth through their reduction of substance use or safer use of substances (Canadian Public Health Association, 1997).

An example of an outreach based health program, with a long history of operating in Edmonton is the Victorian Order of Nurses People in Crisis Program. This primary healthcare program started in 1979, offering client driven nursing service to residents of a women's shelter. This program has grown over the years and now includes nursing visits to the Youth Emergency Shelter three times a week. The nurses meet with youth confidentially to review their overall physical and mental health status and provide health education, as well as assistance and advocacy for clients to get the appropriate referral for their care (*People in Crisis Program*, n.d.). Evaluation of this program could provide important insights on successful program features as well as gaps that still exist.

V. Future Research

Future Research

Investing in youth and their families to prevent homelessness will require resource allocation. In order to change current funding structures to value prevention, a cost-benefit analysis should be completed on preventing a youth from becoming homeless. Analysis should include the cost of investing in and supporting families in the prevention of homelessness versus the costs associated with the life of a homeless person. Costs will include multi system use like child welfare services, housing into adulthood, crime often fueled by addictions, and resulting healthcare costs from risk taking behaviours.

As programs are developed, it will be critical to evaluate the program's accomplishment in meeting its objectives and outcomes. Frankish, Hwang & Quantz (2002) suggest that rarely does research assessing the homeless' needs translate into programs with matching objectives and intervention. What is a meaningful intervention to youth in Edmonton? An attempt at this is Phase II of the *Support Intervention for Homeless Youth*. Community agencies need support to develop the expertise in evaluating the projects they continue to fund.

Another recommendation for future research is determining what housing options youth prefer and provide success for youth. Youth bouncing in and out of a variety of care options does not provide them with a long term secure environment; nor does it allow youth to develop a relationship with a key individual. Do service providers have the skills and resources to work with youth who may have multitude of care needs including mental health, addictions and criminal involvement? Is there a role for harm reduction in these programs that would decrease the barriers to youth accessing service? A longitudinal study of youth moving through children's services with a successful exit may provide insight into what factors aid in success (Serge et al., nd.). Another study could evaluate the effect of increasing the exit ages of programs and youth success (Serge et al., n.d.).

A final recommendation for future research would be to gain an understanding of the barriers to accessing healthcare in Edmonton and what motivates clients to access care. Canada provides universal access to health care for residents; despite this, homeless people have poorer health outcomes. The evaluation of primary care delivery systems in meeting the needs of homeless people is paramount, as health care dollars are invested in outreach services for the homeless.

Limitations of the Research

Several overall limitations of the studies reviewed should be noted. Most of the data collected in the studies used self-reports, the most common method used in studying street-involved youth. However, due to the sensitive nature of topics in the questionnaire, such as child abuse, prostitution or illicit drug use, youth may underestimate their involvement in these activities.

Another limitation of the studies is sample representativeness. It is extremely difficult to establish population characteristics of street youth, due to the transient nature of the population, and the lack of an accurate estimate of population size. Recruiting youth from community based organizations (CBO), as done by all three studies, introduces potential selection bias, as youth not accessing these services are excluded from participation. Street youth accessing CBO have a degree of community awareness. Both street youth disengaged from community resources and youth banned from CBO would be populations missed by this study. In all cases, attempts were made to make the sample as representative as possible by selecting individuals from a variety of locations and with a variety of demographics (e.g. different genders and ethnic backgrounds). The similarities between the two phases of the *Enhanced STD Surveillance of Canadian Street Youth* lend support for the representative nature of the respondents surveyed.

Conclusion

This review of three studies of homeless youth in Edmonton found similar findings. Many of our street youth have multiple needs and participate in behaviours that place them at risk for health consequences. Youth lack permanent housing, are without stable incomes, have dropped out of school and have addiction issues. Youth and service providers report the need for comprehensive service delivery, where youth can access services for all of their needs. A few examples of services in Edmonton have been provided. Future studies need to evaluate these services for their strengths and gaps to meet the future needs of homeless youth.

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